Nippon Life Benefits®

ORTHO SOLUTIONS LC, DBA DYNAFLEX

EFFECTIVE JUNE 1, 2023

Group Plan Booklet Certificate

ALL MEMBERS

Member Life Insurance
Member Accidental Death and Dismemberment Insurance
Dependent Life Insurance
Dependent Accidental Death and Dismemberment Insurance

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

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

Members' rights and benefits are determined by the provisions of the Group Policy, but will never be less than the rights and benefits described in this booklet-certificate. This booklet-certificate outlines what the Member must do to be insured. It explains how to file claims. It is the Member's booklet-certificate while he or she is insured. Members may inspect a copy of the Group Policy upon Written request to the Company or the Policyholder. The Company certifies that the Member is insured for the benefits described in the booklet-certificate, subject to the provisions of the booklet-certificate.

The Member should keep his or her and his or her Dependents' applications, enrollment forms, Proof of Good Health, if any, any change of Beneficiary or change of name forms, or other similar forms with his or her booklet-certificate after the form has been recorded by the Company and returned to him or her.

The Member (and his or her eligible Dependents) are insured only for those coverages shown on the Member's application. Benefits and provisions shown in the booklet-certificate for coverages other than those marked "yes" on the Member's application are not applicable to the Member.

THIS BOOKLET-CERTIFICATE REPLACES ANY PRIOR BOOKLET-CERTIFICATE THAT THE MEMBER MAY HAVE RECEIVED. The Member should remove enrollment material from his or her prior booklet-certificate, place it with this booklet-certificate, and destroy the prior booklet-certificate. If the Member has any questions about this new booklet-certificate, he or she should contact the Policyholder. In the event of future Group Policy changes, the Member will be provided with a new booklet-certificate or a booklet-certificate rider.

PLEASE READ THIS BOOKLET-CERTIFICATE CAREFULLY. The Company suggests that the Member start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet-certificate). The meanings of these terms will help the Member understand the insurance.

The Group 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.

ACCELERATED BENEFITS - Benefits paid as shown in this booklet-certificate for Accelerated Benefits are an advance of a portion of the Member's Life Insurance benefit. This provision:

- **accelerates and reduces the Member's death benefit and Premium;**
- **is not intended to be used as long term care insurance.**

Effect on Government Benefits. If the Member receives payment of Accelerated Benefits, the Member may lose his or her right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. The Member should seek additional information from his or her personal tax advisor about the tax status of the accelerated death benefit payment.

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

NIPPON LIFE INSURANCE COMPANY OF AMERICA
6965 Vista Drive, West Des Moines, Iowa 50266
1-800-374-1835 http://www.nipponlifebenefits.com

GROUP TERM LIFE INSURANCE
RENEWABLE TERM - NONPARTICIPATING

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SUMMARY OF BENEFITS

Policyholder	ORTHO SOLUTIONS LC, DBA DYNAFLEX
Policyholder's Address	8050 HAWK RIDGE TRAIL LAKE ST LOUIS, MO 63367
Policy Number	GV0500
State Of Issue	Missouri
Insurance Department Phone Number	(573) 751-3365
Effective Date	June 1, 2023

This section highlights the benefits provided under this insurance. The purpose is to give the Member 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 the Member's benefits and any limitations or restrictions that might apply.**

NONCONTRIBUTORY MEMBER LIFE INSURANCE

If the Member dies, his or her Beneficiary will be paid the Scheduled Benefit then in force for the Member (however, see the exception noted below). The Scheduled Benefit is based on the Member's class:

Class	* Basic Scheduled Benefit
ALL MEMBERS	$25,000

The Maximum Basic Scheduled Benefit amount will be $25,000.

CONTRIBUTORY MEMBER LIFE INSURANCE

If the Member dies, his or her Beneficiary will be paid the Scheduled Benefit then in force for the Member (however, see the exception noted below). The Scheduled Benefit is based on the Member's class:

Class	* Supplemental Scheduled Benefit
ALL MEMBERS	The amount that is in increments of $10,000.

The Maximum Supplemental Scheduled Benefit amount will be $300,000 and the Minimum Supplemental Scheduled Benefit amount will be $20,000.

Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, age changes, and receipt of Accelerated Benefit payment.

* The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet-certificate in the How to Be Covered – Members section. If, because of these Proof of Good Health requirements, the Company approves an amount of insurance that is different than the Scheduled Benefit, the Member's Beneficiary will be paid the approved amount.

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If the Member is injured and otherwise qualifies, the Company will pay the following percentages of the Member's Scheduled Benefit (or approved amount, if applicable) in force:

- 13% if the toes are severed on one foot; or
- 25% if the thumb and index finger is severed on one hand; or
- 25% if four fingers are severed on one hand; or
- 50% for Loss of one hand; or
- 50% for Loss of one foot; or
- 50% for Loss of the sight of one eye; or
- 50% for Loss of Use of upper or lower limbs; or
- 75% for Loss of one arm or one leg; or
- 100% for Loss of Use of upper and lower limbs; or
- 100% for Loss of speech or hearing in both ears; or
- 100% for Loss of sight of both eyes; or
- 100% for Loss of both arms or both hands; or
- 100% for Loss of both legs or both feet; or
- 100% for Loss of life.

Payment for Loss of life will be to the Member's Beneficiary or as otherwise provided in the Death Benefit provision. Payment for any other Loss will be to the Member. The Scheduled Benefit is based on the Member's class:

NON-CONTRIBUTORY MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Class	*** Basic Scheduled Benefit**
ALL MEMBERS	$25,000

The Maximum Basic Scheduled Benefit amount will be $25,000.

CONTRIBUTORY MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Class	*** Supplemental Scheduled Benefit**
ALL MEMBERS	The amount that is in increments of $10,000

The Maximum Supplemental Scheduled Benefit amount will be $300,000 and the Minimum Supplemental Scheduled Benefit amount will be $20,000.

* The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet-certificate in the How to Be Insured – Members section. If, because of these Proof of Good Health requirements, the Company approves an amount of insurance that is different than the Scheduled Benefit, the Member's Beneficiary will be paid the approved amount.

CONTRIBUTORY DEPENDENT LIFE INSURANCE

If one of the Member's Dependents dies, the Member will be paid the Scheduled Benefit then in force for that Dependent. The Scheduled Benefit is based on the status of the Dependent:

Class

ALL MEMBERS

Dependent	*** Supplemental Scheduled Benefit**
Spouse…….	The amount that is in increments of $2,500
Dependent Children (age at death) 14 days and older……..	The amount that is in increments of $1,000

The Maximum Supplemental Scheduled Benefit amount will be $75,000 for a Spouse.

The Maximum Supplemental Scheduled Benefit amount will be $10,000 for a Dependent Child.

A Dependent Spouse's Supplemental Scheduled Benefit will not exceed 50% of the Member's Supplemental Scheduled Benefit amount. A Dependent Child's Supplemental Scheduled Benefit will not exceed 50% of the Spouse's Supplemental Scheduled Benefit amount. If the Spouse is not insured then the Dependent Child's Supplemental Scheduled Benefit will not exceed 25% of the Member's Supplemental Scheduled Benefit amount.

***** The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet-certificate in the How to Be Insured – Dependents section. If, because of these Proof of Good Health requirements, the Company approves an amount of insurance that is different than the Scheduled Benefit, the Member's Beneficiary will be paid the approved amount.

DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If one of the Member's Dependents is injured and otherwise qualifies, the Company will pay the following percentages of the Scheduled Benefit (or approved amount, if applicable) then in force for that Dependent:

- 13% if the toes are severed on one foot; or
- 25% if the thumb and index finger is severed on one hand; or
- 25% if four fingers are severed on one hand; or
- 50% for Loss of one hand; or
- 50% for Loss of one foot; or
- 50% for Loss of the sight of one eye; or
- 50% for Loss of Use of upper or lower limbs; or
- 75% for Loss of one arm or one leg; or
- 100% for Loss of Use of upper and lower limbs; or
- 100% for Loss of speech or hearing in both ears; or
- 100% for Loss of sight of both eyes; or
- 100% for Loss of both arms or both hands; or
- 100% for Loss of both legs or both feet; or
- 100% for Loss of life.

