Nippon Life Benefits®

ORTHO SOLUTIONS LC, DBA DYNAFLEX

EFFECTIVE JUNE 1, 2023

Group Plan Booklet Certificate

ALL MEMBERS

Dental Expense Coverage

In any discrepancy between this on-line Group Plan Booklet Certificate and the master contract, the master contract will govern. This on-line Group Plan Booklet Certificate does not guarantee benefits or eligibility. All terms, provisions, conditions, limitations, and exclusions shown in the Group Plan Booklet Certificate and master policy (including any supplements) will apply. Copies of the Group Plan Booklet Certificate may be obtained from the Plan Administrator.

A Tradition of Value, Humanity and Service
Nippon Life Insurance Company of America℠
www.nipponlifebenefits.com

Member's Signature

This insurance has been designed to provide financial help for a Member when a covered loss occurs. The insurance is established through a Group Policy issued by the Company, Nippon Life Insurance Company of America.

Member rights and benefits are determined by the provisions of the Group Policy. This booklet-certificate briefly describes those rights and benefits. It outlines what the Member must do to be insured. It explains how to file claims. It is the Member's booklet-certificate while they are insured.

THIS BOOKLET-CERTIFICATE REPLACES ANY PRIOR BOOKLET-CERTIFICATE THE MEMBER MAY HAVE RECEIVED. If the Member has any questions about this new booklet-certificate, please contact the Policyholder. In the event of future changes to the Member's insurance, he or she will be provided with a new booklet-certificate or a booklet-certificate rider.

If the Member has an electronic booklet-certificate, paper copies of this booklet-certificate are also available. Please contact the Policyholder to request a paper copy.

PLEASE READ THIS BOOKLET-CERTIFICATE CAREFULLY. The Company suggests starting with a review of the terms listed in the DEFINITIONS section of this booklet-certificate. The meanings of these terms will help the Member understand the insurance.

The group insurance policy and the Member's insurance under the Group Policy may be discontinued or altered by the Policyholder or the Company at any time without the Member's consent.

These booklet-certificate forms are subject to change upon final review by the state agency that approves insurance booklets.

The insurance provided in this booklet-certificate is subject to the laws of the state of Missouri.

NIPPON LIFE INSURANCE
COMPANY OF AMERICA
P. O. Box 25951, Shawnee Mission, KS 66225-5951

BOOKLET-CERTIFICATE TABLE OF CONTENTS

Page

SUMMARY OF BENEFITS
(Effective June 1, 2023)

This section highlights the benefits provided under this insurance. The purpose is to give the Insured Person quick access to the information he or she will most often want to review. **Please read the other sections of this booklet-certificate for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

DENTAL EXPENSE INSURANCE

If an Insured Person receives dental Treatment or Service listed under the Schedule of Dental Procedures, Scheduled Benefits then in force will be payable. Scheduled Benefits are based on the Member's class and the status of his or her Dependents:

Class	**Scheduled Benefits**
All Members and their Dependent Spouse ……	Dental benefits as described under Dental Care Types 1, 2, and 3
All Dependent Children ……..…	Dental benefits as described under Dental Care Types 1, 2, and 3

(However, benefits for Covered Charges under Dental Care Types 2 and 3 will be limited if the Member or if any of his or her Dependents become insured under the Benefit Waiting Period provision).

PREFERRED PROVIDER ORGANIZATION (PPO)

The Policyholder participates in a Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

Preferred Provider Organization (PPO) plans are arrangements whereby Dentists are contracted to furnish, at negotiated costs, dental care for the Members and their Dependents of participating Policyholders.

It is expected that the Policyholder's participation in the PPO will result in significant savings of funds needed to maintain the Member's insurance. These savings are to be passed on to the Member in the form of higher benefits payable for services received by an Insured Person from Preferred Providers.

Please note that the Policyholder's participation in the PPO does not mean that the Member's choice of provider will be restricted. The Member may still seek needed dental care from any Dentist he or she wishes. However, in order to avoid higher charges and reduced benefit payments, the Insured Person is urged to obtain such care from Preferred Providers whenever possible.

A current listing of the participating providers is available through an on-line Preferred Provider directory. By accessing the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com, the Insured Person can review Preferred Provider directories for the PPO Network. If the Insured Person does not have internet access, the Insured Person can call the number on the Insured Person's ID card. The Company recommends that the Insured Person (1) verify his or her provider's participation in the network before seeking treatment; and (2) confirm the provider's PPO participation when making an appointment.

Benefit Advice

A benefit consulting service is available for the Member and his or her Dependents to provide information about the best use of his or her dental benefits. Examples of information he or she may find helpful include:

- general information on types of services offered by various dental care providers; and
- specific information such as benefits available for a particular dental procedure.

Call the Company's toll-free number (see the Member's ID card or employer for the number to call) if the Insured Person wishes to discuss dental benefits with the Company's benefit consultants.

Dental Care Types

Treatment or Service for which dental benefits are payable are divided into Dental Care Types. The Treatment or Service covered under each type is described in the SCHEDULE OF DENTAL PROCEDURES section.

BENEFITS PAYABLE

Benefits payable during a calendar year for each Insured Person will be the percent of Covered Charges shown below, and will vary depending upon whether or not needed care is received from a Preferred Provider or a Non-Preferred Provider.

Covered Charges under each Dental Care Type will be the actual cost charged to the Insured Person, for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES section but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Dental benefits payable for Treatment or Service received each calendar year will be:

Service	PPO Providers	Non-PPO Providers
Dental Care Type 1		
Preventive Procedures		
Coinsurance	100%	100%
Individual Deductible	None	None
Family Maximum Deductible	None	None

Dental Care Type 2		
Basic Procedures (including in person and Teledentistry visits)		
Coinsurance	80%	80%
Individual Deductible	$50 per calendar year (Types 2 and 3 combined)	$50 per calendar year (Types 2 and 3 combined)
Family Maximum Deductible	$150 per calendar year (Types 2 and 3 combined)	$150 per calendar year (Types 2 and 3 combined)

Dental Care Type 3		
Major Procedures		
Coinsurance	50%	50%
Individual Deductible	$50 per calendar year (Types 2 and 3 combined)	$50 per calendar year (Types 2 and 3 combined)
Family Maximum Deductible	$150 per calendar year (Types 2 and 3 combined)	$150 per calendar year (Types 2 and 3 combined)

Deductible Amount(s)

- An individual calendar year Deductible Amount is paid for each Insured Person for dental Treatment or Service received under each Dental Care Type. The individual Deductible Amount will be the amount shown above. After the Deductibles have been satisfied, the Company will pay Covered Charges at the rate indicated for each Dental Care Type.
- For each Dental Care Type, Covered Charges used to satisfy the calendar year Deductible that is applicable when care is received from Non-Preferred Providers will be counted toward satisfaction of the calendar year Deductible that is applicable when care is received from Preferred Providers, and vice versa.
- Charges are applied to the Deductible Amount in the order they are incurred. However, if Covered Charges are incurred for Types 2 and 3 on the same date, the charges will be applied to the Deductible Amount in the following order:

    - first to Type 2 charges; and
    - then to Type 3 charges.

- In place of individual Deductibles, a family maximum Deductible may be applied. When this family maximum is satisfied for a calendar year, Dental benefits will be payable as if the individual Deductibles had been satisfied for each person in the Member's family. The family maximum Deductible each calendar year will be the amount shown above (but not more than the individual Deductible Amount for any one person in the Member's family).

Maximum Payment Limit

(Applies to combined charges for Treatment or Service received from Preferred Providers and Non-Preferred Providers.)

The Dental Maximum Payment Limit for Dental Care Types 1, 2, and 3 (in combination) for the Member and for each Dependent each calendar year will be $1,500.

Dental Treatment Plan

When charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed $300 for an Insured Person, he or she may file a Dental Treatment Plan with the Company before treatment begins.

HOW TO BE INSURED – MEMBERS

DENTAL EXPENSE INSURANCE

Eligibility

Persons enrolling for insurance must be a Member who Resides in the United States.

For Managers:

If the person is a Member on June 1, 2023, the person will be eligible on that date.

If the person is not a Member until later, the person will be eligible on the first of the Insurance Month coinciding with or next following the date the person begins Active Work.

For All Others:

If the person is a Member on June 1, 2023, the person will be eligible on the later of that date or the first of the Insurance Month coinciding with or next following the date the person completes the Eligibility Waiting Period.

If the person is not a Member until later, the person will be eligible on the first of the Insurance Month coinciding with or next following the date the person completes the Eligibility Waiting Period.

The Eligibility Waiting Period is a period of 60 days during which the person is continuously Actively at Work.

If a person elects to waive insurance under the Group Policy because such person is covered under group dental expense coverage or coverages provided by a Dependent's employer, the date such coverage terminates because that Dependent is no longer eligible under his or her employer's coverage will be considered the date the person is eligible to request insurance as described in this section. Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Dates - Actively at Work

If the Member is not Actively at Work on the date the Member's insurance would otherwise be effective, the Member's insurance will not be in force until the day the Member returns to Active Work.

This Actively at Work requirement will be waived for the Member if:

- the Member is absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- the Member was Actively at Work on the last scheduled work day before the date of the absence; and
- the Member was capable of Active Work on the day before the scheduled effective date of the insurance or change in the insurance, whichever is applicable.

Individual Incontestability and Eligibility

All statements made by any person insured will be representations and not warranties. These statements may not be used to contest the Insured Person's insurance unless:

- the insurance has been in force for less than two years during the Insured Person's lifetime; and
- the statement is in Written form Signed by the Insured Person; and
- a copy of the form which contains the statement is given to the Insured Person or the Insured Person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, the Company may, at any time, adjust premiums and benefits to reflect the correct age.

Effective Date for Initial Insurance

The Member must request initial insurance on a form provided by the Company.

If the Member is required to contribute towards the cost of his or her insurance, insurance will normally be in force on:

- the date the Member is eligible, if he or she makes the request within 31 days after the date such person is eligible; or
- the first of the Insurance Month coinciding with or next following the date of the Member’s request, if he or she makes the request within 31 days after the date such person is eligible.

If request for contributory insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described below.

If request for contributory insurance is made more than 31 days after the date a Member is eligible and other than during an Annual Open Enrollment Period or a Special Enrollment Period described below, insurance for such Member will become effective as described below for Late Enrollees.

If request for contributory insurance is made more than 31 days after the date a Member is eligible but during an Annual Open Enrollment Period described below, insurance for such Member will become effective as described below under Annual Open Enrollment Period.

If request for contributory insurance is made more than 31 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under Special Enrollment Period.

If the Member is not required to contribute toward the cost of his or her insurance, insurance will normally be in force on the date the Member is eligible.

However, if the Member is not Actively at Work on the date insurance would otherwise be effective, his or her insurance will not be in force until the date he or she returns to Active Work.

In addition, the Member's Dental Expense Insurance will be subject to the Benefit Waiting Period Limits.

Effective Date for Late Enrollees

If a Late Enrollee requests insurance other than during an Annual Open Enrollment Period or a Special Enrollment Period, the effective date of insurance for the Late Enrollee will be the day immediately following completion of the Annual Open Enrollment Period, provided on such date:

- the Member continues to meet the Group Policy's definition of a Member; and
- for Dependent insurance, the Dependent continues to meet the Group Policy's definition of Dependent.

Annual Open Enrollment Period

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll; or
- during any previous Annual Open Enrollment Period, or during any subsequent Special Enrollment Period as described below; or
- within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Open Enrollment Period, the Member or Dependent:

- must meet the eligibility requirements described in the Group Policy, including satisfaction of any applicable Eligibility Waiting Period; and
- may not be covered under an alternate dental expense coverage offered by the Policyholder, unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment Period is the one-month period immediately prior to the Policy Anniversary date.

