MassMutual Agents’ Welfare Benefits Plan
Group Term Life and
Group Variable Universal Life Insurance Options
Summary Plan Description
for Career Agents, General Agents and General Managers and
Retired Career Agents, Retired General Agents and Retired General
Managers of MassMutual

Effective January 1, 2014

This Summary Plan Description (SPD), published in February 2014, takes the place of any SPDs and Summaries of Material Modifications (SMMs) previously issued to you describing your benefits.
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Disclaimer

This Summary Plan Description (SPD) provides details of the group term life and group variable life insurance options for MassMutual agents and retired agents available through the MassMutual Agents’ Welfare Benefits Plan, MassMutual Retired Agents’ Welfare Benefits Plan and the Massachusetts Mutual Group Variable Universal Life (GVUL) Insurance Plan for Top Producers (collectively referred to as the “Plan”). This SPD contains detailed and important information about the Plan; every attempt has been made to communicate this information clearly and in easily understandable terms. This SPD replaces and supersedes all previous SPD versions and Summaries of Material Modifications (SMMs).

Benefits are determined under the terms of the Plan in effect at the time you become eligible for the specific benefits. Benefits are based on current laws and regulations, which are subject to change. Massachusetts Mutual Life Insurance Company (“the Company” or “MassMutual”) reserves the right to modify, revoke, change, suspend or terminate any one or all plans, programs, policies, benefits or services described in this SPD or the underlying Plan documents at any time and from time to time. This SPD does not guarantee any particular benefit. Receipt of this SPD describing the Plan or option for which you are not eligible does not imply that you are eligible. To be entitled to benefits, you must meet the Plan’s eligibility requirements.

In the event of a discrepancy between descriptions in this SPD and information in relevant Plan documents, the Plan documents will govern.

Career contract and general agents are independent contractors; provision of benefits does not change that relationship.
Introduction

Once your career contract is endorsed, you automatically receive basic group term life and accidental death and dismemberment insurance coverage. In addition you have the option of electing supplemental life insurance coverage for yourself and dependent life insurance for your spouse/domestic partner and/or eligible dependent children.

If you meet qualification requirements for Strategic Group Variable Universal Life (GVUL) insurance, you will receive an informational package from MassMutual Executive Group Life (EGL) before April 1 each year.

See Appendix A – Group Term Life (GTL) Insurance Certificate for details and coverage provisions for group term life insurance. If enrolled in GVUL, refer to your individual GVUL policy for details and coverage provisions.
## Contact Information

<table>
<thead>
<tr>
<th>Resource</th>
<th>Benefit</th>
<th>Participant Website</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Producer Services and Operation</td>
<td></td>
<td>Website: <a href="https://mmfgonline.massmutual.com">https://mmfgonline.massmutual.com</a> Email: <a href="mailto:AgentBenefitQuestions@MassMutual.com">AgentBenefitQuestions@MassMutual.com</a></td>
<td>800-767-1000, Ext. 48850 on business days, 8 a.m. to 6 p.m., ET.</td>
</tr>
<tr>
<td>MassMutual Executive Group Life (EGL)</td>
<td>Group variable universal life insurance</td>
<td>Website: <a href="http://www.massmutual.com">www.massmutual.com</a> Email: <a href="mailto:LCMClientServices@MassMutual.com">LCMClientServices@MassMutual.com</a></td>
<td>800-548-0073</td>
</tr>
<tr>
<td>UniCare</td>
<td>Group term life, accidental death and dismemberment and dependent life insurance</td>
<td>Website: <a href="http://www.unicare.com">www.unicare.com</a></td>
<td>800-552-2137</td>
</tr>
</tbody>
</table>
Group Term Life (GTL) Insurance

**Note:** Information in this section is a brief overview of group term life insurance; see Appendix A – Group Term Life (GTL) Insurance Certificate for detailed information. Also, refer to the Group Variable Universal Life (GVUL) Insurance section for information about that coverage.

**Eligibility**

**Eligible Participants**

You are eligible for group term life insurance coverage under the Plan if you have an active Career Agent (including sales managers), General Manager (GM) or General Agent (GA) contract with or endorsed by MassMutual. Your eligibility begins on the day your contract is endorsed and you enter active service, provided you meet MassMutual’s current commission requirements, as published annually. Producer Services and Operations will email a benefits enrollment kit to you, explaining your benefit options and how to enroll when you are newly contracted or during annual benefits enrollment each fall.

If you are a newly contracted agent, GA or GM, you must complete your enrollment within 30 days of your contract endorsement date. If you are an active career contract agent, GA or GM, you may generally change your life insurance benefits once a year during annual benefits enrollment (usually held in the fall). Your new benefit election becomes effective January 1 of the following year. You may also change your life insurance election if you have a mid-year qualifying event (see the Mid-Year Qualifying Event section) or if you become unsubsidized.

**If You Retire**

Company-paid retiree life insurance is not available if you retire on or after January 1, 2010. However, you may elect to continue a limited amount of group term life coverage at your own expense.

See Appendix A – Group Term Life (GTL) Insurance Certificate for more information about retiree group term life coverage.

**Ineligible Individuals**

You are not eligible if you are:

- An employee of MassMutual or one of its affiliates;
- A broker;
- An agency staff member;
- A career agent holding a corporate contract entered into on or after January 1, 2011;
- A temporary or leased employee;
- A person formerly under contract with or employed by an agent, formula general agent or general agent or broker who is placed on MassMutual’s payroll during a transition period in which there is no general agent in the agency office;
- A person under contract with or employed by a general agent or by an agent of the general agent in sales support, including, but not limited to, secretaries and development and district office clerks;
- A person otherwise excluded by the specific Plan terms; or
- A person who fails to satisfy qualification requirements.
Eligible Dependents – Dependent Life Insurance

Eligible dependents include your:

- Current legally married spouse or domestic partner; and
- Children (including your spouse’s or domestic partner’s children).

Note: See Appendix A – Group Term Life (GTL) Insurance Certificate for eligible dependent requirements.

If your marriage is annulled, you become divorced or end a domestic partnership, your ex-spouse’s/partner’s dependent life insurance coverage will end on the date your annulment or divorce becomes final or your domestic partnership ends. Your ex-spouse or ex-partner will have the opportunity to convert the dependent life insurance coverage to an individual policy, if requested within 31 days of when participation ends (see Appendix A – Group Term Life (GTL) Insurance Certificate for more information about converting coverage).

To cover a domestic partner, you must submit a signed Affidavit of Domestic Partnership form and three forms of supporting documentation.

If your domestic partnership terminates, you must submit a signed Termination of Domestic Partnership form to remove a domestic partner from your coverage within 30 days of the termination of your partnership. Note: You cannot enroll a new domestic partner as a dependent for at least 12 months following the removal of a previous domestic partner or marriage.

The above forms are available online at FieldNet/My Practice/Benefits/myBenefits/Forms/Benefit Forms.

Important Notes

- You must inform Producer Services and Operations of new dependents within 30 days for a spouse or domestic partner or within 90 days after a child is born or placed with you for adoption. You must also agree to make any required payments to enroll the dependent for coverage.
- MassMutual reserves the right to verify a dependent’s eligibility status for Plan coverage at any time, or from time to time, by requiring you to provide supporting documentation.

Enrollment

Basic life and accidental death and dismemberment (AD&D) insurance coverage begins on the date your career contract is endorsed by MassMutual. Supplemental life (with corresponding AD&D coverage) and dependent life insurance begin on the date your career contract is endorsed, provided you enroll within 30 days of eligibility. If you enroll in supplemental or dependent life insurance during annual benefits enrollment, coverage becomes effective the following January 1.

If you do not enroll within 30 days of your contract endorsement date, you will not have the opportunity to elect supplemental or dependent life insurance until the next annual benefits enrollment period, usually held in the fall, unless you have a mid-year qualifying event; see the Mid-Year Qualifying Event section.

Note: You must be actively in service as a career contract agent, general agent or general manager for your group term life insurance to begin on the date it would normally begin. If your dependent (excluding newborns) is disabled or confined to a bed in a hospital or at home at the time dependent life insurance would normally begin, the dependent life insurance coverage will not begin until the dependent is no longer disabled or no longer confined to a bed in a hospital or at home (see Appendix A – Group Term Life (GTL) Insurance Certificate for more information).
Proof of Good Health/Evidence of Insurability

Proof of good health, also known as Evidence of Insurability (EOI), is not required during initial enrollment for coverage elections up to five times benefits pay. However, EOI is required during initial enrollment if you elect more than five times benefits pay. You may not have to provide EOI if you can document that you are duplicating a GTL benefit of equal value immediately before joining MassMutual. Proof of prior coverage must be submitted to and approved by the insurer. If approved, coverage will be available up to the Plan’s normal limits at initial enrollment. If you are a GA or GM, you duplicate prior coverage only for your first two years of service with MassMutual; thereafter, available coverage is determined under the Plan’s normal benefit schedule.

In addition, proof of good health will be required, if, during an annual benefits enrollment period, you elect:
- To increase your coverage by more than one times your benefits pay if your current election is less than six times your benefits pay; or
- An option of six or more times your benefits pay.

Coverage requiring proof of good health is not effective until it is approved by the insurer. If you enroll due to a mid-year qualifying event, proof of good health is due as soon as possible.

Note: This does not apply to general agents and general managers; refer to Appendix A – Group Term Life (GTL) Insurance Certificate for more information.

Annual Benefits Enrollment

You may change your supplemental life insurance coverage (if you are younger than age 65) and dependent life insurance coverage once a year during annual benefits enrollment and when you have a mid-year qualifying event; see the Mid-Year Qualifying Event section. (If you are age 65 or older, you may not change your supplemental life election during annual benefits enrollment.) Any changes you make during annual benefits enrollment become effective the following January 1.

During annual benefits enrollment, you may:
- Elect coverage, if previously waived;
- Increase or decrease your coverage amount; or
- Decline coverage.

To enroll during annual benefits enrollment, you must enroll by the deadline listed in your enrollment materials. If you do not make any changes to your supplemental or dependent life insurance coverage during annual benefits enrollment, your coverage stays the same, subject to any new Plan provisions and costs.

Mid-Year Qualifying Event

You may make a change to your supplemental or dependent life insurance coverage if you have a mid-year qualifying event, as defined by the Internal Revenue Code (IRC). If you have a mid-year qualifying event, you may be able to change your existing level of supplemental coverage (e.g., from one times to two times your benefits pay) or you may elect or decline dependent life coverage. Any change due to a mid-year qualifying event must be consistent with the mid-year qualifying event under the Plan and the tax rules.

Mid-year qualifying events include:
- A change in your legal marital status, such as marriage, the death of a spouse, divorce or legal annulment;
- A change in your, your spouse’s or your dependent’s employment status (such as a termination or commencement of employment, a strike or lockout, commencement or return from a leave of absence, a change in worksite or a change in employment status that results in a loss or gain of eligibility for coverage;
• A change in the number of your dependents, due to birth, death, legal adoption, placement for adoption, addition of a foster child or addition of child for whom you have become a legal guardian; and
• Your covered dependent becoming eligible or ineligible (e.g., due to age).

Changes you make due to a mid-year qualifying event become effective as of the date of your mid-year qualifying event.