Payment will be to the Member, if he or she survives the Dependent. The Scheduled Benefit is based on the status of the Dependent:

CONTRIBUTORY DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Class

ALL MEMBERS

Dependent	*** Supplemental Scheduled Benefit**
Spouse……..	The amount that is in increments of $2,500
Dependent Children (age at death) 14 days and older……	The amount that is in increments of $1,000

The Maximum Supplemental Scheduled Benefit amount will be $75,000 for a Spouse.

The Maximum Supplemental Scheduled Benefit amount will be $10,000 for a Dependent Child.

A Dependent Spouse's Supplemental Scheduled Benefit will not exceed 50% of the Member's Supplemental Scheduled Benefit amount. A Dependent Child's Supplemental Scheduled Benefit will not exceed 50% of the Spouse's Supplemental Scheduled Benefit amount. If the Spouse is not insured then the Dependent Child's Supplemental Scheduled Benefit will not exceed 25% of the Member's Supplemental Scheduled Benefit amount.

***** The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet-certificate in the How to Be Insured – Dependents section. If, because of these Proof of Good Health requirements, the Company approves an amount of insurance that is different than the Scheduled Benefit, the Member's Beneficiary will be paid the approved amount.

HOW TO BE INSURED - MEMBERS

MEMBER LIFE INSURANCE
MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Eligibility

The Member becomes eligible on the later of the following:

- the date he or she becomes a Member who Resides in the United States;

For Managers:

- June 1, 2023, if he or she is a Member on that date or the first of the Insurance Month coinciding with or next following the date he or she begins Active Work.

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

For All Others:

- the later of June 1, 2023, if he or she is a Member on that date or the first of the Insurance Month coinciding with or next following the date he or she completes 60 consecutive days of Active Work.

If an individual is not a Member until later, he or she will be eligible on the first of the Insurance Month coinciding with or next following the date he or she completes 60 consecutive days of Active Work.

If the Member elects to waive insurance under the Group Policy because he or she is covered under group term life coverage or coverage provided by his or her Spouse's employer, the date such coverage terminates because the Spouse is no longer eligible under his or her employer's coverage will be considered the date the Member is eligible to request insurance as described in this section.

Enrollment

The Company will provide an enrollment form to be completed by any eligible Member electing insurance. Proof of Good Health will be required as described in the Proof of Good Health provision.

For any Contributory Insurance, the Member will be required to authorize payment of Premium.

For Noncontributory Insurance that does not exceed the guaranteed issue amount, the enrollment form requirement may be waived, and all information required to administer insurance will be provided to the Company directly by the Policyholder.

Effective Date – Initial Insurance

If the Member is required to contribute toward the cost of his or her insurance, the Member's insurance will normally be in force on the latest of the following dates:

- the date the Member is eligible, if he or she makes the request within 31 days after the date he or she is eligible; or
- the first of the Insurance Month coinciding with or next following the date of the Member's request, if the Member makes his or her request within 31 days after the date he or she is eligible; or
- the date required Premium is paid or has been authorized to be paid; or
- the date the Member's Proof of Good Health is approved by the Company, if required.

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

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.

The Actively at Work requirement will be waived for the Member when he or she:

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

When insurance under the Group Policy replaces coverage under a Prior Plan, the Active Work requirement may be waived for those Members who:

- are eligible and enrolled under the Group Policy on the date insurance would otherwise be effective; and
- were covered under the Prior Plan on the date of its termination.

In no event will the Active Work requirement be waived for those Members who, on the date of termination of the Prior Plan, either:

- had the option, under the terms of the Prior Plan, to convert their coverage under the Prior Plan to an individual policy; or
- were eligible under the terms of the Prior Plan to have their Premiums waived due to Total Disability.

NOTE: When insurance under the Group Policy replaces coverage under a Prior Plan and the Active Work requirement is waived, any Benefits Payable will be the lesser of the Scheduled Benefit of the Group Policy or the amount that would have been paid by the Prior Plan had it remained in force.

Effective Date for Benefit Changes

If Proof of Good Health is not required, a change in the Member's Scheduled Benefit amount because of a change in the Member's status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change in status. 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 the Member returns to Active Work.

If Proof of Good Health is not required, a change in Scheduled Benefits because of a change in the schedule of insurance elected by the Policyholder will normally be effective on the date of 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 the Member returns to Active Work.

The Member may request an increase in Scheduled Benefits, a decrease in Scheduled Benefits, or the addition of Scheduled Benefits for which the Member was not previously insured if a change in the Member's family status as described below has occurred, provided a request for such increase, decrease, or addition is made in Writing within 31 days after the date of the change in family status:

- marriage or divorce;
- death of the Member's Spouse or child;
- birth or adoption of a child;
- termination of employment by the Member's Spouse or a change in the Member's Spouse's employment that causes loss of group coverage;
- the Member's Spouse becomes employed;
- the Member's employment or the Member's Spouse's employment changes from part-time to full-time or from full-time to part-time;
- the Member or the Member's Spouse takes an unpaid leave of absence.

If Proof of Good Health is not required, a change in the Scheduled Benefits because of a request by the Member when a change in family status has occurred will normally be effective on the first of the Insurance Month coinciding with or next following the date of the request. 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 the Member returns to Active Work.

If Proof of Good Health is required, a change in the Member's Scheduled Benefit amount will normally be effective on the later of:

- the date the change would have been effective had Proof of Good Health not been required; or
- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by the Company.

Exception: Decreases in Member Life and Member Accidental Death and Dismemberment Insurance Scheduled Benefit amounts are effective on the date noted whether or not the Member is Actively at Work.

Proof of Good Health

In some instances, Proof of Good Health will be required to place the Member's insurance in force. The type and form of required proof will be determined by the Company. The Company will pay the reasonable cost for Proof of Good Health. The Member will need to file Proof of Good Health:

- if he or she requests insurance more than 31 days after the date he or she is eligible, including any insurance he or she refuses and later requests.
- if he or she has failed to provide required Proof of Good Health or has been refused insurance under the Group Policy at any prior time.
- if he or she elects to terminate insurance and, more than 31 days later, he or she requests to be insured again.
- on the date the Member is eligible for any increased or additional Scheduled Benefit amount in excess of each $10,000 increment.
- in order for the Member to become insured, initially or through future increases, for the Member Life (and Member Accidental Death and Dismemberment) Insurance Scheduled Benefit amount in excess of $20,000 if the Member is age 70 or over.
- in order for the Member to become insured, initially or through future increases, for the Member Supplemental Life (and Member Accidental Death and Dismemberment) Insurance Scheduled Benefit amount in excess of:

    - $150,000 if the Member is under age 65; and
    - $150,000 if the Member is age 65 or over but under age 70; and
    - $10,000 if the Member is age 70 or over.

- for the Member to become insured for any amended increase in Scheduled Benefit amount that is the lesser of two and one-half times the Member's current Scheduled Benefit amount or $15,000.

HOW TO BE INSURED - DEPENDENTS

DEPENDENT LIFE INSURANCE
DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Eligibility

The Member becomes eligible for Dependent insurance on the latest of the following:

- the date the Member becomes eligible for insurance;
- the date the Member first acquires a Dependent who Resides in the United States; and
- the date the Member enters a class for which Dependent insurance is provided.

If the Member's Dependent is employed and is covered under group term life coverage or coverages provided by the Dependent's employer, the date such coverage is terminated because such Dependent is no longer eligible under his/her employer's plan will be considered the date the Member first acquires that Dependent (and any other Dependent who was also covered under such coverage).

Enrollment

The Company will provide an enrollment form to be completed by any eligible Member electing Dependent insurance. Proof of Good Health will be required based upon the Company's underwriting guidelines and as described in the Effective Date provision below.

