PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Group Universal Term Life Insurance

January 2018
HOW TO USE THIS DOCUMENT

The Table of Contents provides an overview of the detailed information in this Summary Plan Description. For a quick link, place your cursor on the page number and left click with your mouse — this action takes you to the details of the topic selected.

You will find a glossary of terms used in this document.

To quickly search for a specific word or phrase, simply press your “Ctrl” and “F” keys simultaneously to open the search function.
INTRODUCTION

Mayo Clinic sponsors the Voluntary Group Term and Universal Life plan (the “Plan”), which provides Voluntary Group Universal Life (“GUL”) and Family Term Life Insurance (“Family Life”) benefits. Effective January 1, 2018, this document sets forth a summary of the Plan benefits for eligible employees and serves as the Summary Plan Description (“SPD”). This SPD is intended to be easy to use and understand. It contains only highlights of the insurance policy (discussed below), which, together with the SPD, constitute the official plan document for the Plan.

These benefits are optional. You must take action to enroll in this Plan, and you will be responsible for paying the cost of coverage.

These benefits are insured, meaning they are paid from an insurance policy issued to Mayo Clinic by The Prudential Insurance Company of America (“Prudential”).

The benefits offered under the Plan are governed by the insurance policy issued to Mayo Clinic by Prudential. The terms of that insurance policy, not this SPD, are used to administer the Plan. The Plan is administered by, and all claims are decided by, Prudential in its sole discretion, not by Mayo Clinic or any participating employer. If you have a dispute concerning Prudential’s decision about the Plan, you must pursue that dispute with Prudential, not Mayo Clinic; and Mayo Clinic will have no role in resolving that dispute. In the case of a conflict between this SPD and the insurance policy, the insurance policy will control.

You should also not rely on oral descriptions of the Plan provisions, as the written terms of the Plan document will always govern. Mayo Clinic reserves the right to amend, modify, or terminate the Plan at any time and for any reason.

Important Information For Residents Of Certain States: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 45200.

Please review this entire document so that you understand fully what your benefits and responsibilities are under this plan. See the administrative section of this SPD to learn about the right of Mayo Clinic to amend or terminate the Plan. If you have questions, see the contact information in the next section.
For enrollment or general eligibility questions, please contact Mayo Clinic’s HR Connect. The HR Connect Service Center is your human resources office for the Plan.

<table>
<thead>
<tr>
<th>General Questions About Enrollment/Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR Connect</td>
</tr>
<tr>
<td>200 First Street SW</td>
</tr>
<tr>
<td>Rochester, MN 55905</td>
</tr>
<tr>
<td>507-266-0440 (local)</td>
</tr>
<tr>
<td>1-888-266-0440 (toll free)</td>
</tr>
<tr>
<td>M – F, 5 a.m. to 6 p.m., Saturday/Sunday 5 a.m. to 9 a.m. CT (excluding holidays)</td>
</tr>
</tbody>
</table>

HR Connect has access to translation services to meet the needs of many non-English-speaking persons.

El presente Resumen del Plan de Descripción, que también sirve como documento del plan, está redactado en inglés y ofrece detalles sobre sus derechos y beneficios. Si tiene alguna dificultad para entender cualquier parte de este documento, por favor comuníquese con el Centro para Servicios al Empleado a los números que constan abajo.

For questions about claims, see the sections on *Claim Procedures* and *Claim Administration*.
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ELIGIBILITY AND PARTICIPATION

You are eligible for coverage under the Plan if you are classified as (1) Consultant, (2) Voting Staff, or (3) Allied Health Staff at either a Mayo Clinic or Mayo Health System location. See Plan Information for a list of participating employers.

To be eligible, you must be classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least half-time (forty (40) hours or more per pay period) for the employer. Regularly scheduled means your schedule on file with your employer is 0.5 FTE or more. A 0.4 FTE working extra hours does not qualify as regularly scheduled to work 0.5 FTE.

An employer’s classification is conclusive and binding for purposes of determining benefit eligibility under the Plan. No reclassification of an employee’s or non-employee’s status for any reason by a third party, whether by a court, governmental agency, or otherwise, and without regard to whether or not the employer agrees to the reclassification, shall make the employee retroactively or prospectively eligible for benefits. Any uncertainty regarding an employee’s classification will be resolved by excluding that person from eligibility.

See page Error! Bookmark not defined. for rules for dependent eligibility for Family Life.

Employees are eligible on the first day of employment. Dependents are eligible on the later of:

- The employee’s date of eligibility
- The date he/she become a dependent of the employee

Enrollment

For GUL and Family Life coverage, you may enroll anytime on or after the first day you and/or your dependents are eligible. By enrolling within the first 31 days of initial eligibility you will not be required to submit evidence of insurability satisfactory to Prudential.

You must enroll in GUL for yourself in order to be eligible to enroll in Family Life for your dependents.

Effective Date of Coverage

If you enroll within the first 31 days of initial eligibility, you and/or your dependents coverage will be effective on the first day you and/or your dependents are eligible.

If you do not enroll within 31 days of initial eligibility, your coverage will become effective on the date Prudential approves your application.
Evidence of Insurability

If you and/or your spouse do not enroll for coverage within 31 days of when you and/or your spouse are first eligible, or if you wish to increase the amount of your coverage, you must submit evidence of insurability satisfactory to Prudential before you are covered under the Plan. You and/or your spouse will have no coverage under the Plan until Prudential concludes, in its sole discretion, that you have provided satisfactory evidence of insurability.

Evidence of insurability is not required for child life coverage; you may add this coverage at any time by calling HR Connect.

Actively at Work Requirement

Actively at work means you are physically present to work 0.5 FTE or more at the employee’s regular worksite or at an alternative worksite at the request of the employer. If you are not actively at work on the day your coverage (or a change in coverage) is scheduled to begin, your coverage will not begin until the first day you begin or return to your employment.

You are considered actively at work during normal vacation if you are actively at work on your last regularly scheduled workday.

If a dependent is confined for medical care or treatment (at home or elsewhere) on the date coverage (or a change in coverage) would otherwise become effective, the coverage (or change in coverage) will not take effect until the dependent’s final medical release from all such confinement.

Naming a Beneficiary

You have the right to choose a beneficiary for this coverage as long as the beneficiary is not Mayo Clinic, a Participating Employer or a subsidiary of Mayo Clinic that has adopted the Plan. If you choose more than one beneficiary, they will receive equal amounts of the benefit unless you request otherwise in writing.

You may change your beneficiary designation at any time by accessing the Employee Self-Service tool found on HR Connect or you may call HR Connect at (507) 266-0440 or toll free at 1-888-266-0440.

In the event of your death, if there is no beneficiary designation on record, benefits will be paid in the following successive order: (a) surviving spouse, (b) surviving child(ren) in equal shares, (c) surviving parent(s) in equal shares, (d) surviving sibling(s) in equal shares, (e) your estate. This also is true if you name a beneficiary who dies before you and you do not choose a new beneficiary before your death.

This is also true if you name a beneficiary who dies before you and you do not choose a new beneficiary before your death. If you have more than one beneficiary and one of them dies before you, benefits will be divided among the remaining beneficiaries if you do not choose a new beneficiary before your death.

