

LTC-TN

State of Tennessee Employee and Retiree Long-Term Care Insurance Program

Enrollment Booklet

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Daily Benefit Amount: \$100

For Nursing Facility, Assisted Living Facility, Bed Reservation, and Respite Care
\$60 For Home Care, Adult Day Care, and Hospice

Monthly Group Rates - 90 Day Elimination Period

Benefit Period	3 Years		5 Years	
Inflation	None	Compound	None	Compound
Issue Age				
18	\$3.07	\$23.43	\$4.07	\$33.03
19	\$3.19	\$24.14	\$4.21	\$34.03
20	\$3.30	\$24.91	\$4.38	\$35.10
21	\$3.45	\$25.74	\$4.56	\$36.26
22	\$3.60	\$26.61	\$4.77	\$37.48
23	\$3.77	\$27.53	\$5.01	\$38.78
24	\$3.95	\$28.51	\$5.27	\$40.16
25	\$4.16	\$29.55	\$5.55	\$41.61
26	\$4.38	\$30.63	\$5.86	\$43.13
27	\$4.64	\$31.77	\$6.20	\$44.75
28	\$4.91	\$32.98	\$6.58	\$46.44
29	\$5.21	\$34.23	\$6.99	\$48.20
30	\$5.54	\$35.56	\$7.44	\$50.06
31	\$5.89	\$36.93	\$7.93	\$52.01
32	\$6.28	\$38.38	\$8.46	\$54.04
33	\$6.70	\$39.88	\$9.05	\$56.17
34	\$7.16	\$41.47	\$9.69	\$58.41
35	\$7.67	\$43.13	\$10.37	\$60.75
36	\$8.22	\$44.88	\$11.13	\$63.21
37	\$8.80	\$46.70	\$11.95	\$65.77
38	\$9.45	\$48.59	\$12.83	\$68.46
39	\$10.14	\$50.58	\$13.78	\$71.25
40	\$10.88	\$52.66	\$14.78	\$74.15
41	\$11.73	\$54.87	\$15.94	\$77.27
42	\$12.64	\$57.19	\$17.17	\$80.54
43	\$13.61	\$59.62	\$18.53	\$83.97
44	\$14.65	\$62.14	\$19.96	\$87.54
45	\$15.74	\$64.75	\$21.49	\$91.29
46	\$16.81	\$67.38	\$22.96	\$94.97
47	\$18.01	\$70.17	\$24.60	\$98.90
48	\$19.32	\$73.14	\$26.39	\$103.06
49	\$20.75	\$76.26	\$28.35	\$107.47
50	\$22.31	\$79.57	\$30.50	\$112.13
51	\$24.02	\$83.08	\$32.84	\$117.08
52	\$25.90	\$86.81	\$35.43	\$122.33
53	\$27.98	\$90.81	\$38.27	\$127.95
54	\$30.21	\$94.99	\$41.34	\$133.85
55	\$32.68	\$99.48	\$44.72	\$140.17
56	\$35.40	\$104.25	\$48.41	\$146.86

* Annual rates available at a discount of approximately 8%

Spousal Discount: x 0.9

Daily Benefit Amount: \$100

For Nursing Facility, Assisted Living Facility, Bed Reservation, and Respite Care
\$60 For Home Care, Adult Day Care, and Hospice

Monthly Group Rates - 90 Day Elimination Period

Benefit Period	3 Years		5 Years	
Inflation	None	Compound	None	Compound
Issue Age				
57	\$38.34	\$109.29	\$52.44	\$153.96
58	\$41.54	\$114.66	\$56.81	\$161.50
59	\$45.02	\$120.35	\$61.57	\$169.51
60	\$48.95	\$126.87	\$66.91	\$178.66
61	\$52.99	\$133.22	\$72.42	\$187.56
62	\$57.38	\$139.97	\$78.39	\$197.02
63	\$62.13	\$147.12	\$84.83	\$207.03
64	\$67.22	\$154.66	\$91.75	\$217.57
65	\$73.46	\$164.32	\$100.17	\$230.96
66	\$79.64	\$173.07	\$108.56	\$243.22
67	\$86.28	\$182.29	\$117.60	\$256.14
68	\$93.42	\$192.01	\$127.28	\$269.75
69	\$101.06	\$202.23	\$137.68	\$284.06
70	\$109.34	\$213.24	\$148.95	\$299.53
71	\$118.70	\$225.24	\$161.73	\$316.43
72	\$128.75	\$237.89	\$175.47	\$334.28
73	\$139.48	\$251.17	\$190.16	\$353.05
74	\$150.85	\$265.06	\$205.71	\$372.65
75	\$164.32	\$280.98	\$223.61	\$394.54
76	\$179.30	\$298.79	\$244.17	\$419.84
77	\$195.55	\$317.94	\$266.47	\$447.06
78	\$213.21	\$338.59	\$290.76	\$476.44
79	\$232.51	\$360.96	\$317.29	\$508.34
80	\$253.79	\$385.72	\$346.65	\$543.75
81	\$276.51	\$411.72	\$377.98	\$580.97
82	\$300.91	\$439.50	\$411.63	\$620.75
83	\$326.92	\$469.00	\$447.51	\$663.04
84	\$354.69	\$500.41	\$485.82	\$708.07
85	\$384.07	\$533.62	\$526.32	\$755.64
86	\$405.54	\$555.14	\$555.23	\$785.42
87	\$425.30	\$574.20	\$581.41	\$811.08
88	\$442.21	\$589.51	\$603.12	\$830.64
89	\$458.94	\$604.23	\$624.40	\$849.08
90	\$475.24	\$618.05	\$644.88	\$866.02
91	\$490.66	\$630.50	\$663.91	\$880.74
92	\$504.61	\$640.98	\$680.68	\$892.33
93	\$516.09	\$648.65	\$693.77	\$899.60
94	\$528.27	\$657.28	\$707.66	\$908.08
95+	\$569.19	\$690.46	\$754.08	\$942.32

Daily Benefit Amount: \$150

For Nursing Facility, Assisted Living Facility, Bed Reservation, and Respite Care
\$90 For Home Care, Adult Day Care, and Hospice