For any Contributory Insurance, the Member will be required to authorize payment of Premium.

For Noncontributory Insurance that does not exceed the guaranteed issue amount, the enrollment form requirement may be waived, and all information required to administer Dependent insurance will be provided to the Company directly by the Policyholder.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member Life Insurance. If a Member is eligible for Dependent insurance, such insurance will be in force under the same terms as described earlier for Member insurance, except:

- Insurance will not be effective unless the Member is insured for Member insurance.
- If a Dependent Spouse is in a Period of Limited Activity on the date initial Dependent insurance or an increase in Dependent Life Insurance Scheduled Benefit due to a change in the Member's status would otherwise be effective, the Dependent Spouse will not be insured until the Period of Limited Activity ends.
- If a Dependent is confined in a Hospital or Skilled Nursing Facility on the date an increase in Dependent Life Insurance Scheduled Benefits would otherwise be effective, the increase will not be in force until the confinement ends.
- Proof of Good Health will be required to make effective any Dependent Supplemental Life Insurance Scheduled Benefit amount for a Spouse that is, initially or through later increases, in excess of:

    - $50,000 for Dependents who are under age 65; and
    - $50,000 for Dependents who are age 65 or over but under age 70; and
    - $10,000 for Dependents who are age 70 or over.

    The Company will pay the reasonable cost of proof required in this instance.
- the Company must approve any required Proof of Good Health before the Member's Dependent's insurance is effective. The Company will pay the reasonable cost of obtaining any necessary proof.
- If Dependent insurance is then in force for any other Dependent, a new Dependent (other than a newborn child) will be insured on the date acquired, provided the new Dependent is not then confined in a Hospital or Skilled Nursing Facility. Requests for insurance and Proof of Good Health are not required provided the Company has been notified of the new Dependent within 31 days after the date the Dependent is acquired.
- If Dependent insurance is then in force for any other Dependent, a newly born child will be insured on the date the child is 14 day old, provided the child meets the definition of a Dependent Child.

TERMINATION

Termination

Subject to any rights provided in the Continuation, Portability and Conversion provisions, the Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; 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 Company receives Member's Written request to terminate insurance; or
- the date the Member's insurance lapses due to non-payment of Premium; or
- the date the Member ports any part of the Scheduled Benefit; or
- the end of the Insurance Month in which the Member ceases to be a Member; or
- when the Insured Person is outside of the United States, subject to the conditions outlined in the Insurance While Outside of the United States provision below; or
- the end of the Insurance Month in which the Member ceases Active Work.

Subject to any rights provided in the Conversion provision, 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 Life Insurance is removed from the Group Policy; or
- the date Dependent Accidental Death and Dismemberment Insurance is removed from the Group Policy; or
- the date the Member's insurance ceases; or
- for Dependent Accidental Death and Dismemberment Insurance, the date Dependent Life Insurance ceases.

Insurance for any one Dependent will terminate on the last day of the Insurance Month in which he or she ceases to be the Member's Dependent, subject to the Continuation for Disabled Dependent Child provision.

Insurance While Outside of the United States

If the Member or Dependent is outside the United States, his or her insurance will automatically terminate. However, the Member or Dependent will continue to be eligible for benefits provided under the Group Policy if he or she 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 health care diagnosis or treatment; or
- a business assignment; or
- Full-Time Student status, provided the Member or Dependent 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.

The Company's Responsibility to Members

If the Group Policy terminates for any reason, the Policyholder must notify the Member of the effective date of the termination.

CONTINUATION

Insurance that would otherwise terminate may be continued at the Policyholder's option or reinstated as described in this section. The Policyholder must provide a plan of continuation that applies to all Members the same way.

The amount of insurance that may continue will be the same amount in effect on the day before insurance would otherwise terminate, unless otherwise noted below. Continued insurance is subject to any reductions in the Group Policy and will terminate if the Group Policy terminates. Continued insurance for any Dependent will terminate if the Member's insurance terminates. Premiums must be paid for insurance to continue.

All continuation provisions may run concurrently.

Insurance may also be continued under the Portability provision.

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

If, at the end of any continuation period, the Member is no longer eligible for insurance under the booklet-certificate, he or she may purchase individual coverage as described in the Conversion provision. This does not apply when the Member's continued insurance is terminated due to nonpayment of Premium.

Continuation for Total Disability

If the Member ceases Active Work because of Total Disability, he or she may be eligible for limited continuation of coverage of not more than six consecutive months. Coverage continued will be limited to Life Insurance and Accidental Death and Dismemberment benefits that were in force for all Insured Persons on the day before Total Disability began. The Member will be responsible for payment of Premiums on the same basis as Premium was paid on the day before Total Disability began.

If an Insured Person dies while insurance is continued as described in this section, the death benefit will be payable as described in the Death Benefit provision.

Continuation for Disabled Dependent Child

Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of mental or physical disability and is dependent on the Member for primary support. The Member must apply for this continuation and provide proof of disability within 31 days after the child reached the maximum age. The Company may request ongoing proof of disability at reasonable intervals, in order to continue the Dependent Child's insurance.

Insurance for a disabled Dependent Child will continue as long as the child remains incapable of self-sustaining employment because of the disability and continues to meet the definition of Dependent Child except for the age limit.

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

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. Members should see their employer for details on this continuation provision, including eligibility, terms, conditions and cost for continuation of insurance during a leave.

FMLA and Other Continuation Provisions

If the Member's employer is an Eligible Employer and if the continuation portion of the FMLA applies to the Member'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, total disability, layoff, sabbatical, labor dispute 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; or
- the placement of a child with the Eligible Employee for adoption or foster care; or
- to care (physical or psychological care) for the Spouse, child, or parent of the Eligible Employee, if they have a "serious health condition"; or
- 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 forced 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.

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

Reinstatement

A longer reinstatement period may be allowed for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

Re-enrollment of Dependents Following Military Duty

If a Dependent re-enrolls for insurance within 31 days of the date his or her full-time active military duty ends, the amount of Dependent insurance applied for will be equal to the lesser of the amount that was in effect on the day before insurance ended and the then current maximum amount of insurance available for the Dependent under the Group Policy. Such insurance will take effect as of the date of application. If the Dependent is hospitalized, confined to home under a physician's care, or is receiving or applying to receive disability benefits from any source on the date of application, the Dependent's insurance will take effect on the date the Dependent is no longer hospitalized, confined or receiving or applying for disability benefits.

If a Dependent re-enrolls for insurance more than 31 days after the date that full-time active military duty ends, the Dependent will be required to submit Proof of Good Health satisfactory to the Company. The Dependent's insurance will take effect on the date determined by the Company.

During the period that the Dependent is on full-time active military duty, the Member may submit Written request at the Company's Administrative office to terminate the Dependent's insurance.

If a Dependent is no longer eligible for insurance under the booklet-certificate, he or she may purchase individual coverage as described in the Conversion provision.

CONVERSION - MEMBER

The Member will have the right to buy an individual life insurance policy from Gerber Life Insurance Company without submitting Proof of Good Health if:

- The Member's insurance terminates due to one of the following:
    - he or she ceases to be in an eligible class; or
    - he or she ceases Active Work; or
    - his or her continuation of insurance, if any, ends; or
    - the Group Policy ends; or
    - his or her initial, timely application to port coverage is rejected; or
    - the Group Policy is changed and the Member's insurance class is no longer eligible for insurance.

- The Member's insurance is reduced:
    - because the Member changes from one class to another; or
    - due to a change in the Group Policy.

Application/Effective Date

The Member must apply for conversion and the first Premium for the individual policy must be paid to the Company within 31 days after the date the Member's insurance terminates or is reduced under the Group Policy. This period is called the conversion period.

Notice of the conversion right must be given to the Member by the Policyholder at least 15 days prior to the date insurance under the Group Policy terminates or is reduced. The right to convert will expire on the later of 16 days after the Member is given this notice or at the end of the 31-day conversion period. However, in no event will the right to convert extend beyond 60 days after the expiration of the conversion period. Written notice will be given to the Member by the Policyholder. The notice will be mailed to the Member's last known address.