The effective date for any qualified individual requesting insurance during the Annual Open Enrollment Period will be the day immediately following completion of the Annual Open Enrollment Period.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): Benefit Waiting Period Limits will not apply to the Member or his or her Dependent Child if:

- the Member is enrolled (or eligible to be enrolled but had failed to enroll during a previous enrollment period); and
- the Member failed to enroll his or her Dependent Child during a previous enrollment period; and
- the Member is required by a QMCSO or NMSN as defined by federal law and state insurance laws to provide dental coverage for his or her Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and
- will apply only to the Member and/or his or her Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for the Member's or his or her Dependent Child's insurance:

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

Special Enrollment Period

A Special Enrollment Period will be available for a Member or Dependent if enrollment is made after the first period in which the Member or Dependent are eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage. A Special Enrollment Period will apply to the Member or Dependent if all of the following conditions are met:

  - the Member was covered under another group dental expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
  - the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, cessation of Dependent status, or if the other coverage was under COBRA or a state continuation provision, due to exhaustion of the continuation); and
  - request for enrollment is made within 31 days after the other coverage terminates.

  The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

  "Loss of eligibility" does not include:

  - a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the dental expense coverage); or
  - a loss due to a spouse's voluntary termination of his or her dental expense coverage; or
  - a loss due to a spouse's voluntary termination of his or her Dependent dental expense coverage.

- Newly Acquired Dependents. A Special Enrollment Period will apply to the Member or Dependent if:

  - the Member is enrolled (or is eligible to be enrolled but failed to enroll during a previous enrollment period); and
  - a person becomes the Member's Dependent through marriage, birth, adoption or Placement for Adoption; and
  - request for enrollment is made within 31 days after the later of the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Dental Expense Insurance is available to the Member under the Group Policy.

The effective date of the Member's or Dependent's insurance will be:

- in the event of marriage, the date of such marriage; or
- in the event of a Dependent Child's birth, the date of such birth; or
- in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

During a Special Enrollment Period, the Member's Dental Expense Insurance will not be subject to the Benefit Waiting Period Limits.

Effective Date for Benefit Changes

A change in the Member's Scheduled Benefit amount because of a change in status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of change in status.

A change in the Member's Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change.

However, if the Member is not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day he or she returns to Active Work.

Termination

Unless continued as provided below or under the continuation provisions, the Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or
- the end of the Insurance Month in which the Member ceases to belong to a class for which insurance is provided; or
- the end of the Insurance Month in which the Member ceases to be a Member; or
- the end of the Insurance Month in which the Member ceases Active Work.

Termination of insurance will be without prejudice to any claim originating prior to the date of termination and while insured.

Note: Prior to the first Policy Anniversary, the Company may not terminate the Group Policy, except for nonpayment of the required premium or failure of the Policyholder to meet and continue underwriting standards.

Termination for Fraud

The Company may at any time terminate an Insured Person's eligibility under the Group Policy:

- in Writing and with 31 day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law, which constitutes acts or admissions by the Member or his or her Dependent and such information is contained in a Written instrument Signed by the person making such statement;
- in Writing and with 31 day notice, upon finding in a civil or criminal case that an Insured Person has submitted claims that contain false or fraudulent elements under state or federal law and such information is contained in a Written instrument Signed by the person making such statement;
- in Writing and with 31 day notice, when an Insured Person has submitted a claim which, in good faith judgment and investigation, an Insured Person knew contains false or fraudulent elements under state or federal law and such information is contained in a Written instrument Signed by the person making such statement.

Termination of Preferred Provider Organization (PPO)

The Company has the right to terminate the Preferred Provider Organization (PPO) portion of the Group Policy if the Company or the Preferred Provider Organization (PPO) terminates the arrangement.

The Company also has the right to identify different Preferred Provider Organizations from time to time and to terminate the designation of any Preferred Provider at any time.

Continuation

If the Member ceases Active Work because he or she is sick or injured, he or she may be eligible for limited continuation of insurance for not more than six consecutive months.

If the Member ceases Active Work because of layoff or approved leave of absence, insurance may be continued on a limited basis for up to one month.

The Member's insurance may also be continued by paying the required contribution, if any, under the continuation provisions.

All continuation provisions may run concurrently.

If the Member is interested in continuing his or her insurance beyond the date it would normally terminate, he or she should consult with the Policyholder before his or her insurance terminates.

Insurance While Outside of the United States

If the Member is outside the United States, his or her insurance will automatically terminate. However, the Member will continue to be eligible for benefits provided under the Group Policy if the Member is temporarily outside of the United States for a period of six months or less for one of the following reasons:

- travel, provided the travel is for a reason other than securing dental care diagnosis or treatment; or
- a business assignment; or
- Full-Time Student status, provided the Insured Person is either:

    - enrolled and attending an accredited school in a foreign country; or
    - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit.

HOW TO BE INSURED – DEPENDENTS

DENTAL EXPENSE INSURANCE

Eligibility

A Member's spouse must Reside in the United States to be eligible for Dependent insurance.

A Member will be eligible for Dependent insurance on the latest of:

- the date the Member is eligible for Member insurance; or
- the date the Member enters a class for which Dependent insurance is provided; or
- the date the Member first acquires a Dependent.

If the Member's Dependent is employed and is covered under group coverage provided by his or her employer, the date such coverage is terminated because the Member's Dependent is no longer eligible under his or her employer's plan will be considered the date the Member first acquired that Dependent (and any other Dependent who was also covered under such coverage). Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

The Member may elect to waive insurance for his or her Dependent Child until 31 days after the child's third birthday. If request for insurance is more than 31 days after the Dependent Child's third birthday, benefits will be subject to the Benefit Waiting Period Limits.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance for his or her Dependents will be in force under the same terms (including application of the Eligibility Waiting Period) as described earlier for Member insurance, except:

- a Dependent acquired after the Member's Dependent insurance is already in force will be insured on the date acquired.
- the Actively at Work requirement does not apply to the Member's Dependents.

In addition, Dependent Dental Expense Insurance will be subject to the Benefit Waiting Period Limits.

Individual Incontestability and Eligibility

Dependents will be subject to the Individual Incontestability and Eligibility provision as described earlier for Member insurance.

Annual Open Enrollment Period

Dependents will be subject to the Annual Open Enrollment Period provisions as described earlier for Member insurance.

Special Enrollment Period

Dependents will be subject to the Special Enrollment Period provisions as described earlier for Member insurance.

Termination

Unless continued as provided under the continuation provisions:

- Insurance for all of the Member's Dependents will terminate on the earliest of:
    - the end of the Insurance Month in which the Member ceases to belong to a class for which Dependent insurance is provided; or
    - the date Dependent insurance is removed from the Group Policy; or
    - the date the Member's insurance ceases; or
    - the end of the Insurance Month in which the last premium is paid for the Member's Dependent Dental Expense Insurance.

- Insurance for a spouse or Dependent Child will terminate on the earlier of:
    - for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or
    - the last day of the Insurance Month in which a spouse or Dependent Child ceases to be a Dependent. However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined.

Notwithstanding the above, insurance will terminate on the last day of the calendar month in which the Member's Dependent Child turns age 26.

However, Dental Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on the Member for primary support. The Member must apply for this continuation within 31 days after the child reaches the maximum age.

Termination for Fraud

Dependents will be subject to the Termination for Fraud provisions as described earlier for Member insurance.

Insurance While Outside of the United States

Dependents will be subject to the Insurance While Outside of the United States provisions as described earlier for Member insurance.

Continuation

In addition, under certain conditions, Dependent Dental Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions.

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of the insurance.

A. Qualified Persons/Qualifying Events

Continuation of group dental coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

(1) A Member (and any covered Dependents) following the Member's:

(a) termination of employment for a reason other than gross misconduct; or
(b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, absence due to sickness or injury, or, when applicable, retirement.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

(2) A Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
(3) A Member's surviving spouse (and any Dependent Children) following the Member's death; and
(4) A Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
(5) A Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and

(6) A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
(7) If the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree dental benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, dental coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or
(2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A(2) through A(5) is 36 months from the date of the qualifying event.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.
(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, would result in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end on the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends on the earliest of the following:

(1) The date the maximum continuation period ends; or
(2) The date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A(7); or
(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
(4) The date the Group Policy is terminated (and not replaced by another group dental plan); or

(5) The date the qualified person becomes covered by another group dental plan; however, this does not apply to a person who is already covered by the other group dental plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group dental plan are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A(7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent has a qualifying event due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirements

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group dental coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider dental enrollment options carefully.

M. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Dental Plan: ORTHO SOLUTIONS LC, DBA DYNAFLEX Dental Plan
Contact Name/Area: ORTHO SOLUTIONS LC, DBA DYNAFLEX Benefits Department
Address: 8050 HAWK RIDGE TRAIL, LAKE ST LOUIS, MO 63367
Phone Number: (314) 426-4020

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

FMLA and Other Continuation Provisions

If the Policyholder is an Eligible Employer and if the continuation portion of the FMLA applies to the Eligible Employee's insurance, these FMLA continuation provisions:

- Are in addition to any other continuation provisions of the Group Policy, if any; and
- Will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a “qualifying exigency” arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty, as applicable to retired regular armed forces members, reserve members, National Guard members, and members in contingency operations, as defined under federal law.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to Eligible Employees to care for a “covered service member” with a “serious injury or illness”.

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

Contact the Policyholder for details on this reinstatement provision.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Federal law requires that if insurance would otherwise end because the Member enters into active military duty or inactive military duty for training, he or she may elect to continue insurance (including Dependent Insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If Active Work ends because the Member enters active military duty or inactive military duty for training, insurance may be continued until the earliest of:

- for the Member and Dependents:
    - the date the Group Policy is terminated; or
    - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
    - the date 24 months after the date the Member enters active military duty; or
    - the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.
- for the Member's Dependents:
    - the date Dependent Dental Expense Insurance would otherwise cease; or
    - the end of any Insurance Month, if requested by the Member before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If the Member qualifies for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in the Group Policy, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

DESCRIPTION OF BENEFITS
DENTAL EXPENSE INSURANCE

(PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by the Group Policy for an insured class, the Member and his or her Dependents:

- be insured in that class on the date dental Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES section.

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS.

DENTAL EXPENSE INSURANCE

Payment Conditions

If the Member or Dependent receives any Treatment or Service that is listed in the SCHEDULE OF DENTAL PROCEDURES, the Company will pay Dental benefits for Covered Charges:

- in excess of the Deductible Amount(s); and
- at the payment percentage(s) indicated; and
- to the maximum allowances (indicated in the SCHEDULE OF DENTAL PROCEDURES) and Maximum Payment Limits;

as described in the SUMMARY OF BENEFITS section.

Benefit Waiting Period Limits for Late Enrollees (requests made more than 31 days after (1) the date eligible; or (2) the date the Member elects to terminate insurance)

If the Member requests Member or Dependent insurance more than 31 days after the date the person is eligible, or elects to terminate insurance and more than 31 days later requests to be insured again, during the first 24 months in which insurance is in force, benefits will be limited as follows:

- During the first 12 months, benefits will be payable only for Dental Care Type 1 (Preventive Procedures) Covered Charges.
- During the second 12 months, benefits will be payable only for Dental Care Type 1 (Preventive Procedures) Covered Charges and Dental Care Type 2 (Basic Procedures) Covered Charges.

After insurance has been in force for 24 consecutive months, benefits will be payable for charges incurred for Covered Charges under Dental Care Types 1, 2, and 3.

These Benefit Waiting Period provisions will not apply to Covered Charges incurred for an Accidental Injury that results from an accident that occurred on or after the date the Member or Dependent insurance became effective.

These Benefit Waiting Period provisions will not apply if the Member requests Member or Dependent insurance during the Annual Open Enrollment Period or the Special Enrollment Period or to coverage required under a QMCSO or NMSN.

Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures shown in the SCHEDULE OF DENTAL PROCEDURES section subject to the maximum allowance for each procedure. Also:

- If the Company determines that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the maximum allowance for the least expensive of the procedures that would provide professionally acceptable results.
- Covered Charges will include only those charges for Treatment or Service that begins (see below) while the Member and Dependents are insured under the Group Policy.
- Covered Charges will include only those charges for Treatment or Service that is completed while the Member and Dependents are insured under the Group Policy (except when the Treatment or Service is covered under the Extended Benefits provision).

Beginning Date for Treatment or Service

Treatment or Service will be considered to begin:

- for root canal therapy, on the date the pulp chamber is opened, and the pulp canal explored to the apex; and
- for crowns, fixed bridgework, inlays or onlay restoration, on the date the tooth or teeth are fully prepared; and
- for complete or partial dentures, on the date the master impression is made; and
- for all other, on the date the Treatment or Service is performed.

Completion Date for Treatment or Service

Treatment or Service will be considered to be completed:

- for root canal therapy, on the date the tooth is sealed; and
- for crowns, on the date the crown is seated; and
- for fixed bridgework, on the date the bridge is seated; and
- for inlay or onlay restorations, on the date the inlay or onlay is seated; and
- for complete or partial dentures, on the date the complete or partial denture is seated.

Limitations

Dental Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not for Necessary Dental Care; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- the services of any person in the Member's or Dependent's Immediate Family; or
- charges for personal protective equipment (PPE) including but not limited to N95 masks, surgical masks, face shields, gowns and shoe coverages, protective barriers, disinfection protocols, isolation systems, air purifiers, and filters; or
- personalization of dentures or crowns (or any other Treatment or Service that is primarily cosmetic); or
- Treatment or Service that does not meet professionally recognized standards of quality; or
- drugs and medicines (other than antibiotic injections); or
- instructions for plaque control, oral hygiene, or diet; or
- bite registration or occlusal analysis; or
- Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or
- Treatment or Service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance; or
- Orthodontic Treatment or Service; or
- Treatment or Service that results from:
    - an injury arising out of or in the course of any employment for wage or profit if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
    - a sickness that is covered by a Workers' Compensation Act or other similar law; or
- Treatment or Service due to any form of temporomandibular joint dysfunction/disorder, including but not limited to diagnosis, braces, splints, appliances, restorations, or surgery of any type; or
- Treatment or Service that is temporary unless provided otherwise in the SCHEDULE OF DENTAL PROCEDURES; or
- Treatment or Service replacing tooth structure lost from abrasion or attrition; or
- Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or

- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or
- Treatment or Service provided outside the United States, unless the Insured Person is temporarily outside the United States, for a period of six months or less for one of the following reasons:
    - travel, provided the travel is for a reason other than securing dental care diagnosis or treatment; or
    - a business assignment; or
    - Full-Time Student status, provided the Insured Person is either:
        - enrolled and attending an accredited school in a foreign country; or
        - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or
- Treatment or Service for which the Member or Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- Treatment or Service that results from war or act of war; or
- Treatment or Service for which benefits are payable under any group medical expense coverage; or
- Treatment or Service that results from participation in criminal activities.

SCHEDULE OF DENTAL PROCEDURES

If dental care is received from Preferred Providers, the maximum allowance for each of the listed procedures will be the actual cost charged to the Member or Dependent, but only to the extent that the actual cost charged does not exceed the negotiated fee amount (determined by the Provider and the PPO).

If dental care is received from Non-Preferred Providers, the maximum allowance for each of the listed procedures will be the actual cost charged to the Member or Dependent, but only to the extent that the actual cost charged does not exceed Prevailing Charges. The Member will be responsible for payment of any amount over Prevailing Charges.

Unless the Company agrees otherwise, Covered Charges will include only charges for procedures listed in the SCHEDULE OF DENTAL PROCEDURES. If a non-listed procedure is accepted, the Company will determine its maximum allowance based on the maximum allowance for a listed procedure of comparable nature.

Dental Care Type 1 - Preventive Procedures

Dental Procedure

Preventive Examinations

Oral examination (evaluation)

Periodic examination (evaluation)

Only one of the listed examinations will be covered in any six consecutive months.

Oral cancer screening, including brush biopsy to assist in the early detection of oral cancer covered once in any 24 consecutive months.

Radiographs

Full Mouth Survey

Complete series (including bitewings)
Panoramic

Only one of the listed full mouth surveys will be covered in any 60 consecutive months.

Dental Procedure

Radiographs (Continued)

Bitewing

For Dependent Children under age 18, only one set will be covered in any twelve consecutive months.

For adults 18 years of age or older, only one set will be covered in any twelve consecutive months.

Preventive Services

Prophylaxis (cleaning of teeth)

Covered once in any six consecutive months.

Topical application of fluoride

Applicable only to Dependent Children under the age of 16. Only one application will be covered in any twelve consecutive months.

Topical application of sealants

Applicable only to first and second permanent molars for Dependent Children under age 16. Covered once each tooth in any 36 consecutive months.

Topical reapplication of sealants

Applicable only to first and second permanent molars for Dependent Children under age 16. Covered once each tooth in any 36 consecutive months.

SCHEDULE OF DENTAL PROCEDURES

If dental care is received from Preferred Providers, the maximum allowance for each of the listed procedures will be the actual cost charged to the Member or Dependent, but only to the extent that the actual cost charged does not exceed the negotiated fee amount (determined by the Provider and the PPO).

If dental care is received from Non-Preferred Providers, the maximum allowance for each of the listed procedures will be the actual cost charged to the Member or Dependent, but only to the extent that the actual cost charged does not exceed Prevailing Charges. The Member will be responsible for payment of any amount over Prevailing Charges.

Unless the Company agrees otherwise, Covered Charges will include only charges for procedures listed in the SCHEDULE OF DENTAL PROCEDURES. If a non-listed procedure is accepted, the Company will determine its maximum allowance based on the maximum allowance for a listed procedure of comparable nature.

Dental Care Type 2 - Basic Procedures

Dental Procedure

Radiographs

Occlusal
Periapical

Extraoral X-Rays

Sialography
TMJ
Posterior-anterior or lateral skull and facial bone survey
Other extraoral

Only one of the listed extraoral procedures will be covered in any six consecutive months.

Diagnostic x-rays performed in conjunction with orthodontic treatment will not be considered Type 2 Covered Charges.

Restorations

Fillings (amalgam or resin-based composite)

Anterior

Multiple restorations on one surface will be paid as a single filling.

Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface.

Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

Posterior

Benefits for composite restorations on posterior teeth will be based on the benefits for the corresponding amalgam restorations.

Minor Oral Surgery

Simple extractions
Surgical access of an unerupted tooth
Harvest of bone for use in autogenous grafting procedure
Surgical excision of soft tissue lesions
Surgical excision of intra-osseous lesions
Incision and drainage of abscess - intraoral soft tissue
Incision and drainage of abscess - intraoral soft tissue - complicated, including drainage of multiple fascial spaces
Incision and drainage of abscess - extraoral soft tissue
Incision and drainage of abscess - extraoral soft tissue - complicated, including drainage of multiple fascial spaces

Complex Oral Surgery

Surgical extractions
Oroantral fistula closure
Primary closure of a sinus perforation
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)

Mobilization of erupted or malpositioned tooth to aid eruption
Surgical repositioning of teeth
Transseptal fiberotomy/supra crestal fiberotomy
Alveoloplasty
Vestibuloplasty
Excision of bone tissue
Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
Removal of reaction producing foreign bodies, musculoskeletal system
Partial ostectomy/sequestrectomy for removal of non-vital bone
Maxillary sinusotomy for removal of tooth fragment or foreign body
Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous
Sinus augmentation with bone or bone substitutes via a lateral open approach
Sinus augmentation via a vertical approach
Bone replacement graft for ridge preservation – per site
Repair of maxillofacial soft and/or hard tissue defect
Frenulectomy (aka frenectomy or frenotomy)
Frenuloplasty
Excision of hyperplastic tissue – per arch
Excision of pericoronal gingiva
Surgical reduction of fibrous tuberosity

Periodontic Services

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive months.

Periodontal prophylaxis (includes probing, charting, exam, polishing, scaling, root planing, and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment and then not more than twice in twelve consecutive months.

Periodontal Surgical Procedures

Gingival flap procedure
Gingivectomy
Gingival curettage
Osseous surgery
Pedicle soft tissue graft
Free soft tissue graft

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 36 consecutive months.

Other Periodontal Services

Periodontal appliance

One appliance is covered in any 36 consecutive months.

Endodontic Services

Vital pulpotomy

Covered for deciduous teeth only.

Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care.

Apexification
Apicoectomy
Retrograde filling
Root resection
Hemisection

Anesthesia

General anesthesia
IV sedation

General anesthesia or IV sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under the Group Policy (and only when performed in a dental office).

Other Services

Limited oral evaluation - problem focused

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit. For Teledentistry only two visits to a non-specialist will be covered in any twelve consecutive months.

Antibiotic drug injection

Bacteriologic culture

Histopathologic examination

Space Maintainers

Applicable only to Dependent Children under age 16. Repairs to space maintainers are not covered.

Biopsy of oral tissue

Restorations

Stainless steel

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay or onlay are covered only if at least seven years (84 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth are limited to resin or stainless steel crowns.

SCHEDULE OF DENTAL PROCEDURES

If dental care is received from Preferred Providers, the maximum allowance for each of the listed procedures will be the actual cost charged to the Member or Dependent, but only to the extent that the actual cost charged does not exceed the negotiated fee amount (determined by the Provider and the PPO).

If dental care is received from Non-Preferred Providers, the maximum allowance for each of the listed procedures will be the actual cost charged to the Member or Dependent, but only to the extent that the actual cost charged does not exceed Prevailing Charges. The Member will be responsible for payment of any amount over Prevailing Charges.

Unless the Company agrees otherwise, Covered Charges will include only charges for procedures listed in the SCHEDULE OF DENTAL PROCEDURES. If a non-listed procedure is accepted, the Company will determine its maximum allowance based on the maximum allowance for a listed procedure of comparable nature.

Dental Care Type 3 - Major Procedures

Dental Procedure

Other Services

Recementing

Inlay
Onlay
Crown
Bridgework

Covered only if done more than twelve months after initial insertion of inlay, onlay, crown, or bridge, and then not more than one time in any 24 consecutive months.

Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

Repairs to complete or partial denture, bridge, or crown

Covered only if repair is done more than twelve months after initial insertion of the denture, bridge, or crown, and then not more than one time in any 24 consecutive months.

Relining or rebasing complete or partial dentures

Covered only if relining or rebasing is done more than twelve months after initial insertion of the denture, and then not more than one time in any 36 consecutive months.

Tissue Conditioning

Covered only if at least twelve months have elapsed since the insertion of a complete or partial denture, and then not more than one time in any 24 consecutive months.

Denture Adjustment

Covered once in any twelve consecutive months and only if at least twelve months have elapsed since the insertion of the denture.

Restorations

Gold inlays and onlays

Gold inlays or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement.

Labial Veneer

Veneer restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement.

Crowns (single restorations only)

Resin (laboratory)
Resin, prefabricated
Resin with nonprecious metal
Resin with semiprecious metal
Resin with gold
Porcelain
Porcelain with nonprecious metal
Porcelain with semiprecious metal
Porcelain with gold
Gold (3/4 cast)
Gold (full cast)
Nonprecious metal (full cast)
Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least seven years (84 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay or onlay are covered only if at least seven years (84 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crown on vital teeth are limited to resin or stainless steel crowns.

Post and core in addition to crown, indirectly fabricated

Covered only for teeth that have had root canal therapy.

Prefabricated post and core in addition to crown

Covered only for teeth that have had root canal therapy.

Steel post and composite or amalgam

Covered only for teeth that have had root canal therapy.