Monthly Group Rates - 90 Day Elimination Period

Benefit Period	3 Years		5 Years	
Inflation	None	Compound	None	Compound
Issue Age				
18	\$4.62	\$35.14	\$6.10	\$49.54
19	\$4.77	\$36.22	\$6.32	\$51.05
20	\$4.95	\$37.36	\$6.57	\$52.66
21	\$5.16	\$38.60	\$6.85	\$54.38
22	\$5.40	\$39.91	\$7.16	\$56.23
23	\$5.64	\$41.30	\$7.51	\$58.18
24	\$5.93	\$42.77	\$7.90	\$60.23
25	\$6.24	\$44.32	\$8.32	\$62.41
26	\$6.58	\$45.96	\$8.80	\$64.70
27	\$6.96	\$47.67	\$9.31	\$67.12
28	\$7.36	\$49.47	\$9.88	\$69.65
29	\$7.81	\$51.35	\$10.49	\$72.31
30	\$8.29	\$53.33	\$11.17	\$75.10
31	\$8.84	\$55.39	\$11.90	\$78.01
32	\$9.41	\$57.56	\$12.70	\$81.07
33	\$10.05	\$59.83	\$13.57	\$84.27
34	\$10.74	\$62.21	\$14.52	\$87.62
35	\$11.49	\$64.70	\$15.56	\$91.13
36	\$12.31	\$67.30	\$16.69	\$94.81
37	\$13.21	\$70.03	\$17.91	\$98.66
38	\$14.17	\$72.89	\$19.24	\$102.67
39	\$15.21	\$75.88	\$20.66	\$106.87
40	\$16.33	\$78.99	\$22.18	\$111.24
41	\$17.59	\$82.32	\$23.91	\$115.91
42	\$18.95	\$85.79	\$25.77	\$120.81
43	\$20.42	\$89.43	\$27.78	\$125.94
44	\$21.97	\$93.22	\$29.94	\$131.31
45	\$23.61	\$97.14	\$32.23	\$136.92
46	\$25.21	\$101.06	\$34.42	\$142.44
47	\$27.01	\$105.26	\$36.89	\$148.36
48	\$28.98	\$109.69	\$39.59	\$154.60
49	\$31.12	\$114.39	\$42.52	\$161.20
50	\$33.46	\$119.35	\$45.75	\$168.19
51	\$36.04	\$124.63	\$49.26	\$175.62
52	\$38.86	\$130.22	\$53.13	\$183.50
53	\$41.96	\$136.20	\$57.40	\$191.92
54	\$45.32	\$142.49	\$62.00	\$200.77
55	\$49.04	\$149.21	\$67.08	\$210.25
56	\$53.09	\$156.36	\$72.63	\$220.29

* Annual rates available at a discount of approximately 8%

Spousal Discount: x 0.9

Daily Benefit Amount: \$150

For Nursing Facility, Assisted Living Facility, Bed Reservation, and Respite Care
\$90 For Home Care, Adult Day Care, and Hospice

Monthly Group Rates - 90 Day Elimination Period

Benefit Period	3 Years		5 Years	
Inflation	None	Compound	None	Compound
Issue Age				
57	\$57.51	\$163.94	\$78.65	\$230.93
58	\$62.31	\$171.99	\$85.22	\$242.24
59	\$67.54	\$180.54	\$92.34	\$254.25
60	\$73.41	\$190.29	\$100.37	\$267.98
61	\$79.50	\$199.85	\$108.63	\$281.36
62	\$86.07	\$209.96	\$117.57	\$295.53
63	\$93.18	\$220.69	\$127.24	\$310.53
64	\$100.83	\$232.00	\$137.62	\$326.35
65	\$110.19	\$246.48	\$150.25	\$346.45
66	\$119.44	\$259.60	\$162.84	\$364.82
67	\$129.42	\$273.44	\$176.38	\$384.22
68	\$140.13	\$288.02	\$190.93	\$404.63
69	\$151.59	\$303.34	\$206.52	\$426.10
70	\$164.01	\$319.87	\$223.43	\$449.29
71	\$178.05	\$337.86	\$242.61	\$474.66
72	\$193.12	\$356.82	\$263.22	\$501.44
73	\$209.21	\$376.77	\$285.23	\$529.58
74	\$226.27	\$397.58	\$308.58	\$558.97
75	\$246.48	\$421.46	\$335.43	\$591.80
76	\$268.94	\$448.19	\$366.25	\$629.76
77	\$293.32	\$476.92	\$399.72	\$670.58
78	\$319.83	\$507.88	\$436.14	\$714.65
79	\$348.76	\$541.44	\$475.94	\$762.50
80	\$380.68	\$578.58	\$519.96	\$815.62
81	\$414.77	\$617.59	\$566.96	\$871.44
82	\$451.37	\$659.26	\$617.45	\$931.13
83	\$490.37	\$703.51	\$671.27	\$994.55
84	\$532.04	\$750.62	\$728.74	\$1,062.11
85	\$576.11	\$800.44	\$789.48	\$1,133.44
86	\$608.31	\$832.72	\$832.85	\$1,178.13
87	\$637.95	\$861.29	\$872.13	\$1,216.63
88	\$663.31	\$884.27	\$904.68	\$1,245.95
89	\$688.42	\$906.33	\$936.60	\$1,273.62
90	\$712.86	\$927.07	\$967.30	\$1,299.03
91	\$735.98	\$945.76	\$995.88	\$1,321.11
92	\$756.91	\$961.47	\$1,021.01	\$1,338.49
93	\$774.14	\$972.97	\$1,040.66	\$1,349.40
94	\$792.40	\$985.92	\$1,061.49	\$1,362.11
95+	\$853.79	\$1,035.68	\$1,131.13	\$1,413.48

Daily Benefit Amount: \$200

For Nursing Facility, Assisted Living Facility, Bed Reservation, and Respite Care
\$120 For Home Care, Adult Day Care, and Hospice

Monthly Group Rates - 90 Day Elimination Period

Benefit Period Inflation Issue Age	3 Years		5 Years	
	None	Compound	None	Compound
18	\$6.15	\$46.85	\$8.13	\$66.07
19	\$6.37	\$48.28	\$8.42	\$68.06
20	\$6.60	\$49.83	\$8.76	\$70.21
21	\$6.89	\$51.47	\$9.14	\$72.51
22	\$7.19	\$53.22	\$9.56	\$74.96
23	\$7.53	\$55.07	\$10.02	\$77.56
24	\$7.90	\$57.03	\$10.53	\$80.31
25	\$8.32	\$59.10	\$11.10	\$83.21
26	\$8.78	\$61.27	\$11.73	\$86.27
27	\$9.27	\$63.56	\$12.42	\$89.49
28	\$9.82	\$65.95	\$13.17	\$92.87
29	\$10.41	\$68.46	\$13.99	\$96.41
30	\$11.06	\$71.10	\$14.89	\$100.13
31	\$11.78	\$73.87	\$15.86	\$104.01
32	\$12.56	\$76.75	\$16.93	\$108.10
33	\$13.40	\$79.78	\$18.10	\$112.36
34	\$14.33	\$82.94	\$19.36	\$116.83
35	\$15.33	\$86.27	\$20.75	\$121.51
36	\$16.42	\$89.74	\$22.24	\$126.41
37	\$17.60	\$93.38	\$23.88	\$131.55
38	\$18.89	\$97.19	\$25.65	\$136.90
39	\$20.28	\$101.17	\$27.55	\$142.51
40	\$21.78	\$105.31	\$29.58	\$148.32
41	\$23.45	\$109.75	\$31.88	\$154.54
42	\$25.27	\$114.39	\$34.36	\$161.07
43	\$27.22	\$119.24	\$37.04	\$167.92
44	\$29.30	\$124.29	\$39.92	\$175.08
45	\$31.47	\$129.52	\$42.98	\$182.56
46	\$33.62	\$134.75	\$45.90	\$189.92
47	\$36.02	\$140.35	\$49.19	\$197.81
48	\$38.64	\$146.26	\$52.78	\$206.13
49	\$41.50	\$152.52	\$56.71	\$214.93
50	\$44.62	\$159.15	\$60.98	\$224.26
51	\$48.04	\$166.17	\$65.69	\$234.14
52	\$51.81	\$173.64	\$70.84	\$244.66
53	\$55.95	\$181.60	\$76.53	\$255.88
54	\$60.42	\$189.98	\$82.67	\$267.70
55	\$65.38	\$198.95	\$89.44	\$280.33
56	\$70.79	\$208.48	\$96.84	\$293.72

* Annual rates available at a discount of approximately 8%

Spousal Discount: x 0.9

Daily Benefit Amount: \$200

For Nursing Facility, Assisted Living Facility, Bed Reservation, and Respite Care
\$120 For Home Care, Adult Day Care, and Hospice