If the Member's insurance is reduced and he or she does not elect to convert the reduced amount within the 31 day time period, the Member may not convert the reduced amount on a later date.

Conversion Policy

The conversion policy will be for life insurance. No disability or other benefits will be included.

- The policy will be on one of the forms, other than term insurance, then issued by Gerber Life Insurance Company to persons in the risk class to which the Member belongs on the individual policy's effective date.

- The maximum amount the Member may convert is the Member Life Insurance amount in force on the date of termination of the Group Policy, less any Accelerated Benefit payment and less the amount for which the Member becomes eligible under any group policy within 31 days.
- Premium will be based on the Member's attained age, the Member's risk class and Gerber Life Insurance Company's standard rate for the policy form to be issued.

Any individual conversion policy issued will then be in force on the day after the conversion period ends.

During the conversion period, the Member's life insurance will continue under the terms of this booklet-certificate. If the Member dies within the 31 day purchase period, the Member's Beneficiary will be paid the life insurance amount, if any, the Member had the right to convert. This payment will be made whether or not the Member has applied for an individual policy. If the application and Premium payment have been received for the conversion policy, the Premiums will be refunded. In no event will the Company be liable to pay a death benefit under both this booklet-certificate and the conversion policy.

CONVERSION – DEPENDENT

The Member may convert his or her Dependent's insurance to an individual life insurance policy from Gerber Life Insurance Company without submitting Proof of Good Health if:

- such Dependent's insurance terminates for any reason other than nonpayment of Premium. This includes termination of a Dependent's insurance due to the Member's death; or
- a person insured as a Spouse no longer meets the definition of Spouse in this booklet-certificate because of divorce or separation from the Member; or
- a person insured as Dependent Child no longer meets the definition of Dependent Child in this booklet-certificate; or
- the Dependent's insurance is reduced:

    - because the Member changes from one eligible class to another; or
    - due to a change in the Group Policy.

The Member's Spouse may convert his or her insurance to an individual life insurance policy from Gerber Life Insurance Company without submitting Proof of Good Health if his or her insurance ends because the individual no longer meets the definition of Spouse.

The Member's Dependent Child may convert his or her insurance to an individual life insurance policy from Gerber Life Insurance Company without submitting Proof of Good Health if the child's insurance terminates due to the child's age.

Application/Effective Date

The Member or his or her Dependent must apply for conversion and the first Premium for the individual policy must be paid to the Company within 31 days after the date the Member's Dependent's insurance terminates or is reduced under the Group Policy. This period is called the conversion period.

Notice of the conversion right must be given to the Member by the Policyholder at least 15 days prior to the date insurance under the Group Policy terminates or is reduced. The right to convert will expire on the later of 16 days after the Member is given this notice or at the end of the 31-day conversion period. However, in no event will the right to convert extend beyond 60 days after the expiration of the conversion period. Written notice will be given to the Member by the Policyholder. The notice will be mailed to the Member's last known address.

If the Member's Dependent's insurance is reduced and the Member or his or her Dependent do not elect to convert the reduced amount within the 31 day time period, the Member may not convert the reduced amount on a later date.

Conversion Policy

The conversion policy will be for life insurance only. No disability or other benefits will be included.

- The policy will be on one of the forms, other than term insurance, then issued by Gerber Life Insurance Company to persons in the risk class to which the Member's Dependent belongs on the individual policy's effective date.
- The maximum amount the Member may convert is the Amount of Dependent's Life Insurance amount in force on the date of termination of the Group Policy, less any Accelerated Benefit payment and less the amount for which the Dependent become eligible under any group policy within 31 days.
- Premium will be based on such Dependent's attained age, his or her risk class and Gerber Life Insurance Company's standard rate for the policy form to be issued.

Any individual conversion policy issued will then be in force on the day after the conversion period ends.

During the conversion period, the Member's Dependent life insurance will continue under the terms of this booklet-certificate. If the Member's Dependent dies within the 31 day purchase period, the Member will be paid the life insurance amount, if any, the Member or his or her Dependent had the right to buy on the Dependent's life. This payment will be made whether or not the Member or his or her Dependent has applied for an individual policy. If the application and Premium payment have been received for the conversion policy, the Premiums will be refunded. In no event will the Company be liable to pay a death benefit under both this booklet-certificate and the conversion policy.

DESCRIPTION OF BENEFITS – MEMBER LIFE INSURANCE

Death Benefit

If the Member dies while insured for Member Life Insurance, the Company will pay his or her Beneficiary the Scheduled Benefit in force on the date of the Member's death less any Accelerated Benefit payment as discussed later in this section.

If the Member dies by suicide within 2 years after the effective date of his or her Member Life insurance, the Company will pay his or her Beneficiary the amount of any Premium paid by the Member to the Company during the period of time the Member's insurance was in force in lieu of the Scheduled Benefit (or approved amount, if applicable) in force on the date of the Member's death. The 2 year period includes the continuous period of time the Member's Life Insurance was in force under the Prior Plan and initial insurance under the Group Policy. Any such payment will discharge the Company to the full extent of such payment.

If the Member dies by suicide within 2 years after the effective date of an increase in Member Life Insurance because of a request by the Member, the Company will pay his or her Beneficiary the amount of any Premium paid by the Member to the Company for the increased amount in lieu of the increased Scheduled Benefit (or approved amount, if applicable) in force on the date of death. Any such payment will discharge the Company to the full extent of such payment.

Beneficiary

The Member should name a Beneficiary at the time he or she enrolls for insurance. If two or more Beneficiaries are designated and their shares are not specified, their shares will be divided equally. If no Beneficiary survives the Member, the Company will make payment in the following order of precedence:

- to the Member's Spouse
- to the Member's child(ren) born to or legally adopted by the Member
- to the Member's parent(s)
- to the Member's brother(s) and sister(s)
- if none of the above, to the executor or administrator of the Member's estate or other persons as provided in the Group Policy.

However, if a Beneficiary is suspected or charged with the Member's death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If a Beneficiary is found guilty of the Member's death, such Beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent Beneficiary or to the executor or administrator of the Member's estate.

The Member will be deemed his or her Dependent's Beneficiary, unless another Beneficiary is designated. If the Member is not alive on the date of the Dependent's death, the Member's estate will be deemed the Beneficiary. If the Member and Dependent both die within the same week, the Dependent's death benefit will be paid to the Member's estate.

Any payment of the death benefit made in good faith shall discharge the Company from liability to the extent of such payment.

The Member may later change his or her Beneficiary by filing a Written request with the Company. See the Policyholder for change request forms. Unless the Member specifies otherwise, the change of Beneficiary will become effective as of the date signed, subject to any payments made or actions taken by the Company prior to the Company's receipt of this notice, at its Administrative Office. An irrevocable Beneficiary may not be changed without the Beneficiary's Written consent.

Waiver of Premium

If the Member ceases Active Work for any reason, his or her insurance will normally terminate. However, if the Member ceases Active Work because he or she is Totally Disabled, he or she might qualify to continue his or her Member Life Insurance and Member Accidental Death and Dismemberment Insurance and Dependent Life Insurance and Dependent Accidental Death and Dismemberment Insurance. This continuation is called Waiver of Premium. This Waiver of Premium provision does not apply to the Member if he or she has continued coverage under the Portability or Conversion provisions.

To be qualified for insurance during Total Disability, the Member must:

- become Totally Disabled while insured for Member Life Insurance; and
- become Totally Disabled before the earlier of retirement or age 60; and
- return any conversion policy that was issued; and
- remain Totally Disabled continuously for a waiting period of 270 days, during which time Premiums were paid as due and remain Totally Disabled thereafter; and
- be under the regular care and attendance of a Physician; and
- send proof of Total Disability to the Company within one year of the date Total Disability starts and as often thereafter as the Company may reasonably require.