Prosthodontics, Fixed

Fixed bridges - initial placement or replacement

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the Insured Person's insurance will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is insured under the Group Policy (provided that tooth was not an abutment to an existing partial denture that is less than five years old). In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the Group Policy.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than seven years old (84 consecutive months) and is not serviceable and cannot be repaired.

Prosthodontics, Removable

Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the Insured Person's insurance will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while insured under the Group Policy. In that event, benefits are payable only for the replacement of those teeth which were extracted while insured under the Group Policy.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than five years old (60 consecutive months) and is not serviceable and cannot be repaired.

Covered Charges for complete or partial dentures do not include any additional charges for over-dentures or for precision or semi-precision attachments.

Temporary partial or complete dentures

Covered once in any 12 consecutive months. If the temporary denture is not replaced with a permanent denture within 12 months, it will be deemed a permanent denture and will be subject to the requirements described above.

Implants

Surgical placement of implant body (endosteal, eposteal, or transosteal implant)
Implant connecting bars and supporting structures
Implant repair and removal
Implant maintenance procedure (twice per year)

Coverage for dental implants is limited to persons over the age of 16.

Initial placement of dental implants and/or supporting structures to support the replacement of teeth which were missing prior to the effective date of the Member’s or Dependent's insurance will not be covered.

Benefits for the replacement of an existing implant are payable only if the existing implant is no longer serviceable and 84 consecutive months have elapsed since the last placement of the implant. Dental implants to replace existing fixed bridgework, partial or full denture will not be covered unless 84 consecutive months have elapsed since the last placement of the fixed bridgework, partial or full denture.

DENTAL EXPENSE INSURANCE
EXTENDED BENEFITS
(after termination of insurance)

If Dental Expense Insurance under the Group Policy ceases and if the Member or Dependents qualify, the Company will pay for:

- root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while the Member or Dependent was insured under the Group Policy; and
- crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while the Member or Dependent was insured under the Group Policy; and
- complete or partial dentures, but only if the master impression was made while the Member or Dependent was insured under the Group Policy;

provided the Treatment or Service is received within 30 days after the Member's or Dependent's insurance terminates.

The Member or Dependent will qualify if:

- he or she would have qualified for benefit payment under the Group Policy had insurance remained in force; and
- the Treatment or Service began while he or she was insured under the Group Policy; and
- the Group Policy is in force at the time Treatment or Service is received.

However, no extended benefits will be paid for Treatment or Service received on or after the date the Member or Dependent becomes eligible for other group dental expense coverage.

DENTAL EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when the Member or Dependent has dental care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Insured Person or the Prevailing Charge for a Treatment or Service.

Definitions

*"Plan" is any of these which provide benefits or services for, or because of, medical care or dental care or treatment:

- group insurance and group subscriber contracts; and
- uninsured arrangements of group or group-type coverage; and
- group or group-type coverage through a Health Maintenance Organization or other prepayment, group practice and individual practice plans; and
- group-type contracts; and
- the amount by which group or group-type hospital indemnity benefits exceed $100 per day; and
- the medical benefits coverage in group, group-type and individual automobile no-fault but, as to traditional automobile fault-type contracts only the medical benefits Written on a group or group-type basis may be included; and
- Medicare or other governmental benefits, except as provided below and except as mandated by Federal law.

The term Plan will not include benefits provided under:

- individual or family insurance contract; or
- individual or family subscriber contracts; or
- individual or family coverage under other prepayment, group practice and individual practice plans; or
- group or group-type hospital indemnity benefits of $100 per day or less; or
- student accident-type coverage covering grammar, high school and college students for accident only, including athletic injuries, on a twenty-four hour basis or on a to-and-from school basis; or
- a state plan under Medicaid and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

The term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

* In the event a husband and wife are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

"This Plan" is the dental expense benefits described in this booklet-certificate.

"Primary Plan/Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary or a Secondary Plan as to another Plan covering the person.

- When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
- When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense for dental care; when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When benefits are reduced under a Primary Plan because an Insured Person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to preferred provider arrangements.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the part of a calendar year during which the Member or Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

When This Plan is the Secondary Plan, benefits payable under This Plan will be reduced by the sum of benefits payable for the same Treatment or Services under all other Plans, and will not exceed what This Plan would have paid as the Primary Plan.

For this purpose:

- No benefits will be payable under This Plan if the Primary Plan's reimbursement is equal to or more than what This Plan would have paid had This Plan been the Primary Plan.
- If the Primary Plan's reimbursement is less than what This Plan would have paid had This Plan been the Primary Plan, benefits payable under This Plan will be equal to the difference between This Plan's payment, had This Plan been Primary, and the Primary Plan's payment.
- Benefits payable under other Plans will include the benefits that would have been paid had claim been made for them.
- For any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The Plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

    - Secondary to the Plan covering the person as a Dependent; and
    - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee);

then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- **Dependent Child – Parents Not Separated or Divorced.** If a Dependent Child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- **Dependent Child - Separated or Divorced Parents.** If a Dependent Child of legally separated or divorced parents is covered under two or more Plans, benefits for the Dependent Child are determined in this order:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the Dependent Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the Dependent Child shall follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced.

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Continuation of Coverage**. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

    - first, the benefits of a Plan covering the person as an employee, Member, or subscriber (or as that person's Dependent);
    - second, the benefits under the continuation coverage.

    If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider dental enrollment options carefully.

How COB Works

Example 1: The natural father is covered as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. The Company would then determine the benefits payable, if any, under This Plan.

Example 2: Mrs. Smith has filed a claim for $1,000 with both Company A and Company B. Company A covers Mrs. Smith as an employee under a Plan, which pays 80% of Covered Charges. Company B covers her as a dependent spouse under a Plan, which pays 90% of Covered Charges.

Both Plans have a COB provision, therefore, Company A would pay first since it covers Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

	Company A
Allowable Expenses	$ 1,000
x 80% coinsurance	x 80%
Benefit Payable	$ 800

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B.

	Company B
Allowable Expenses	$ 1,000
x 90% coinsurance	x 90%
	$ 900
Less Company A's benefit	-800
Benefit Payable	$ 100

Example 2A: Mrs. Smith has filed a claim for $1,000 with both Company A and Company B. Company A covers Mrs. Smith as an employee under a Plan, which pays 80% of Covered Charges. Company B covers her as a dependent spouse under a Plan, which pays 80% of Covered Charges.

Both Plans have a COB provision, therefore, Company A would pay first since it covers Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

	Company A
Allowable Expenses	$ 1,000
x 80% coinsurance	x 80%
Benefit Payable	$ 800

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B.

	Company B
Allowable Expenses	$ 1,000
x 80% coinsurance	x 80%
	$ 800
Less Company A's benefit	-800
Benefit Payable	$ 0

Example 2B: Mrs. Smith has filed a claim for $1,000 with both Company A and Company B. Company A covers Mrs. Smith as an employee under a Plan, which pays 80% of Covered Charges. Company B covers her as a dependent spouse under a Plan, which pays 70% of Covered Charges.

Both Plans have a COB provision, therefore, Company A would pay first since it covers Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

	Company A
Allowable Expenses	$ 1,000
x 80% coinsurance	x 80%
Benefit Payable	$ 800

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B.

	Company B
Allowable Expenses	$ 1,000
x 70% coinsurance	x 70%
	$ 700
Less Company A's benefit	-800
Benefit Payable	$ 0

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to the Company within 20 calendar days after the date of loss or as soon as reasonably possible. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Except in the case of dental care received from Preferred Providers, claim forms and other information needed to prove loss must be filed with the Company in order to obtain payment of benefits. The Policyholder will provide forms to assist in filing claims. If the forms are not provided within 15 calendar days after the Company receives such notice of claim, the Insured Person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to the Company within 90 calendar days after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. The Company may request additional information to substantiate the Insured Person's loss or require a Signed unaltered authorization to obtain that information from the provider. The Company may also require x-rays, dental charts, and other evidence needed to determine the dental condition treated and the services provided. Failure to furnish proof of loss within such time will not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof of loss is otherwise required.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Company will either deny the claim or send a Written explanation requesting information prior to the expiration of the 30 calendar days. If the Company does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits will be payable sooner, provided the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for its denial.

State Time Limits: Unless otherwise preempted by the Employee Retirement Income Security Act (ERISA), state time limits will apply. State law requires that benefits payable under the Group Policy will be payable not more than 30 days after receipt of proof and subject to proof of loss.

A claimant or a designated representative or provider acting on the Insured Person's behalf may request an appeal of a claim denial or file a Grievance by Written request to the Company within 180 calendar days of receipt of the notice of denial. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card). The Company will acknowledge receipt, in Writing, of a Grievance within ten (10) business days of receipt.

The Company will make a full and fair review of the claim. Persons not involved in the circumstances giving rise to the Grievance or its investigation will determine the Grievance decision. The Company may require additional information to make the review. The Company will notify the claimant in Writing of the appeal decision within 30 calendar days of receiving the appeal request for post-service claims and 15 calendar days for pre-service claims. If the Company cannot complete the review within this time, the Company may take an additional ten (10) business days. The Company will provide the claimant Written notice of the extension and the reason for the delay on or before the twentieth business day after receipt of a post-service Grievance and on or before the fifteenth calendar day after receipt of a pre-service Grievance. The Company will notify the claimant in Writing of the appeal decision within 72 hours for urgent care claims and an expedited Grievance review. A request for an expedited Grievance review may be submitted orally or in Writing by the claimant or a designated representative or provider acting on the Insured Person's behalf. Written confirmation of an expedited Grievance decision will be sent within three business days.

The appeal review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal process, a claimant or a designated representative or provider acting on the Insured Person's behalf may request a voluntary appeal or a second-level Grievance review. The appeal must be requested in Writing within 60 calendar days of receipt of the final internal adverse benefit determination or Grievance decision. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card). The Company will acknowledge receipt, in Writing, of a Grievance within ten (10) business days of receipt.

The Company will make a full and fair review of the claim. Upon receipt of a request for a second-level Grievance review, the Company will appoint a Grievance advisory panel consisting of other Members and persons who were not involved in the circumstances giving rise to the Grievance or in any subsequent investigation or determination of the Grievance. When the Grievance involves an Adverse Determination, the panel will consist of a majority of persons who are appropriate clinical peers. The claimant may submit Written comments, documents, records, and other information relating to the claim for benefits. The Company will make a determination within 30 calendar days of request for a voluntary appeal review for post-service claims and 15 calendar days for pre-service claims. If the Company cannot schedule and hold the Grievance review meeting within this time, the Company may take an additional ten (10) business days. The Company will provide the claimant Written notice of the extension and the reason for the delay on or before the twentieth business day after receipt of a post-service Grievance and on or before the fifteenth calendar day after receipt of a pre-service Grievance.

Election of a second appeal is voluntary and does not negate the claimant's right to bring civil action following the first appeal, nor does it have any effect on the claimant's right to any other benefit under the Group Policy. The Company offers the voluntary appeal review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the voluntary appeal review process, the claimant may file a civil action or pursue any other legal remedies.

If at any time (prior to, during, or after the Grievance process), the claimant is not satisfied with actions taken by the Company, the claimant may contact the Director, Missouri Department of Insurance, 301 West High Street, Room 530, Jefferson City, MO 65102 or by telephone at 1-800-726-7390.

As used in this provision:

- "Adverse Determination" means a determination that an admission, availability of care, continued stay or other dental care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is denied, reduced or terminated.

- "Grievance" means a complaint concerning the availability, delivery, or quality of dental care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review; claim payment, handling or reimbursement for dental care services; or matters pertaining to the contractual relationship between an Insured Person and the Company.
- "Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, dental care services, procedures or settings.

For purposes of this section, "claimant" means the Member or the Member's Dependent.

Preferred Providers

When a person becomes insured, such person will be issued an identification card. This card should be presented to each Preferred Provider at the time the Insured Person receives needed dental care. Each Preferred Provider will provide the Insured Person with a claim form and other filing assistance.