To make changes to your coverage, you must notify Producer Services and Operations and provide appropriate documentation within 30 days of the event (or 90 days in the case of birth, adoption or placement for adoption). Otherwise, you will have to wait until the next annual benefits enrollment to make the change, effective on January 1 of the following calendar year. If you have any questions regarding mid-year qualifying events, contact Producer Services and Operations.

Designating Beneficiaries

When you choose a coverage amount during annual benefits enrollment, you must designate a beneficiary. You may change your beneficiary at any time by logging on to the enrollment portal (https://benedirect.massmutual.com/irj/portal) and selecting Maintain Dependents/Beneficiaries.

As the Plan participant, you are always the beneficiary for dependent life insurance.

Note: See Appendix A – Group Term Life (GTL) Insurance Certificate for more information about beneficiaries.

Amount of Coverage

See Appendix A – Group Term Life (GTL) Insurance Certificate for information about the amount of basic and supplemental life, AD&D and dependent life coverage for which you may be eligible.

Cost of Coverage

MassMutual pays the full basic group term life insurance and accidental death and dismemberment coverage premium provided you meet your minimum production requirements.

You pay the full premium of any supplemental group term life insurance and dependent life insurance you elect on an after-tax basis:
• Supplemental life insurance rates are based on your current benefits pay (see Appendix A – Group Term Life (GTL) Insurance Certificate for more information) and your age on December 31 of the prior plan year.
• Dependent life insurance rates are based on your age.

Imputed Income

The value of group term life insurance in excess of $50,000 is required to be reported as taxable income. This amount, known as “imputed income,” is assigned a value by the Internal Revenue Service for federal income tax, FICA and some state and/or local income taxes. The imputed income amount will be stated on your pay statement under GTL IMP.

Note: If applicable, you may elect coverage of a flat $50,000 if you do not want imputed income.
## Imputed Income Worksheet

### Monthly Imputed Federal Income Tax Factors (effective July 1, 1999)

<table>
<thead>
<tr>
<th>Age</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 25</td>
<td>0.05</td>
</tr>
<tr>
<td>25 – 29</td>
<td>0.06</td>
</tr>
<tr>
<td>30 – 34</td>
<td>0.08</td>
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<td>35 – 39</td>
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<td>40 – 44</td>
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<tr>
<td>55 – 59</td>
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<td>0.66</td>
</tr>
<tr>
<td>65 – 69</td>
<td>1.27</td>
</tr>
<tr>
<td>70 +</td>
<td>2.06</td>
</tr>
</tbody>
</table>

To calculate your imputed income for total life insurance and to estimate your monthly FICA and federal income taxes on this imputed income, follow the steps below:

### Step

1. Write your total life insurance election to the right

2. Subtract $50,000 from your total life insurance election

3. Life insurance subject to imputed income

4. Divide the result from Step 3 by $1,000

5. Multiply your answer from Step 4 by the appropriate factor listed in the Monthly Imputed Federal Income Tax Factors chart above

6. Monthly imputed income

7. Estimate the tax owed on your monthly imputed income from Step 6 by multiplying it by your federal tax rate (generally, either 15% or 28%*) and the combined FICA tax rate of 0.0565 (OASDI is 0.042; HI is 0.0145)

*For a general estimate, we suggest using the 15% federal tax rate if your combined taxable family income is less than $30,000 or the 28% federal tax rate if your combined taxable family income is greater than $30,000; state income tax may also apply.

### Basic and Supplemental Life Insurance

For specific information about your GTL basic life and AD&D and supplemental and dependent life insurance, refer to Appendix A – Group Term Life (GTL) Insurance Certificate, which includes information on:

- How the Plan works;
- Benefit amounts and limits, including retiree coverage;
- Additional coverage the Plan provides;
- Coverage exclusions;
- Claims and appeals procedures; and
- Definitions of terms with special meanings.
About Your Coverage

If You Become Disabled

If your career contract is maintained while you are receiving long term disability benefits, your group term life insurance, including AD&D coverage and dependent life coverage, may continue on an after-tax basis. The amount of your group term life coverage in effect at the time of your disability is frozen. You may be eligible for a waiver of premium for basic and supplemental coverage if you become disabled before age 65, as described below.

Waiver of Premium

A waiver of premium is available for your group term basic and supplemental life insurance, effective June 1, 2001. If you become totally disabled on or after this date and before age 65, your group term life insurance may be continued at no cost to you if you meet the insurer’s requirements for total disability and waiver of premium after you have been disabled for six months. If your waiver of premium ends, you may convert your group term basic and supplemental life insurance to an individual policy within 31 days of the denial of your waiver request. See Appendix A – Group Term Life (GTL) Insurance Certificate for more information.

To apply for a waiver of premium, contact UniCare (see the Contact Information section). You must apply and be approved for a waiver of premium within 12 months of the disability date.

Continuation of Insurance Benefit: If you became disabled between January 1, 2001, and May 31, 2001, and meet the life insurer’s requirements for disability or are receiving disability income benefits from a group or individual policy, MassMutual will continue to pay premiums until the earliest of the end of total disability (as determined by the insurer), age 65 or your retirement date.

Loss of Coverage

If you lose coverage due to a termination of your career contract or attaining age 65, you may convert your group term basic and supplemental life insurance coverage that is lost to an individual policy. If your dependent loses dependent life insurance coverage due to your ineligibility, termination of your career contract or your dependent ceasing to be a qualified dependent due to age, your dependent may convert dependent life coverage to an individual policy. See Appendix A – Group Term Life (GTL) Insurance Certificate for more information about converting coverage.

Note: Accidental death and dismemberment insurance cannot be converted.

When You Turn Age 65

At age 65, your accidental death and dismemberment coverage ends. Your basic and supplemental group term life insurance coverage is frozen and then begins to reduce annually for a period. Refer to Appendix A – Group Term Life (GTL) Insurance Certificate for more information about what happens when you reach age 65.

If You Die

If you die, dependent life insurance ends on the date of your death. However, your surviving dependents who are covered under this Plan when you die will be offered the opportunity to convert their group coverage to an individual policy. To convert coverage, your dependents must apply in writing and pay the first premium within 31 days of your death (see Appendix A – Group Term Life (GTL) Insurance Certificate for more information about the right to convert coverage).
When Participation Ends

Your group term basic life insurance (including AD&D) coverage ends on the earliest of the date:

- You die;
- Your career contract ends;
- The policy is terminated;
- The Plan is terminated or amended to limit eligibility; or
- You do not pay the required premium as scheduled (if you are unsubsidized).

Your group term supplemental life (and corresponding AD&D) and/or dependent life insurance coverage end on the earliest of:

- The date you do not pay the required premium as scheduled;
- The date you or your dependent no longer meet the eligibility requirements;
- The January 1 following an annual benefits enrollment period in which you decline supplemental or dependent life insurance;
- The date the policy is terminated;
- The date the Plan is terminated or amended to limit eligibility; or
- The date your career contract terminates.

Conversion to an Individual Policy

If group term life insurance coverage ends for you or a covered dependent, the coverage may be converted to an individual policy if written application is made, using necessary forms, and the first premium is paid within 31 days. Some restrictions apply. See Appendix A – Group Term Life (GTL) Insurance Certificate for more information about converting coverage.

Claiming Benefits

Group term life insurance benefits include basic life, supplemental life, dependent life and AD&D insurance, which are administered by UniCare. UniCare’s decisions are final and binding under the terms and conditions of the group life insurance policies.

For help filing a claim, contact Producer Services and Operations (800-767-1000, Ext. 48850 or AgentBenefitQuestions@MassMutual.com).

To File a Death Claim

Upon your death, your beneficiary must contact Producer Services & Operations within 30 days after a covered loss occurs or as soon as reasonably possible. Your beneficiary will be provided with required forms and deadlines. When filing a claim, your beneficiary must include a certified copy of the death certificate (if applicable) and a completed claim form.

To File a Dismemberment Claim

Upon your loss, you should follow the instructions above and submit proof of loss to receive benefits. The loss must be directly related to the injuries from the accident and have taken place within a year of the accident. When filing a claim, you must include a completed claim form.
**Appeal Procedures**

If a claim for benefits is denied or reduced, you may appeal the decision. To initiate a claim review, send a written request for claim review to UniCare. See [Appendix A – Group Term Life (GTL) Insurance Certificate](#) for information on the claims and appeals process.

**Exception:** Send appeals related to Plan eligibility matters (including loss or denial of coverage) within 180 days of loss or denial of coverage to the Claims Review Committee. If your appeal to the Claims Review Committee is denied, you may initiate a second-level appeal with the Plan Administrative Committee. Decisions made by the Plan Administrative Committee are final. The Claims Review and Plan Administrative Committees may be contacted at:

MassMutual Benefits  
1295 State Street, F105  
Springfield, MA 01111-0001

**Legal Action**

The Plan is governed by ERISA. For ERISA programs, you have the right to bring a civil action under ERISA Section 502(a) if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against the Plan until you have completed the appeal processes.

No action may be commenced more than six months following the decision of an appeal.

**Right of Recovery**

If for some reason a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency that received it. UniCare, as this Plan’s representative, must produce any instruments or papers necessary to ensure the right of recovery, unless prohibited by law, and present them to the person receiving benefits.
Group Variable Universal Life (GVUL) Insurance

As an added incentive to certain high-producing agents, MassMutual offers a $150,000 Company-paid Group Variable Universal Life (GVUL) insurance benefit if you are ages 18 to 75 and meet the qualification requirements under the Massachusetts Mutual Group Variable Universal Life Plan for Top Producers (GVUL Plan) and the underwriting requirements of the insurer. Although this program is summarized here, it is not part of the MassMutual Agents’ Welfare Benefits Plan.

Strategic Group Variable Universal Life (GVUL) Insurance, a MassMutual product, provides $150,000 of GVUL coverage to you if you meet the qualifications. In addition, you have the option of setting aside money on an after-tax basis in the policy’s Guaranteed Principal Account (GPA), an interest bearing account. In addition to the GPA, several investment options are available upon activating the variable rider. Additional details and contribution limits are included with an information package you will receive from MassMutual Executive Group Life Client Services if you are eligible for GVUL coverage. The account pays interest on a tax-deferred basis. Contributions are subject to certain taxes and a sales charge, which are described separately. The balance in your cash value account may be used to pay future premiums (if you do not qualify for a subsidy) or, if you die while insured under the policy, to pay a portion of the death benefit. The program is administered by MassMutual Executive Group Life. If you have questions, contact MassMutual Executive Group Life (see Contact Information).

Eligibility

To qualify, you must hold a career contract, earn the required level of Aggregated Agent Allowance Weighted Commission Credits (AAA WCC) and not be younger than age 18 or older than age 75 on the date coverage would begin (April 1 following the year in which you qualify). You must re-qualify each year by earning the required level of weighted commission credits. In 2014, the requirement is $66,000 in AAA WCC. The requirement is subject to change annually. Once you qualify, you can enroll during the designated enrollment period in the first quarter of the following year. You must enroll and complete an application to receive coverage.

Applying for Coverage

If you are a qualifying agent, you will be asked to apply for coverage during the annual GVUL application period by using MassMutual Executive Group Life’s online application process.

You must name your beneficiary when you apply online. For changes to your beneficiary(ies) after you have applied, complete a Change of Beneficiary form and return the completed form to the mailing address provided on the form. If you do not name a beneficiary, your benefit will be paid to your estate.