If a Total Disability starts during a grace period, the Premium due must be paid before any Premiums will be waived.

The Company has the right to require a second or third medical opinion, at the Company's expense, to confirm eligibility for Waiver of Premium. The Company may designate the Physician for the second medical opinion. In the case of conflicting opinions, eligibility for this benefit will be determined by a third medical opinion provided by a Physician that is mutually acceptable to the Member and the Company.

If the Member dies during the waiting period, proof of Total Disability should be submitted to the Company after death. Proof of Total Disability includes supporting documentation that the Total Disability continued without interruption from the date the waiver benefit started to the date of death. If the Member had converted the continued coverage to an individual life insurance policy, the Member will qualify for continued life insurance if the individual policy is returned without claim.

The Company will send the Member notice advising whether the Member is approved for Waiver of Premium or not and the amount of Premium being waived. If the Member is approved, Premium will not be charged for Member Life Insurance and Member Accidental Death and Dismemberment Insurance and Dependent Life Insurance and Dependent Accidental Death and Dismemberment Insurance while the Waiver of Premium is in force. Premiums will be refunded from the date of Total Disability, but in no event will Premiums be refunded more than one year prior to the date notice of claim is received at the Company's Administrative Office. Premiums must continue to be paid when due until the Member's claim is approved. After the initial approval, the Company may periodically request additional proof of continuing Total Disability, but will not do so more frequently than once every six months.

Premiums waived by the Company will not be deducted from any booklet-certificate proceeds.

Waiver of Premium benefits will cease on the earliest of:

- the date of the Member's death; or
- the date the Member is no longer Totally Disabled; or
- the date the Member is age for Normal Retirement if he or she is Totally Disabled prior to age 60; or
- the date the Member fails to provide required proof of Total Disability; or
- the date the Member refuses to be examined by a Physician; or
- the date the Policyholder terminates the Waiver of Premium provision under the Group Policy.

Waiver of Premium benefits for any Dependent Life Insurance and Dependent Accidental Death and Dismemberment Insurance will end on the earliest of:

- the date the Member's waiver benefit ends; or
- the date the Member dies; or
- the date the Dependent is no longer eligible for insurance under the Group Policy.

If the Member dies while Waiver of Premium is in force, the Company will pay the Member's Beneficiary the Member Life Insurance benefit, if any, that would have been paid had the Member remained insured under the benefit schedule in force on the date the Member Total Disability began. Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to age change and receipt of an Accelerated Benefit payment.

On the date the Waiver of Premium ends, the Member may convert his or her or his or her Dependents' Life Insurance in effect on such date, unless the Member has returned to Active Work and are insured under the Group Policy or unless the Member has already converted all or a portion of the Member's or his or her Dependents' Life Insurance coverage. Conversion must be elected as described in the Conversion provision.

Note that Waiver of Premium will not be in force and NO BENEFIT WILL BE PAID if notice and Written proof of Total Disability is not sent to the Company within ONE YEAR of the date Total Disability starts. However, failure to give notice and Written proof within the time specified will not invalidate or reduce any claim if Written proof is given as soon as reasonably possible.

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of the Member's Life Insurance benefit. To qualify for an Accelerated Benefit, the Member must:

- be insured for a Member Life Insurance benefit of at least $10,000; and
- be Terminally Ill; and
- send a request for Accelerated Benefit payment to the Company; and
- send proof, satisfactory to the Company, of the Member's Terminal Illness to the Company; and
- provide a release from the assignee, if the Member's Life Insurance Benefit has been assigned.

Proof of Terminal Illness will consist of a statement from the Member's Physician, and any other medical information that the Company believes is needed to confirm the Member's status.

If the Member qualifies, the Company will pay the Member any amount he or she requests; except that:

- only one Accelerated Benefit payment will be made during the Member's lifetime; and
- the Member must request a payment of at least $5,000; and
- the Company will not pay the Member more than the lesser of: (1) 50% of the Member's Life Insurance benefit; or (2) $100,000

The Company will pay the Member the Accelerated Benefit payment in a lump sum immediately upon receipt of due Written proof of eligibility.

If an Accelerated Benefit is paid, the Member Life Insurance benefit otherwise payable to the Member's Beneficiary upon his or her death will be reduced by the Accelerated Benefit payment.

Upon the Member's request to accelerate the death benefit and payment of the Accelerated Death Benefit, the Company will provide a statement to the Member and any assignee of record or irrevocable Beneficiary of record demonstrating the effect of the acceleration on the death benefit and Premium of the booklet-certificate. The statement will disclose the Premium necessary to continue any remaining insurance following the acceleration.

Following is an EXAMPLE of how this benefit affects the final death benefit.

BENEFIT EXAMPLE

Member Life Insurance Benefit Amount	$100,000
Accelerated Benefit Amount Requested (Member would receive $50,000)	$50,000
Accelerated Benefit paid on August 15 Member death occurs on December 15	(92 days after payment)
Payment to Member's Beneficiary ($100,000 - $50,000)	$50,000

If the Member dies after electing to receive accelerated benefits, but before any such benefits are received, the election will be cancelled and the death benefit paid pursuant to the booklet-certificate.

The Member is free to choose not to apply for the Accelerated Benefit. The Member cannot be compelled to apply for the Accelerated Death Benefit before qualifying for Medicaid, and cannot be required by creditors to apply for the Accelerated Death Benefit. Payment of an Accelerated Death Benefit for one Insured Person will not reduce any other Insured Person's insurance and will not reduce accidental death and dismemberment benefits, if any, provided in or with this booklet-certificate.

Termination of this booklet-certificate, and the Accelerated Benefit, will not prejudice the payment of benefits for any Terminal Illness that occurred while the booklet-certificate was in force.

DESCRIPTION OF BENEFITS – DEPENDENT LIFE INSURANCE

Death Benefit

If one of the Member's Dependents dies while insured for Dependent Life Insurance, the Company will pay the Scheduled Benefit in force for that Dependent less any Accelerated Benefit payment as discussed later in this section.

Payment will be to the Member if he or she survives the Dependent. If not, the Company will pay the Beneficiary the Member named for Member Life Insurance. However, if the Member is suspected or charged with the Dependent's death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If the Member is found guilty of the Dependent's death, the Member may be disqualified from receiving any benefit due. Payment may then be made to any contingent Beneficiary or to the executor or administrator of the Dependent's estate.

No payment will be made before the Company receives Written proof of the Dependent's death.

If the Member's Dependent dies by suicide within 2 years after the effective date of his or her Dependent Life Insurance, the Company will pay the amount of any Premium, attributable to that Dependent, paid by the Member to the Company during the period of time the Dependent Life Insurance for the Member's Dependent was in force in lieu of the Scheduled Benefit (or approved amount, if applicable) in force on the date of the Dependent's death. The 2 year period includes the continuous period of time the Dependent's Life Insurance was in force under the Prior Plan and initial insurance under the Group Policy. Any such payment will discharge the Company to the full extent of such payment.

If the Member's Dependent dies by suicide within 2 years after the effective date of an increase in Dependent Life Insurance requested by the Member, the Company will pay his or her Beneficiary the amount of any Premium paid by the Member to the Company for the increased amount in lieu of the increased Scheduled Benefit (or approved amount, if applicable) in force on the date of death. Any such payment will discharge the Company to the full extent of such payment.

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of the Dependent's Life Insurance benefit. To qualify for an Accelerated Benefit, the Dependent must:

- be insured for a Dependent Life Insurance benefit of at least $10,000; and
- be Terminally Ill.

The Member must:

- send a request for Accelerated Benefit payment to the Company; and

- send proof, satisfactory to the Company, of the Dependent's Terminal Illness to the Company; and
- provide a release from the assignee, if the Dependent's Life Insurance Benefit has been assigned.

Proof of Terminal Illness will consist of a statement from the Dependent's Physician, and any other medical information that the Company believes is needed to confirm the Dependent's status.