Dental Treatment Plan

When charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed $300, a Dental Treatment Plan may be filed with the Company before Treatment or Service begins. A form will be provided for this purpose. Upon receipt of the Dental Treatment Plan, the Company will indicate the benefits that will be payable for the proposed Treatment or Service and will return the form to the attending Dentist.

The filing of a Dental Treatment Plan is intended to help avoid any misunderstanding between the Insured Person, the Dentist, and the Company as to how much will be paid for dental work. A Dental Treatment Plan is not a guarantee of what the Company will pay. It informs the Insured Person and the Dentist, in advance, what the Company will pay for a covered dental Treatment or Service named in the Dental Treatment Plan. Payment is subject to the Benefit Qualifications. If the Company does not agree with a Dental Treatment Plan, or if one is not sent in, the Company has the right to base payments on Treatment or Service suited to the Insured Person's condition by accepted standards of dental practice.

Facility of Payment

The Company will normally pay all benefits to the Member. However, if the claimed benefits result from a Dependent's dental care, the Company may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Company to the full extent of those payments.

- If payment amounts remain due upon the Member's death, those amounts may, at the Company's option, be paid to the Member's estate, spouse, child, parent, or provider of dental services.
- If the Company believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Company may pay whoever has assumed the care and support of the person an amount up to $2,000.
- Benefits payable to a Preferred Provider will be paid directly to the Preferred Provider on behalf of the Insured Person.

Unbundling

When certain complicated dental procedures are performed, other less extensive procedures are performed at the same time, as component parts of the primary procedure. For benefit payable purposes under the Group Policy, these less extensive procedures are considered to be integral components of the primary procedure. Even if the Dentist bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

Dental Examinations

The Company may have the person whose loss is the basis for claim examined by a Dentist. The Company will pay for these examinations and will choose the Dentist to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 60 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in this booklet-certificate.

As a participant in this plan the Member is 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 the Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and 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 description. The 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 annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Member, spouse, State Registered Domestic Partner or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. The Member and his or her Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing COBRA continuation coverage rights.

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 employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Member and other plan participants and beneficiaries. No one, including the Member’s employer, union, or any other person, may fire the Member or otherwise discriminate against the Member in any way to prevent the Member from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcing the Member's Rights

If the Member's claim for a welfare benefit is denied or ignored, in whole or in part, the Member has 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 the Member can take to enforce the above rights. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or Federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Member may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his or her rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

Assistance with Questions

If the Member has any questions about his or her plan, he or she should contact the plan administrator. If the Member has any questions about this statement or about his or her rights under ERISA, or if he or she needs assistance in obtaining documents from the plan administrator, the Member should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Member may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

SUPPLEMENT
TO THE BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 43-1813595
   PN: 501

2. **Type of Administration:**

   Dental Expense Insurance: Insurance Contract

3. **Plan Administrator:**

   ORTHO SOLUTIONS LC, DBA DYNAFLEX
   8050 HAWK RIDGE TRAIL
   LAKE ST LOUIS, MO 63367

   See the employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   ORTHO SOLUTIONS LC, DBA DYNAFLEX
   8050 HAWK RIDGE TRAIL
   LAKE ST LOUIS, MO 63367

   A complete list of the employers and/or employee organizations sponsoring the plan may be obtained upon Written request to the plan administrator and is also available for examination at the business office of the plan administrator.

   Upon Written request, participants may receive from the ERISA Plan Administrator information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan, and if the employer or employee organization is a plan sponsor, their address.

5. **Agent for Service of Legal Process:**

ORTHO SOLUTIONS LC, DBA DYNAFLEX
8050 HAWK RIDGE TRAIL
LAKE ST LOUIS, MO 63367
Telephone: (314) 426-4020

Legal process may also be served upon the plan administrator.

6. **Type of Participants Insured Under the Plan:**

All active Full-Time Employees of ORTHO SOLUTIONS LC, DBA DYNAFLEX and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS section of this booklet-certificate.

7. **Sources and Methods of Contributions to the Plan:**

Employee pays all of employee's contribution. Employee pays all of Dependent's contribution (if employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

May 31

DEFINITIONS

Several words and phrases used to describe insurance are capitalized whenever they are used in this booklet-certificate. These words and phrases have special meanings as explained in this section.

Accidental Injury means an injury to natural teeth that is caused by an accident. Not included is any injury that results from chewing.

Active Work; Actively at Work mean the active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Benefit Waiting Period means the period after the effective date of an Insured Person's insurance during which benefits are not payable. The Benefit Waiting Period may vary based on the type of Treatment or Service.

Company means Nippon Life Insurance Company of America.

Covered Charges mean charges for the types of Treatment or Service listed under Covered Charges of the booklet-certificate, to the extent the charges do not exceed Prevailing Charges.

Deductible; Deductible Amount mean a specified dollar amount of Covered Charges that must be incurred by the Insured Person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the calendar year.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Treatment Plan means the Dentist's report of proposed dental Treatment or Service which:

- is Written on a form provided by the Company; and
- lists the procedures required for the Period of Dental Treatment; and
- shows the charges for each procedure; and
- is accompanied by any diagnostic materials that the Company might require.

Dentist means:

- a person licensed to practice dentistry; and
- a licensed Physician who provides dental Treatment or Service.

Dependent means:

- A Member's spouse, if that spouse:

  - Resides in the United States; and
  - is not in the armed forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is legally wed to the Member.

- A Member's Dependent Child (or Children), as defined below.

Dependent Child; Dependent Children means:

- A Member's natural, stepchild or legally adopted child, if that child is less than 26 years of age.

  A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- A Member's foster child, provided:

  - the child meets the requirements above; and
  - the child has been placed with the Member or the Member's spouse insured under this booklet-certificate by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; and
  - the required documentation has been provided and the child is approved in Writing by the Company as a Dependent Child.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap, as determined by the Company, which:

- results from intellectual disability, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Eligibility Waiting Period means with respect to a group dental plan and an individual who is a potential enrollee in the plan, the period of time that must pass before insurance for an individual who is otherwise eligible to enroll for benefits under the terms of the plan can become effective.

Emergency Treatment means any Necessary Dental Care which is rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

Experimental or Investigational Measure(s) means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of dentistry, as determined by the Company.

Full-Time Employee means any person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means a Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria; and
- is dependent on the Member for principal support.

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the chewing process in the Insured Person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

Generally Accepted means Treatment or Service which:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed dental and scientific literature; and
- is in general use in the dental community; and
- is not under continued scientific testing or research as a therapy for the particular injury or sickness which is the subject of claim.

Group Policy means the policy and booklet-certificate of group insurance issued to the Policyholder by the Company which describes benefits and provisions for the Policyholder and Insured Persons.

Immediate Family means an Insured Person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month means calendar month.

Insured/Insured Person means a Member or Dependent who:

- applied for insurance; and
- meets the eligibility rules set forth in the Group Policy; and
- is approved for insurance by the Company; and
- for whom all applicable premiums are paid, and is therefore insured.

When Insured is used alone, it does not include the Dependent.

When Dependent is used alone, it does not include the Member.

Lapse in Coverage means any break in coverage during which a person is not covered under any other group dental expense coverage, including but not limited to any Policyholder benefit-waiting period. Continuation provided under COBRA or any state required continuation will not be considered a break in coverage.

Late Enrollee means a Member or Dependent who enrolls more than 31 days after the date the Member or Dependent is eligible other than during a Special Enrollment Period. The term also means a Member or Dependent who:

- was previously insured under the Group Policy but elected to terminate the insurance; and
- reapplies for insurance more than 31 days after the termination date; and
- does not qualify for one of the Special Enrollment Periods.

Maximum Allowable Charge means the maximum amount, as determined by the Company, for reimbursement of a Treatment or Service.

Member means any person who Resides in the United States and is a Full-Time Employee of the Policyholder.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured).

Necessary Dental Care means any Treatment or Service prescribed by a Dentist and considered by the Company to be:

- necessary and appropriate; and
- not Experimental or Investigational Measures and not in conflict with Generally Accepted dental standards.

Non-Preferred Provider(s)/Non-PPO Provider(s) means a Dentist not contracted with the Dental Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

Physical Handicap means a Dependent Child's substantial physical or intellectual impairment, as determined by the Company, which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Policy Anniversary means June 1, and the same day of each following year.

Policyholder means the business, firm, union, trustee(s), or other entity to whom the Group Policy is issued (see Title Page).

Preferred Provider(s)/PPO Provider(s) means a Dentist contracted with a Dental Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

The Policyholder's participation in the PPO network does not mean that an Insured Person's choice of provider will be restricted. The Insured Person may seek needed dental care from any Dentist of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the Insured Persons are urged to obtain such care from Preferred Providers whenever possible.

Prevailing Charges means:

- For dental care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.
- For dental care received from Non-Preferred Providers, the actual cost charged, but only to the extent that the actual cost charged does not exceed an amount that is equal to the Maximum Allowable Charge.

Reside(s) in the United States means a Member or Dependent who:

- maintain a home in the United States; and
- live in that home in the United States; and
- do not leave the United States for more than six consecutive months.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by the Company.

Teledentistry (subject to state law) means the mode of delivering dental Treatment or Service that generally occurs in-person, but instead is provided via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of an Insured Person's dental health care while the Insured Person is at the originating site and the Dentist, Dental Hygienist, or other dental practitioner is at a distant site. Teledentistry provided through the following modalities may be included:

- live videoconferencing (synchronous): live, two-way interaction between an Insured Person and a provider using audiovisual telecommunication technology; and
- store-and-forward (asynchronous): transmission of recorded health history to a practitioner, usually a Specialty Provider, who uses the information to evaluate the case outside of a real-time visit; and
- remote patient monitoring (RPM): personal health and medical data collection from an Insured Person in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care; and
- mobile health (mHealth): dental care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA) often using an app; and
- any other method required by state law.

The Company reimburses Teledentistry at the same rate as in-person visits under Dental Care Type 2. The use of standard telephone, facsimile transmissions, or unsecured electronic mail, or a combination thereof are not considered Covered Charges for the purposes of Teledentistry. As a pre-condition for being considered a Covered Charge, the Insured Person must be virtually present and participating in the Teledentistry Treatment or Service.

Treatment or Service, when used in this booklet-certificate, will be considered to mean: "treatment, service, substance, material or device".

United States (U.S.) means the contiguous United States consisting of the 48 adjoining U.S. states plus Washington, D.C. (federal district), Alaska, and Hawaii, on the continent of North America.

We, Us, and Our mean Nippon Life Insurance Company of America, West Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

BOOKLET-CERTIFICATE NOTICE

Missouri insurance law requires that the booklet-certificate include the address and telephone number of the insurance company issuing the Group Policy. The information is as follows:

Nippon Life Insurance Company of America
P. O. Box 25951
Shawnee Mission, KS 66225-5951
Telephone: 1-800-374-1835

This Notice is for an Insured Person's information only and does not become a part or condition of this booklet-certificate.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Summary Concerning Coverage, Limitations, and Exclusions under the Alaska Life and Health Insurance Guaranty Association Act

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010-21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, not does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in Alaska and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. The beneficiary, payee, or assignee of an insured person is protected as well, even if a non-resident of Alaska.

EXCLUSION FROM COVERAGE

The association does not protect a person holding a policy if:

- the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state; or
- the policy is issued by an organization that is not a member of the Alaska Life and Health Insurance Guaranty Association.

The association does not provide coverage for:

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividends;
- a credit given in connection with the administration of a policy by a group contract holder;
- an employers' plan to the extent that is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;

- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference state in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the association will pay a maximum of:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits, $100,000 for coverages not defined as disability income, health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance and long-term care insurance;
- $500,000 for health benefits plans;
- $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- with respect to a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000 in the aggregate, of present-value annuity benefits, including net cash surrender and net cash withdrawal values with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. 401, 26 U.S.C 403(b), or 26 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased; or
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder, with respect to any one contract or plan sponsor whose plans owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value annuity benefits including net cash surrender and net cash withdrawal per individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907) 269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The guaranty association should not be contacted regarding the financial information of an insurance company.