Monthly Group Rates - 90 Day Elimination Period

Benefit Period	3 Years		5 Years	
Inflation	None	Compound	None	Compound
Issue Age				
57	\$76.67	\$218.60	\$104.87	\$307.92
58	\$83.08	\$229.32	\$113.61	\$322.99
59	\$90.05	\$240.72	\$123.12	\$339.01
60	\$97.88	\$253.73	\$133.82	\$357.31
61	\$105.99	\$266.46	\$144.85	\$375.14
62	\$114.76	\$279.96	\$156.77	\$394.04
63	\$124.24	\$294.24	\$169.65	\$414.05
64	\$134.45	\$309.34	\$183.50	\$435.14
65	\$146.91	\$328.64	\$200.33	\$461.93
66	\$159.26	\$346.13	\$217.13	\$486.42
67	\$172.56	\$364.59	\$235.18	\$512.28
68	\$186.84	\$384.02	\$254.58	\$539.50
69	\$202.14	\$404.46	\$275.35	\$568.13
70	\$218.69	\$426.49	\$297.91	\$599.07
71	\$237.39	\$450.48	\$323.48	\$632.87
72	\$257.49	\$475.77	\$350.96	\$668.58
73	\$278.95	\$502.35	\$380.32	\$706.11
74	\$301.69	\$530.11	\$411.44	\$745.30
75	\$328.65	\$561.95	\$447.24	\$789.06
76	\$358.59	\$597.60	\$488.33	\$839.67
77	\$391.09	\$635.88	\$532.96	\$894.11
78	\$426.44	\$677.17	\$581.52	\$952.87
79	\$465.02	\$721.92	\$634.60	\$1,016.67
80	\$507.57	\$771.43	\$693.29	\$1,087.49
81	\$553.02	\$823.46	\$755.94	\$1,161.93
82	\$601.84	\$879.01	\$823.26	\$1,241.50
83	\$653.84	\$938.00	\$895.02	\$1,326.08
84	\$709.38	\$1,000.83	\$971.66	\$1,416.14
85	\$768.14	\$1,067.25	\$1,052.64	\$1,511.26
86	\$811.07	\$1,110.29	\$1,110.46	\$1,570.83
87	\$850.60	\$1,148.38	\$1,162.84	\$1,622.18
88	\$884.42	\$1,179.02	\$1,206.24	\$1,661.27
89	\$917.88	\$1,208.45	\$1,248.81	\$1,698.16
90	\$950.47	\$1,236.09	\$1,289.74	\$1,732.03
91	\$981.32	\$1,261.01	\$1,327.83	\$1,761.47
92	\$1,009.22	\$1,281.97	\$1,361.35	\$1,784.67
93	\$1,032.19	\$1,297.30	\$1,387.56	\$1,799.20
94	\$1,056.54	\$1,314.56	\$1,415.32	\$1,816.15
95+	\$1,138.38	\$1,380.91	\$1,508.17	\$1,884.64

LTC-TN

State of Tennessee Employee and Retiree Long-Term Care Insurance Program

Instructions



How to Enroll

This information is designed to help you complete your enrollment form.

Note: Each person applying must complete an Enrollment Form. Additional Enrollment Forms are available by contacting Customer Service at **1-866-615-LTCi (5824)** toll free.

Step 1: Review the information in your kit and tear out the appropriate Enrollment Form from this booklet. There are two Enrollment Forms (*Enrollment Form A & Enrollment Form B*).

- **Enrollment Form A is for active employees enrolling during the initial open enrollment period and new employees enrolling within 90 days of date of hire.**
- **Enrollment Form B is for retirees, eligible family members and active employees enrolling after their initial open enrollment period.**

Please look at **Section A** of each enrollment form that defines who is eligible to enroll. Use the form that applies to you and check the box that describes who you are.

Also, if you are completing **Enrollment Form B** be sure to complete the **Standard Issue Health Statement**.

Step 2: Complete **Section A** with the **General Information** for the person who is the member of the group.

Step 3: If you are completing **Enrollment Form B**, complete **Section A-1** with the **Enrollee Information** for the person who is applying for this insurance.

Note: The answers to **Sections B** through **H** should be for the Enrollee (*the person applying for insurance*).

Use the information below to help you enroll in your long-term care insurance plan.

Go to **Section B** of the Enrollment Form, **Benefit Selections**.

Decision 1: (B1) Benefit Period:

Choose from the options in **Section B1**.

On to Decision 2.

Decision 2: (B2) Daily Benefit Amount: What Daily Benefit Amount is right for you?

Choose from the options in **Section B2**.

After choosing your Daily Benefit Amount, refer to the Monthly Rate Sheet for that amount.

On to Decision 3.

QUESTIONS?

CALL OUR CUSTOMER SERVICE CENTER toll-free: 1-866-615-LTCi (5824)

Decision 3: Inflation Protection: Inflation Protection increases your Lifetime Benefit Amount and Daily Benefit each year to offset future increases in the cost of long-term care services.

Choose from the options in **Section C**.

Your Monthly Rate Sheet includes rates for these options.

Sections E to H:

Section E – Payment Method: Choose a payment method and payment frequency.

Section F – Insurance Information: Please provide the insurance information requested in this section.

Section F-1 – Enrollment Form B: Physician Information. Please provide information for each of your physicians.

Section G - Enrollment Form A and B – Options and Signatures: Be sure to **SIGN** and **DATE** the Enrollment Form.

If you are completing **Enrollment Form B:** You must also complete the **Standard Issue Health Statement**.
Be sure to **SIGN** and **DATE** the Health Statement.



Administrative Offices:
165 Court Street
Rochester, NY 14647

www.LTC-TN.com

QUESTIONS?
CALL OUR CUSTOMER SERVICE CENTER toll-free: 1-866-615-LTCi (5824)



Administrative Offices:
 165 Court Street
 Rochester, NY 14647
 1-800-544-0327

Enrollment Form A
CARE DIRECTIONS[®] Premier

GUARANTEED ISSUE

State of Tennessee Employee and Retiree Long-Term Care Insurance Program - Group #60
Long-Term Care Insurance Certificate #TGR11-342-MA-TN-601

A Separate Enrollment Form Must be Completed for Each Enrollee.

A GENERAL INFORMATION

ELIGIBLE EMPLOYEE NAME: (Last) (First) (M.I.)	Social Security Number
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Address

City	County	State	Zip
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Home Phone: ()	Work Phone: ()	Best Time to be Reached: <input type="checkbox"/> AM <input type="checkbox"/> PM
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Date of Birth Month/Day/Year ____/____/____	Age	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
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Check ONE, if applicable <input type="checkbox"/> Spouse is enrolling at this time. (Please submit enrollment forms together) <input type="checkbox"/> Spouse is a current certificateholder	Spouse's Social Security Number (Required if Spouse is applying or a certificateholder) _____
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MUST be 18 years or older to Apply

Use this form if you are Actively at Work and you are:*

- AN EMPLOYEE** applying during the initial open enrollment period
- AN EMPLOYEE** applying within 90 days of your hire date;

DATE OF HIRE: ____/____/____

*** To meet the Active-at-Work Requirement:** the Employee must meet the "Positive Pay Status Requirement". The Employee must, on the day coverage is to begin, be at the employer's place of business or at a location to which the employer's business requires the Employee to travel and be able to fully perform the duties of the position for that Employee's normal workday. It includes any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay.