If the Dependent qualifies, the Company will pay the Member any amount he or she requests; except that:

- only one Accelerated Benefit payment will be made during the Dependent's lifetime; and
- the Member must request a payment of at least $5,000; and
- the Company will not pay the Member more than the lesser of: (1) 50% of the Dependent's Life Insurance benefit; or (2) $100,000.

The Company will pay the Member the Accelerated Benefit payment in a lump sum immediately upon receipt of due Written proof of eligibility.

If an Accelerated Benefit is paid, the Dependent Life Insurance benefit otherwise payable to the Member upon his or her death will be reduced by the Accelerated Benefit payment.

Upon the Member's request to accelerate the death benefit and payment of the Accelerated Death Benefit, the Company will provide a statement to the Member and any assignee of record or irrevocable Beneficiary of record demonstrating the effect of the acceleration on the death benefit and Premium of the booklet-certificate. The statement will disclose the Premium necessary to continue any remaining insurance following the acceleration.

Following is an EXAMPLE of how this benefit affects the final death benefit.

BENEFIT EXAMPLE

Dependent Life Insurance Benefit Amount	$100,000
Accelerated Benefit Amount Requested	$50,000
(Member would receive $50,000)	
Accelerated Benefit paid on August 15	
Dependent death occurs on December 15	(92 days after payment)
Payment to Member's Beneficiary	
($100,000 - $50,000)	$50,000

If the Dependent dies after the Member elects to receive accelerated benefits, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the booklet-certificate.

The Member is free to choose not to apply for the Accelerated Benefit. The Member cannot be compelled to apply for the Accelerated Death Benefit before qualifying for Medicaid, and cannot be required by creditors to apply for the Accelerated Death Benefit. Payment of an Accelerated Death Benefit for one Covered Person will not reduce any other Covered Person's coverage and will not reduce accidental death and dismemberment benefits, if any, provided in or with this booklet-certificate.

Termination of this booklet-certificate, and the Accelerated Benefit, will not prejudice the payment of benefits for any Terminal Illness that occurred while the booklet-certificate was in force.

DESCRIPTION OF BENEFITS - ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

This section describes additional benefits that may be payable if a Insured Person sustains death, dismemberment or other specified loss due to an accidental Injury while insured for these benefits. Certain accidental Injuries are excluded, as described in the Limitations provision.

Accidental Death

If any Insured Person dies as a result of Injury, the Company will pay the Scheduled Benefit shown in the Summary of Benefits. Death must occur within 365 days of the accident.

Payment for the Member's loss of life will be to the Beneficiary named for Member Life Insurance. Payment for all other losses will be to the Member.

Accidental Dismemberment

If an Insured Person sustains an irrevocable Loss or Loss of Use due to Injury, the Company will pay the applicable dismemberment benefit shown in the Summary of Benefits. Loss or Loss of Use must occur within 365 days of the date of the accident.

Total payment for all Accidental Dismemberment losses that result from the same accident will not exceed 100% of the Insured Person's Scheduled Accidental Death and Dismemberment Benefit. Payment will be to the Member, unless he or she designates otherwise. If the Insured Person is disabled and later dies as a result of a single accident, the Accidental Death benefit is payable in lieu of the Accidental Dismemberment benefit.

Seat Belt Benefit

If an Insured Person loses his or her life as a result of an accidental injury sustained while driving or riding in an Automobile and the Accidental Death Benefit is payable, an additional benefit equal to 50% of the Scheduled Benefit will be paid provided:

- the Automobile is equipped with factory installed Seat Belts; and
- the Seat Belt was in actual use by the Insured Person and properly fastened at the time of the accident; and
- the position of the Seat Belt is certified in the official report of the accident or by the investigating officer.

In the case of the Member's death, the benefit will be paid to the Member's Beneficiary. Otherwise, the benefit will be paid to the Member.

Limitations – Accidental Death and Dismemberment

Payment will not be made for any Injury caused or contributed to by:

- disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity; or
- suicide or attempted suicide, or any intentionally self-injury, while sane or insane; or
- active participation in a riot or insurrection; or
- committing or attempting to commit a felony or illegal occupation or activity; or
- travel in or descent from an aircraft, if the Insured Person acted in a capacity other than as a passenger; or
- participation in flying, ballooning, parachuting, parasailing, bungee jumping, or other aeronautic activity, aviation except as a passenger on a commercial aircraft or as a passenger or crew member in a Policyholder-owned or leased aircraft on company business; or
- war or act of war; or
- the Insured Person's intoxication. For purposes of this exclusion, intoxication means having a blood alcohol level in excess of that allowed by the jurisdiction where the Injury occurred; or
- the voluntary intake of any drug, including any narcotics or hallucinogens, unless prescribed or administered by a Physician and taken in accordance with the Physician's instructions or an over the counter drug, taken in accordance with the instructions; or
- driving or riding in an air, land or water vehicle in a race, speed or endurance contest.

Payment will also not be made for any Injury for which workers' compensation benefits are payable.

Termination – Accidental Death and Dismemberment

Benefits in this section will terminate under the same terms as the rest of the booklet-certificate. Termination of this benefit will not prejudice the payment of benefits for any accident that occurred while the benefit was in force.

DESCRIPTION OF BENEFITS - PORTABILITY

Group Plan Provisions

If the Member's or the Member's Dependents' insurance terminates, the Member may be eligible to continue insurance under a new group policy issued by the Company specifically for, and limited to, providing portability for Members and their Dependents whose insurance ends under an employer group plan. The portability booklet-certificate will describe the benefits provided, and such benefits may not be the same as those provided by the Group Policy. The portability booklet-certificate will provide Insured Persons a right to convert to individual coverage if the portability coverage terminates.

With respect to any notice the Member is required to provide to the Policyholder under other provisions of the Group Policy, such notice must be provided to the Company by the Member while the Member's insurance is continued.

Member Supplemental Life Insurance

Eligibility

The Member will be eligible to port his or her Member Supplemental Life Insurance under this Portability feature on the date his or her employment ends for any reason, other than the termination of the Group Policy provided he or she has been continuously insured for three months. Insurance may be continued under this section if:

- the Member is age 65 or under at the time employment ends; or
- the Member's insurance is not continued under Waiver of Premium provisions described in this booklet-certificate; or
- the Member has not received a benefit under Member Accelerated Benefit provision in the booklet-certificate; or
- the Member has not elected to convert to an individual policy his or her insurance in effect immediately prior to the date insurance would terminate.

Amount of Continued Member's Insurance

The maximum amount of Member Supplemental Life Insurance that may be continued is equal to the lesser of:

- the Member's Scheduled Benefit in force on the date his or her employment ends, less any Accelerated Benefit payment, less any amounts for which he or she has made application to convert; or
- $300,000.

The Member may continue any lesser amount of at least $20,000. Any ported insurance must be in increments of $10,000. The Member may not at any time increase the amount of insurance continued under this section.

Any disability coverage provided by amendment or rider to this booklet-certificate will not be included in the continued insurance. Any accelerated death benefit insurance will not be ported. Waiver of Premium insurance may not be ported.

Termination of Continued Insurance

The Member's insurance under any portability insurance will be terminated as described in the portability booklet-certificate.

Dependent Supplemental Life Insurance

Eligibility

The Member will be eligible to continue Dependent Supplemental Life Insurance under this Portability feature on the date the Member is eligible to continue his or her Member Supplemental Life Insurance provided the Member's Dependent has been continuously insured for three months.

Amount of Continued Dependent's Insurance

The maximum amount of Dependent Supplemental Life Insurance you may continue for your Dependent is equal to the lesser of:

- the amount of Dependent Supplemental Life Insurance in force for such Dependent on the date the Member's employment ends; less any Accelerated Benefit payment, less any amounts for which the Member or the Member's Dependent has made application to convert; or
- $75,000 for a Spouse and $10,000 for a Dependent Child.

The Member may continue any lesser amount for his or her Dependent in increments of $2,500 for a Spouse and $1,000 for a Dependent Child. The Member may not at any time increase the amount of Dependent Supplemental Life Insurance, which has been continued under this section.