The association is not an agency of the State of Alaska nor are there any guarantees by the State of Alaska regarding the payment of claims by the Association. The guaranty is not your insurance company.

Alaska Life and Health Insurance Guaranty Association
P.O. Box 220207
Anchorage, Alaska 99522-0207
(907) 243-2311

Division of Insurance
550 West Seventh Avenue, Suite 1560
Anchorage, Alaska 99501-3567
(907) 269-7900

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organizations becomes impaired or insolvent. COVERAGE MAY NOT BE AVAULABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverages to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association

c/o The Liquidation Division

1023 West Capitol

Little Rock, Arkansas 72201

Arkansas Insurance Department

1 Commerce Way, Suite 102

Little Rick, Arkansas 72202

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, *et seq.* Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Associations.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights, and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plan to the extend they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under the Federal Pension Benefit Corporation (“FPBC”), regardless of whether the FPBC is yet liable;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer’s obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverage. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from assets of the impaired or insolvent insurer.

Nippon Life Benefits®

Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice of Protection Provided by California Life and Health Insurance Guaranty Association - CA

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities, and structured settlements annuities are member of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. The protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, which or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuities:

For life insurance policies, annuities and structured annuities, the Association will provide the following:

Life Insurance

-- 80% of death benefits but not to exceed $300,000

-- 80% of cash surrender or withdrawal values but not to exceed $100,000

Annuities and Structured Settlement Annuities

-- 80% of the present value of annuity benefits, including net case withdrawal and net case surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number if policies or contracts covering the individual.

Health Insurance

The maximum amount of protection by the Association to an individual, as of December 31, 2019, is $602,469. This amount will increase or decrease based upon change in the health care component of the consumer price index from January 1, 1991 to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

Coverage Limitations and Exclusions From Coverage

The Association may not provide coverage for this policy. Coverage by the Association generally required residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage.

-- A policy or contract issued by an insurer that was not authorized to do business when it issued the policy or contract;

-- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual company, an insurance exchange, or a grants and annuities society;

-- If the person is provided coverage by the guaranty association of another state.

-- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guarantee annuity benefits to an individual;

-- Employer and association plans, to the extent they are self-funded or uninsured;

-- A policy or contract providing any health care benefits under Medical Part C or Part D;

-- An annuity issued by an organization that is only licensed to issue charitable gift annuities;

-- A policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract;

-- Any policy of reinsurance unless an assumption certificate was issued;

-- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

Notices

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org contract either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hill, CA 90209-3319
Phone: (323) 782-0182

or

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
Phone: (800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice of Protection Provided by Life and Health Insurance Protection Association - CO

This notice provides a brief summary of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which provides who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  $300,000 in death benefits
  $100,000 in case surrender or withdrawal values

- **Heath Insurance**
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care insurance benefits
  $100,000 in other types of health insurance benefits

- **Annuities**
  $250,000 in withdrawal and cash values

In general, the maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. These are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org or contact:

Colorado Life and Health Insurance Protection Association 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - DC

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of the Guaranty Association is to provide statutorily-determined benefits with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The Guaranty Association, established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et. seq.*), provides insolvency protection for certain types of insurance policies and contracts.

The insolvency protections provided by the Guaranty Association is generally conditioned on a person being 1) a resident of the District of Columbia and 2) the individual insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they reside in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts or certificates:
  - $300,000 in life insurance death benefits for any one life, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability insurance benefits;
  - $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;
  - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net case surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life ($500,000 in the event of basic hospital, medical and surgical insurance or major medical insurance).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insured that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of any employer or associated that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure documents.

Policy or contract holders with additional questions may contact wither:

District of Columbia
Department of Insurance, Securities and Banking
1050 First Street, NE, Suite 801
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant of Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent on connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - HI

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII LIFE AND DISABILITY INSURANCE GUARANTY ASSOCATION ACT

Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The Hawaii Life and Disability Insurance Guaranty Association 1132

Bishop Street, Suite 1590

Honolulu, HI 9683

Department of Commerce & Consumer Affairs

Insurance Division

P.O. Box 3614

Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; not does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or Disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state); or
- the insurer was not a member of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give the rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The basic protections provided by the Association re:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contract, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits and with regard to one owner or multiple non-group policies of life insurance.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - ID

IDAHO LIFE AND HEATH INSURANCE GUARANTY ASSOCIATION

GUARANTEY ASSOCIATION ACT SUMMARY DOCUMENT

Residents of Idaho who purchase life insurance, annuities, or health/disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Idaho Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for money to pay the claims of insured persons who reside in Idaho, and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is not unlimited, however, and is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

The Idaho Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Idaho. You should not rely on coverage by the Idaho Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Insurance companies and their agents are required by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any kind of insurance policy.

This information is provided by:

Idaho Life & Health Insurance Guaranty Association
3355 N Five Mile Rd # 210
Boise, Idaho 83713
208-378-9510
www.idlifega.org

Idaho Department of Insurance
700 West State Street
P O Box 83720
Boise, Idaho 83720-0043
208-334-4250
1-800-334-4250
www.doi.idaho.gov

The state law that provides for this safety-net coverage is called the Idaho Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law; nor does it in any way change your legal rights or obligations under the Association's legal rights or obligations which are defined by and set forth under the Act.**

COVERAGE:

Generally, individuals will be protected by the Association if they live in Idaho and own a life or health/disability insurance policy, an annuity contract, or if they are an insured certificateholder under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons may be protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE:

However, persons holding such policies are **not** protected by this Association if:

- they are eligible for protection under the laws of another;
- the insurer was not authorized to do business in that state;
- their policy was issued by a reciprocal insurer, a mutual benefit association, fraternal benefit society, hospital and medical service corporation, limited managed care plan, or self-funded health care plan.

The Association also does **not** provide coverage for:

- any policy or contract or any portion of a policy or contract which is not guaranteed by the insurer or under which the risk is borne by the policyholder;
- any policy of reinsurance;
- interest rate yields that exceed an average rate;
- unallocated annuity contracts (any annuity not issued to and owned by an individual) except to the extent benefits are guaranteed to an individual under the contract or certificate; and
- Medical Part C and Part D plans.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay out more than what the insurance company would owe under a policy or contract. Also, the aggregate liability per policy shall not exceed $100,000 in case surrender values, $500,000 in major medical insurance benefits, $300,000 in health/disability insurance benefits other than major medical, $250,000 in present value of annuity, or $300,000 in life insurance death benefits.

However, in no event will the Association be obligated to cover more than $300,000 in the aggregate for all benefits for any one life, except for major medical benefits which are subject to a limit of $500,000 for any one life.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCAE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per Insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in case surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and case values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health
Insurance Guaranty Association
1520 Kensington Road, Suite 112
Oak Brook, Illinois 60523-2140
(773) 714-8050

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767
(217) 782-4515

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 in health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net case surrender or net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2 (o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medical Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more above the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, Indiana 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis, Indiana 46204
(317) 232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned or continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, Indiana 46204, (telephone) (317) 232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or life, health insurance policy or annuity should be directed to your insurance company or agent.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values

Annuities

- $250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in the applicable Iowa law and generally includes hospital or medical expenses policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association website at www.ialifega.org or contract:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Avenue
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, and S&P Global Rating.

The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk Counts, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - KS

GENERAL PURPOSES AND LIMITATIONS OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

K.S.A. 40-3001, et. seq

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN KANSAS. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
3745 SW Wanamaker Road, Suite C
Topeka, KS 66610

Kansas Insurance Department
1300 SW Arrowhead Road
Topeka, KS 66604

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association
Notice - LA

Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely events that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of certain claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA	**Department of Insurance**
P.O. Box 3337	P.O. Box 94214
Baton Rouge, Louisiana 70821	Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth as R.S. 22:2081 *et seq*. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not coverall all provisions of the law; nor does it in any way change any person's rights to obligations under the law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well even if they live in another state unless they afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA of:

- He is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- His policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
- Dividends, premium refunds, or similar fees or allowances described under the Law;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by insurance company, even if an insurance company administers them) or uninsured;
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b));
- An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owners' rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, which is earlier.

LIMITS ON AMOUNT OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

- LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not impaired or an insolvent insurer.
- For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
- For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any on individual.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Association (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in hospital, medical, and surgical insurance or major medical insurance provided by health benefits plans
- $300,000 for disability insurance
- $300,000 for long-term care insurance
- $100,000 for a type of health insurance not listed above, including net case surrender and net cash withdrawal values under the types of health insurance listed above

Annuities

- $250,000 in present value of annuity benefits, including net cash withdrawal values and net case surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contract:

Maryland Life and Health
Insurance Guaranty Corporation
8817 Belair Road, Suite 208
P.O. Box 671, Suite 216C
Perry Hall, Maryland 21236
410-248-0407

Maryland Insurance
Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

Nippon Life Benefits®

Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951
1-800-374-1835

Notice Concerning Policyholder Rights In An Insolvency Under The Minnesota Life and Health Insurance Guaranty Association Law - MN

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchased life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
(651) 407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, or that defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUE FOR USING CASE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION. THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADIVS POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE. ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provide by the Association are:

Life Insurance

$300,000 in death benefits

$100,000 in net cash surrender and net cash withdrawal values

Health Insurance

$500,000 for health benefit plans (see definition below)

$300,000 in disability income insurance benefits

$300,000 in long-term care insurance benefits

$100,000 in other types of health insurance benefits

Annuities

$250,000 in the present value of annuity benefits, including net case surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. §83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medical Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract. There are also various residency requirements and other limitations under Mississippi law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, limitations and exclusions, as well protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance
Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Life and Health Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice pro vides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association ("the Association" and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event your life, annuity or health company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are as follows:

Life Insurance

- $300,000 in death benefit, but not more than $100,000 in net cash surrender and net cash withdrawal values

Health Insurance

- $500,000 for health benefit plans
- $300,000 in disability insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in the present value of annuity benefits, including net case surrender and net case withdrawal values

The maximum amount of protection of each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans
- $500,000 in aggregate for health benefit plans
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

"Heath benefit plan" is defined in section 376.718, RSMo.

Note: Certain policies and contracts may not be covered or fully covered. For example, covered does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga,org, or contract:

Missouri Life and Health Insurance
Guaranty Association
2210 Missouri Boulevard
Jefferson City, Missouri 65109
Ph: 573-634-8455
Fax: 573-634-8488

Missouri Department of Commerce
and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice of Protection Provided By Montana Life and Health Insurance Guaranty Association Notice - MT

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Montana law, which determines who and what is covered and the amounts of coverage.

The Association was established under Montana law to provide protection in the unlikely event that a life, annuity or health insurance insurer becomes financially unable to meet its obligations and is placed into liquidation. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate, and subject to the following maximum limits:

- **Life Insurance**
  - $300,000 in death benefits, but limited to $100,000 in cash surrender and net cash withdrawal values.
- **Health Insurance**
  - $500,000 in health insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- **Annuities**
  - $250,000 present value, including net cash surrender and net cash withdrawal values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to the $500,000 maximum in health insurance benefits but not including disability, long term case or other types of health insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

NOTE: Other restrictions to coverage apply. Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.mtlifega.org or contact:

Montana Life and Health Insurance Guaranty Association PO Box 8247 Missoula, MT 59807 877-678-1048 or administrator@mtlifega.org	Office of the Montana State Auditor Commissioner of Securities and Insurance 840 Helena Ave. Helena, MT 59601 406-444-2040

IF YOUR INSURANCE COMPANY IS IN GOOD STANDING AND NOT IN LIQUIDATION, PLEASE DIRECT QUESTIONS ABOUT YOUR POLICY TO YOUR INSURANCE COMPANY.