****An Employee shall mean** any person in the service of the employer who is paid by the employer and who:

- is regularly scheduled to work not less than 30 hours per week; or
- is a seasonal or part-time employee with 24 months of service, and is certified by an appointing authority to work at least 1,450 hours per fiscal year.

B **BENEFIT SELECTIONS (Please Complete Sections 1 & 2)**

1) Benefit Period: <input type="checkbox"/> 1095 days (3 Years) <input type="checkbox"/> 1825 days (5 Years)	2) Daily Benefit Amount: Nursing Facility, Assisted Living Facility, Bed Reservation and Respite Care: <input type="checkbox"/> \$100 (*\$60) <input type="checkbox"/> \$150 (*\$90) <input type="checkbox"/> \$200 (*\$120) (*Home Care, Adult Day Care, and Hospice)	3) Lifetime Elimination Period: <p style="text-align: center;">90 Days</p>
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C **OPTIONAL BENEFIT APPLIED FOR (Choose ONE)**

Inflation Protection Option Compound Inflation (5% for Life) No Inflation Benefit

D **PAYMENT TERM:**

Lifetime

E **PAYMENT METHOD (Choose ONE of the following three options)**

1) <input type="checkbox"/> Direct Bill Payment Frequency (Choose One) <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	2) <input type="checkbox"/> Bank Account Draft OR <input type="checkbox"/> Credit Card <div style="text-align: right;"><input type="checkbox"/> VISA <input type="checkbox"/> Mastercard</div> Payment Frequency (Choose ONE) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Credit Card <small>(Account withdrawal is the 5th of the month.)</small> <hr/> Bank Name <u>Attach Voided Check</u> Bank Account # _____ <hr/> Credit Card # _____ Expiration Date _____ I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution or credit card company and MedAmerica Insurance Company in writing. X _____ Signature of Account Holder X _____ Signature of Joint Account Holder	3) <input type="checkbox"/> Payroll Deduction I authorize my employer to deduct the applicable premium from my salary. I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy. I may revoke this authorization at any time by written notice to my employer and to MedAmerica Insurance Company. X _____ Employee Signature Employer Budget Code: _____ _____
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Administrative Offices:
 165 Court Street
 Rochester, NY 14647
 1-800-544-0327

Enrollment Form B



STANDARD ISSUE

State of Tennessee Employee and Retiree Long-Term Care Insurance Program - Group #60
 Long-Term Care Insurance Certificate #TGR11-342-MA-TN-601

A Separate Enrollment Form Must be Completed for Each Enrollee.

A | GENERAL INFORMATION

ELIGIBLE EMPLOYEE/ELIGIBLE/RETIREE NAME: (Last) (First) (M.I.)	Social Security Number
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Address

City	County	State	Zip
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Home Phone: ()	Work Phone: ()	Best Time to be Reached: <input type="checkbox"/> AM <input type="checkbox"/> PM
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MUST be 18 years or older to Apply
Use this form if you are:

<input type="checkbox"/> AN EMPLOYEE* OUTSIDE the 60 day Initial Open Enrollment Period.	<input type="checkbox"/> Spouse
<input type="checkbox"/> A Newly Hired/Eligible EMPLOYEE* OUTSIDE 90 days of your hire date.	<input type="checkbox"/> Parent
<input type="checkbox"/> Retired Employee	<input type="checkbox"/> Parent-in-law
<input type="checkbox"/> Unmarried Dependent Child (including adopted & step), up to age 24. Ages 19-24 must be full-time student or declared on the employees Income Tax return.	<input type="checkbox"/> Dependent Survivor

*** To meet the Active-at-Work Requirement:** the Employee must meet the “Positive Pay Status Requirement.” The Employee must, on the day coverage is to begin, be at the employer’s place of business or at a location to which the employer’s business requires the Employee to travel and be able to fully perform the duties of the position for that Employee’s normal workday. It includes any day on which the Employee is on vacation or on authorized leave provided such absence is not due to illness or injury or Leave Without Pay. Employees on disability will be eligible to enroll for coverage when returning to active employment status.

***An Employee shall mean** any person in the service of the employer who is paid by the employer and who:

- is regularly scheduled to work not less than 30 hours per week; or
- is a seasonal or part-time employee with 24 months of service, and is certified by an appointing authority to work at least 1,450 hours per fiscal year.

A-1 ENROLLEE INFORMATION

Name (First)	(Middle Initial)	(Last)	Social Security Number:
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Address

City	County	State	Zip
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Home Phone: ()	Work Phone: ()	Best Time to be Reached: <input type="checkbox"/> AM <input type="checkbox"/> PM
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Date of Birth Month/Day/Year ____/____/____	Age	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
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Check ONE, if applicable

Spouse is enrolling at this time. (Please submit enrollment forms together)

Spouse is a current certificateholder

Spouse's Social Security Number
(Required if Spouse is applying or a certificateholder)

B BENEFIT SELECTIONS (Please Complete Sections 1 & 2)

1) Benefit Period: <input type="checkbox"/> 1095 days (3 Years) <input type="checkbox"/> 1825 days (5 Years)	2) Daily Benefit Amount: Nursing Facility, Assisted Living Facility, Bed Reservation and Respite Care: <input type="checkbox"/> \$100 (*\$60) <input type="checkbox"/> \$150 (*\$90) <input type="checkbox"/> \$200 (*\$120) (*Home Care, Adult Day Care, and Hospice)	3) Lifetime Elimination Period: <p style="text-align: center;">90 Days</p>
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C OPTIONAL BENEFIT (Choose ONE)

Inflation Protection Option Compound Inflation (5% for Life) No Inflation Benefit

D PAYMENT TERM:

Lifetime

E PAYMENT METHOD (Choose ONE of the following three options)

1) <input type="checkbox"/> Direct Bill Payment Frequency (Choose One) <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	2) <input type="checkbox"/> Bank Account Draft OR <input type="checkbox"/> Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> Mastercard Payment Frequency (Choose ONE) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Credit Card (Account withdrawal is the 5th of the month.) <hr/> Bank Name _____ Bank Account # _____ Attach Voided Check <hr/> Credit Card # _____ Expiration Date _____ I authorize my financial institution or credit card company to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution or credit card company and MedAmerica Insurance Company in writing. X _____ Signature of Account Holder X _____ Signature of Joint Account Holder	3) <input type="checkbox"/> Payroll/Retirement Deduction I authorize my employer/retirement system to deduct the applicable premium from my salary/retirement. I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage as provided by the Group Policy. I may revoke this authorization at any time by written notice to my employer /retirement system and to MedAmerica Insurance Company. X _____ Employee/Retiree Signature Employer/Retirement Budget Code: _____
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F	INSURANCE INFORMATION
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1. Are you covered by a state assistance program (Medicaid)? Yes No

2. **List all** accident, sickness, disability, **nursing home, home health care and long-term care insurance policies**, including any health care service contracts and health maintenance organization contracts **that are currently in force**. (Include any MedAmerica Insurance Company policies.)