In no event will the Member's Dependent's Scheduled Benefit be more than 50% of the Member's Scheduled Benefit amount.

The amount of the Member's continued Dependent insurance will be reduced or terminated according to the Scheduled Benefit in force on the date his or her employment ends.

Termination of Continued Dependent Insurance

The Member's Dependent's insurance under any portability insurance will be terminated as described in the portability booklet-certificate.

Portability – General

Application/Effective Date

Notice of the Portability option must be given to the Member by the Policyholder before insurance under the Group Policy terminates, or as soon as reasonable possible thereafter.

The Member must apply and pay the first Premium for the continued insurance within 31 days after he or she becomes eligible for the Portability option. Proof of Good Health is not required. If the Member does not exercise the Portability option within this time period, he or she may not request Portability on a later date.

If an Insured Person dies within 31 days of the date insurance ends under the booklet-certificate and an application for portability coverage is not received, the Company will pay the life insurance benefit in accordance with the Conversion provision. If application and Premium payment is made for portability coverage for an Insured Person and that Insured Person dies during this 31 day period, the Company will pay the amount of life insurance, exclusive of additional benefits that the Member is able to convert under the terms of the booklet-certificate. Premium payments for portability coverage not provided will be refunded. In no event will the Company be liable to pay a death benefit under the Group Policy, any conversion policy and any portability policy. Only one death benefit is payable for each Insured Person.

Any continued insurance under the Portability option will be in force on the 32nd day after such termination date.

CLAIM PROCEDURES

Life Insurance Benefits

Claim Form

The Policyholder will provide forms to assist the Member or the Member's Beneficiary, or the Member or the Member's Beneficiary may request claim forms by contacting the Company by mail, telephone or electronically at the Company's Administrative Office. The process for completing and submitting the claim form will be provided in the claim form kit.

Due Proof of Death

The claimant will be required to provide the Company with due proof of the Insured Person's death. Due proof of death means a certified copy of the Insured Person's death certificate or other lawful evidence providing equivalent information. The claimant must also provide proof of his or her interest in the proceeds.

Payment of Death Benefit

Upon receipt of due proof of death and proof of the claimant's interest, the Company will pay the death benefit in a lump sum subject to the terms of this booklet-certificate and the Group Policy.

Interest will be added to the death benefit as follows:

- Interest will accrue and be payable from the date of death. This interest will be payable at the rate applicable to funds left on deposit with the Company or, if the Company has not established a rate for funds left on deposit, at the two Year Treasury Constant Maturity Rate as published by the Federal Reserve in effect on the date of death.
- Additional interest, at a rate of 10% annually will be payable beginning 31 days from the latest of the following dates:

    - the date due proof of death is received by the Company;
    - the date the Company receives sufficient information to determine the Company's liability, the extent of liability and the appropriate payee legally entitled to the death benefit proceeds;
    - the date that all legal impediments to payment of proceeds that depend on the action of parties other than the Company are resolved and sufficient evidence of the same is provided to the Company. Legal impediments include, but are not limited to the establishment of guardianships and conservatorships, the appointment and qualification of trustees, executors and administrators, and the submission of information required to satisfy state or federal reporting requirements.

Accidental Death and Dismemberment Benefits

Notice of Claim

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

Claim Forms

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 the Member in filing claims. If the forms are not provided within 15 days after the Company receives such notice, the Member will be considered to have complied with the requirements of the Group Policy 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 days after the date of the loss. Proof required includes the date, nature, and extent of the loss. The Company may request additional information to substantiate the Member's loss or require a signed unaltered authorization to obtain that information from the provider. The Member's failure to comply with such request could result in declination of the claim.

Payment, Denial and Review

The Employment Retirement Income Security Act (ERISA) permits up to 90 days for processing claims and up to 60 days for the review of denied claims.

In actual practice, benefits will be payable sooner, provided the Company receives complete and proper Proof of Loss. Furthermore, if a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for the Company's denial.

A Claimant may request a review of a claim denial by Written request to the Company within 120 days of receipt of notice of the denial. The Claimant must give all additional information to the Company within one year of receipt of notice of denial. The Company will notify the Claimant of the final decision and the reasons in support of the Company's decision.

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

GENERAL PROVISIONS

Assignments

Only assignments of Member Life Insurance will be allowed under the Group Policy, to the extent allowed by law. To do so, the Member must provide the Company a Written notice of assignment in a form acceptable to the Company. The assignment must be signed by the Member, the assignee, and any irrevocable Beneficiary. The Company is not responsible for the validity of any assignment. Unless the Member indicates otherwise, an assignment will become effective on the date it is signed, subject to any actions the Company takes or payments the Company makes prior to receipt of the Assignment.

Autopsy

The Company reserves the right to make a reasonable request for an autopsy at the Company's expense where permitted by law if payment for loss of life is claimed.

Conformity with Interstate Insurance Product Regulation Commission (IIPRC) Standards, State Law and Federal Law

This booklet-certificate and the Group Policy were approved under the authority of the IIPRC and issued under IIPRC standards. The booklet-certificate and Group Policy are also subject to state and federal law. Any provision of the Group Policy or this booklet-certificate that, on the provision's effective date, is in conflict with IIPRC standards, state law or federal law for this product type is hereby amended to conform to the IIPRC standards or law applicable to this product type as of the provision's effective date.

Entire Contract

Insurance for all Insured Persons is provided under the Group Policy and the entire contract includes the Group Policy, the Policyholder's application, the booklet-certificates, Member and Dependent enrollment forms, and any riders, endorsements or amendments to the Group Policy or the booklet-certificates will constitute the entire contract.

Individual Incontestability

All statements made by any Insured Person will be representations and not warranties. In the absence of fraud when permitted by applicable law in the state where the booklet-certificate is delivered or issued for delivery, 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

- the statement is material to the risk accepted or the hazard assumed by the Company; 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.

Legal Action

Legal action with respect to a claim may not be started earlier than 90 days after Proof of Loss has been filed. Further, no legal action may be started later than the time limit on legal actions for loss based on applicable law of the state with jurisdiction over this booklet-certificate.

Medical Examinations

The Company may have the Member or the Member's Dependent whose loss is the basis for claim examined by a Physician. The Company will pay for these examinations and will choose the Physician to perform them.

Misstatement of Age

If an Insured Person's age is misstated, the Company may, at any time, adjust Premiums and benefits to reflect the correct age.

Time Limits

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

DEFINITIONS

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

Active Work; Actively at Work means the active performance of all of the Member's usual and customary job duties on a full time basis at the Policyholder's usual place or places of business, any alternate place of business approved by Policyholder or any place the Policyholder's business requires the Member to travel.

Administrative Office means the Company's office at P.O. Box 25951, Shawnee Mission, KS 66225-5951.

Automobile means a four-wheel passenger vehicle, station wagon, pick-up truck, or van-type vehicle, but excludes recreational-type vehicles such as "dune-buggy" or an "all-terrain" vehicle.

Beneficiary means the person(s) to whom the Company will pay the life insurance benefits in accordance with the Beneficiary provision of the booklet-certificate.

Company means Nippon Life Insurance Company of America.

Contribution means the amount the Policyholder may require the Member to pay towards the total Premium that the Company charges for the insurance provided under the Group Policy.

Contributory Insurance means insurance for which the Policyholder requires the Member to pay any part of the Premium.

Date of Issue means the date the Group Policy is placed in force: June 1, 2023.

Dependent means:

- the Member's Spouse, as defined below; and
- the Member's Dependent Child (or Children), as defined below.

Dependent will also include any person described above who elects to continue insurance under the Portability provisions described in this booklet-certificate.