If you name more than one beneficiary, you must specify how you want the benefit divided (designations must be made in whole percentages). If you do not, the benefit will be divided equally among those listed.

To change your beneficiary, complete a Change of Beneficiary form and return the completed form to the mailing address provided on the form. To request a form, call MassMutual Executive Group Life (see the Contact Information section). Your new beneficiary designation is effective as of the date the signed form is received and found to be completed in good order by EGL.
When Participation Begins

Subject to enrollment and application approval, coverage begins April 1 following the year in which you qualify, provided you are in active service for the 90 days preceding the date coverage is to start and you are not receiving, nor entitled to receive, long-term disability benefits. Coverage generally continues for a 12-month period. You must qualify each year by earning $66,000 of AAA WCC.

Underwriting

For newly qualified agents:

- Guaranteed issue underwriting is available if you are a member of the eligible age group of age 18 through 70, to a maximum of $150,000;
- Simplified issue underwriting is available if you are a member of the eligible age group of age 71 through 74, to a maximum of $150,000; or
- Full underwriting is required if you are a member of the eligible age group of age 75.

Note: If you are younger than age 18 or older than age 75, you are not eligible for GVUL coverage.

To qualify for the above underwriting criteria, you must submit an application for coverage within 60 days of becoming a member of the eligible age group.

Additional underwriting requirements or evidence of insurability may be required if you were previously eligible for coverage but did not apply for that coverage.

GVUL Coverage

For specific information about your GVUL coverage, refer to your policy or the latest prospectus, which include information on:

- Supplemental coverage;
- Accelerated benefit plan;
- Waiver of premiums;
- Coverage exclusions;
- Claims and appeals procedures; and
- Definitions of terms with special meanings.

When GVUL Participation Ends

Company-paid coverage ends on the last day of the month following the month in which one of the following occurs:

- Termination of your career contract;
- Retirement;
- Change to agent emeritus status;
- Change to broker status; or
- You are otherwise ineligible.
If you fail to meet the weighted commission credit requirements necessary to qualify for the Strategic Group Variable Universal Life (GVUL) Insurance subsidy, Company-paid coverage ends the following March 31.

The policy becomes portable and you may continue coverage by paying the full premium yourself. Contact MassMutual Executive Group Life for details (see the Contact Information section).

**Other Information**

For each year in which you qualify, MassMutual pays the full cost for $150,000 of GVUL coverage. However, the value of the coverage must be treated as income. Additional details, including policy illustrations, are provided in the application materials you will receive if you qualify for coverage. If you have questions about policy features, including loans, surrenders, withdrawals, transfers, ownership changes or beneficiary changes, call MassMutual Executive Group Life Client Services (see the Contact Information section).

**Accelerated Benefit Plan**

The accelerated benefit plan provision pays a benefit when a legally qualified doctor certifies that death is expected within 12 months. You may receive a portion of your Strategic Group Variable Universal Life (GVUL) Insurance death benefit (less an administrative fee of up to $250); the remaining benefit will be paid to your beneficiary(ies) upon your death. This is a one-time election. You cannot elect an additional amount later.

**Note:** A legally qualified doctor is a physician licensed in the state in which he or she practices medicine and who is acting within the scope of that license. A legally qualified physician cannot be the insured individual and may not be a spouse, mother-in-law, father-in-law, step parent, natural or adoptive brother, sister, parent, grandparent or child. Certification must be provided by a legally qualified physician who has diagnosed the terminal illness. MassMutual may require an examination by a physician of its choice, at its expense, to verify terminal illness. You must comply with any such request within 90 days of the date it is requested by MassMutual.

**Limitations**

You are not eligible to receive an accelerated benefit for Strategic Group Variable Universal Life (GVUL) Insurance if you are required to request the payment by any third party or as the result of a court order. A third party includes any creditor, government agency or trustee in bankruptcy.

To be considered for an accelerated benefit, you must make a request in writing to MassMutual EGL Client Services. You must include with your request your written permission to release your medical records as well as the written consent of any assignee and any beneficiary entitled to a benefit from the plan. An accelerated benefit may be taxable. You may want to seek tax advice before requesting an accelerated benefit (see the Contact Information section).

If you receive an accelerated benefit, the death benefit will be reduced by the amount of the accelerated benefit.

If you receive an accelerated benefit, and you are paying the premium for your Strategic Group Variable Universal Life (GVUL) insurance coverage, you must continue making contributions for the cost of the coverage to maintain the coverage. Your contributions will be based on the reduced amount of your Strategic GVUL insurance coverage.
Waiver of Premium

If you become disabled you may qualify for a waiver of premium. You must be totally disabled for six months (as defined in the policy) and be younger than age 65. To apply for a waiver of premium, contact MassMutual EGL and request the necessary form. Complete the form and return it promptly to the mailing address on the form (see the Contact Information section).

If you are granted a waiver of premium, it will take effect six months after your disability date and continue until the date you are no longer disabled, you attain age 65, or you retire, whichever occurs first. If your request for a waiver of premium is denied, you may, if you want, continue your Strategic GVUL insurance coverage by paying the required premiums directly to MassMutual EGL Client Services. For rates and payment information, contact MassMutual EGL. If you retire, you may continue your Strategic GVUL Insurance coverage by paying full premium costs directly to MassMutual EGL. For rates and payment information, contact MassMutual EGL (see the Contact Information section).

Claiming Benefits

Group variable life insurance benefits are administered by MassMutual Executive Group Life. MassMutual Executive Group Life’s decisions are final and binding under the terms and conditions of the group life insurance policies. To file a claim, contact MassMutual Executive Group Life (see the Contact Information section).

If your claim is denied in whole or in part, you or your beneficiary will receive a written notice of the denial within a reasonable period, but not later than 90 days after receipt of your claim. The 90-day period may be extended up to a total of 180 days if special circumstances require additional time to process your claim. If an extension is necessary, you will be notified, in writing, before the end of the 90-day period of why the extension is needed and the expected decision date.

If Your Claim Is Denied or Reduced

If a claim for benefits is denied or reduced, you or your beneficiary will be notified in writing of the reason for the denial. The notice will include:

- The specific reason or reasons for denial with reference to specific GVUL Plan provisions on which the denial is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;
- A description of the GVUL Plan’s appeals procedures and time frames, including a statement of your right to bring a civil action under ERISA following an adverse decision on appeal; and
- If applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, other similar criterion was relied upon and a copy thereof will be provided free of charge upon request.

Appeals Procedures

If your claim is denied or reduced, you may, within 60 days, submit an appeal to MassMutual Executive Group Life. Appeals must be in writing, signed and dated and include:

- A copy of the denial;
- Any additional documentation that supports the approval of the claim (such as written comments, documents, records or any other information you feel will support your claim); and
- The specific reasons why you think the claim should be reconsidered and approved.
You may request to review any pertinent documents. You may also request, free of charge, copies of all documents, records and information relevant to your claim.

A final written decision will be made on your claim within 60 days of receipt of the appeal. Specific reasons for the decision and references to GVUL Plan provisions on which the decision was based will be given. The 60-day period may be extended for another 60 days if special circumstances warrant an extension of time. If an extension of time for review of your appeal is required because of special circumstances, written notice will be furnished to you before the extension begins. If you do not receive a decision on your appeal by the end of the first 60-day period plus any required extension, you should consider your appeal denied. The decision on appeal is final and binding under the terms and conditions of the group life insurance policies.

**Exception:** Send appeals related to Plan eligibility matters (including loss or denial of coverage) within 180 days of loss or denial of coverage to the Claims Review Committee. If your appeal to the Claims Review Committee is denied, you may initiate a second-level appeal with the Plan Administrative Committee. Decisions made by the Plan Administrative Committee are final. The Claims Review and Plan Administrative Committees may be contacted at:

MassMutual Benefits  
1295 State Street, F105  
Springfield, MA 01111-0001

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- The specific reason or reasons for the adverse determination;
- Reference to specific plan provisions on which the determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other relevant information as defined;
- A statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to bring an action under ERISA section 502(a); and
- Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal.

**Relevant Information**

Relevant information is any document, record or other information that:

- Was relied upon in making the benefit determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
Legal Action

The GVUL Plan is governed by ERISA. For ERISA programs, you have the right to bring a civil action under ERISA Section 502(a) if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against the GVUL Plan until you have completed the appeal processes.

No action may be commenced more than six months following the decision of an appeal.

Right of Recovery

If for some reason a benefit is paid that is larger than the amount allowed by the GVUL Plan, the GVUL Plan has a right to recover the excess amount from the person or agency that received it. MassMutual Executive Group Life, as the GVUL Plan’s representatives, must produce any instruments or papers necessary to ensure the right of recovery, unless prohibited by law, and present them to the person receiving benefits.
Plan Information

The information presented in this SPD is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974.

Plan Name and Number

Group Term Life for Agents: MassMutual Agents’ Welfare Benefits Plan, 506
Group Term Life for Retired Agents: MassMutual Retired Agents’ Welfare Benefits Plan, 546
Group Variable Universal Life: Massachusetts Mutual Group Variable Universal Life Plan for Top Producers, 539

Plan Administrator

The Plan Administrator is the Plan Administrative Committee, which is appointed by MassMutual’s Chief Executive Officer. The Plan Administrative Committee has the authority to control and manage the operations and administration of the Plan. You can reach the Plan Administrative Committee at:

Massachusetts Mutual Life Insurance Company
MassMutual Benefits
1295 State Street, F105
Springfield, MA 01111-0001
866-662-6448

Plan Sponsor

Massachusetts Mutual Life Insurance Company
1295 State Street, F105
Springfield, MA 01111-0001
866-662-6448

Employer Identification Number (EIN)

The EIN of Massachusetts Mutual Life Insurance Company is 04-1590850.

Plan Year

The Plan Year is January 1 through December 31.

Agent for Service of Legal Process

General Counsel of Massachusetts Mutual Life Insurance Company
1295 State Street
Springfield, MA 01111-0001

If legal action is necessary to settle a claim, any action may also be served upon the Plan Administrator.
Plan Type and Funding

This Plan is a welfare plan providing group term life insurance benefits on an insured basis in accordance with the provisions of Contract #1450, issued by UniCare Life & Health Insurance Company. Premiums are paid from the general assets of the Company and participant contributions, where applicable. The GVUL Plan is a welfare plan providing group universal life insurance benefits on an insured basis through policies issued by Massachusetts Mutual Life Insurance Company.

For subsidized agents, group term life premiums are paid by MassMutual for basic life and accidental death and dismemberment. Premiums for supplemental life insurance and dependent life insurance are paid by Plan participants. Unsubsidized agents pay the full cost of all group term life coverage. MassMutual pays the cost for $150,000 coverage for qualified GVUL participants.

Claims Administrator

The claims administrator for group term life insurance coverage (life insurance, supplemental life insurance, dependent life insurance, accidental death and dismemberment insurance) is UniCare. The claims administrator for group variable universal life is MassMutual Executive Group Life. See the Strategic Group Variable Universal Life Prospectus for more detailed information on GVUL coverage and features. Refer to the Contact Information section for details. The claims administrator has full discretion and fiduciary authority to determine claims and appeals arising under this Plan.

Type of Administration

Group term life insurance coverage (life insurance, supplemental life insurance, dependent life insurance, accidental death and dismemberment insurance) is provided through a group insurance policy issued to Massachusetts Mutual Life Insurance Company by UniCare Health & Life Insurance Company, 233 S. Wacker Drive, Suite 3700, Chicago, IL 60606. Group variable universal life insurance is provided through MassMutual Executive Group Life, 1295 State Street, Springfield, MA 01111-0001.