Company Name <small>(Use extra paper if necessary)</small>	Address <small>(Street, City, State, Zip)</small>	Policy Type	Policy Number	Intend to Replace
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

3. **Did you have another** nursing home, home health care or long-term care insurance policy or certificate **in force during the last twelve (12) months?** Yes No

If Yes, Name of Company _____

If Policy Lapsed, **Date of Lapse** _____

4. Have you ever been turned down for nursing home, home health care, long-term care or disability insurance? Yes No

If Yes, please explain: _____

F-1	PHYSICIAN INFORMATION
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Physician(s) Name	Physician(s) Street Address City, State, Zip	Phone #	Date Last Seen
1. Primary Care Physician			
2. Other Physicians (Indicate Specialty)			

G | **OPTIONS AND SIGNATURE**

1. **PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days after** a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, **I select one of the following options:**

- I elect NOT to designate** any person to receive such notice.
- I designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

Name	Address	City	State	Zip	Telephone
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2. **INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection, and

- I ACCEPT** inflation protection (see **Optional Benefits, Page 2**).
- I REJECT** inflation protection.

Declaration and Enrollment Form Conditions

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this enrollment form and my health statement is for consideration and the company will use this enrollment form and my health statement, if applicable, or require, at their expense, that I see a health care professional to determine if I am accepted. My coverage will begin on the effective date noted on the schedule page issued to me provided that payment of the first premium has been made. To receive benefits under this certificate, I will satisfy the elimination period and the benefit eligibility requirements as set forth in the certificate.

Authorization to Obtain and Disclose Information

I agree to permit company representatives to contact me to discuss my enrollment.

I understand that only information contained on this enrollment form and my health statement, if applicable, may be used to rescind my Certificate.

I authorize any physician, medical practitioner, hospital, clinic, other health care provider or health-related facility, insurance or reinsuring company or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to furnish MedAmerica Insurance Company and/or insurance support organizations representing MedAmerica Insurance Company any information needed to determine eligibility for insurance or benefits. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES.

I agree that a photocopy of this release and authorization shall be as valid as this original.

I agree that this authorization will be valid for 24 months from the date this enrollment form is signed.

I acknowledge receipt of "A Shopper's Guide to Long-Term Care Insurance," published by the National Association of Insurance Commissioners, and the Outline of Coverage.

X _____ Dated at _____ on _____
Enrollee's Signature (City/State) (Month/Day/Year)

CAUTION: If your answers on this enrollment form or your health statement, if applicable, are incorrect or untrue, MedAmerica Insurance Company has the right to deny benefits or rescind your policy.

FRAUD NOTICE: Any person who knowingly presents false or fraudulent claim for payment of a benefit or knowingly presents false, incomplete or misleading information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COMPANY USE

Ap Rec _____ Ap Status _____ Effective Date _____ UW/Date _____

PART II If any question in Part II is answered Yes, give full details in **Part IV**.

Yes No

- 1. During the past **2 YEARS** have you been hospitalized for any medical condition or special tests?
- 2. During the past **2 YEARS** have you had or been medically advised to have any surgery?
- 3. Are you **CURRENTLY** receiving Physical Therapy, Occupational Therapy, or Rehabilitation Services?
- 4. Are you **CURRENTLY** receiving disability income, worker's compensation, or Social Security **Disability** benefits?

PART III If any question in Part III is answered Yes, give full details in **Part IV**.

Yes No During the past **5 Years** have you received Medical Advice, Consultation, or Treatment for any of the following:

- 1. Heart problem or heart failure, heart or vascular surgery, circulatory or blood disease, stroke, TIA, angina, or high blood pressure?
- 2. Arthritis, osteoporosis, bone or joint problem, or any condition causing limitations or use of medical equipment?
- 3. Any respiratory problem, asthma, Chronic Obstructive Pulmonary Disease (COPD), or emphysema?
- 4. Any diabetes, cancer, loss of vision, neurological or muscular disorder?
- 5. Any bowel, bladder, digestive, kidney or liver problem?
- 6. Any memory loss, mental or emotional disorder or alcohol/drug problem?

PART IV List ALL Medications AND Detail ALL CONDITIONS noted in Part II and Part III.

Part/ Question #	Description of Accident or Sickness	Date of Onset	Type of Treatment/Medication	Length of time on Medication

Use this space for additional information

SIGNATURE:

I certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief. I certify that no material information has been **withheld** or **omitted** concerning the past and present state of my health.

I agree to advise you if, prior to the date my insurance takes effect, there is a change to the answers to these questions.

I understand that this health statement will be made a part of the certificate applied for and that false and/or incomplete responses or statements may result in rescission of coverage and/or non payment of claims under the certificate during the two-year incontestability period.

X _____

Enrollee's Signature

Date



**GROUP LONG-TERM CARE INSURANCE CERTIFICATE
OUTLINE OF COVERAGE**

**State of Tennessee Employee and Retiree Long-Term Care Insurance Program
Certificate Form Number TGR11-342-MA-TN-601
Group Number 60**

This Policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code.

Caution: The issuance of this long-term care Certificate is based upon your responses to the questions on your enrollment form. A copy of your enrollment form is enclosed. If your answers are incorrect or untrue, the Company has the right to deny Benefits or rescind your Certificate. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the Company at the address above.

Notice to Buyer: This Certificate may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Certificate limitations.

1. **POLICY.** This is a Group Policy which was issued in Tennessee.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the Group Policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the Group Policy contains governing contractual provisions. This means that the Group Policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CERTIFICATE CAREFULLY!**
3. **TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.** If you feel this Certificate does not meet your insurance needs, return it to us within 30 days. If you do so, we will return any premium you may have paid. We also will void your Certificate from its effective date.

When we are notified of your death, we will make a pro-rata refund to your estate of any premium paid for the period beyond your death. There is no refund when the Certificate is surrendered.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company. Neither MedAmerica Insurance Company nor its agents represent Medicare, the federal government, or any state government.

5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. These services must be provided in a setting other than an acute care unit of a hospital, such as a nursing facility, in the community, or in the home.

This Certificate provides coverage of 100% of actual charges incurred up to the Daily Benefit Amount as listed on the Schedule page of your Certificate, for qualified long-term care services. Coverage is subject to Group Policy and Certificate limitations and an elimination period.

6. **BENEFITS PROVIDED BY THIS POLICY.**

- (a) **Benefit Eligibility:** To be eligible for Benefits provided by the Group Policy, we must receive periodic proof from a Licensed Health Care Practitioner that you are a person who meets the following conditions:

- You need Substantial Assistance from another person to perform at least two of the Activities of Daily Living (Bathing, Dressing, Eating, Toileting, Transferring, Continence) for a period expected to last at least 90 days; or
- You need Substantial Supervision to protect you from threats to health and safety due to Severe Cognitive Impairment. This is deterioration or irreversible loss in Your intellectual capacity that requires substantial supervision to protect Yourself or others. This is established by clinical evidence and standardized tests that reliably measure Your impairment in the areas of:
 1. Your short or long-term memory; and
 2. Your orientation as to person (such as who You and others are), place (such as Your location) and time (such as day, date and year); and
 3. Your deductive or abstract reasoning.

Note: Severe Cognitive Impairment can result from Alzheimer's Disease.

Consistent with medical practice, the standardized tests employed in the benefit determination assessment are the Short Portable Mental Status Questionnaire (SPMSQ) and the Folstein Mini-Mental State Exam.

- An insured is considered to have Severe Cognitive Impairment if they meet one of the following:
- Incorrectly answer 4 or more questions on the SPMSQ.
- Achieve a score of 23 lower on the Folstein Mini-Mental State Exam. Exhibit specific behavioral problems requiring daily supervision, including, but not limited to, wandering, abusive or assultive behavior, poor judgement or uncooperativeness which poses a danger to themselves or others, extreme or bizarre personal hygiene habits. These behaviors are evaluated clinically by our Licensed Health Care Practitioner working cooperatively with the insured's physician, family and other health care providers.