The employee is the beneficiary for any dependent coverage under Family Life.

Personal, Disability, USERRA, FMLA, or Parental Leaves of Absence

Your benefits continue in force based on the salary in effect at the beginning of your authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave for the duration of the authorized leave. If your leave ends and you do not return to work, your coverage ends. You will be billed the appropriate premiums for any coverage in which you are enrolled.
When Coverage Ends

Your coverage will end on the day on which the earliest of the following events occurs:

- The last day of your employment or the day you cease to be an eligible employee
- The day the employer terminates the Plan or its participation in the Plan
- The effective date of an amendment to the Plan causing you to lose coverage
- The last day of an authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave if you do not return to work at the end of the leave
- The day before the first day of any leave other than an authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave
- The date on which you are no longer actively at work unless you are on an authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave
- The date of your death
- For dependents, the day they cease to be an eligible family member (as defined on page 16)
- For dependents, the day the employee ceases to be eligible for or covered under GUL
- The date you or Mayo Clinic fails to pay, when due, any premium required for your coverage
- Term life insurance under the GUL plan will terminate upon attainment of age 95

Under some circumstances, the events described above may not result in termination of coverage:

- Paid up insurance under the GUL plan will continue until the employee dies, unless surrendered or voided
- Coverage for a dependent child under Family Life will not end when the child reaches his/her limiting age if the child is mentally or physically incapacitated, and the child otherwise meets the definition of an eligible family member
- GUL term life insurance and Family Life insurance may be converted to an individual policy as detailed in the Conversion to an Individual Policy section
- GUL term life insurance and Family Life insurance may be continued, as detailed in the Continuation of Coverage section.

Cost of Coverage

You pay the cost of GUL and Family Life coverage under the Plan. Additional details are provided in the Plan Benefits section which follows.
PLAN BENEFITS

GUL

GUL is a type of voluntary life insurance on yourself that you may purchase to supplement any employer-paid life insurance coverage offered under Mayo’s Group Life Insurance Plan (Employer Paid) plan (“Employer Paid Plan”).

GUL has three major parts each of which are detailed in this section. They are:

1. Term life insurance on your life in one of the following:
   - One times annual salary, up to a maximum of $1,000,000 in coverage
   - Two times annual salary, up to a maximum of $2,000,000 in coverage
   - Three times annual salary, up to a maximum of $3,000,000 in coverage
   - Four times annual salary, up to a maximum of $4,000,000 in coverage
   - Five times annual salary, up to a maximum of $5,000,000 in coverage
   - Six times annual salary, up to a maximum of $6,000,000 in coverage

2. A cash accumulation fund account made up of amounts you choose to contribute to the fund and any premium refunds the Plan pays. Premium refunds are unused premiums.

3. Paid-up life insurance purchased by your cash accumulation fund.

Salaries not in even thousands are rounded to the next higher thousand.

Term Life Insurance

Under GUL, you may purchase term life insurance equal to one, two, three, four, five or six times your annual salary.

If you are not enrolled in the Plan or if you are enrolled in coverage up to five times your annual salary, you may increase your GUL coverage at any time up to six times your annual salary by submitting satisfactory evidence of insurability to Prudential. Any increase you apply for and enroll in becomes effective on the date Prudential approves your written request.

In addition, at any time you may discontinue coverage or reduce coverage to a lower multiple of your annual salary during your employment by contacting HR Connect. The effective date will be the date HR Connect receives your request.

Cash Accumulation Fund (CAF)

When you enroll in GUL, Prudential sets up a CAF in your name. Deposits to the fund are made from premium refunds and any additional amounts you choose to contribute.

Premium Refunds

Premium refunds, a non-taxable return of unused premiums, may be paid if you are contributing to GUL. Any premium refunds you are eligible to receive are automatically deposited to your CAF.
Your Contributions

In addition, you may increase the balance in your fund by contributing an amount on an after-tax basis equal to one through twelve times your monthly premium for GUL. These contributions may be made only by payroll deduction. The minimum contribution you may make is $10 per month.

There is a CAF Tax of 2.64%, which is paid by a deduction from each fund contribution at the time the money is deposited into the account.

You may increase or decrease your contributions to the CAF account at any time during the year.

Interest

Your CAF earns interest. Prudential expects to credit your fund with a competitive interest rate. While the rate may vary, in no event will it be less than four percent.

Loans

After you have contributed to your fund for one year, you may borrow money from it as long as you continue contributions by payroll deduction. The loan must be for at least $500 and may not exceed the balance in your fund.

For purposes of earning interest, any loan amounts will not be subtracted from your fund. You continue to maintain the growth potential of your fund while retaining easy and continued access to your money. Prudential will charge a handling fee for processing your loan.

You will also pay an interest charge on your loan. Interest on the loan balance will be charged daily at a yearly rate of 1-1/2 percent greater than the rate of interest your fund is earning.

Interest is due at one of these three times:

- Each January 1
- When all or part of the loan is paid back
- When the loan becomes due, as described below

Interest not paid when due is added to the loan balance. A loan and any interest charged will be due at one of the following times:

- When no contributions are being deposited into your fund
- Whenever the loan balance plus interest charged exceeds the balance in your fund
- When your GUL ends
- When you die

In the event of your death, the loan balance and interest charged will be deducted from the benefit payable to your beneficiary.

You may pay back all of a loan at any time. If you wish to pay back part of a loan, the amount repaid must be at least $500. You may request that a loan be canceled or reduced by at least $500 by having Prudential deduct the amount needed from your fund.

The amount of the canceled loan or repayment no longer will be part of your account and will not be earning interest.
More specific information on applying for and repaying loans is available from HR Connect.
Withdrawals

You may withdraw all or part of your fund at any time by making a written request to Prudential. The withdrawal must be for at least $500 or the balance of the fund if less than $500 and may not include any loan and interest charges that you have not paid back.

More specific information on requests for withdrawals is available from HR Connect. You can also visit Prudential’s website at www.prudential.com/gulgvl.

Interest amounts you earn on your fund are tax deferred until your withdrawal exceeds your cost basis. In other words, earnings are not taxable until they are withdrawn. Loans also are not taxable. If your withdrawal is taxable, you will receive a 1099 directly from Prudential. There are additional tax implications not included in this SPD. Please consult your own tax advisor.

<table>
<thead>
<tr>
<th>Net Amount of Cash Accumulation Fund</th>
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<tbody>
<tr>
<td>At any time, the amount of your cash accumulation fund is equal to:</td>
</tr>
<tr>
<td>Sum of your premium refunds and contributions</td>
</tr>
<tr>
<td>minus</td>
</tr>
<tr>
<td>taxes, fees, withdrawals, and amounts used to purchase paid-up life insurance</td>
</tr>
<tr>
<td>plus</td>
</tr>
<tr>
<td>earned interest</td>
</tr>
</tbody>
</table>

Paid-Up Insurance

Paid-up life insurance means all your costs for the insurance are paid up front. You pay no premium for coverage. The coverage continues until your death, whether or not you continue your employment, unless you cancel your coverage.