Continuation of the Plan

Although MassMutual does not now intend to terminate the benefits described in this SPD, nevertheless it reserves the right to modify, revoke, change, suspend or terminate the Plan, policies, benefits or services described here or in the underlying Plan document at any time or from time to time, with or without notice.
ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator’s office or other specified locations, such as worksites, all documents governing the Plan. These include any insurance contracts and copies of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request, copies of documents governing the operation of the Plan. These include any insurance contracts and copies of the latest annual report (Form 5500 series) and current Summary Plan Description. A reasonable charge may be required for the copies.
- Receive a summary of the Plan’s annual financial report (summary annual report), which is required by law to be provided to each member.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan’s claim and appeal procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a Plan document or the latest annual report and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator’s control.

If you have a claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan’s money or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
**Assistance with Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in getting documents from the Plan Administrator, you should contact the nearest office of EBSA or the national office at:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue NW  
Washington, DC 20210  
866-444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).
Appendix A – Group Term Life (GTL) Insurance Certificate

Note: Appendix numbering restarts with page 1 of certificate.
IMPORTANT NOTICE

This booklet contains a Personal Accelerated Death Benefit provision within the Personal Life Insurance section. Benefits are payable as shown on the Schedule of Benefits. Please refer to the Personal Accelerated Death Benefit provision of this booklet for a complete benefit description.

This Personal Accelerated Death Benefit is **NOT** a long-term care policy or a nursing home insurance policy. You may use your Personal Accelerated Death Benefit for any purpose.

**PERSONAL LIFE INSURANCE AND SUPPLEMENTAL LIFE INSURANCE BENEFITS, IF ANY, WILL BE REDUCED IF YOU ARE PAID A PERSONAL ACCELERATED DEATH BENEFIT.**

**RECEIPT OF PERSONAL ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS, BUT NOT LIMITED TO, MEDICAID.**

**RECEIPT OF PERSONAL ACCELERATED DEATH BENEFITS MAY BE TAXABLE**

Agents, General Agents and General Managers
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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.
CERTIFICATE

UniCare Life & Health Insurance Company certifies that it has issued Group Policy Number GI 1450 to

MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY
(herein called the Plan Sponsor)

insuring certain Agents, General Agents and General Managers under Career Contract with the Plan Sponsor. This booklet describes the benefits provided as of January 1, 2014. Certain terms of the Group Policy which affect your insurance are contained in the following pages.

The Group Policy was issued in the Commonwealth of Massachusetts. Its laws and rules will govern in resolving any questions about the Group Policy.

While you remain insured, this booklet is your Certificate of Insurance. It replaces any prior booklet given to you for the types of insurance described here.

233 S. Wacker Drive, Suite 3700
Chicago, IL  60606

UniCare Life & Health Insurance Company

[Signature]

President
SCHEDULE OF BENEFITS

The amounts of Personal and Dependent Insurance shown on your Statement of Coverage form are determined by this schedule. You are not insured for any type of coverage for which your statement form shows the amount as “none”.

Changes due to your age or retirement are the only changes to become effective while you are disabled. Here, the term “disabled” means that an injury or illness prevents you from doing substantially all of your usual duties for the Plan Sponsor.

Changes in amounts of Dependent Insurance under this schedule are effective on the date they apply to the dependent provided the dependent is not disabled on that date.

PERSONAL BASIC LIFE, PERSONAL SUPPLEMENTAL LIFE, AND PERSONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE FOR AGENTS

Your Statement of Coverage shows your amounts.

The Plan Sponsor provides Personal Basic Life Insurance equal to one times your Earnings, not to exceed $50,000, at no cost to you. Accidental Death & Dismemberment (AD&D) coverage is automatically provided in an identical amount.

In addition to this Basic amount provided by the Plan Sponsor, you may elect one of the following Supplemental Life and AD&D coverage options at your cost:

<table>
<thead>
<tr>
<th>Option</th>
<th>Life Insurance</th>
<th>AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One times Benefits Pay (up to $150,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>2</td>
<td>Two times Benefits Pay (up to $250,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>3</td>
<td>Three times Benefits Pay (up to $350,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>4</td>
<td>Four times Benefits Pay (up to $450,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>5</td>
<td>Five times Benefits Pay (up to $550,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Coverage Level</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Six times Benefits Pay (up to $650,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>7</td>
<td>Seven times Benefits Pay (up to $750,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>8</td>
<td>Eight times Benefits Pay (up to $850,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>9</td>
<td>Nine times Benefits Pay (up to $950,000)</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
</tbody>
</table>

Coverage levels exceeding five times Benefits Pay require evidence of insurability; however, such evidence is not required if you are newly contracted and provide documentation sufficient to the Insurer that you are duplicating an employer provided coverage level in effect immediately prior to your contract date with the Plan Sponsor. Evidence of insurability is also required for a coverage level increase of more than one times Benefits Pay at any subsequent enrollment period.

The maximum amount of combined Basic and Supplemental Life Insurance available is $1,000,000. Your amount is rounded up to the next higher $100, if not already a multiple thereof.

**PERSONAL BASIC LIFE, PERSONAL SUPPLEMENTAL LIFE, AND PERSONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE FOR GENERAL AGENTS (GA) AND GENERAL MANAGERS (GM)**

Your Statement of Coverage shows your amounts.

The Plan Sponsor provides Personal Basic Life Insurance equal to $50,000, at no cost to you. Accidental Death & Dismemberment (AD&D) coverage is automatically provided in an identical amount.

In addition to this Basic amount provided by the Plan Sponsor, you may elect one of the following Supplemental Life and AD&D coverage options at your cost. During the first calendar year of service, the amount of Supplemental Life and AD&D insurance is calculated annually based on a rolling three-year average of agency first-year commissions (FYC). The amount for a GA or GM with more than one calendar year but less than three calendar years is calculated based on the average of calendar years of service completed. However, the above calculations will not apply during your first 2 years of service if you are newly contracted and provide documentation sufficient to the Insurer that you are duplicating an
employer provided coverage level in effect immediately prior to your contract date with the Plan Sponsor.

<table>
<thead>
<tr>
<th>Option</th>
<th>Agency FYC</th>
<th>Life Insurance</th>
<th>AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Up to $999,999</td>
<td>$150,000</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>2</td>
<td>$1.0 to 1.99 million</td>
<td>$350,000</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>3</td>
<td>$2.0 to 2.99 million</td>
<td>$550,000</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>4</td>
<td>$3.0 to 3.99 million</td>
<td>$750,000</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
<tr>
<td>5</td>
<td>$4.0 + million</td>
<td>$950,000</td>
<td>Equal to Life Insurance Coverage</td>
</tr>
</tbody>
</table>

Coverage level increases of more than one Option at subsequent enrollment periods require evidence of insurability. The maximum amount of combined Basic and Supplemental Life Insurance available is $1,000,000.

**Reduction Schedule for Basic and Supplemental Life Insurance**

After you attain age 65, the amount of your Personal Basic and Supplemental Life Insurance may not be increased. Beginning on the first January 1st following your 65th birthday, the total amount of your Personal Basic and Supplemental Life Insurance is reduced by 10%. On each anniversary of your first reduction, the amount of your Personal Basic and Supplemental Life Insurance will be further reduced by the same dollar amount until your coverage is 50% of the amount you had when you reached age 65. Reduced amounts are rounded up to the next $100, if not already a multiple thereof. In no event will your total coverage be reduced below $10,000 nor can your total coverage be more than $300,000 for Agents or $500,000 for General Agents and General Managers.

**For Agents,** on your 65th birthday, if you had elected level 6, 7, 8, or 9 times for Supplemental Life Insurance, the multiple will be reduced to five times Benefits Pay, not to exceed a combined total of $600,000 ($50,000 basic and 5X Benefits Pay supplemental).

If you are contracted or become eligible for insurance at age 65 or later, your Basic Life Insurance amount, and any Supplemental Life
Insurance amount you elect, will be adjusted to reflect the reduction schedule described above.

**When You Become Retired**

**For Agents**, if you retire, your contract endorsement date was prior to January 1, 2000, you are at least 60 years of age and have six years of continuous service under a contract, you may continue your Personal Life Insurance up to the amount you had immediately preceding retirement, but not to exceed the coverage maximums as stated in the following sections for Agents. The same requirements for continuing Personal Life Insurance apply to you if your contract endorsement date is January 1, 2000 or later, but you must have 10 years of continuous service under a contract on your retirement date.

If you retire at age 65, you may continue your Personal Life Insurance if you have at least five continuous years of service under a contract up to the amount you had immediately preceding retirement, but not to exceed the coverage maximums as stated in the following sections for Agents.

**For Agents who retired before January 1, 2001 under the Plan Sponsor's retirement plan**

When you retire, the Plan Sponsor will provide you with Basic Life Insurance of the lesser of $50,000 or one times your pre-retirement Benefits Pay. You may continue Supplemental Life Insurance at your cost up to the amount you had immediately preceding retirement, but not to exceed four times your pre-retirement Benefits Pay or $450,000, whichever is less. The combined maximum amount of Basic and Supplemental Life Insurance available is $500,000. All amounts of insurance are subject to reduction at and after age 65 as described in the Reduction Schedule for Basic and Supplemental Life Insurance.

**For Agents who retired between January 1, 2001 and December 31, 2009 under the Plan Sponsor's retirement plan**

When you retire, the Plan Sponsor will provide you with Basic Life Insurance of the lesser of $10,000 or one times your pre-retirement Benefits Pay. You may continue the balance of your Basic Life Insurance and Supplemental Life Insurance at your cost up to the amount you had immediately preceding retirement. Supplemental Life Insurance cannot exceed four times your pre-retirement Benefits Pay or $450,000, whichever is less. The combined maximum amount of Basic and Supplemental Life Insurance...
available is $500,000. All amounts of insurance are subject to reduction at and after age 65 as described in the Reduction Schedule for Basic and Supplemental Life Insurance.

For Agents who are eligible to retire under the Plan Sponsor’s retirement plan on or after January 1, 2010

If you retire in 2010 or later and satisfy the Plan Sponsor’s eligibility criteria for retirement, you may continue, at your expense, life insurance under this Group Policy up to the amount you had immediately preceding retirement, but not to exceed Basic Life Insurance plus Supplemental Life Insurance up to four times your pre-retirement Benefits Pay or $450,000, whichever is less. The combined maximum of Basic plus Supplemental is $500,000.

Your Basic Life coverage options as an eligible retiree are:

- No Retiree life coverage
- $10,000
- One times your pre-retirement Benefits Pay up to $50,000

If you have elected Basic Life Insurance you may also elect one of the following Supplemental Life Insurance options;

- One times pre-retirement Benefits Pay up to $150,000, or
- Two times pre-retirement Benefits Pay up to $250,000, or
- Three times pre-retirement Benefits Pay up to $350,000, or
- Four times pre-retirement Benefits Pay up to $450,000

The maximum amount of combined Basic and Supplemental Life Insurance available is $500,000.

Your Basic and Supplemental Life Insurance are subject to reduction at and after age 65 as described in the Reduction Schedule for Basic and Supplemental Life Insurance.