Each of the following is an **Activity of Daily Living**:

Bathing: This means washing Yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: This means the ability to maintain control of bowel or bladder functions; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: This means the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: This means the ability to feed oneself by getting food into Your body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.

Toileting: This means the ability to go to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: This means the ability to move into or out of a bed, chair or wheelchair.

We will work with you, your family and your physician when we need information about your condition. We will review the status of your Activities of Daily Living and cognitive function. We will use this information to make an evaluation of your condition to determine whether you qualify or continue to qualify for Benefits under the Group Policy. This information may be gathered by us or one of our representatives.

We must receive certification from a Licensed Health Care Practitioner at least every 12 months that you meet the above conditions.

- (b) This is a once per Lifetime Elimination Period of 90 calendar days, as shown in Your Schedule, before benefit payments shall begin. The Elimination Period begins on the first day You are certified as meeting Benefit Eligibility as defined in this Certificate. The Elimination Period continues until the first such calendar day you are no longer Benefit Eligible or you reach the 90 Calendar days. Days used to satisfy Your Lifetime Elimination Period do not need to be consecutive as long as they are accumulated within a period of one calendar year (365/366 days).
There is no Lifetime Elimination Period for Respite Care Benefits. This Benefit may not be used to satisfy the Lifetime Elimination Period. If You are receiving Hospice Program Benefits paid by another insurer, We will waive the Lifetime Elimination Period for all covered services as outlined in this Certificate.
- (c) To calculate your **Lifetime Benefit Amount**, multiply the daily benefit amount listed in your Certificate schedule, by the number of days which you have selected. We will deduct from this amount all Benefits we pay for all covered services provided under this Certificate.
- (d) Our **Personal Care Advisor** is available to help you and/or your family members plan for your care through our benefit planning service. This service is provided at your option and without cost to you.
- (e) Qualified Long-Term Care Services must be provided by **Approved Providers** in order to be reimbursed. Approved Providers are any of the following:

- **Nursing Facility;**
 - **Assisted Living Facility;**
 - **Hospice Program;**
 - **Home Health Care Agency; or**
 - **Adult Day Care Center; or**
 - **Alternate Care.**
- (f) The maximum amount We will pay for all charges You incur on any one day, whether under one or more of the categories of Benefits described below, is the Daily Benefit Amount shown in Your Schedule.
- (g) If you meet Benefit Eligibility, we will reimburse the actual charges incurred up to the Daily Benefit Amount as chosen on your enrollment form for **services provided in a Nursing Facility or Assisted Living Facility** that are Qualified Long-Term Care Services.
- (h) If you meet Benefit Eligibility, we will reimburse the actual charges incurred up to the Daily Benefit Amount as chosen on your enrollment form for **services provided for Home Care, an Adult Day Care Center, or a Hospice Program** that are Qualified Long-Term Care Services. Home Care Services are Qualified Long-Term Care Services provided in your home by a Home Health Care Agency and are:
- nursing services;
 - physical, occupational, respiratory and speech therapy and nutritional services;
 - home health aide or personal care attendant services including such things as: personal hygiene, performing Activities of Daily Living, managing medications, and other related supportive services; or
 - homemaker services including light work, household tasks, preparing meals, doing laundry and other incidental household tasks that do not require the services of a trained aide or attendant.
- (i) We will reimburse for **Bed Reservation Benefits** up to the Daily Benefit Amount shown on your enrollment form, if you are hospitalized and we are paying for Benefits in a Nursing Facility or Assisted Living Facility and that facility charges you a fee to reserve your bed. We will pay to reserve your bed for up to 21 days per calendar year.
- (j) If you meet Benefit Eligibility and you are at Home, **Respite Care Benefits** will be paid for Respite Care provided in your Home, in a Nursing Facility, or in an Assisted Living Facility.

We will pay Benefits for up to the Daily Benefit Amount shown in your Schedule for a maximum of 21 days per calendar year. Benefits paid for Respite Care will be deducted from your Lifetime Benefit Amount. This Benefit is not subject to, and may not be used to satisfy, the Lifetime Elimination Period.

- (k) If you meet Benefit Eligibility, We may reimburse for **Alternate Care Benefits** for Qualified Long-Term Care Services that are medically acceptable, and agreed to by You, an authorized legal representative and/or Your physician, and by Us. This may include medically necessary transportation to and from Adult Day Care and/or unlicensed providers.
- (l) This coverage is provided anywhere within the United States and its possessions.

7. **LIMITATIONS AND EXCLUSIONS.**

- (a) **Pre-existing conditions:** There are no pre-existing condition limitations in this Certificate.
- (b) **Exclusions:** Expenses for the following will not be covered under this Certificate:
 - 1. Substance abuse treatment for alcohol or drug addiction.
 - 2. Treatment for illness or medical condition arising out of:
 - War or any act of war, declared or undeclared.
 - Participation in a felony, riot or insurrection.
 - Service in the armed forces or auxiliary units thereto.
 - 3. Services for which any Benefits are provided under Workers' Compensation, employer's liability program, occupational disease law or mandatory no-fault insurance.
 - 4. Services provided by a member of Your Family.
 - 5. Services for which no charge is normally made in the absence of insurance.
 - 6. Services while the Insured is outside the United States and its possessions.
- (c) **Nonduplication:** We will not pay Benefits for services or expenses to the extent that they are reimbursable under Medicare or under any other federal, state, or other governmental health care plan or law (except Medicaid). This exclusion also applies to services or expenses that would be reimbursable by Medicare but have been applied to a deductible or coinsurance amount, except where Medicare is secondary.

THIS CERTIFICATE MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.**

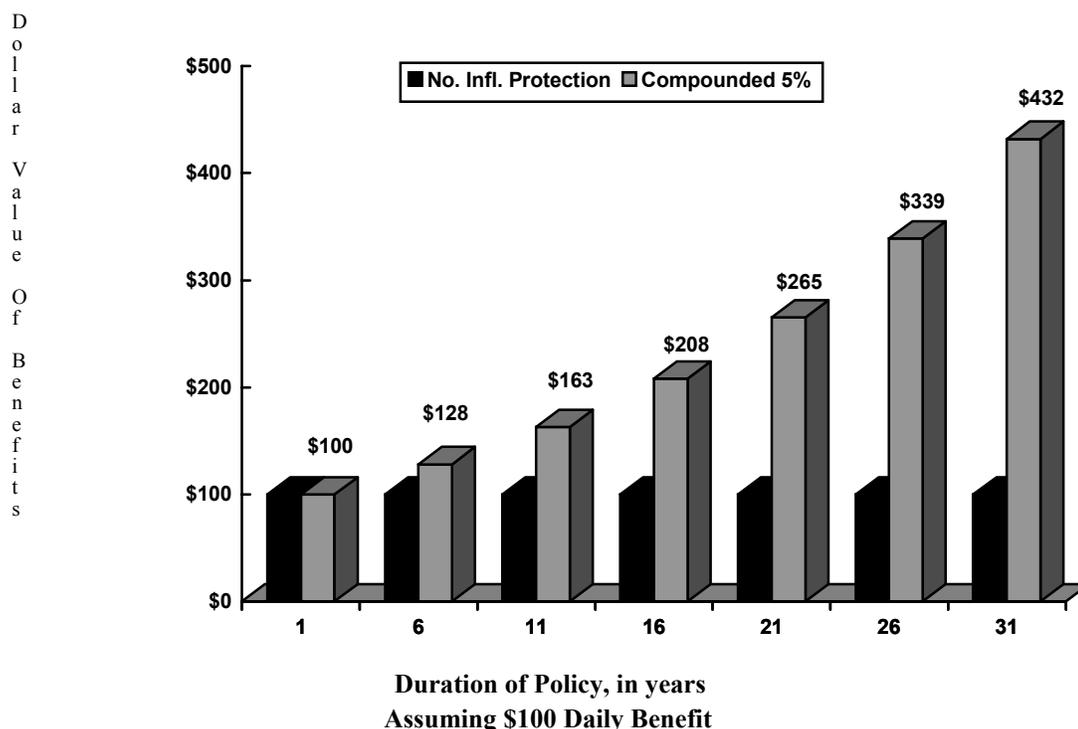
Because the costs of long-term care services will likely increase over time, you should consider whether and how the Benefits of this plan may be adjusted.