Purchasing Paid-Up Insurance

Your CAF balance may be used to purchase paid-up insurance at the following times:

- When your GUL ends
- When your CAF balance reaches its limit, which occurs when your CAF balance can provide an amount of paid-up insurance equal to the sum of your GUL coverage and your CAF balance. (Please contact Prudential with questions regarding your CAF limit.)

Your CAF reaches its limit when the amount of paid-up life insurance that your fund would purchase exceeds the sum of your term life insurance and your CAF amount. The minimum paid-up policy issued is $500.

An Example

Assume you are age 35 and have $50,000 in term life insurance and $15,000 in your CAF account. At that age, the $15,000 in your fund would purchase $59,744 of paid-up insurance. In this case, the limit of your fund has not been reached because $59,744 is less than the sum of term life insurance and the fund amount, or $65,000 ($50,000 + $15,000).
Another Example

Assume you are age 35 and have $50,000 in term life insurance and $20,000 in your CAF; you could purchase $79,659 of paid-up insurance, which is greater than the sum of your term life insurance and the fund amount, or $70,000 ($50,000 + $20,000).

CAF Limit

When your fund reaches its limit, 30 percent of the fund will be used to purchase paid-up insurance. However, if the amount left in the fund after the 30 percent is taken out would be less than the balance of any outstanding loans or interest charges, the 30 percent will be used to reduce the loan balance instead of to purchase paid-up insurance.

In the event your coverage under the Plan ends and you have not requested a complete withdrawal, all of your fund will be used to purchase paid-up insurance.

Cash Value

Your paid-up insurance will have a cash value. You may cancel your policy and receive its cash value at any time. You may cancel part of your paid-up life insurance, but it must have a cash value of at least $500. Prudential charges a handling fee for canceling all or part of your coverage.

Premium Refunds on Insurance

Prudential may determine that a premium refund should be paid on your paid-up insurance. The premium refunds will automatically be used to increase the amount of your insurance.
Cost of Coverage

You pay the cost for any GUL in which you enroll on an after-tax basis. The premiums are provided in the Prudential contract. In general, they are determined by the number of people covered by the Plan and the amount paid in benefit claims in the preceding year.

The current monthly cost for each $1,000 of GUL coverage is based on your age according to the following table:

<table>
<thead>
<tr>
<th>Your Age</th>
<th>Monthly Cost per $1,000 of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.039</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.047</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.063</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.070</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.078</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.117</td>
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<tr>
<td>50-54</td>
<td>$0.180</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.336</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.516</td>
</tr>
<tr>
<td>65-69</td>
<td>$0.993</td>
</tr>
<tr>
<td>70-74</td>
<td>$1.611</td>
</tr>
<tr>
<td>75-79</td>
<td>$2.158</td>
</tr>
<tr>
<td>80-84</td>
<td>$3.237</td>
</tr>
<tr>
<td>85+</td>
<td>$6.256</td>
</tr>
</tbody>
</table>

In determining the premium amount, it is calculated as if your age changes on the January 1 coinciding with or preceding your birthday. However, if you are age 65 or older, it is assumed your age changes on your birthday.

An Example
Assume you are age 40, your annual salary is $30,000, and you enrolled in GUL coverage for one time the amount of your annual salary.

First divide $30,000 by $1,000 ($30,000 ÷ $1,000), which is 30. Then multiply 30 times your monthly cost per $1,000 of coverage at age 40, which is $0.078. That works out to a monthly cost of $2.34 (30 x $0.078) for $30,000 of coverage.

When Benefits Are Payable
GUL benefits are payable to your beneficiary when Prudential receives and approves the claim. To initiate the claim, please contact HR Connect to notify Mayo Clinic of the death.
Benefits Payable from GUL

In the event of your death, the benefit payable to your beneficiary from GUL will be the sum of the following:

- The total term life insurance amount
- The balance in your CAF
- The amount of any paid-up insurance you have

However, the balance of any outstanding loans and interest charges will be deducted from the benefits payable.

Reports

Prudential will provide you with a detailed report of your CAF account and any paid-up insurance on a quarterly basis. You also will receive notification of any paid-up insurance you have after your GUL ends.

Legal Action

No action at law or in equity shall be brought as a claim for benefits under the Plan until 60 days after the written proof described above is furnished. No such action shall be brought more than three years after the end of the time within which proof of loss is required.
Family Life

If you are enrolled in GUL, you also may enroll in and purchase Family Life. Family Life pays benefits to you in the event of the death of one of your enrolled family members.

Eligible Family Members

Family members eligible for Family Life are:

- Your spouse
- Your child or children who are under the age of 26. A Child or Children include an Employee’s biological children, stepchildren, legally adopted children, or children legally placed with you for adoption.

Family members not eligible to enroll in Family Life are:

- Children who also are covered under the Employer Paid Plan as employees of Mayo Clinic or Mayo Health System
- Children prior to live birth
- A child in active duty in any military, navy, or air force of any country
- A spouse already covered under GUL
- A child already covered under Family Life by another participant in the Plan. For example, both you and your spouse may not purchase coverage for your children under this Plan.

Coverage for New Family Members

During your employment, you may add Family Life coverage for your new family members if you have already enrolled in GUL.

If you marry during your employment, your spouse is eligible on the date of your marriage. If HR Connect is notified within 31 days of the marriage, no evidence of insurability will be required before coverage begins. After this time, your spouse will be required to complete evidence of insurability. Coverage will become effective on the date Prudential approves your spouse’s application.

Your newly born or adopted children are eligible on the date of their birth or adoption. Stepchildren are eligible on the date they first meet the eligibility requirements described in the section preceding titled Eligible Family Members. Evidence of insurability is not required for child life coverage; you may add this coverage at any time by calling HR Connect.
Coverage for Spouse

You may purchase Family Life on your spouse in one of the following:

- One times your annual salary, up to a maximum of $1,000,000 in coverage
- Two times your annual salary, up to a maximum of $1,300,000 in coverage

Salaries not in even thousands are rounded to the next higher thousand.

Whatever option you choose, coverage for your spouse will never be less than $3,000 or greater than the amount of life insurance coverage you have under GUL.

To determine coverage amounts, round your annual salary to the next higher thousand before applying your election. See the example on page 18.

You pay the premiums for your spouse coverage as described in the Cost of Coverage for Spouse section.

In addition, at any time you may discontinue coverage or reduce coverage to one time your annual salary during your employment by contacting HR Connect.

Coverage for Children

When your spouse is enrolled, each eligible child is insured for $10,000. There is no cost for this coverage. If you are unmarried but you have eligible children, they are covered without cost to you; however, you must be enrolled in both GUL and Family Life.

If you are legally married and choose not to purchase coverage for your spouse, you may purchase Family Life for your eligible children in the amount of $10,000 per child. If you purchase insurance coverage for children only, you are required to enroll all eligible children. Refer to the Cost of Coverage for Children section.

Reduction of Coverage for Spouse

There will be automatic reductions to your spouse’s coverage when your spouse reaches:

- Age 65 — coverage reduces to 65 percent
- Age 70 — coverage reduces to 50 percent
- Age 75 — coverage reduces to 40 percent

The automatic reductions will occur on the first of the month following your spouse’s birthday. The reductions will be in addition to any reduction of coverage you elect for yourself under GUL. At no time, however, will your spouse’s coverage be less than $3,000.
Cost of Coverage for Spouse

As described earlier, when you are enrolled in Family Life coverage, you pay the premiums for your spouse’s coverage on an after-tax basis. There is no cost for coverage of your eligible children when you enroll your spouse.