For General Agents, if you retire and have at least 12 years of continuous general agent service under a contract, you may continue, at your expense, your Personal Life Insurance up to the amount you had immediately preceding retirement. All amounts of insurance are subject to reduction at and after age 65 as described in the Reduction Schedule for Basic and Supplemental Life Insurance.

For General Managers, if you retire, your contract endorsement date was prior to January 1, 2000, you are at least 60 years of age and have six years of continuous service under a contract, you may continue, at your expense, your Personal Life Insurance up to the
amount you had immediately preceding retirement. The same requirements for continuing Personal Life Insurance apply to you if your contract endorsement date is January 1, 2000 or later, but you must have 10 years of continuous service under a contract on your retirement date.

If you retire at age 65, you may continue, at your expense, your Personal Life Insurance if you have at least five continuous years of service under a contract up to the amount you had immediately preceding retirement.

All amounts of insurance are subject to reduction at and after age 65 as described in the Reduction Schedule for Basic and Supplemental Life Insurance.

PERSONAL ACCELERATED DEATH BENEFIT

If you are certified as being terminally ill and have a life expectancy of 12 months or less, you may make a one-time election to receive up to 50% of the Personal Life Insurance to which you are entitled while you are living.

However, the minimum Personal Accelerated Death Benefit the Insurer will pay is $10,000.

If the amount of your Personal Life Insurance is scheduled to reduce due to age within 12 months following the date you apply for a Personal Accelerated Death Benefit, your Personal Accelerated Death Benefit will be based on the reduced amount.
PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Your full amount is equal to your basic and supplemental amounts of Personal Life Insurance as shown earlier in this schedule. Additional benefits are shown below:

Additional Accidental Death Benefit if Death Occurs When a Seatbelt Was in Use

An amount equal to 10% of your Accidental Death Benefit to a maximum of $25,000.

Additional Benefit for Repatriation of Remains

Reimbursement up to $5,000

Additional Accidental Death Benefit While On Public Transportation

An amount equal to your AD&D benefit or $200,000, whichever is less.

PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE - TRAVEL STATUS

Your full amount is equal to your full amount of Personal Life Insurance with a minimum of $200,000 and a maximum of $1,000,000.

DEPENDENT LIFE INSURANCE

You may elect one of the following options:

Option 1
  For your spouse:........ $10,000
  For each child:......... $5,000

Option 2
  For your spouse:........ $20,000
  For each child:......... $10,000

Coverage amounts for Options 1 and 2 above require that your Personal Basic Life Insurance is equal to or greater than $20,000 for Option 1 or equal to or greater than $40,000 for Option 2.

All benefits payable are subject to the provisions, limitations and exclusions contained in the Group Policy.
BASIC TERMS

Here, some basic terms of the benefit plan are discussed. Where these terms are used in this booklet, they have the meaning explained here.

**Average Earnings:** the average of Earnings for up to the three most recent consecutive calendar years from the current contract date. There is no annualizing or proration of partial year earnings.

**Benefits Pay:** means Average Earnings except in the following circumstances:

1. For Financed Agents and Agents with a Contract Date within the current or preceding year: Use the greater of current year’s Career Contract commission requirement (currently $38,000) and Average Earnings.

2. For Agents and Sales Managers, with current contract dates within the current or preceding calendar year, who provide proof of similar financial services experience immediately prior to the current contract date: Use the greater of the average of substitute earnings and Average Earnings from their current contract date. No annualizing or proration of partial year earnings.

Substitute earnings are up to three calendar years of like commissions and management compensation immediately preceding the current contract date. Only those earnings as appropriate for their contract may be substituted; proof of prior experience and compensation must be provided.

In all circumstances described above, Benefits Pay will be updated annually and will apply for each 12-month period from April 1 through March 31 that an Agent or Sales Manager maintains a Career Contract at MassMutual.

**Covered Person:** a Plan Member or a dependent with respect to whom a Plan Member is insured by the Group Policy.

**Earnings:** First year and renewal commissions earned and paid by MassMutual (and reported as W-2 income) during the calendar year while a participant is a Career Agent, excluding MMLISI, MMLIAI and income from certain private placement products, as determined by the Plan Sponsor. In addition to the preceding, Earnings also include production compensation and deferred production compensation paid by MassMutual during the calendar year while a participant is a Sales Manager. Earnings also include financing
payments by MassMutual during the calendar year while a participant is a financed Agent.

**Injury and Illness:** In this plan, the word “injury” means an accidental bodily harm and the word “illness” means a sickness that impairs a covered person’s normal functioning of mind or body.

**Insurer:** Benefits are provided through a group insurance policy. The policy is issued by UniCare Life & Health Insurance Company (the “Insurer”), whose home office is located at 233 S. Wacker Drive, Suite 3700, Chicago, IL 60606-6309. Inquiries to the Insurer should be made to that office. Please include your Group Policy number as shown in the Certificate in the front of this booklet. The Claims and Plan Member Rights section of this booklet tells where and how benefit claims should be made.

**Personal and Dependent Insurance:** “Personal Insurance” means your insurance under the Group Policy with respect to yourself. The words “Dependent Insurance” refer to insurance for your dependents under the Group Policy. The Plan Membership section of this booklet discusses how you may obtain insurance under the Group Policy for yourself and your qualified dependents.

**Plan Member or Member:** a person who is a full-time Agent, General Agent or General Manager under Career Contract with Massachusetts Mutual Life Insurance Company and who is insured by the Group Policy with respect to himself or herself.

**Plan Sponsor:** the company who makes this benefit plan available to you.

**Retiree:** a former Massachusetts Mutual Life Insurance Company Agent, General Agent or General Manager who has retired in accordance with the Plan Sponsor’s eligibility criteria for retirement.
ELIGIBILITY FOR INSURANCE

This section describes how you may become insured. The term “Personal Insurance” means your insurance under the Group Policy with respect to yourself. Reference to “Dependent Insurance” means your insurance under the Group Policy with respect to your dependents.

Personal Insurance

You are eligible for Personal Insurance if you have an active Career Agent, General Agent (GA), or General Manager (GM) contract with or endorsed by Massachusetts Mutual Life Insurance Company and you meet the current commission requirements as published annually.

Specific information regarding the Group Policy and its terms may be obtained from the Plan Sponsor.

Dependent Insurance

If you are a Member, you may obtain Dependent Insurance for your qualified dependents. Your “qualified dependents” are your spouse and children as defined and limited here.

The term “spouse” means your husband or wife. Your marriage must not have ended in a valid divorce decree or annulment.

The term “spouse” also includes your domestic partner. You and your domestic partner must submit a complete domestic partner affidavit and meet the following criteria to qualify your domestic partner for insurance under this Group Policy. For at least 12 consecutive months prior to the effective date of your domestic partner insurance, you and your domestic partner:

1. are and have been each other’s sole domestic partner, and have maintained the same principal place of residence and intend to do so indefinitely;
2. are both at least 18 years of age;
3. are not married or related by blood; and
4. are jointly responsible for each other’s welfare and financial obligations.

Reference to your “child” means your own direct offspring, and includes your spouse’s or domestic partner’s direct offspring. The term also includes your stepchild or adopted children from the date
of placement in the home, by the state or licensing agency or from the date of the filing of the petition to adopt. A “child” will also mean a foster child, for whom you have been receiving foster care payments, from the date of placement in the home by the state or licensing agency. Such child must be under age 26.

Your spouse or child who is a full-time member of a country’s armed forces is not a qualified dependent.

You are eligible for Dependent Insurance on the earliest date that:

1. you are in an employment class covered for dependent insurance; and

2. you are eligible for similar Personal Insurance under the Group Policy; and

3. you have a qualified dependent.

If you and your spouse both have Personal Life Insurance under the Group Policy, you both may purchase Dependent Life Insurance on your children and each other.
EFFECTIVE DATE OF INSURANCE

Once you have become eligible for insurance, this section tells when your insurance will begin.

Personal Insurance

If you are newly eligible, your Personal Insurance begins on the date your contract is endorsed, provided you enroll within 30 days of the endorsement date.

If you do not enroll for Supplemental Life Insurance within 30 days of becoming eligible, you will have to wait until the next annual enrollment period or until you experience a qualifying change in status, whichever comes first.

When you become insured, you will receive a Statement of Coverage form confirming your insurance under the Group Policy. That form will show your name and certain details of your insurance.

The Plan Sponsor may require Members to contribute toward the cost of all or part of their Personal Insurance. Any such contributory insurance will not become effective for you before you sign a form agreeing to make those contributions. The form may be obtained from the Plan Sponsor.

If you are disabled on the date your Personal Insurance would begin, that insurance will not become effective until you return to full-time active service. Here, the term “disabled” means that an injury or illness prevents you from doing substantially all of your usual duties for the Plan Sponsor.

Special Provision for Supplemental Insurance

In addition to the provisions shown above, your Supplemental Life Insurance will not become effective until the date the Insurer approves your evidence of insurability if you:

1. apply for Supplemental Life Insurance more than 30 days after your eligibility date; or
2. elect an amount of Supplemental Life Insurance for which evidence of insurability is required, if such election is allowed.
Dependent Insurance

Any Dependent Insurance for which you are eligible will begin on the date that:

1. you have similar Personal Insurance in effect under the Group Policy; and
2. you have a qualified dependent who can be insured as discussed in this section; and
3. with respect to domestic partner insurance, you submit a complete domestic partner affidavit; and
4. you elect Dependent Insurance on a form provided by the Plan Sponsor.

The Plan Sponsor may require Members to contribute toward the cost of all or part of their Dependent Insurance. The form for this agreement may be obtained from the Plan Sponsor.

Your newborn child is insured from the date of his or her live birth. Your foster or adoptive child will be insured from the date he or she is placed by the state or a licensed agency in your home. Within 90 days after the live birth of the child, or within 90 days after the placement of the foster or adoptive child in your home, you need to tell the Plan Sponsor and agree to any required contributions toward the cost of the child’s insurance. Otherwise, insurance for the child will cease at the end of the applicable period.

You may acquire a new qualified dependent while your insurance for other dependents is in effect. If so, the new dependent, other than a domestic partner, will automatically become insured.

If your dependent, other than your newborn child, is disabled on the date insurance would normally become effective, insurance for such a dependent will not become effective until the date the dependent is no longer disabled. Here, the term “disabled” means that an injury or illness prevents your dependent from doing substantially all of the usual duties of a person of like age.

You may have only one dependent domestic partner enrolled for dependent insurance under the Group Policy at any time. Once you have submitted notice of termination of insurance for a domestic partner, you may not enroll another domestic partner for a period of 12 months from the date of the previous termination.
Change In Level of Plan Benefits Option During Annual Enrollment or Due to a Qualifying Status Change

The Plan Sponsor has made different levels of Life Insurance options available to you and your insured dependents. You may elect to change your options once each year during the Plan Sponsor’s annual enrollment period. Changes are effective January 1 of the following calendar year provided you or your dependent(s), as applicable, are not disabled on that date. During the annual enrollment you may:

- Elect coverage previously waived;
- Increase or decrease your coverage;
- Decline coverage.

An increase of one times Benefits Pay will be allowed without evidence of insurability. If you request an increase of more than one times your Benefits Pay, the excess amount is subject to evidence of insurability that must be approved by the Insurer. Increases for levels six, seven, eight or nine times Benefits Pay always require evidence of insurability.