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting any insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Effective On or Before July 1, 2022

This notice provides a **brief summary** regarding the protections provided to policyholders by the Nevada Life and Health Insurance Guaranty Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies and health maintenance organizations licensed in Nevada to see life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is limited and is *not* a substitute for consumers' care in selecting insurers.

Your policy or contract may not be covered, and if covered, there are substantial coverage limitations and exclusions. Further, coverage is dependent on continued residence in Nevada.

Below is a brief summary of the coverages, exclusions, and limits provided by the Association. This summary does not cover all provisions of the law, and the law may change.

COVERAGE:

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in Nevada at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees whether or not the live in Nevada.

Amounts of Coverage

For any one life, per company, the coverage protections provided by the Association shall not exceed.

- **Life Insurance**
  - Death benefits: $300,000
  - Cash surrenders or withdrawal values: $100,000

- **Annuities and Structured Settlement Annuities**
  - Present value of annuity benefits and structured settlement annuities, including case surrenders or withdrawal values: $250,000
  - Participants in a government retirement plan covered by an unallocated annuity as described by NRS 686.C.035: $250,000

- **Health Insurance**
  - Disability Income and long-term care insurance, including net case surrender values: $300,000
  - Health Benefit Plans: $500,000
  - Health insurance, other than disability income, long-term care insurance or Health Benefit Plan: $100,000

Please note that the maximum protection provided by the Association to an individual for all life insurance, annuities, and structured settlement annuities with one insurer is $300,000; or for all life insurance, annuities, structured settlement annuities, and benefits for health benefit plans with one insurer, $500,000, regardless of the number of policies or contracts covering the individual.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The following policies and persons are examples of those excluded from the Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Nevada when it issued the policy
- A policy or contract issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or an organization that is only licensed to issue charitable gift annuities
- Persons provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual except for annuities owned by a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code
- Employer and association plans, to the extend they are self-funder or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy or reinsurance unless the assumption certificate was issued
- Interest rate yields exceed an average rate

NOTICES

Member insurers or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. The member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or coverage offered by a health maintenance organization. You may file a complaint with the Nevada Insurance Commissioner if you believe any provision of the Nevada Life and Health Insurance Guarantee Association law has been violated. To learn more about coverage provided by the Association, please visit the Association's website at www.nvlifega.org, or contact wither of the following:

Nevada Life and Health Insurance
Guaranty Association
2377 Gold Meadow Way, Suite 100
Gold River, CA 95670

Nevada Division Insurance
Department of Business and Industry
1818 E. College Pkwy, Suite 103
Carson City, NV 89706

When selecting an insurer, you should not rely on Association coverage. If there is inconsistency between this notice and Nevada law, Nevada law will control.

Nippon Life Benefits®

Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

General Information Regarding
The Life and Health Insurance
Guaranty Association Act - NJ

TO: All Group Life and Health Policyholders in New Jersey
RE: New Jersey Life and Health Insurance Guaranty Association
State Required Disclosure Statement

Residents of New Jersey who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy. Policyholders with additional questions may contact:

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center
Newark, NJ 07102
State of New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

Coverage

The following is a brief summary of the law's coverages, exclusions, and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health, or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

However, persons holding such policies are **not** protected by this Association if:

-- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
-- the insurer was not authorized to do business in that state;
-- their policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does **not** provide coverage for:

-- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
-- any policy of reinsurance (unless an assumption certificate was issued);
-- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
-- dividends;
-- credits given in connection with the administration of a policy by a group contract holder;
-- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limits on Amount of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $500,000 in life insurance death benefits and present value annuity benefits, including net case surrender and net cash withdrawals values. Within this overall limit, the Association will not pay more than $100,000 in cash surrender values for life insurance, $100,000 in case surrender values for annuity benefits, $500,000 in life insurance death benefits, or $500,000 in present value of annuities – again, no matter how many policies and contracts that were with the same company, and no matter how many different types of coverages.

The Association will not pay more than $2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Associates will pay with respect to any one group, blanket, or individual accident and health insurance policy.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - NM

NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

The notice provides a **brief summary** of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of policies or contracts, is $300,000 ($500,000 for hospital, medical and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is $250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Associations' website at www.nmlifega.org or contact:

New Mexico Life Insurance
Guaranty Association
P.O. Box 2880
Santa Fe, NM 87504-2880
505-820-7355

Insurance Division
Public Regulation Commission
P.O. Box 1269
Santa Fe, NM 87504-1269
888-427-5772

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the next page is a brief summary of this law's coverages, exclusions, and limits. **This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.**

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contact, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state;
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plan to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- A policy or contract commonly known as Medical Part C, Medical Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.

(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvent, no matter how many policies or types of policies issued by the insolvent company.

(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contractholder.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life, Accident & Sickness
Insurance Guaranty
Association Notice - ND

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

The notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Associations' website at www.ndlifega.org or contact:

North Dakota Life & Health Insurance
Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505
1-800-522-0071 or (405) 521-2828

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for any insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice Concerning Coverage Limitations and Exclusions Under The Life and Health Insurance Guaranty Association Act- OH

TO: All Group Life and/or Medical Expense Policyholders in Ohio
RE: Ohio Life and Health Insurance Guaranty Association

Residents of Ohio who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.
Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, Ohio 43220
Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On Page 2 is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Basic Provisions of the Ohio Life and Health Insurance Guaranty Association Act

Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, if they are insured under a group insurance contract, issued by a member insurer, or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage

However, persons holding such policies are **not** protected by this Association if:

-- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
-- the insurer was not authorized to do business in that state;
-- their policy was issued by a medical, health, or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

-- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
-- any policy of reinsurance (unless an assumption certificate was issued);
-- interest rate yields that exceed an average rate;
-- dividends;
-- credits given in connection with the administration of a policy by a group contract holder;
-- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limits on Amount of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000, except as specified below, no matter how many policies and contracts there were with the same company, even if they provide different types of coverages. The Association will not pay more than $100,000 in case surrender values, $500,000 in major medical insurance benefits, $300,000 in disability or long term care insurance benefits, $100,000 in other health insurance benefits, $250,000 in present value annuities, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages, the Association will pay a maximum of $300,000, except for coverages involving major medical insurance benefits, for which the maximum of all coverages is $500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: For unallocated annuities that fund governmental retirement plans under §§401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net case withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

For more information about the Ohio Life and Health Insurance Guaranty Association, visit the website at: www.olhiga.org.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY THE
OKLAHOMA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This note provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $300,000 in the present value of annuity benefits, including net case surrender and net case withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies, is $300,000, except with regard to health benefit plans for which, the maximum amount of protection is $500,000 for each individual.

"Heath benefit plan" is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org or contract:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite, 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
400 NE 50th Street
Oklahoma City, OK 73105
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage or HMO coverage. When selecting an insurance company, you should not reply on Association coverage. If there is any inconsistency between this notice and Oklahoma law, the Oklahoma law will control.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

NOTICE OF PROTECTION PROVIDED BY PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual annuities

- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:
- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

SUMMARY

COVERAGE, LIMITATIONS and EXCLUSIONS UNDER RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT ("Act")

A resident of Rhode Island who purchases life insurance, annuities, long-term care, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Life and Health Insurance Guaranty Association
235 Promenade Street, # 426
Providence, RI 02908
Tel. (401) 273-2921

Rhode Island Division of Insurance
1511 Pontiac Avenue
Cranston, RI 02920
Tel. (401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island and Health Insurance Guaranty Association Act, ("the Act") can be found beginning at R.I. Gen. Laws section 27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE

Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health contract, long-term contract or annuity contract; or is insured under a group insurance contract issued by a law member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they lived elsewhere.

EXCLUSIONS FROM COVERAGE:

The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association; or
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employers' plan to the extent that is self-funded (that is, nit insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not allowed by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer; or
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (Commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

LIMITATIONS ON COVERAGE:

The Act limits the amount of the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, surgical, major medical insurance, or long-term care insurance including any net cash surrender and net cash withdrawal values;
- $300,000 for disability insurance;
- $300,000 for long-term care insurance;
- $500,000 for basic hospital, medical, and surgical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- $250,000 in present value per payee with respect to structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. Sections 401, 403(b) or 457 covered by an unallocated annuity contract, or the beneficiaries of the each such individual if deceased; or
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner of plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contact holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws section 27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.

Nippon Life Benefits®

Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice of Protection Provided by South Carolina Life and Accident and Health Insurance Guaranty Association SC

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents in South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SC LAH IGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCHLAHIGA to provide coverage for every policy**. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association
P.O. Box 8625
Columbia, SC 29202

or

South Carolina Department of Insurance
Attn: Office of Consumer Services
121 Main Street, Suite 1000
Columbia, SC 29201
Electronic complaint submission via
www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions, and limits does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE:
Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a life, accident, health or annuity policy, plan or contract insured by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE:
Persons who hold a covered life, accident, health or annuity policy, plan or contract are riot protected by SCHLAIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, associated or other person under: (a) a multiple employer welfare arrangement (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any feeds or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approved requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medical Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external reference but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE:
The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net case surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawals values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

Nippon Life Benefits®
Nippon Life Insurance Company
of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - SD

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCITION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for the consumers' care in the selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations to exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy.

South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificate holder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage.

LIMITS ON AMOUT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net case surrender and net cash withdrawal values; (ii) for health insurance, not more than $500,000 for basic hospital, medical and surgical insurance, not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect for basic hospital, medical and surgical insurance, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of South Dakota Division of Insurance at www.dlr.sd.gov/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Notice Concerning Coverage Under the Life and Health Insurance Guaranty Association Act - TN

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities, or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box on Page 2, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions, and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
    - - $100,000 for limited benefits and supplemental health coverages
    - - $300,000 for disability and long term care insurance
    - - $500,000 for basic hospital, medical and surgical insurance or major medical insurance
- health insurance benefits for companies declared insolvent on or after January 1, 2011:
    - - $300,000 for limited benefits and supplemental health coverages
    - - $300,000 for disability and long term care insurance
    - - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

NOTE

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
P.O. Box 190434
Nashville, TN 37219
Website: www.tnlifega.org

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - TX

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects your by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life Insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual Annuities**: Up to $250,000 in present value of benefits, including case surrender and net cash withdrawal values.

- **Other policy types**: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit**: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street, Suite 230 Austin, Texas 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, Texas 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951
1-800-374-1835

Notice Of Protection Provided By The Utah Life and Health Insurance Guaranty Association - UT

This disclaimer provides a **brief summary** of the Utah Life and Health Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under the Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.

The basic protections provided by the Associations are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values

- Accident and Health Insurance
  - $500,000 for health benefits plans
  - $500,000 in disability income insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in other types of health insurance benefits

- Annuities
  - $250,000 in present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefits plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investments additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South, #150
Salt Lake City, UT 84101
(801) 320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

NOTICE OF PROTECTION PROVIDED BY THE VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 for health benefit plans
- $300,000 in disability insurance benefits
- $100,000 in other types of accident and sickness insurance benefits

Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rose Road, Suite 101
Henrico, VA 23229-5105
(804) 282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
(804) 371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

Nippon Life Benefits®
Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Life and Health Insurance Guaranty Association Notice - WA

PROTECTION FOR YOU AND YOUR INSURANCE POLICY THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

PREFACE

This brochure briefly describes the coverage provided through the Washington Life and Disability Insurance Guaranty Association ("Association").

The Association is a nonprofit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48.32 A RCW ("Act"). Every company licensed as a life or disability insurer, health care service contractor or health maintenance organization and authorized to do business in Washington state is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex-officio, oversee the operation of the Association.

The Expense of the Association are paid by assessments made against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or protection provided under the Act.