The premiums are provided in the Prudential contract. In general, they are determined by the number of people covered by the Plan and the amount paid in benefit claims in the preceding Plan year.

The current monthly cost for each $1,000 of Family Life on your spouse is based on your spouse’s age according to the following table:

<table>
<thead>
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</tbody>
</table>

In determining the premium amount, it is assumed that your spouse’s age changes on the January 1 coinciding with or preceding your spouse’s birthday, except when your spouse reaches age 65. At age 65 and above the rate changes on your spouse’s birthday.

An Example

Assume your spouse is age 35, your annual salary is $29,600, and you elected two times annual salary of coverage for your spouse. Based on your selection, your spouse’s coverage is $60,000 (29,600 rounded to next higher thousand of $30,000 x 2).

To determine the cost of $60,000 of coverage, first divide $60,000 by $1,000 ($60,000 ÷ $1,000), which is 60. Then multiply 60 times your monthly cost per $1,000 of coverage at age 35, which is $.0070. The result is a monthly cost of $4.20 (60 x $0.070) for $60,000 of coverage on your spouse.
Cost of Coverage for Children

The cost of Family Life is $0.7150 per month for $10,000 of coverage. This cost of coverage applies when you have a spouse but choose to enroll in coverage for children only. **Reminder:** You must enroll all eligible children in the Plan.

When Benefits Are Payable

Family Life benefits are payable when Prudential receives and approves the claim. To initiate the claim, please contact HR Connect to notify Mayo Clinic of the death.

Legal Action

No action at law or in equity shall be brought as a claim for benefits under the Plan until 60 days after the written proof described above is furnished. No such action shall be brought more than three years after the end of the time within which proof of loss is required.
Your coverage under GUL and Family Life (if you are enrolled) will continue while you are on an approved disability under a Mayo sponsored disability plan. Your coverage will end if your disability ends and you do not return to work for a participating employer.

Cost of Coverage During Disability

During disability, you continue to pay the premiums for any GUL or Family Life insurance in which you are enrolled. You will be billed for the cost of coverage or it will be deducted from your disability payment, except as noted below.

If your disability has been approved by Prudential as a waiver of premium disability, there is no cost to continue your GUL term life insurance (if you are under age 65 at the time of disability). The waiver of premium due to disability also carries over into retirement, if retirement occurs at or after age 65. Contributions to your CAF are not permitted while on waiver of premium.

Waiver of Premium Disability

For purposes of the GUL term life insurance, waiver of premium disability means:

- You are not working at any job for wage or profit
- You are less than age 65 when the total disability starts.

Once you have been disabled between 9 and 12 months, you must begin to submit annually evidence of your continued disability to Prudential for your coverage to be continued. From time to time, Prudential also may request that you have a medical examination by physicians it selects. The purpose of the examination would be to provide further evidence of your disability. After your coverage has been continued for two years, Prudential may not request an examination more than once a year.

When Waiver of Premium Disability Ends

The waiver of premium during disability will end under any one of these circumstances:

- You do not furnish annual proof of your continued disability to Prudential
- You do not submit to a medical examination as requested by Prudential
- You no longer meet the definition of waiver of premium disability
CONVERSION TO AN INDIVIDUAL POLICY

If GUL or Family life insurance ends, you may be able to convert the coverages to individual whole life policies. Prudential will send you a notice of your right to convert your term life insurance coverage. You may request a conversion packet to be completed and returned within 31 days.

The premium for your converted policies will be based on Prudential’s rate for the amount of insurance, your age when the insurance becomes effective, and the class to which you belong. Information on the rate will be available from Prudential at the time you convert coverage.

If you or a covered family member should die after your coverage ends but before any converted coverage is in effect, your GUL term life insurance or Family Life insurance coverage in force before termination of coverage will be payable to your beneficiary.
CONTINUATION OF COVERAGE

GUL

If your employment ends for any reason, including retirement, your GUL term life insurance coverage will end on your last day of employment. You may, however, continue the coverage by electing continuation coverage and paying the required premiums. The rates are the same as when you were an active employee. This continued coverage would end if:

- The premium is not paid on time
- Coverage by another group plan takes effect
- Termination of Mayo’s contract with Prudential

If you choose to cancel your coverage, you may use your CAF balance, if any, to purchase paid-up insurance or you may take it as cash.

Your paid-up insurance will continue until death, unless surrendered or voided.

Prudential will mail you a notice of your right to continue your term life insurance coverage. You may request an application to continue coverage, which must be completed and returned with the first required payment within 60 days of the later of: (1) the date the insurance would normally terminate; (2) the date you receive the notice informing you of the right to continue.

Family Life

If your employment ends for any reason, including retirement, your Family Life coverage ends on your last day of employment. You have the right to continue your Family Life coverage for up to 18 months if your coverage ends because (1) your employment ends or, (2) your status changes to non-benefits eligible. This continued coverage would end before the 18-month maximum period of time if:

- The premium is not paid on time
- Coverage by another group plan takes effect
- Termination of Mayo’s contract with Prudential

Prudential will mail you a notice of your right to continue your term life insurance coverage. You may request an application to continue coverage, which must be completed and returned with the first required payment within 60 days of the later of: (1) the date the insurance would normally terminate; (2) the date you receive the notice informing you of the right to continue.

Also, at the conclusion of 18 months of continued coverage, you may elect to convert your Family Life to individual whole life policies. See the section entitled Conversion to an Individual Policy for details.
CLAIMS PROCEDURES

How to Receive Benefits

In the event of your death HR Connect should be contacted as soon as possible. They can provide assistance in filing a claim for benefits.

Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension, and the date by which the Plan expects to decide your claim shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension, and the date by which the Plan expects to decide on your claim shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- The specific reason(s) for the denial
- References to the specific Plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A description of Prudential’s appeal procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request

Appeal of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial. Your appeal should describe the decision you are appealing and state the reasons why you think the decision on your claim was incorrect. You may submit with your appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.
Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- The specific reason(s) for the adverse determination
- References to the specific Plan provisions on which the determination was based
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request
- A description of Prudential’s review procedures and applicable time limits
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A statement describing any appeal procedures offered by the Plan, and your right to bring a civil suit under ERISA

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.
If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.
CLAIMS ADMINISTRATION

The Claim Administrator and contact for the claims/appeals process is:

The Prudential Insurance Company of America
Life Claims Management
P.O. Box 8517
Philadelphia, PA 19176

Overnight Mail to:
2101 Welsh Road
Dresher, PA 19025

Phone: (844) 656-MAYO (6296)
Fax: (888) 227-6764
Plan Administration

Powers and Duties of the Plan Administrator

The Plan Administrator will have the powers and duties of general administration of the Plan including the following:

- The discretion to determine all factual and legal questions relating to the eligibility of individuals to participate, or for you to remain a participant in the Plan and to receive benefits under the Plan. With respect to claims for benefits, the Plan Administrator has delegated authority and discretion as stated in “Claims Administration.”