If you want to add dependent coverage, you may elect Option 1 without evidence of insurability. If you currently have Option 1 dependent coverage, you may increase your dependent coverage to Option 2 during any annual enrollment period without evidence of insurability. However, any initial request for Option 2 coverage will be subject to evidence of insurability that must be approved by the Insurer.

Any insurance for which evidence of insurability is required will begin on the date the Insurer approves in writing the evidence of insurability.

You may also change your options whenever there is a mid-year qualifying event as defined by the Plan Sponsor. To do so, however, you must notify the Plan Sponsor and provide proof within 30 days of a qualifying status change (90 days in the case of a live birth, adoption or placement for adoption). With timely notification, the change in your coverage will be effective on the date of the status change. Otherwise, you must wait until the next annual enrollment period.
DISCONTINUANCE OF INSURANCE

Your Personal and Dependent Insurance under each coverage will cease on the first to occur of these dates:

1. the date the Group Policy is discontinued.
2. the date you are no longer eligible for that coverage. This may be due to a change in the Group Policy or because you transfer to a class that is not eligible.
3. the date you fail to make any required contribution toward the cost of insurance.
4. the date you cease active work for the Plan Sponsor, except that:
   a. if you are receiving short term disability benefits but maintain your contract, life insurance for you and your dependents may be continued for the amounts in force immediately preceding your disability. If you are not approved under the waiver of premium provision, you may continue your Personal Life Insurance while your contract continues and you pay for such coverage in full.
   b. if your contract is terminated while you are receiving short term disability benefits, your insurance may continue under the following situations:
      (i) if you were contracted after 1999 and have at least 10 years of continuous service, your Basic Life Insurance may be continued.
      (ii) if you were contracted prior to 2000 and have six or more years of continuous service, your Basic Life Insurance may be continued.
   c. if you retire, all insurance terminates at the end of the month in which you retire, unless you satisfy the Plan Sponsor’s criteria for continuation of Retiree life insurance (see pages 6 and 7).

AD&D insurance terminates on the date you become disabled or retire.

Under all circumstances, your travel accident insurance terminates on your last day of active service.

Your insurance for any one dependent will cease on the date he or she ceases to be your qualified dependent.
Handicapped Child Extension

If your insured child is handicapped upon reaching the age limit for qualified dependents, you may continue his or her Dependent Life Insurance as discussed here. The term “handicapped” means that the child is physically or mentally unable to earn a living. In order to continue the child’s insurance, proof of the handicap must be given to the Insurer at reasonable intervals. The first proof is due within 30 days after the child reaches the age limit for qualified dependents.

See the Plan Sponsor for the needed proof forms. Premiums for the child’s insurance will not change.

The Insurer, at its expense, may have its doctor examine the child at reasonable intervals; but such exams will not be more than once a year after the second year that the child’s insurance has been continued under this section. In no event will the child remain insured beyond the date his or her insurance would cease had the child not reached the age limit for qualified dependents.
DESCRIPTION OF THE COVERAGES

The pages of this section specify when plan benefits will be paid. Any conditions governing whether and how much benefit is paid for those events are also discussed in this section.

To receive plan benefits, you must be insured as described in the Plan Membership section of this booklet. Then, your amounts of insurance are determined by the Schedule of Benefits.

Should you become entitled to benefits, the Claims and Plan Member Rights section of this booklet tells how to present your claim.

ASSIGNMENT

As a Plan Member planning your estate, you may wish to assign ownership of any death benefits to someone else. The Group Policy allows assignment of all present and future right, title, interest and incidents of ownership as to: (a) any life insurance; (b) any disability provision of life insurance; and (c) any accidental death insurance under this plan. The assignment will include, but is not limited to, the rights: (a) to make any contribution required to keep the insurance in force; (b) to exercise any conversion privilege; and (c) to change the beneficiary named.
PERSONAL LIFE INSURANCE

Death Benefit

The Insurer will pay a benefit if you die while insured by this coverage. This death benefit will be paid to your beneficiary when due proof of your death is received by the Insurer. The needed claim forms may be obtained from the Plan Sponsor or the Insurer. See the Schedule of Benefits of this booklet for the amount of death benefit to be paid.

The death benefit is normally paid in one sum. You may, however, elect that payment be made in installments. This is called a settlement option. If no settlement option is in effect upon your death, your beneficiary may then elect such an option. Any settlement option requires a written agreement with the Insurer. The Insurer should be contacted for instructions.

Beneficiary

You have the right to name your “beneficiary”. That term means the person or persons to whom the death benefit will be paid. You may change beneficiaries at any time. To do so, you must provide written notice to the Plan Sponsor. The change will be effective on the date the notice is provided to the Plan Sponsor. But if you die before the notice is received by the Plan Sponsor, any death benefit the Insurer may have already paid will be deducted from the amount payable to the new beneficiary.

If you name more than one person to share any death benefit, your beneficiary notice should describe how the benefit is to be divided among them. Otherwise, they will share the benefit equally. All rights of any beneficiary cease if he or she dies before you do.

Alternate Payment Provisions

If there is no living beneficiary when your death occurs, or none has been named, the death benefit will be paid to the executors or administrators of your estate. If there is no executor or administrator, the Insurer may at its option: (a) pay the benefit to your then living spouse; or (b) if there is no living spouse, pay equal shares of the benefit to your then living children; or (c) if there are no living children, pay the benefit in equal shares to your direct parents then living.
Total Disability Premium Waiver

This section tells how your Personal Life Insurance can be continued without premiums if you become totally disabled before your 65th birthday.

Here, the term “totally disabled” means that an injury or illness prevents you from performing any occupation for which you are qualified by education, training or experience. If you can engage in any such occupation, you are not deemed to be “totally disabled”.

Death Before Proof Is Due

If you die within the first 12 months of being totally disabled, a death benefit may be payable, even if premium payments for your insurance have stopped. In this case, due proof is required that:

1. you became totally disabled while insured and before your 65th birthday; and that
2. you remained totally disabled at all times until your death occurred.

When the Insurer receives such proof, a death benefit will be paid to your beneficiary.

Proof Required Within 12 Months

Within the first 12 months that you are totally disabled, but have not died, due proof must be given that:

1. you became totally disabled while insured and before your 65th birthday; and that
2. you have continued to be totally disabled for at least 6 months, but less than 12 months.

Such proof may be given by you or someone acting for you. When the Insurer receives that proof, it will provide Personal Life Insurance for you without premiums while it is shown that you remain totally disabled.

While your Personal Life Insurance is provided without premiums, due proof that you remain totally disabled will be required at reasonable intervals. Such proof will be required at least once a year. The Insurer, at its expense, may also require that you be examined by its doctor at reasonable intervals. Such exams by a doctor will not be more often than once a year after your insurance has been provided without premiums for two years.
If you die while your Personal Life Insurance is provided without premiums, the Insurer will pay a death benefit. Due proof is required that you remained totally disabled until your death occurred. When that proof is received, the Insurer will pay that death benefit to your beneficiary.

**Amount Of Benefit Provided**

The amount of Personal Life Insurance and Personal Supplemental Life Insurance, if any, provided for you without premiums will normally be the amount for which you were insured by the Group Policy when you became totally disabled. However, the Schedule of Benefits of this booklet may require that life insurance amounts be reduced at a certain age or upon retirement; in such case, your insurance provided without premiums will be so reduced when those events occur.

One other factor may affect your amount of Personal Life Insurance provided without premiums. A right to convert your life insurance under the Group Policy to an individual policy is explained later in this coverage. Any part of your life insurance that you may have converted will not be provided without premiums unless:

1. you were totally disabled when you applied to convert; and
2. you return the individual policy to the Insurer with no claim other than a refund of the premiums you paid for it.

**When A Premium Waiver Ceases**

Insurance provided for you without premiums will cease when any of these events occur:

1. you are no longer totally disabled; or
2. due proof that you remain totally disabled is not provided when required by the Insurer; or
3. you do not allow a doctor to examine you when required by the Insurer.

Your insurance under this total disability premium waiver may continue after you retire under the Plan Sponsor’s eligibility criteria for retirement.

When your insurance without premiums ceases, you may be entitled to the Right To Convert provision explained later in this coverage. That Right To Convert provides insurance for the next 30 days. During that time:
1. If you again return to full-time active work, you may not convert your insurance. But you may again be eligible for Personal Life Insurance that requires premiums.

2. If you do not return to full-time active work, you may convert to an individual policy of life insurance. The things you must do to obtain such a policy are discussed in the Right To Convert provision.

While you are totally disabled, it may happen that:

1. the Group Policy is discontinued; or
2. the Group Policy is changed to terminate Personal Life Insurance.

In either event, while you continue to be totally disabled, you will have the same rights as though this life insurance was still in effect.

**Personal Accelerated Death Benefit**

The Group Policy provides a personal accelerated death benefit. You may elect to receive a portion of your Personal Basic and Supplemental Life Insurance benefit while you are still living. This personal accelerated death benefit will be paid provided that:

1. you elect the benefit in writing on the form provided by the Insurer or the Plan Sponsor; and
2. you submit to the Insurer written certification from a doctor that you have a life expectancy of 12 months or less, and the Insurer approves this certification.

The Insurer reserves the right to have you examined by one or more doctors of its choice in connection with your claim for a personal accelerated death benefit. Such an examination will be done at the Insurer’s expense.

See the Schedule of Benefits in this booklet to determine the maximum amount of personal accelerated death benefit you may elect.

**Payment Provisions**

The personal accelerated death benefit must be paid to you during your lifetime. You may elect less than the maximum benefit, but you can receive a personal accelerated death benefit only once. Payment will be made in one lump sum to you. If you have received a personal accelerated death benefit and then you recover from the qualifying condition, you will not be required to refund the benefit paid to you.
Effect of Payment on Other Benefits

The amount of your Personal Basic and Supplemental Life Insurance will be reduced by the amount of personal accelerated death benefit paid to you. The remaining Personal Basic and Supplemental Life Insurance benefit, if any, will be paid in accordance with the terms of the Group Policy. Any amount of Personal Basic and Supplemental Life Insurance you may have a right to convert, as explained later in this coverage, will be reduced by the amount of personal accelerated death benefit paid to you. The personal accelerated death benefit paid to you does not affect the amount of your Personal Accidental Death and Dismemberment Insurance.

Payment of Premium

Premium payments must continue, and will be based on the reduced amount of your Personal Basic and Supplemental Life Insurance.

When the Plan Sponsor stops paying premium for you, you are no longer eligible for a personal accelerated death benefit unless:

1. your doctor certifies that the qualifying condition was present before the date that premium payments ceased;
2. your doctor certifies that you have a life expectancy of 12 months or less from the date that premium payments ceased; and
3. you apply for an accelerated death benefit within 30 days from the date that premium payments ceased.

However, you will again be eligible for a personal accelerated death benefit when you are approved for the Total Disability Premium Waiver which is explained elsewhere in this booklet.

Exclusions

The personal accelerated death benefit will not be paid if:

1. you submit written certification from your doctor that you have a life expectancy of 12 months or less, and the Insurer disapproves this certification;
2. you have received an accelerated death benefit under the Group Policy;
3. you are required by law or court order to use your Personal Life Insurance benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
4. you live in a community property state, and the Insurer has not received consent in writing from your spouse;
5. you are divorced, and as a part of your court approved divorce agreement all or part of your Personal Life Insurance benefit must be paid to your children or former spouse; or
6. you have assigned your rights under the Personal Life Insurance coverage to an assignee or an irrevocable beneficiary, and the Insurer has not received consent, in writing, that the assignee or irrevocable beneficiary has agreed to payment of the personal accelerated death benefit to you.