Coverage is provided for certain life, annuity and disability insurance products – including health benefit plans. However, the Association does not cover all such insurance. Coverage that is provided is subject to the definitions, limitations and exclusions provided by the Act.

The purpose of this brochure is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contract either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance
Guaranty Association
P.O. Box 2292
Shelton, WA 98584
800-562-6900

Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255
360-725-7220

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

   The Act applies to life insurance policies, disability insurance policies, and annuity contracts by an insurance company or health plan authorized to do business in Washington state. The term "disability insurance," as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance." Together, all of these policies and contracts are sometimes referred to as "covered policies," a term used in this brochure.

2. ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

   The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued in Washington state by an insurer at a time when the insurer was not licensed or did not have a certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

   The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, self-funded multiple employer welfare arrangements, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities

3. WHO IS PROTECTED UNDER THE ACT?

You are covered by the Act if you are an over of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity); and

- You are a Washington resident; or
- You are not a Washington resident, but only of: the insurer is domiciled in Washington; there is an association like the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or
- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident, or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is generally determined at the earlier of the time of entry of an order of rehabilitation or an order of liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

4. HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. The association may also directly provide benefits and coverage as authorized by the Act. The Association has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

5. WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all member companies doing business in Washington state. The funds collected from an assessment are used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

6. DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

The Association generally cannot make an assessment for covered policies issued by a company until after the order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time of twelve to eighteen months is not unusual.

When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

7. WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

   The Act provides the following maximum amounts of protection:

   Life Insurance Death Benefits.....$500,000
   Disability and Health Benefits.....$500,000
   (including Long Term Care Benefits and Benefits under Health Benefit Plans)
   Present Value of Individual Annuities.....$500,000
   Unallocated Annuity Contracts, other than certain government retirement plans
   (limit is per contract owner or plan sponsor).....$5,000,000
   Government Retirement Plans established under Internal Revenue Code § § 401, 403(b), or 457
   if covered by an unallocated annuity (limit is per participant).....$100,000

   This protection becomes effective at the time of entry of a Court order of liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

   Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim. The maximum protection is per covered person per insolvent company.

8. IF A HUSBAND AND WIFE EACH INDIVIDUALLY OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

   Yes, if residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum under the Act.

9. WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT ITS POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

   Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be under the Act.

10. WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

    Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently, will generally not discuss the subject of a guaranty act with clients.

11. WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

    You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

CONCLUSION

This brochure has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public is a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in Washington. The Association does not, by this brochure, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

For more information on answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Office of the Insurance Commissioner, whose addresses and telephone numbers are shown in the Preface.

This brochure is prepared by and made available through the Washington Life and Disability Insurance Guaranty Association, which has granted member insurance companies permission to reproduce and distribute the brochure. It is the responsibility of the company, or any representative of a company, reproducing this brochure, to ensure that the use thereof does not violate applicable laws or regulations.

SUMMARY OF THE WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

(Effective July 1, 2019)

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies and health maintenance organizations licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy and contract owners, certificate holders and enrollees of covered policies and contracts will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurer for the money to pay the claims of covered persons who love in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies and health maintenance organizations or their agents are required by law to give or send you this notice. *However, insurance companies, health maintenance organizations and their agents are prohibited by law from using the existence of guaranty association to induce you to purchase any kind of insurance policy or health maintenance organization coverage.*

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
900 Pennsylvania Avenue
P.O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386 Toll Free 1-888-879-9842
TDD: 1-800-435-7381

The state law that provides for this safety net coverage is called West Virginia Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life, health and annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24) and health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- Their policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contractholder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
    - multiple employer welfare arrangements;
    - minimum premium group insurance plan;
    - stop loss group insurance plan; or
    - administrative services only contract.
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract which is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medical Part C and D or Medicaid;
- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials, claims based on side letters or riders not approved by the Commissioner, misrepresentations regarding policy benefits, extracontractual claims or claims for penalties or consequential or incidental damages;
- A contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;
- Standard settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also, for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(1 0)); and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long term care insurance, or health benefit plans.

Also, for any one insured life, the Guaranty Association will only pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company – for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under §§ 401(k), 403 (b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

NOTICE TO INSUREDS: Employee Retirement Income Security Act (ERISA) Plan Disclosures and Claims Procedures

The federal Department of Labor has adopted two regulations that affect ERISA-governed health plans in a number of ways. First, sponsors of employee benefit plans are required to provide additional, more specific information to employees about their benefits. Second, health care plans must be administered in such a way as to assure a medical patient's right to fair, faster claim payments and appeals of adverse benefit decisions.

Group Health Plan Disclosures

In a regulation affecting group health plans on the first day of the second plan year on or after January 22, 2001, the Department of Labor requires that summary plan descriptions (SPDs) for group health plans contain descriptions of such features as:

- Cost-sharing provisions (premiums, deductibles, coinsurance and copayments);
- Any annual or lifetime caps or other limits;
- Preventive care services;
- Covered and excluded prescription drugs;
- Limitations on the coverage of medical tests, devices and procedures;
- Description of provisions for using network providers and receiving non-network coverage (separate listings of providers may be furnished);
- Conditions or limits for primary and specialty medical care;
- Emergency care services;
- Provisions for utilization review or pre-authorizations;
- Circumstances for disqualification, denial, loss, offset, reduction or recovery;
- Required COBRA information;
- Federal and state requirements for maternity and newborn infant coverage;
- Procedures governing qualified medical child support order determinations;
- Fees or charges imposed on a participant or beneficiary;
- A statement of ERISA rights.

Certificate-Booklets from Nippon Life Insurance Company of America (Nippon Life Benefits)

Nippon Life Benefits provides certificate-booklets containing appropriate health plan information to assist employers in meeting ERISA disclosure obligations. From time to time, Nippon Life Benefits will update and amend policies and certificate-booklets to reflect changes in federal law, state law, plan benefit designs, and plan procedures.

Employers and plan beneficiaries are encouraged to read the information contained in the certificate-booklets. Explanations and benefit advice may also be obtained from our administration staff at 1-800-374-1835, extension 43780, or by writing or telephoning our claims office, at the address and telephone number printed on the identification cards.

Group Health Plan Claims and Appeals Procedures

For claim payments on and after July 1, 2002, another federal regulation requires certain standards for claim payments and benefit appeals. These standards will be added to the procedures that Nippon Life Benefits uses to administer health plans. The new standards affect claims payments under Medical, Prescription Drugs, Dental or Vision Care Expense Insurance.

Nippon Life Benefits' Response to the Changes

Nippon Life Benefits' procedures already include claims and appeals processes required by the states in which its health policies are issued. Nippon Life Benefits' procedures also include the standards of a national accreditation organization that reviews how U.S. insurers manage both the utilization of health care services and the appeals of adverse health care decisions. So, the new ERISA claims and appeal procedures form yet another layer of protection, assuring fairness and efficiency in how individuals with group health coverage are treated.

Though claims payment methods and appeal procedures have been streamlined for years, thanks to computers, faxes, and other information technology, the federal regulation establishes standards which Nippon Life Benefits' current procedures can accommodate. The following chart highlights some of the federal standards.

Time Limits

	Urgent Health Claims	**Pre-Service Health Claims**	**Post-Service Health Claims**
Company's response to an initial claim	**72 hours;** oral communication may also be given	**15 calendar days**; an extension of another **15 days** may be used	**30 calendar days**; an extension of another **15 days** may be used
Claimant's deadline to provide additional information	**48 hours**	**45 days**	**45 days**
Company's notice of failure to file a claim correctly	ASAP**;** not to exceed **24 hours**	ASAP; not to exceed **5 days**	**N/A**
Company's notice of an incomplete claim	ASAP; not to exceed **24 hours**	Not required	Not required

Company's notice of appeal decision	**72 hours**	**30 calendar days for both the mandatory and voluntary appeal.**	**60 calendar days**; **30 calendar days** for each of a two-level appeal process
• **Concurrent care** decisions for **urgent care** must be made by the Company within **24 hours** when request is made at least 24 hours before the end of the period of authorized care. • An authorized representative of the claimant may act on behalf of the claimant. • Claimants are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to the claim. • After a **first-level mandatory appeal**, a **second-level voluntary appeal process** is available to the claimant to submit additional information. At anytime during the voluntary appeal process, the claimant retains the right to pursue civil action.			

Any special state requirements relating to claim payments or appeal procedures will remain unchanged unless they fail to comply with ERISA requirements. The net result is that Nippon Life Benefits will pay claims and conduct appeals according to the more stringent set of state or federal rules in order to produce the most beneficial results for claimants.

Sometime in the future, Nippon Life Benefits will amend its policies and certificate-booklets to reflect changes in state claims and appeal procedures as individual states change rules to comply with the federal requirements.

This Notice is for your information only and does not become a part or condition of this group plan.

Nippon Life Benefits®

Notice of Privacy Practices for Protected Health Information (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how your medical information obtained in connection with your health benefit plan administration may be used and disclosed and how you can access the information. The terms of this Notice apply to current and former plan members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and has been revised most recently effective November 1, 2013.

We are required by law to maintain the privacy of our current and former members' and dependents' protected health information, to provide notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of any revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization

Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed an authorization form. You have the right to revoke an authorization by written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to revoke an authorization can be obtained from the Privacy Officer and will be honored upon receipt by us.

Disclosures for Treatment

We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment

We may use and disclose your protected health information as necessary for payment purposes. For instance, we may use it to process or pay claims, to exercise legal subrogation rights, to perform a Precertification, to determine whether services are for medically necessary care, or to perform prospective reviews. We may also forward information to another insurer in order for them to process or pay claims on your behalf.

Uses and Disclosures for HealthCare Operations

We may use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, premium rating (when allowable by law), conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your protected health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures

We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment

We may request and receive from you and your health care providers protected health information prior to your enrollment under the group policy. When allowable by law, we may use this information to determine rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state privacy laws.

Genetic Information

We will not use or disclose any genetic information we obtain about you in any regard, including underwriting purposes.

Business Associate

Certain aspects and components of our insurance services are performed by outside vendors known as 'Business Associates.' Business Associates are under an independent duty to safeguard your privacy. Additionally we require them to sign a Business Associate Agreement, which is a contract to adhere to our privacy practices.

Plan Sponsor

We may disclose your protected health information to the plan sponsor, provided that the plan sponsor certifies that the information will be used and maintained in a compliant confidential manner and will not be utilized or disclosed for employment-related actions or decisions or in connection with any other benefit plan of the plan sponsor.

Family, Friends and Personal Representatives

With your approval, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your health care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information without your approval. We may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures
We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Uses and Disclosures Requiring Authorization
We are required by law to obtain your authorization prior to using or disclosing your protected health information in the following circumstances:

- Uses and disclosures of protected health information for marketing purposes.
- Uses and disclosures that constitute the sale of protected health information.
- Most uses and disclosures of psychotherapy notes.
- Other uses and disclosures not described in this notice will be made only with the individual's written authorization. An individual may revoke an authorization, provided that the revocation is in writing and we have not taken action in reliance upon the authorization.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your Protected Health Information
You have the right to request restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information
You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information
You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with some exceptions. To request access to your information, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request access to your protected health information can be obtained from the Privacy Officer. A fee may be charged for copying and postage.

Amendment of Your Protected Health Information You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information
You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee may be charged for any subsequent request for an accounting during that same time period.

Complaints
If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

IF you have any questions or need any assistance regarding this Notice or your privacy rights, you may call Nippon Life Insurance Company of America at: English and Non-English (800) 374-1835; Japanese (800) 971-0638; or Korean (877) 827-8713.

Please attach your copy of the enrollment card to this page. The effective date of your coverage is as shown on the card.

Any Change of Beneficiary or Change of Name forms should also be attached to this page after having been properly recorded and returned to you.

You should also attach any riders to this page.

Notes

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, Kansas 66225-5951

GV0500