- To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition of eligibility for you or eligible family members to participate under the Plan and to receive any benefits under the Plan.

- By action to delegate to other persons authority to carry out any duty or power which, under the terms of the Plan or applicable law, would otherwise be a responsibility of the Plan Administrator, including but not limited to appointment of and delegation of duties to the Salary and Benefit Committee.

- To maintain or delegate to others the duty of maintaining necessary records for the administration of the Plan.

- To interpret the provisions of the Plan, make and publish such rules and procedures for regulation of the Plan, and prescribe such forms as the Plan Administrator will deem necessary.

Records

The Plan Sponsor, Plan Administrator, Claims Administrator, and others to whom the Plan Sponsor has delegated duties and responsibilities under the Plan shall keep accurate and detailed records of any matters pertaining to administration of the Plan in compliance with applicable law.

Allocation of Responsibilities

The Named Fiduciaries may designate other persons who are not Named Fiduciaries to carry out such fiduciary responsibilities. The responsibilities imposed by the Plan on each Named Fiduciary are not joint responsibilities with any other fiduciary unless specifically so designated therein. No fiduciary is responsible for the act, or failure to act, of any other fiduciary.

Amendment and Termination of Plan

Mayo Clinic reserves the right to amend or terminate the Plan, or any benefit option described in any document for the Plan, including this document at any time, for any reason, and in any respect. Mayo Clinic’s right to amend or terminate the Plan or benefit options includes, but is not limited to, changes in eligibility requirements, employer contributions, benefits provided, and termination of all or a portion of any coverage provided under the Plan. If the Plan or any benefit option is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered, or increased accordingly as of the effective date of the amendment or termination. You do not have ongoing rights to any plan or program benefit other than payment of benefits to which you are entitled prior to the Plan amendment or termination. You do not have rights to vested benefits in the Plan. The rights with respect to amendment and termination of the Plan have been delegated to the Salary and Benefits Committee.
STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

Receive Information About the Plan and Benefits

Examine without charge at the Plan Administrator’s office and 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 Pension and Welfare Benefit 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 Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of these summary annual reports each year.

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 benefits plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest, and that of other plan participants and beneficiaries.

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

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court after you have exhausted the Plan’s claims procedure. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.
Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Live assistance is available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time by calling 1-866-4-USA-DOL (1-866-487-2365), or TTY 1-877-889-5627.
PLAN INFORMATION

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Voluntary Group Term and Universal Life</th>
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| Plan Sponsor and Plan Administrator | Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440 |
| Plan Sponsor EIN | 41-6011702 |
| Named Fiduciaries | Salary and Benefits Committee  
Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
The Prudential Insurance Company of America (named claim fiduciary)  
751 Broad Street  
Newark, NJ 07102 |
| Agent for Service of Legal Process | Mayo Clinic  
c/o William A. Brown, Assistant Treasurer  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440  
The Plan Administrator may also be served with process |
| Plan Year | January 1 – December 31 |
| Type of Plan | Life Insurance |
| Plan Number | 504 |
| Type of Administration | The Plan is insured and administered by The Prudential Insurance Company of America (“Prudential”). Address all claims correspondence to Prudential at:  
The Prudential Insurance Company of America  
Life Claims Management  
P.O. Box 8517  
Philadelphia, PA 19176  
Overnight Mail to:  
2101 Welsh Road  
Dresher, PA 19025  
Phone: (844) 656-MAYO (6296)  
Fax: (800) 778-4797 |
| Sources of Contributions | The Plan is insured by Prudential. All premiums for the Plan are paid by participants electing coverage under the voluntary insured components on an after-tax basis. |
| Participating Employers | Charterhouse  
Franklin Heating Station |
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<tr>
<th>Organization</th>
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<tbody>
<tr>
<td>Gold Cross Ambulance Service</td>
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<td>Herman House LLC</td>
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<tr>
<td>Mayo Clinic</td>
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<tr>
<td>Mayo Clinic Arizona</td>
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<tr>
<td>Mayo Clinic Florida (a non-profit corporation)</td>
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<tr>
<td>Mayo Clinic Health System – Decorah Clinic Physicians</td>
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<td>Mayo Clinic Health System – Fairmont</td>
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<tr>
<td>Mayo Clinic Health System – Franciscan Medical Center, Inc.</td>
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<td>Mayo Clinic Health System – Lake City Medical Center</td>
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<td>Mayo Clinic Health System – Northwest Wisconsin Region, Inc.</td>
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<td>Mayo Clinic Health System – Pharmacy &amp; Home Medical, Inc.</td>
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<td>Mayo Clinic Health System – Southeast Minnesota Region</td>
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<tr>
<td>Mayo Clinic Health System – Southwest Minnesota Region</td>
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<td>Mayo Clinic Health System – St. James</td>
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<td>Mayo Clinic Hospital – Rochester</td>
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<td>Mayo Clinic Jacksonville (a non-profit corporation)</td>
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<tr>
<td>Mayo Collaborative Services, LLC</td>
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<tr>
<td>Mayo Foundation for Medical Education and Research</td>
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<tr>
<td>Rochester Airport Company</td>
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</tbody>
</table>
GLOSSARY

Annual Salary
Annual salary means your basic salary and does not include bonuses, commissions, overtime pay, shift pay, or other extra compensation. If you receive a draw (because of production based compensation), your base salary will be your draw for the year in which you or your covered family member’s death occurs.

Beneficiary
The beneficiary for employee coverage is the person or persons (including a trust) that you designate, who will receive your life insurance benefits in the event of your death. You may designate more than one beneficiary. The employee is the beneficiary for any dependent coverage under Family Life. You can update your beneficiary by accessing the Employee Self-Service tool found on the For You page by or you may call HR Connect at (507) 266-0440 or toll free at 1-888-266-0440.

Continuous Service
Period of unbroken service from hire date to termination date with the employer or an affiliated company by an employee who is classified as a regular employee and is scheduled to work at least half-time (.5 FTE). Vacations and approved leaves of absence are not breaks in service except for educational leaves of more than six months for a non-critical employment need. Transfers between the Employer and affiliated companies are not breaks in service as long as the employee continues to be classified as a regular employee and continues to be scheduled to work at least half-time. A break in service occurs upon termination of employment, upon transfer to a non-regular classification, or upon change to a schedule that is less than half-time. A regular employee classification does not include temporary, supplemental, casual employees, or residents, research fellows or health-related science students.

Employee
A person classified by the employer for payroll and personnel purposes as a regular employee, except it shall not include a self-employed individual as described in Section 401(c) of the Internal Revenue Code of 1986. Employee does not include any person classified by the employer as any of the following:

- Any individual who is a temporary employee
- Any individual who is a supplemental or non-benefit eligible employee
- Any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under the Plan
- Any individual who is a nonresident alien and receives no earned income from the employer from sources within the United States.
- Any individual who is a leased employee as defined in Section 414(n)(2) of the Internal Revenue Code of 1986.
- Any individual who performs services for the employer through, and is paid by, a third party (including, but not limited to, an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the employer
- Any individual who performs services for the employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employer

An employer’s classification is conclusive and binding for purposes of determining benefit eligibility under the Plan. No reclassification of a worker’s status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, and without regard to whether or not the employer agrees to the reclassification shall make the worker retroactively or prospectively eligible for benefits. Any uncertainty regarding a worker’s classification will be resolved by excluding that person from eligibility.