Right To Convert

If your Personal Life Insurance ceases or is reduced, you could have a right to “convert” that group insurance to an individual policy. This section tells when you may acquire that right. **Note that your prompt application and payment is required at that time.**

Change In Your Status

You can obtain an individual policy of life insurance if your Personal Life Insurance under the Group Policy ceases because your contract terminates or you reach an age at which the Group Policy requires life insurance to be reduced.

Evidence of your health will not be required, but you must apply in writing and pay the first premium to the Insurer within 31 days after that Personal Life Insurance ceased.

Such an individual policy will not include disability benefits. The policy shall be one of the forms then normally being issued by the Insurer except term insurance. At your option, the amount of your policy may equal or be less than your Personal Life Insurance that ceased under the Group Policy. The premium will be determined by the form and amount of your policy, as well as by your class of risk and age on its effective date.

Group Policy Termination Or Change

Your Personal Life Insurance under this plan may cease because:

1. the Group Policy is terminated; or
2. the Group Policy is changed to exclude your class of eligible members.

In such event, you have the right to obtain an individual life insurance policy under certain conditions. One condition is that you have been insured by the Group Policy for at least five years. The
other condition is that your Personal Life Insurance was not fully replaced by this or another group insurance plan within the next 31 days. If both of these conditions are met, all other terms of this Right To Convert will apply as though your status had changed; but the amount of your individual policy will not exceed $2,000.

**Death While Eligible To Convert**

Any individual policy issued to you under this Right To Convert provision will become effective at the end of the 31-day period allowed for you to apply. If you should die during that 31 days, a death benefit will be paid by the Group Policy. This is true regardless of whether you applied for an individual policy. The amount of benefit payable will be the full amount you were entitled to convert. The benefit will be paid to the beneficiary you last named, whether for the Group Policy or a conversion policy.
DEPENDENT LIFE INSURANCE

Death Benefit

The Insurer will pay a benefit upon the death of a dependent for whom you have insurance under this coverage. This death benefit is payable to you when the Insurer receives due proof of the dependent’s death. The required claim forms will be provided by the Plan Sponsor or the Insurer. The Schedule of Benefits of this booklet shows the amount of death benefit to be paid.

Right To Convert

If a dependent’s life insurance under the Group Policy ceases, he or she could have a right to “convert” that group insurance to an individual policy. This section tells when the dependent may acquire that right. Note that prompt application and payment is required at that time.

Ceasing Qualification For Group Coverage

A dependent can obtain an individual policy of life insurance if his or her group life insurance under the Group Policy ceases for certain reasons. Those reasons are:

1. your death or your contract terminates; or
2. your transfer to an ineligible class; or
3. your insured spouse’s divorce, annulment of marriage, or the termination of your domestic partnership; or
4. your insured child ceases to be a qualified dependent.

Evidence of the dependent’s health will not be required. But the dependent must apply in writing and pay the first premium to the Insurer within 31 days after his or her insurance ceased. If the dependent is a minor or otherwise legally unable to apply, you or another legal guardian may apply on the dependent’s behalf.

The individual policy will insure the dependent only and will not include disability benefits. The policy shall be one of the forms then normally being issued by the Insurer except term insurance. At the dependent’s option, the amount of the policy may equal or be less than his or her dependent life insurance that ceased under the Group Policy. The premium will be determined by the form and amount of the dependent’s policy, as well as by his or her class of risk and age on its effective date.
Group Policy Termination Or Change

A dependent’s life insurance under the Group Policy may cease because:

1. the Group Policy is terminated; or
2. the Group Policy is changed to exclude your class of covered members.

In such event, the dependent has the right to obtain an individual policy of life insurance under certain conditions. One condition is that the dependent has been insured by this coverage for at least five years. The other condition is that his or her Dependent Life Insurance was not fully replaced by this or another group insurance plan within the next 31 days. If both of these conditions are met, all other terms of this Right To Convert provision will apply; but the amount of the dependent’s individual policy will not exceed $2,000.

Death While Eligible To Convert

Any individual policy issued to a dependent under this Right To Convert will become effective at the end of the 31-day period allowed for him or her to apply. If the dependent should die during that 31 days, a death benefit will be paid by the Group Policy. This is true regardless of whether or not the dependent applied for an individual policy. The amount of benefit payable will be the full amount he or she was entitled to convert. If the dependent has applied for a policy under this Right To Convert, the benefit will be payable to the beneficiary he or she named. Otherwise, the benefit will be paid to you, the Plan Member (Agent, General Agent or General Manager under Career Contract). But if the payee was not living when the dependent’s death occurred, the benefit will be paid to the dependent’s estate.
PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Death Benefit
The Insurer will pay a benefit if your death occurs under these conditions:

1. the death is a result of your accidental injury; and
2. the injury occurred while you were insured by this coverage; and
3. the death occurred within 180 days of the injury.

This accidental death benefit will be paid when the Insurer receives due proof that your death occurred under the conditions stated in this section. The benefit will be paid to your beneficiary. This benefit is the “full amount” of your accidental death and dismemberment insurance in effect under the terms of the Schedule of Benefits of this booklet on the date the accident occurred.

Additional Accidental Death Benefit While On Public Transportation
The Insurer will pay an additional death benefit if:

1. the accidental death benefit discussed above in this coverage becomes payable as a result of your injury; and
2. that injury occurred while you were a fare paying passenger on public transportation.

This additional death benefit will be paid when the Insurer receives due proof that your death occurred as specified in this section. This additional death benefit will then be paid to your beneficiary. The amount of this additional death benefit is the lesser of: (a) an amount equal to the accidental death benefit payable under the above section of this coverage; or (b) $200,000.

Additional Accidental Death Benefit If Death Occurs When A Seat Belt Was in Use
The Insurer will pay an additional death benefit if:

1. the accidental death benefit discussed in this coverage becomes payable as a result of your death; and
2. death occurred while you were using a seat belt and you were involved in an automobile accident and the automobile you were in was not driven by a person under the influence of drugs or alcohol.
This additional death benefit will be paid when the Insurer receives due proof that your loss or death occurred as specified in this section and due proof that you were using a seat belt at the time of the accident. This additional death benefit will then be paid to your beneficiary. The amount of this additional death benefit is shown on the Schedule of Benefits.

**Benefit for the Repatriation of Remains**

The Insurer will pay a benefit for covered expenses incurred in order to return your body to your home in the United States or Canada if you suffer the loss of life while you are outside a 75 mile radius from your home up to the maximum benefit shown on the Schedule of Benefits.

Covered expenses include but are not limited to:
- embalming;
- cremation;
- coffins; and
- transportation of your remains.

**Benefit For Loss Of Hand, Foot Or Sight**

The Insurer will pay a benefit if you incur the permanent loss of a hand, foot or sight under these conditions:

1. the loss is a result of your accidental injury which occurred while you were insured by this coverage; and
2. the loss occurred within 180 days of the injury; and
3. an accidental death benefit is not payable by this coverage for the same accident.

The benefit will be paid to you when the Insurer receives due proof of a loss as specified in this section. Your “full amount” of accidental death and dismemberment insurance will be determined under the terms of the Schedule of Benefits of this booklet as of the date the accident occurred. The benefit to be paid is that full amount or one-half of it as shown in the schedule below. Payment will be made for each loss without regard to prior losses. But, the total benefit to be paid for two or more losses in any one accident will not exceed your full amount of accidental death and dismemberment insurance under the Group Policy on the date the accident occurred.
Schedule Of Losses And Benefits

Your full amount of coverage is payable for the permanent loss of:
- both hands; or
- both feet; or
- sight of both eyes; or
- one hand and sight of one eye; or
- one foot and sight of one eye; or
- one hand and one foot.

One-half of your full amount is payable for the permanent loss of:
- one hand; or
- one foot; or
- sight of one eye.

Reference to loss of a hand means severance at or above the wrist. Reference to loss of a foot means severance at or above the ankle. Reference to loss of sight means total loss of sight which cannot be recovered.

A surgically reattached hand or foot will be deemed a “permanent loss” if, 12 months after reattachment, the limb has regained less than 50% of its normal function.

Exclusions

No benefit will be paid by this coverage for a death or loss that results from, or that is caused directly, wholly or partly by:

1. a disease, infection, or mental illness, or the treatment of these conditions.
2. suicide or intentional self-injury.
3. your commission of a felony.
4. a war, whether or not it is a declared war.
5. your being under the influence of drugs or intoxicants unless taken under the advice of a physician.

Beneficiary

You have the right to name your “beneficiary”. That term means the person or persons to whom the death benefit will be paid. You may change beneficiaries at any time. To do so, you must provide written notice to the Plan Sponsor for entry in the plan’s records. Then, the change will be effective on the date of the notice. But if you die before the notice is recorded, any death benefit the Insurer
may have already paid will be deducted from the amount payable to the new beneficiary.

If you name more than one person to share any death benefit, your beneficiary notice should describe how the benefit is to be divided among them. Otherwise, they will share the benefit equally. All rights of any beneficiary cease if he or she dies before you do.

**Alternate Payment Provisions**

If there is no living beneficiary when your death occurs, or none has been named, the death benefit will be paid to the executors or administrators of your estate. If there is no executor or administrator, the Insurer may at its option: (a) pay the benefit to your then-living spouse; or (b) if there is no living spouse, pay equal shares of the benefit to your then-living children; or (c) if there are no living children, pay the benefit in equal shares to your direct parents then living.

**No Right to Convert**

If your Personal Accidental Death and Dismemberment Insurance ceases or is reduced, you cannot “convert” that group insurance to an individual policy.
PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE - TRAVEL STATUS

Travel Status

You shall be in a “travel status” whenever, by authority of the Plan Sponsor, you shall depart from your customary office or place of residence for the purpose of furthering the business of the Plan Sponsor and you shall remain in “travel status” until your return from such authorized travel to your customary office or place of residence, whichever first occurs, except that, in no event shall travel from your place of residence to customary office and return be considered “travel status”.

Accidental Death Benefit

The Insurer will pay a benefit if your death occurs under these conditions:

1. the death is a result of your accidental injury; and
2. the injury occurred while you were insured by this coverage; and
3. the death occurred within 180 days of the injury.

This accidental death benefit will be paid when the Insurer receives due proof that your death occurred under the conditions stated in this section. The benefit will be paid to your beneficiary. This benefit is the “full amount” of your accidental death and dismemberment insurance in effect under the terms of the Schedule of Benefits of this booklet on the date the accident occurred.

Benefit For Loss Of Hand, Foot Or Sight

The Insurer will pay a benefit if you incur the permanent loss of a hand, foot or sight under these conditions:

1. the loss is a result of your accidental injury which occurred while you were insured by this coverage; and
2. the loss occurred within 180 days of the injury; and
3. an accidental death benefit is not payable by this coverage for the same accident.

The benefit will be paid to you when the Insurer receives due proof of a loss as specified in this section. Your “full amount” of accidental death and dismemberment insurance will be determined under the terms of the Schedule of Benefits of this booklet as of the date the accident occurred. The benefit to be paid is that full
amount or one-half of it as shown in the schedule below. Payment will be made for each loss without regard to prior losses. But, the total benefit to be paid for two or more losses in any one accident will not exceed your full amount of accidental death and dismemberment insurance under the Group Policy on the date the accident occurred.