Dependent Child; Dependent Children means:

- the Member's natural or legally adopted child, if that child:
  - resides in the United States; and
  - is not married or in a legally sanctioned domestic partnership or civil union; and

- is not on full-time active duty in the Armed Forces of any country. If a child begins full-time active duty while insurance is in force, the Member must promptly inform the Policyholder. Upon Written notice to the Company that the child is no longer eligible, the child's insurance will be terminated. The Company will refund Premium paid for any period the child was not insured, but in no case will more than 60 days Premium be refunded; and
- is not insured under the Group Policy as a Member; and
- is at least 14 days but less than 19 years of age. Notwithstanding this limit, a child will be insured from birth for any accidental death and dismemberment benefits.

- the Member's Spouse's child, if that child:
  - meets the requirements above; and
  - lives with the Member; and
  - receives support from the Member in whole or in part.

- the Member's foster child, if that child:
  - meets the requirements above; and
  - lives with the Member; and
  - receives support from the Member in whole or in part; and
  - is approved in Writing by the Company as a Dependent Child.

- the Member's child 19 years but less than 25 years of age who otherwise qualifies above, if that child receives principal support from the Member and is a Full-Time Student, as defined.

Any other child required to be insured based on the family or domestic relations law of the state in which the booklet-certificate is delivered or issued for delivery.

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

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

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.

Full-Time Student means the 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.

Group Policy means the policy of group insurance issued to the Policyholder by the Company which describes benefits and provisions for insured Members and Dependents.

Hospital means an institution that is licensed as a hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Injury means a bodily injury sustained by an Insured Person as a direct result of an accident, independent of sickness, disease or bodily or mental illness or infirmity or any other cause, and which occurs while this booklet-certificate is in force. See the Limitations provision for injuries not covered.

Insurance Month means Calendar month.

Insured Person means all persons insured by this booklet-certificate under the Group Policy and includes the Member and all insured Dependents.

Loss means:

- for Loss of a finger or thumb, the finger or thumb is permanently severed at or above the metacarpophalangeal joints;
- for Loss of a toe, the permanent severance of one entire phalanx of the big toe or all phalanges of any other toes;
- for Loss of a hand, the hand is permanently severed at or above the wrist, but below the elbow;
- for Loss of an arm, the arm permanently severed at or above the elbow;
- for Loss of foot, the foot is permanently severed at or above the ankle, but below the knee;
- for Loss of leg, the leg is permanently severed at or above the knee;
- for Loss of sight, permanent and uncorrectable loss of sight in the eye that continues for 180 days after the accident. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees;
- for Loss of hearing, the entire and irrecoverable loss of hearing in both ears that continues for at least 180 days following the date of the accident;
- for Loss of speech, the entire and irrecoverable loss of speech that continues for at least 180 days after the accident; and
- for Loss of life, death.

Loss of Use means total and permanent impairment of voluntary movement and sensory function of arms or legs without severance. A Physician must determine the Loss of Use to be permanent, complete and irreversible.

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

Member will also include any such person who Resides in the United States and elects to continue insurance under the Portability provisions described in this booklet-certificate.

Noncontributory Insurance means insurance for which the Policyholder does not require the Member to pay any part of the Premium.

Normal Retirement Age means the Social Security Normal Retirement Age as figured by the 1983 amendment or any later amendment to the Social Security Act.

Year of Birth	**Full (normal) Retirement Age**
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Period of Limited Activity means any period of time during which a person is:

- confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or
- Home Confined. "Home Confined" means that, due to sickness or injury, the person is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical treatment.

Physical Handicap means a Dependent Child's substantial physical or mental 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 malfunction of the body.

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

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

Policyholder means ORTHO SOLUTIONS LC, DBA DYNAFLEX.

Premium means the amount the Policyholder shall pay to the Company for the insurance provided under the Group Policy.

Prior Plan means the group life insurance policy carried by the Policyholder on the day before the Policy Effective Date and will only include the portion of coverage under any such policy which is transferred to the Company.

Proof of Good Health means Written evidence that a person is insurable under the Company's underwriting standards. This proof must be provided in a form satisfactory to the Company.

Proof of Loss means Written evidence satisfactory to the Company that an Insured Person has satisfied the conditions and requirements for any benefit described in the booklet-certificate. The Proof of Loss shall establish:

- the nature and extent of the loss or condition; and
- the Company's obligation to pay the claim; and
- the claimant's right to receive payment.

Reside(s) in the United States means the Member and Member's Dependent must:

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

Seat Belt means a factory installed device that forms an occupant restraint and injury avoidance system.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), or a licensed registered nurse (R.N.); and

- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one (M.D.) or (D.O.); and
- has an existing contract for the services of an (M.D.) or (D.O.), maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places for treatment of mental disease, drug addiction, or alcoholism.

Spouse means the Member's lawful spouse and any other person required to be insured as the Member's Spouse under the civil union marriage or other family or domestic relations laws, including case law, of the state where this booklet-certificate is delivered or issued for delivery. To be insured as a Dependent, the Member's Spouse must:

- Reside in the United States; and
- not be on full-time active duty in the Armed Forces of any country. If a spouse begins full-time active duty while insurance is in force, the Member must promptly inform the Policyholder. Upon Written notice to the Company that the spouse is no longer eligible, the spouse's insurance will be terminated. The Company will refund Premium paid for any period the spouse was not insured, but in no case will more than 60 days Premium be refunded; and
- not be insured under the Group Policy as a Member.

Terminal Illness, Terminally Ill means a medical condition that a Physician certifies is reasonably expected to result in death in 12 months or less.

Therapeutic Counseling means treatment or counseling provided by a state licensed psychiatrist, psychologist, therapist, or counselor who is registered or certified to provide psychological treatment or counseling.

Totally Disabled, Total Disability means the Insured Person's inability, due to sickness or injury, to perform the material duties of his or her regular job and inability to perform for remuneration or profit any other job for which the Insured Person is fit by education, training, or experience.

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

NIPPON LIFE INSURANCE COMPANY OF AMERICA

A Stock Company
6965 Vista Drive, West Des Moines, Iowa 50266
1-800-374-1835
http://www.nipponlifebenefits.com

Statement of Rights Booklet-Certificate Rider

STATEMENT OF RIGHTS

Federal law requires that this section be included in the 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.

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 Members and other plan participants and beneficiaries. No one, including the employer, union, or any other person, may fire the Member or otherwise discriminate against the Member in any way to prevent him or her from obtaining a welfare benefit or exercising rights under ERISA.

Enforce 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 do not receive them within 30 days, the Member 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, 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 the Member's Questions

If the Member has any questions about his or her plan, the Member should contact the plan administrator. If the Member has any questions about this statement or about his or her rights under ERISA, or if the Member needs assistance in obtaining documents from the plan administrator, the Member should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

SUPPLEMENT
TO YOUR BOOKLET-CERTIFICATE

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

1. **Employer Plan Identification Number:**

   EIN: 43-1813595
   PIN: 501

2. **Type of Administration:**

   Group Term Life: Insurance Contract.

3. **Plan Administrator:**

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

   See your 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 for 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 the booklet-certificate.

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

Employee pays none of employee's contribution for Basic Life Insurance. Employee pays all of employee's contribution for Supplemental Life Insurance. Employee pays all of Dependent's contribution for Supplemental Dependent Life Insurance (if employee elects to enroll Dependent's in the plan).

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

May 31.

NOTHING CONTAINED IN THIS BOOKLET-CERTIFICATE RIDER SHALL VARY, ALTER, OR EXTEND ANY PROVISIONS OR CONDITIONS OF THE PLAN OTHER THAN AS STATED IN THIS BOOKLET-CERTIFICATE RIDER.

NIPPON LIFE INSURANCE COMPANY OF AMERICA

Aimee Averill
Senior Vice President, Service, IT Strategy & Project Management

Takashi Nakayama
President and Chief Executive Officer

MISSOURI NOTICE

Missouri insurance law requires that the certificate must 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

Written correspondence is preferable so that a record of the inquiry is maintained. Please identify all correspondence with the group account number and the Insured Person's full name and address.

This Notice is for your 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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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

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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.

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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.

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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.

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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.

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