Employer
Mayo Clinic and any subsidiary or affiliated entities recognized by Mayo Clinic as eligible to participate and that agrees to participate in the Plan. In this document, employer shall mean the participating employers listed in Plan Information.

Mayo Clinic Health System
A family of clinics, hospitals and health care facilities serving over 70 communities in Iowa, Wisconsin and Minnesota.
NOTICE OF PROTECTION PROVIDED BY
ALASKA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Alaska Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Alaska 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 regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Alaska 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 in hospital, medical and surgical insurance benefits
  - $300,000 for disability insurance or long term care insurance
  - $100,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in present value of annuity benefits including withdrawal and cash values
  - $5,000,000 for covered unallocated annuities that fund other plans

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.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the Association provide benefits greater than those given in the life, annuity, or health insurance policy or contract.

**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 Alaska law.

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Alaska 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 Association should not be contacted regarding the financial information of an insurance company.
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.aklifega.org, or contact:

Alaska Life and Health Insurance  
Guaranty Association 5  
1007 West Third Avenue, Ste. 400  
Anchorage, AK 99501  
(907) 243-2311

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

Insurance companies and agents are not allowed by Alaska 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 Alaska law, then Alaska law will control.
LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, 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 owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the 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 insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association (“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 this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are 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 Guaranty Association to induce you to purchase any kind of insurance policy.

Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). 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 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, 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 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 or contract was issued by a 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 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 a 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 and voting rights and experience rating credits;
- 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);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued in connection with benefit plans protected under Federal Pension Benefit Corporation (“FPBC”) (whether the FPBC is yet liable or not);
- 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, or claims for policy misrepresentations, or 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 trustees).

LIMITS ON AMOUNTS 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 and annuity benefits and $500,000 in health insurance benefits—no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within these overall limits, the Association will not pay more than $300,000 in disability and long term care benefits, $500,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values—again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.
NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

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 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 licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This 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.

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 California 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 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 settlement 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 cash withdrawal and net cash 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 of policies or contracts covering the individual.

• Health Insurance
The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index 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 requires 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 in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment 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 guaranty 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 Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- 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 of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(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, or contact either of the following:

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

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(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.
NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

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 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 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 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.

**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 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 [http://colorado.lhiga.com](http://colorado.lhiga.com), email jkelldorf@gmail.com or contact:

<table>
<thead>
<tr>
<th>Colorado Life and Health Insurance Protection Association</th>
<th>Colorado Division of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>P. O. Box 36009</td>
<td>1650 Broadway, Suite 850</td>
</tr>
<tr>
<td>Denver, CO 80236</td>
<td>Denver, CO 80202</td>
</tr>
<tr>
<td>(303) 292-5022</td>
<td>(303) 894-7499</td>
</tr>
</tbody>
</table>

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.
SUMMARY OF GENERAL PURPOSES, CURRENT 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 associated 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 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 in the present value of structured settlement 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 cash 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**

Policy or contract holders 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 domiciled in a state whose guaranty association law protects insureds 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 an employer or association 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](http://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 document.

Policy or contract holders with additional questions may contact either:

**District of Columbia**
**Department of Insurance, Securities and Banking**
810 First Street, N.E., Suite 701
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 to the 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 in 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.
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 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.

The Hawaii Life and Disability Insurance Guaranty Association
1132 Bishop Street, Suite 1590
Honolulu, HI 96813

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; 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 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 insureds 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 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 are:

Life Insurance
  o $300,000 in death benefits
  o $100,000 in cash surrender or withdrawal values
Health Insurance
  o $500,000 in hospital, medical and surgical insurance benefits
  o $300,000 in disability insurance benefits
  o $300,000 in long-term care insurance benefits
  o $100,000 in other types of health insurance benefits
Annuities
  o $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 and with regard to one owner or multiple non-group policies of life insurance.
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 (the “Association”) and the protection it provides for policyholders. This safety net was created under Iowa 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 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 and withdrawal values

Health Insurance
- $500,000 in basic hospital, medical-surgical or major medical insurance benefits
- $300,000 in disability income protection insurance benefits
- $300,000 in long-term care insurance benefits
- $300,000 in other types of health insurance benefits

Annuities
- $250,000 in annuity benefits, 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 hospital, medical-surgical and major medical insurance benefits.

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.

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’s website at www.ialifega.org, or contact:

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

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
(515) 281-5705
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, Inc., and Standard & Poor’s. That information may be accessed from the “Helpful Links & Information” page located on the website of the Iowa Insurance Division at www.iid.state.ia.us.

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 County, 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. 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.
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 the 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 your 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 prohibited 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
1-800-721-3272
www.doi.idaho.gov

(continued on next page)
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 or 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 the Association if:
- they are eligible for protection under the laws of another state
- the insurer was not authorized to do business in Idaho
- the policy was issued by a reciprocal insurer, 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 any 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
- Medicare 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 cash 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 benefits, 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 INSURANCE 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 that 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 placed into Receivership by its Insurance Department of the state in which the company is domiciled. 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 insololvency 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, 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:

<table>
<thead>
<tr>
<th>Illinois Life and Health Guaranty Association</th>
<th>Illinois Department of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1520 Kensington Road, Suite 112</td>
<td>4th Floor</td>
</tr>
<tr>
<td>Oak Brook, Illinois 60523-2140</td>
<td>320 West Washington Street</td>
</tr>
<tr>
<td>(773) 714-8050</td>
<td>Springfield, Illinois 62727</td>
</tr>
<tr>
<td></td>
<td>(217) 782-4515</td>
</tr>
</tbody>
</table>

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.
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. 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 obligation. 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.

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 to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

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

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

Annuities
- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

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 basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will ILHIGA provide benefits greater than those given 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 the 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.

To learn more about 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, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

IN-SD (Ed. 9-16)
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 on 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, IN 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. (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 your life, health insurance policy or annuity should be directed to your insurance company or agent.
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 THIS STATE. 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. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association Kansas Insurance Department
2909 SW Maupin Lane 420 SW 9th Street
Topeka, KS 66614 Topeka, KS 66612

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.
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 members of the
Louisiana 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. However, the valuable
extra protection provided by these insurers through the Guaranty Association is limited. 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 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 always 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**  
P.O. Drawer 442126  
Baton Rouge, Louisiana 70804

**Department of Insurance**  
P.O. Box 94214  
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 following 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 any person’s rights or obligations under the Act or the rights or obligations of the 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, or an annuity, or if they are insured under
a group insurance 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.
EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this 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 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, or by an insurance exchange.

The Association also does not provide coverage for:

(1) 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;

(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 contract holder;

(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) Medicare Part C benefits or Medicare Part D benefits;

(8) certain unallocated annuity contracts (which give rights to group contract holders, not individuals), and certain structured settlement annuity contracts;

(9) Other exceptions and exclusions may also be applicable depending upon the insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Guaranty Association Law, Louisiana Revised Statutes R.S. 22:2081 et seq.