- (a) Benefits will not increase over time if you do not purchase inflation protection.
- (b) Benefit adjustment provision:

If you purchase \$100 per day nursing facility coverage, following are your Benefits over time:

- (c) If you purchase compound indexing Benefits, your Lifetime Benefit Amount and Daily Benefit Amount will each increase on every anniversary of the effective date of your Certificate. Annual increases will apply to Benefits payable for any expenses you incur on or after the date of the increase. This first increase will be equal to 5% of your original amounts. Each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase. Benefits increase without regard to health status.

**Comparison of Daily Benefit Level
with and without Inflation Protection
Compounded 5% Interest - Lifetime Duration**



- (d) The difference in premium for a certificate with or without inflation protection is based on the differences of the expected Benefits over your lifetime.

9. **TERMS UNDER WHICH THE CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

(a) **RENEWABILITY: THIS CERTIFICATE IS GUARANTEED RENEWABLE.** This means that you have the right, subject to the terms of your Certificate, to continue your coverage as long as you pay your premiums on time. MedAmerica Insurance Company cannot change any of the terms of your Certificate on its own, except that, in the future, IT MAY CHANGE THE PREMIUM YOU PAY AS LONG AS THE CHANGES ARE CONSISTENT WITH THE PREMIUM CHANGES IN THE GROUP MASTER POLICY.

(b) **CONTINUATION OF COVERAGE:** If We are notified that You are no longer eligible for coverage under the Group Policy for any reason, You may continue coverage without interruption as long as You pay all premiums when due. If Your premium was paid by payroll deduction, You must pay premiums directly to us.

You will not be eligible for continuation of coverage if the Group Policy terminates.

(c) **CONVERSION:** If the Group Policy terminates, You may elect to purchase a new individual direct payment contract which provides benefits identical to the benefits provided under the Group Policy without proof of insurability and at the same premium rates. In order to purchase such coverage You must make written application for the conversion policy and pay the first premium due within thirty-one (31) days of the termination date of the Group Policy.

The new policy will be effective on the date your coverage under the Group Policy ended and will be guaranteed renewable.

(d) **WAIVER OF PREMIUM.** Your premium payments will be waived on a monthly basis starting:

- On the first day You are certified as meeting Benefit Eligibility, You have satisfied the Lifetime Elimination Period, and We have approved benefits.

This waiver of premium payment ends when You are no longer Benefit Eligible as defined in the Certificate for a period of 90 calendar days.

(e) **OUR RIGHT TO CHANGE PREMIUM.** We can change your premium with thirty (30) days written notice, but only if we change the premiums for all persons in the same payment class consistent with premium changes made in the Group Master Policy.

10. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The Group Policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Coverage is contingent upon documentation by a licensed health care practitioner that you are severely cognitively impaired requiring substantial supervision. This Benefit is subject to the same benefit eligibility provisions and lifetime elimination period limitations as other Benefits.

11. **PREMIUM.**

- (a) The total annual premium for your long-term care coverage is shown in your Certificate Schedule. The cost of any optional benefits or riders is also shown.
- (b) An initial grace period of 31 days will be granted for each premium that is unpaid on the date due. After 30 days, a notice will be sent to you, if you pay premium to us directly, explaining that a payment has been missed and that your Certificate risks lapsing. You will have an additional 35 days from the date we mail notice to you during which any unpaid premium must be paid. Payment will allow your Certificate to continue in force without interruption. Failure to pay any unpaid premium by the end of this Grace Period will result in the termination of your Certificate as of the premium due date.

12. **ADDITIONAL FEATURES.**

- (a) Medical underwriting of your enrollment form is used to determine your eligibility for long-term care insurance, unless you qualify for guaranteed issue.
- (b) Benefits may be available after termination if you are receiving Benefits covered under the Group Policy. See the “Extension of Benefits” section of your Certificate for specific requirements.
- (c) If the coverage under your Certificate terminates because of non-payment of premium, you may apply for reinstatement of your Certificate.
- (d) No prior hospitalization is required before you can receive coverage for services under this Certificate.
- (e) Appeal rights are available if you disagree with a claim decision.

Things You Should Know Before You Buy Long Term Care Insurance

Long-Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local County Department of Social Services.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of the appropriate Shopper's Guide regarding Long Term Care Insurance approved by Your States Commissioner of Insurance. Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Long Term Care Insurance Potential Rate Increase Disclosure Form

1. **Premium Rate:** Your premium rate that is applicable to you and that will be in effect until a request is made and filed with Your State Department of Insurance for an increase is shown on your schedule page in your policy.
2. The premium for this Policy will be shown on the schedule page of your policy.
3. **Rate Schedule Adjustments:** If your rates are changed, the new rates will become effective on the next billing date. The new rates will remain in effect until another request is made and filed with Your State Department of Insurance. You have the right to receive a revised schedule page if the premium rate is changed.

We have sold long-term care insurance since 1987. We have never raised rates for any long-term care policy sold in this state or any other state.

4. **Potential Rate Revision: This policy is Guaranteed Renewable.** This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to your age or declining health, but your rates may go up based on the experience of all insureds with a policy similar to yours. If you receive a premium rate increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:
 - (a) Pay the increased premium and continue your coverage in force as is.
 - (b) Reduce your coverage benefits to a level such that your premiums will not increase.
 - (c) Exercise your long-term care nonforfeiture option, if purchased. This option is available for purchase for an additional premium.
 - (d) Exercise your contingent nonforfeiture rights - See No. 3. This option is available if you do not purchase a long-term care nonforfeiture option mentioned in (c) above.

Contingent Nonforfeiture Rights

If the premium rate for your policy goes up in the future and you do not buy a long-term care nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

- (a) You will keep some long-term care insurance coverage, if:
 - (1) Your premium after the increase exceeds your original premium by the percentage shown, or more, in the table (provided on the next page/below); and
 - (2) You do not pay your premium within 120 days of the increase causing your policy to lapse.
- (b) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining

maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

- (c) Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for ten years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to not pay any more premiums causing your policy to lapse.
- Your "paid-up" policy benefits are \$10,000, provided you have at least \$10,000 of benefits remaining under your policy.