**Schedule Of Losses And Benefits**

Your full amount of coverage is payable for the permanent loss of:
- both hands; or
- both feet; or
- sight of both eyes; or
- one hand and sight of one eye; or
- one foot and sight of one eye; or
- one hand and one foot.

One-half of your full amount is payable for the permanent loss of:
- one hand; or
- one foot; or
- sight of one eye.

Reference to loss of a hand means severance at or above the wrist. Reference to loss of a foot means severance at or above the ankle. Reference to loss of sight means total loss of sight which cannot be recovered.

A surgically reattached hand or foot will be deemed a “permanent loss” if, 12 months after reattachment, the limb has regained less than 50% of its normal function.

**Exclusions**

No benefit will be paid by this coverage for a death or loss that results from, or that is caused directly, wholly or partly by:

1. a disease, infection or mental illness, or the treatment of these conditions.
2. suicide or intentional self-injury.
3. your commission of a felony.
4. a war, whether or not it is a declared war.
5. your being under the influence of drugs or intoxicants unless taken under the advice of a physician.
Beneficiary

You have the right to name your “beneficiary”. That term means the person or persons to whom the death benefit will be paid. You may change beneficiaries at any time. To do so, you must provide written notice to the Plan Sponsor for entry in the plan’s records. Then, the change will be effective on the date of the notice. But if you die before the notice is recorded, any death benefit the Insurer may have already paid will be deducted from the amount payable to the new beneficiary.

If you name more than one person to share any death benefit, your beneficiary notice should describe how the benefit is to be divided among them. Otherwise, they will share the benefit equally. All rights of any beneficiary cease if he or she dies before you do.

Alternate Payment Provisions

If there is no living beneficiary when your death occurs, or none has been named, the death benefit will be paid to the executors or administrators of your estate. If there is no executor or administrator, the Insurer may at its option: (a) pay the benefit to your then-living spouse; or (b) if there is no living spouse, pay equal shares of the benefit to your then-living children; or (c) if there are no living children, pay the benefit in equal shares to your direct parents then living.

No Right to Convert

If your Personal Accidental Death and Dismemberment Insurance - Travel Status ceases or is reduced, you can not “convert” that group insurance to an individual policy.
CLAIMS AND PLAN MEMBER RIGHTS

How To Claim Benefits
Due written proof of claim is required in order to receive benefits under the Group Policy. The requirements for Personal Life Insurance proof forms are discussed in that coverage. The requirements for other types of group coverage are discussed here.

Notice of Claim
Notice of a claim must be given within 90 calendar days after a covered loss starts, or as soon as reasonably possible. Written notice can be given to the Insurer at its home office or to the Insurer's agent. Reference to a “loss” merely means that an event occurred or an expense was incurred for which a benefit is payable under the Group Policy. The notice must identify you along with the Group Policy number shown in this booklet.

Claim Forms
When the Insurer receives the notice of claim, it will send the claimant forms for filing proof of loss. The needed forms may also be obtained from the Plan Sponsor. If these forms are not given to the claimant within 15 calendar days, the claimant will meet the proof of loss requirements by giving the Insurer a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Loss
Due written proof of loss must be given to the Insurer within 90 calendar days after such loss. Failure to furnish the proof within that time shall not invalidate or reduce the claim if the proof is given as soon as reasonably possible. But, unless delayed by the claimant’s legal incapacity, the required proof must be furnished within 2 years of the specified time.

Filing Claim Forms
The proof of loss “claim forms” contain instructions as to how they should be completed and where they should be sent. Be sure to fully complete your portion of the forms. Incomplete claim forms may delay the processing of your claim.

Time of Payment of Claims
All benefits will be payable as soon as the Insurer receives due written proof of loss. Within 90 work days after receipt of the proof of loss, the Insurer shall either: (a) pay the benefits due; or (b) mail the Plan Member a statement of the reasons why the claim has, in
whole or in part, not been paid. Such a statement shall also list any
documents or information that the Insurer needs to process the
claim or that part of the claim not paid.

In the event that the Insurer does not comply with its obligations
under this Time of Payment of Claims provision, the Insurer shall
pay the Plan Member interest at the rate required by law on the
proceeds or benefits due the member under the terms of the Group
Policy.

**Physical Examinations**

The Insurer has the right to have a doctor it chooses examine the
person whose injury or illness is the basis of a claim. This may be
required at reasonable intervals until the claim is paid. If the person
has died, the Insurer may require an autopsy, unless it is prohibited
by law. Such an exam or autopsy will be at the Insurer’s expense.

**Legal Actions**

There are time limits as to when legal action can be taken to obtain
group policy benefits. No legal action can be taken until 60
calendar days after written proof of loss has been given as
discussed above. No legal action can be taken more than 3 years
after written proof of loss was required by the above terms. Legal
action with respect to a claim that has been denied, in whole or in
part, shall be contingent upon having obtained the Insurer’s
reconsideration of that claim, as explained next in this section.

**Reconsideration Of A Denied Claim**

If you are a Plan Member or a Member’s beneficiary, and your
benefit claim is totally or partially denied, the Insurer will give you a
written notice. The notice will give the reasons for denial. If you do
not agree with the reasons given, you may request reconsideration
of your claim.

To do so, you should write to the Insurer within the 60 calendar
days after you received the notice of denial. The Insurer’s name
and address appear in this booklet. They will also be on the notice
of denial. You should say why you believe the claim was improperly
denied. Include any data, questions or comments that you think are
appropriate. Unless the Insurer requests additional material in a
timely fashion, you will be advised of its decision within 60 calendar
days after your letter is received.
SUMMARY PLAN DESCRIPTION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not part of your Certificate. But, this document, together with the attached Certificate issued by UniCare Life & Health Insurance Company, constitutes the Summary Plan Description required by ERISA.

**Plan Names.** The designated names of the Plans are:

- MassMutual Agents’ Welfare Benefits Plan
- MassMutual Retired Agents’ Welfare Benefits Plan

**Plan Sponsor.** The name and address of the entity which established and maintains the Plan is:

Massachusetts Mutual Life Insurance Company
1295 State Street, F105
Springfield, MA  01111-0001

**Employer Identification Number (EIN).** 04-1590850

**Plan Numbers.** 506 (Active Agents)
546 (Retired Agents)

**Type of Plan.** The Plan is an employee welfare benefit plan providing group life and accidental death & dismemberment benefits.

**Source of Plan Contributions.** The contributions necessary to finance the Plan are provided by the Plan Sponsor and Plan participants.

**Plan Year.** The Plan’s records are maintained on a plan year basis beginning each year on January 1st and ending on the following December 31st.

**Type of Administration/Funding.** Benefits are furnished under a life and accidental death and dismemberment plan purchased by the Plan Sponsor and provided by UniCare Life & Health Insurance Company (UniCare) under which UniCare is financially responsible for the payment of claims.

UniCare’s address is:

UniCare Life & Health Insurance Company
233 S. Wacker Drive, Suite 3700
Chicago, IL  60606-6309
Plan Administrator. The name, address and telephone number of the Plan Administrator is:

Massachusetts Mutual Life Insurance Company  
1295 State Street, F105  
Springfield, MA  01111-0001  
Phone Number:  1-866-662-6448

Agent for Services of Legal Process. The name and address of the designated agent for the service of legal process for the Plan is:

General Counsel  
Massachusetts Mutual Life Insurance Company  
1295 State Street  
Springfield, MA  01111-0001

Description of Benefits. The Certificate pages set forth the benefits provided under the MassMutual Agents’ Welfare Benefits Plan and the MassMutual Retired Agents’ Welfare Benefits Plan. A brief explanation of these benefits may be found in the section titled SCHEDULE OF BENEFITS. A more detailed description of the benefits appears in the sections titled PERSONAL LIFE INSURANCE, PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, and DEPENDENT LIFE INSURANCE.

Eligibility for Participation. The eligibility requirements for participation under the Plan are set forth in the Certificate booklet in the section titled PLAN MEMBERSHIP under the subsections ELIGIBILITY FOR INSURANCE and EFFECTIVE DATE OF INSURANCE.

Grounds for Ineligibility or Loss or Denial of Benefits. Details describing the circumstances which may result in: (a) disqualification from the Plan; (b) ineligibility for benefits; or (c) denial, loss forfeiture or suspension of benefits under the Plan are set forth in the Certificate booklet, as outlined below:

- Reasons for ineligibility or loss of benefits may be found in the section titled PLAN MEMBERSHIP under the subsection DISCONTINUANCE OF INSURANCE.
- Benefits may be denied or adjusted if statements a Plan participant has made in connection with obtaining coverage were false.
- Benefits may be denied if claims were not made within the required time frames.
• Information concerning situations under which benefits may be reduced or denied may also be found in the sections titled SCHEDULE OF BENEFITS, PERSONAL LIFE INSURANCE, PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, DEPENDENT LIFE INSURANCE, and BASIC TERMS.

Claims Procedures. The Certificate contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or UniCare. In addition to this information, if this Plan is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in the Certificate.

UniCare must notify you, within 90 calendar days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 90 calendar days to determine your benefits, due to reasons beyond their control, they must notify you within that 90-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 180 calendar days to determine your benefits.

If your claim is denied in whole or in part, you will receive a written notice of the denial within 90 calendar days after UniCare has all the information they need to process your claim, if the information is received in a timely manner. (The 90-day period may be extended up to a total of 180 calendar days if they need more time to process your claim for reasons beyond their control.) The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the adverse benefit determination was made. You have 60 calendar days to appeal their adverse benefit determination. Your appeal must be in writing. Within 60 calendar days after they receive your appeal, they must notify you of their decision about it. Their notice to you of their decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with UniCare and request a review of the denial. In connection with such a request:
• Documents pertinent to the administration of the Plan may be reviewed free of charge; and
• Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

• Examine, without charge, at the Plan Administrator’s office and at other locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

• Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.

• Receive a summary of the Plan’s annual financial report; the Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of your benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if your request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials requested and to pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court, except that, any dispute concerning denial or partial denial of a claim must be resolved by binding arbitration as provided in the Plan booklet, unless otherwise prohibited under any applicable state or federal law.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are unsuccessful, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
In accordance with state insurance law, this booklet is composed of the following forms on file with the State Insurance Department.

CERTIFICATE: GCR 100
SCHEDULE OF BENEFITS: GCR 130, GCR 131, GCR 132
BASIC TERMS: GCR 1127, GCR 1128, GCR 1140, GCR 1198
ELIGIBILITY: GCR 120, GCR 121
EFFECTIVE DATE: GCR 12258, GCR 12259
DISCONTINUANCE OF INSURANCE: GCR 12317
COVERAGE PROVISIONS: GCR 140
PERSONAL LIFE INSURANCE: GCR 2057, GCR 2025, GCR 2058, GCR 2059-13, GCR 2060, GCR 022, GCR 20107, GCR 20108, GCR 20110, GCR 205, GCR 206
DEPENDENT LIFE INSURANCE: GCR 208, GCR 209
ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE: GCR 217, GCR 2112, GCR 2113, GCR 2114
CLAIMS: GCR 170, GCR 1750, GCR 1751