LIMITS ON AMOUNTS 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 $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the Association will not pay more than $500,000 in health insurance benefits; $250,000 in present value of annuities (including cash surrender and cash withdrawal values); or $300,000 in life insurance death benefits (but not more than $100,000 in cash surrender and cash withdrawal values) – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. Other conditions, requirements or exclusions may apply.

Effective Date: August 1, 2014

LA-SD (Ed. 07-14)
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 Corporation (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**
  - [$300,000 in health insurance benefits, including net cash surrenders and net cash withdrawal values]
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit 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 any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- **Annuities**
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash 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, [are the amounts listed above] 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 contact:

Maryland Life and Health Insurance Guaranty Corporation
9199 Reisterstown Road
P.O. Box 671—Suite 216C
Owings Mills, Maryland 21117
410-998-3907

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.
NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

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 purchase 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

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 the present value of annuity benefits, including 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, other than 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 SUBSTITUTE FOR USING CARE 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 ADVISE 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.
This notice provides 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 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 Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are as follows:

- **Life Insurance**
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal
- **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 as follows:

- $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
- $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

*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 Missouri 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.mo-iga.org, or contact:

<table>
<thead>
<tr>
<th>Missouri Life and Health Insurance Guaranty Association</th>
<th>Missouri Department of Insurance, Financial Institutions and Professional Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>994 Diamond Ridge, Suite 102</td>
<td>301 West High Street, Room 530</td>
</tr>
<tr>
<td>Jefferson City, Missouri 65109</td>
<td>Jefferson City, Missouri 65101</td>
</tr>
<tr>
<td>Ph.: 573-634-8455</td>
<td>Ph.: 573-522-6115</td>
</tr>
<tr>
<td>Fax: 573-634-8488</td>
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</tr>
</tbody>
</table>

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. 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.
This policy or contract is not covered by the Missouri Life and Health Insurance Guaranty Association. If the company providing this policy or contract is unable to meet its obligation by reason of insolvency or financial impairment, the fund(s) of the Missouri Life and Health Insurance Guaranty Association will not be available to protect the policy or contract holder or his/her beneficiaries, payees, or assignees.

MO-SD (Ed. 8-16)
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.

The maximum amount of protection with respect to any one (1) life, regardless of the number of policies or contracts, is:

Life Insurance
• $300,000 in death benefits
• $100,000 in net cash surrender and net cash withdrawal values

Health Insurance
• $500,000 in basic hospital, medical and surgical or major medical benefits
• $300,000 in disability benefits
• $300,000 in long-term care insurance benefits
• $100,000 in other types of health insurance benefits

Annuities
• $250,000 in net cash surrender and net cash withdrawal values

The Association may not cover this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Mississippi. You should not rely on coverage by the Association when selecting an insurer.

To learn more about the above protections, limitations and exclusions, as well as 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 Insurance 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.
NOTICE OF
PROTECTION PROVIDED BY
MONTANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Montana Life and Health Insurance Guaranty Association (the 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 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 Montana 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 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 is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect 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. 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 web site at www.mtlifega.org or contact:

<table>
<thead>
<tr>
<th>Montana Life and Health Insurance Guaranty Association</th>
<th>Montana Department of Insurance</th>
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</thead>
<tbody>
<tr>
<td>PO Box 951</td>
<td>State Auditor's Office</td>
</tr>
<tr>
<td>Oconomowoc, WI 53066-0951</td>
<td>840 Helena Ave.</td>
</tr>
<tr>
<td>877-678-1048 or <a href="mailto:administrator@mtlifega.org">administrator@mtlifega.org</a></td>
<td>Helena, MT 59601</td>
</tr>
<tr>
<td></td>
<td>406-444-2040</td>
</tr>
</tbody>
</table>

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 an 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.
Residents of this state 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 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 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 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 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.

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

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

The state law that provides for this safety-net coverage is called the North Carolina 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 life and health guaranty association if they live in this state and hold a life or health 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 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 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 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’ 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), 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 Medicare Part C or Part D 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 insolvency, 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 basic hospital, medical and surgical insurance and major medical insurance.
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 contract holder.
NOTICE OF PROTECTION PROVIDED BY THE
NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This 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 Association’s website at www.ndlifega.org or contact:

North Dakota Life and 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

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 an 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.
Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire 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 policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers’ care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

**IMPORTANT DISCLAIMER**

The New Hampshire 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 Hampshire. Other conditions may preclude coverage.

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 Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
10 Chestnut Drive, Unit B
Bedford, NH 03110
(603) 472-3734

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261
SUMMARY:

The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law’s coverage, exclusions and limits. This summary does not cover all provisions of the law and it does not in any way change one’s rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE:

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

Coverage provided under the current, amended Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

EXCLUSIONS FROM COVERAGE:

Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the state of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or any entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with an insurance policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;
• any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
• any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery; or
• any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.
• a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, 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 an impaired or insolvent insurer under this chapter, whichever is earlier.
• 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 and D, or any regulations issued pursuant thereto.

**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.

With respect to any one life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages, except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual. For life insurance benefits the Association will not pay more than $300,000 in life insurance death benefits and will not pay more than $100,000 in net cash surrender or withdrawal values. For health insurance benefits the Association will not pay more than $100,000 in health insurance benefits not defined as disability insurance or basic hospital, medical and surgical insurance or long-term care insurance, $300,000 in disability coverage, $300,000 in long-term care benefits, and $500,000 for basic hospital medical and surgical insurance or major medical insurance. For annuity benefits the Association will not pay more than $250,000 in present value of annuity benefits, including net cash surrender or withdrawal values.

The limit of coverage to one owner of multiple non-group policies of life insurance is $5,000,000.

With respect to any one contract holder of an unallocated annuity contract, not including a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code, the Association will pay a maximum of $5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.
ADDITIONAL INFORMATION:

Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.

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August 2015
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.

The New Jersey Life and Health Insurance Guaranty Association
One Gateway Center, 9th Floor
Newark, NJ 07102

State of New Jersey
Department of Banking and Insurance
20 West State Street
P.O. Box-325
Trenton, NJ 08625-0325

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**

Following 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.
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 this state;
- the policy is 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 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).

**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 any 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 cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $100,000 in cash 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 contractholder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.
NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This 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 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 income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- **Annuities**
  - $250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number 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 annuities 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. There are also various residency requirements and other limitations under New Mexico law.

To learn more about the above protections, please visit the Association’s website at www.nmlifega.org, or contact:

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

Insurance Division
Public Regulation Commission
PO 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 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 New Mexico law, then New Mexico law will control.
Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in the state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Association). The purpose of the 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 assesses its other member insurance 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 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 Nevada Life and Health Insurance Guaranty Association may not provide coverage for a policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Association when selecting an insurance company or when selecting an insurance policy.

Coverage is NOT provided for a policy or any portion of it that is not guaranteed by the Insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to you. However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation or to induce the purchase of any kind of insurance policy.

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. Below is a brief summary of this law’s coverages, exclusions and limits. The 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 Association. Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance, at the applicable address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.