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

**Percentage increase is cumulative from date of original issue.
It does NOT represent a one-time increase.**

Issue Age	Substantial Percent Over Initial Premium	Issue Age	Substantial Percent Over Initial Premium
29 and under	200%	70	40%
30-34	190%	71	38%
35-39	170%	72	36%
40-44	150%	73	34%
45-49	130%	74	32%
50-54	110%	75	30%
55-59	90%	76	28%
60	70%	77	26%
61	66%	78	24%
62	62%	79	22%
63	58%	80	20%
64	54%	81	19%
65	50%	82	18%
66	48%	83	17%
67	46%	84	16%
68	44%	85	15%
69	42%		



TENNESSEE Long Term Care PARTNERSHIP PROGRAM

*Encouraging You to Plan
for Your LTC Needs*



Tennessee Long Term Care Partnership Program

The Long Term Care Partnership (LTCP) Program is a joint effort between the federal Medicaid Program and Long Term Care (LTC) insurers. The Long Term Care Partnership was developed to encourage people to plan for their future LTC needs, such as residing in a nursing facility or assisted living facility, or receiving LTC services in a home or community-based setting.

TennCare is Tennessee's name for the federal Medicaid program. In order to participate in TennCare's LTCP program, a person must have purchased and received the benefits of a qualified Partnership policy.

A person who requests TennCare payment of LTC services after exhausting some or all benefits of a qualified LTCP policy may have certain assets "disregarded" equal to the benefits paid by the qualified LTCP policy at the time the person is determined eligible for TennCare. These assets are not counted when the person's TennCare eligibility is determined and will not be recovered during estate recovery when the person dies. *This means that with the Partnership's dollar-for-dollar asset protection, Tennesseans can protect personal assets if there is a need to apply for TennCare.*

How the LTCP Program and TennCare Work Together

- 1) A LTCP participant in Tennessee is someone who either:
 - Requests TennCare payment of LTC services after exhausting all benefits of a qualified LTCP policy, OR
 - Exhausts all benefits of a LTCP policy while receiving TennCare payment of LTC services, OR
 - Receives TennCare payment of LTC services and dies before the LTCP policy benefits are exhausted.
- 2) When determining TennCare eligibility, the Department of Human Services (DHS) shall disregard an individual's assets in an amount equal to the amount of payments made by the individual's qualifying LTC policy for services covered under the policy.

It is the responsibility of the LTCP policyholder to inform the DHS eligibility worker that he or she has a Partnership policy. A TennCare applicant will also be required to submit written proof of benefits paid from his or her LTCP policy.

- 3) A LTCP participant receives the following benefits during his or her lifetime:
 - Assets may be designated for disregard in an amount equal to the benefits paid out by the qualified LTCP policy as of the date of application for Medicaid eligibility.
 - Designated assets are not counted toward the TennCare asset limit for eligibility purposes.
 - The designated assets may be transferred to any other person without penalty.
 - Additional benefits paid by the qualified LTCP policy after application for Medicaid eligibility shall not be disregarded in future review and/or determination of Medicaid eligibility.
- 4) After the LTCP participant is deceased:
 - Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery.
 - When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the LTCP policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying LTC policy for services covered under the policy
 - If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above - even if LTCP policy benefits were not completely exhausted.

- 5) When should an individual apply for TennCare?
- If the LTCP policyholder exhausts the benefits of his or her LTCP policy.
 - When the Partnership policyholder/spouse/family/friend feels that the policyholder can no longer afford to pay for the cost of care.
- 6) Does a LTCP policy guarantee access to TennCare?
NO! Owning a LTCP policy does NOT guarantee access to TennCare – even if the policyholder exhausts his or her benefits. Individuals still must meet all other TennCare eligibility requirements in order to be eligible.

REMEMBER: Only DHS can determine whether a person will qualify for TennCare.

General Criteria for TennCare LTC Eligibility

To be eligible for TennCare, a person must qualify in one of the eligibility groups that are covered under the TennCare Medicaid program and meet specific requirements relating to residency, citizenship, income and resources. To be eligible for TennCare payment of LTC services, a person must meet all of the following criteria:

- a) Have a Pre-Admission Evaluation (PAE) that determines a need for a level of care provided in one of these settings:
 - 1) Nursing facility
 - 2) Intermediate Care Facility for people with Mental Retardation (ICF-MR)

A person who meets the level of care and eligibility requirements for care in a nursing facility or ICF-MR may then be able to choose to receive LTC services in an alternative home- and community-based setting, such as an HCBS Waiver program.

- b) Reside in a TennCare-certified Long Term Care facility or receive TennCare home-and community-based LTC services under a federally approved waiver program.
- c) Meet income and resource guidelines.
- d) Disclose an interest in an annuity for self and spouse, if married. The state must be named as remainder beneficiary of annuities owned by the person or spouse.
- e) Not be in a penalty period for an uncompensated transfer of income or assets. During a penalty period, TennCare will not pay the cost of LTC services.
- f) Have home equity of \$500,000 or less unless a spouse, child under the age of 21, or blind or disabled child is lawfully residing in the home.

How to Apply for TennCare

In Tennessee, the Department of Human Services (DHS) accepts applications for TennCare through the county DHS offices. To locate local DHS offices, call DHS's Family Assistance Service Center at 1-866-311-4287 or visit the DHS website at http://www.tennessee.gov/humanserv/st_map.htm.

Those interested in applying do not need an appointment at the county office to receive an application. One can be picked up at their county DHS office or they can have one mailed to them or they can apply online. To request an application, call the county office or the Family Assistance Service Center. Individuals can also apply online by visiting TennCare's website: <http://tennessee.gov/tenncare/mem-apply.html>.

If the person does not apply online, the application must be returned to the county DHS office for processing, by mail, fax or personal delivery. DHS recommends scheduling an intake appointment with a county DHS worker once the individual has completed the application. A face-to-face interview is not required but applicants should be sure to mention that they are in need of LTC services.

Disclaimers

- *This document is solely intended to provide a general overview of how the Long Term Care Partnership Program works in Tennessee. It is **not** an endorsement of a particular long term care insurer or long term care insurance policy.*
- *Information in this document is up-to-date as of February 10, 2009.*

APPENDIX K

LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM NOTICE

IMPORTANT CONSUMER INFORMATION REGARDING THE TENNESSEE LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM

Some long-term care insurance policies sold in Tennessee may qualify for the Tennessee Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies that qualify as Partnership Policies may protect the policyholder's assets through a feature known as "Asset Disregard" under TennCare, Tennessee's Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds \$500,000. Asset Disregard is not available under a long-term care insurance policy that is not a Partnership Policy. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.**

What are the Requirements for a Partnership Policy? In order for a policy to qualify as a Partnership Policy, it must, among other requirements:

- be issued to an individual on or after February 8, 2006;
- cover an individual who was a Tennessee resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under § 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and
- meet the following inflation requirements:
 - For ages 60 or younger - provides compound **annual** inflation protection
 - For ages 61 to 75 - provides some level of inflation protection
 - For ages 76 and older - no purchase of inflation protection is required

If you apply and are approved for long-term care insurance coverage, MedAmerica Insurance Company will provide you with written documentation as to whether or not your policy qualifies as a Partnership Policy.

What Could Disqualify a Policy as a Partnership Policy. Certain types of changes to a Partnership Policy could affect whether or not such policy continues to be a Partnership Policy. If you purchase a Partnership Policy and later decide to make *any* changes, you should first consult with MedAmerica Insurance Company to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Partnership Policy, you would not receive beneficial treatment of your policy under the Medicaid program of that state. The information contained in this disclosure is based on current Tennessee and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy under Tennessee's Medicaid program.

Additional Information. If you have questions regarding long-term care insurance policies please contact MedAmerica Insurance Company. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Bureau of TennCare.