The Nevada Life and Health Insurance Guaranty Association
P. O. Box 3302
Reno, Nevada 89505

Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, Nevada 89706
COVERAGE

Generally, individuals will be protected by the Association if they live in this state and hold a life or health 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 the 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 law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside the state);
- the insurer was not authorized to do business in this state; or
- their policy was insured by a nonprofit hospital or medical service organization, a health maintenance organization (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 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;
- 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);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code 26 U.S.C. §§ 401, 403(b) and 457, respectively, or trustees of such a plan; or
- Medicare or Medicare Advantage contracts

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.

With respect to life insurance policies on any one insured life, the Association will pay a maximum of $300,000, regardless of how many policies and contracts there are with the same company, and even if they provide different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, 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 coverage. With respect to annuities, the Association will not pay more than $250,000 in the present value of benefits, including net cash surrender and withdrawal.
With respect to health insurance for any one life, the Association will not pay more than: 1) $100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; 2) $300,000 for disability insurance or long term care insurance; or 3) $500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $250,000 in present values of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in NRS 686C, the maximum coverage allowed is an aggregate of $250,000 in present-value annuity benefits including the value of net cash for surrender and net cash for withdrawal, regardless of the number of contracts issued by any one member company.

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of $300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate of $500,000 in benefits, including benefits for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

FOR MORE INFORMATION AND ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS, PLEASE VISIT THE ASSOCIATION’S WEB SITE:

www.nvlifega.org
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
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio 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 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 this 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 provided different types of coverages. The association will not pay more than $100,000 in cash 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 of 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 coverage 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 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. 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 & Health Insurance Guaranty Association, visit our website at: www.ohliga.org.
This notice 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 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 Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

• Life Insurance
  o $300,000 in death benefits
  o $100,000 in cash surrender or withdrawal values

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

• Annuities
  o $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid 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 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 contact:

Oklahoma Life & Health Insurance Guaranty Association Oklahoma Department of Insurance
201 Robert S. Kerr, Suite 600 3625 NW 56th Street, Suite 100
Oklahoma City, OK 73102 Oklahoma City, OK 73112
Phone: (405) 272-9221 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. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.
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.

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 by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage 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 Life 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 insurance contract, long-term care contract or annuity contract; or is 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 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 was issued by an organization that is not a member of the Association;
• 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 employer’s plan to the extent that it 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;
• certain contracts which establish benefits by reference to a portfolio of assets not owned 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.
• 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 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, and 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 a 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;
- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or 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 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.

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.
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 consumers' care in 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 or 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.
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 certificateholder 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 AMOUNT 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 cash 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 to benefits 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](http://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 the South Dakota Division of Insurance at [www.dlr.sd.gov/insurance](http://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 that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.
NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE
TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Tennessee 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 Tennessee 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 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; 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 contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. 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:
(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 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 also does not provide coverage for:
(1) 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;
(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), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.
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 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages.

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
1200 One Nashville Place
150 4th Avenue North
Nashville, Tennessee 37219-2433

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243-0565
IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:
- Residents of Texas (regardless of where the policyholder lived when the policy was issued)
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder’s state of residence has a similar guaranty association; and
  3. The policyholder is not eligible for coverage by the guaranty association of the policyholder’s state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:
- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:
- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:
- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:
- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:
- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and 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. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

TX-SD (Ed. 10-14)
Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under 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, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 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 $500,000. 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 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. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

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

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.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.  Utah Insurance Department
60 East South Temple, Suite 500  3110 State Office Building
Salt Lake City UT 84111  Salt Lake City UT 84114-6901
(801) 320-9955  (801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.
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 a life, annuity or health insurance company 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 life and health 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 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 the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, 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:
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.
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 & 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 48.32A RCW (“Act”). Every life and disability insurance company authorized to do business in Washington 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 expenses 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 the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the 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 contact either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance Guaranty Association
P.O. Box 2292
Shelton, WA  98584
360-426-6744

Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40256
Olympia, WA  98504-0259
360-725-7214

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 issued by an insurance company authorized to do business in Washington. 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 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 owner 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 if: the insurer is domiciled in Washington; there is an association similar to 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 time of entry of 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 life and disability insurance companies doing business in Washington. 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 an 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 period 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 Benefits ............................................................................... $500,000
- 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
  (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.

8. IF A HUSBAND AND WIFE EACH INDIVIDUALLY OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

Yes. As long as the residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum amount.

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 covered under the Act.
You should not rely on coverage under the Act when selecting an insurance company.

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 in 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 or answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Office of the Insurance Commissioner, whose addresses and telephone numbers are shown in the Preface.

This brochure is prepared by and made available through the Washington Life and Disability Insurance Guaranty Association, which has granted member insurance companies permission to reproduce and distribute the brochure. It is the responsibility of the company, or any representative of a company, reproducing this brochure, to ensure that the use thereof does not violate applicable laws or regulations.
Residents of West Virginia 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 West Virginia Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy holders 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 West Virginia 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 West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. 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 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 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
1124 Smith Street, Rm 309
P.O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386
Toll Free 888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the 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 or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group life, health or annuity insurance 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). 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 this state;

• The policy was issued at a time when the insurer was not licensed or authorized to do business in the state;

• Their policy was issued by an HMO, a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy holder is subject to future assessments, an insurance exchange, or any entity similar to the above.

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 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 by a group contract holder;

• 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:

  i. multiple employer welfare arrangement;

  ii. minimum premium group insurance plan;

  iii. stop loss group insurance plan; or

  iv. administrative services only contract.

• Any unallocated annuity contract issued to an employee 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 or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D;

• An obligation that does not arise under the written terms of the policy, including claims based on marketing materials; claims based on side letters or riders not approved by the Commissioner; misrepresentations regarding policy benefits; extra contractual 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 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.

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, regardless of the number of policies or contracts, the 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 insurance;
• $300,000 for long term care insurance;
• $250,000 in the present value annuity benefits, including net cash surrender and net cash withdrawal values;
• $500,000 for basic major hospital medical and surgical insurance or major medical insurance, and;
• $100,000 for all other types of accident and sickness insurance than those listed above (disability, long term care, and major medical).

Also for any one insured life, the 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 major medical insurance, 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 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; for covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.
NOTICE OF NON-COVERAGE

(Effective July 10, 2009)

The West Virginia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent.

THE POLICY OR CONTRACT YOU ARE PURCHASING IS NOT COVERED BY THE WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION.

If the company providing this policy or contract is unable to meet its obligation by reason of insolvency or financial impairment, the West Virginia Life and Health Insurance Guaranty Association will not be available to protect the policy or contract holder or his/her beneficiaries, payees or assignees.

If you have any questions concerning this Notice, you may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

or

West Virginia Insurance Commissioner
Consumer Services Division
1124 Smith Street, Rm 309
P.O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386
Toll Free 1-888-879-9842
TDD 1-800-435-7381
NOTICE OF PROTECTION
PROVIDED BY
WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming 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 Wyoming 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
  - $300,000 in hospital, medical and surgical insurance benefits or major medical insurance
  - $300,000 in disability insurance benefits
  - $300,000 in disability income insurance
  - $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 $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 Wyoming law.

EXCLUSIONS FROM COVERAGE

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 this state;
• their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder 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 pursuant to the reinsurance policy of contract);
• interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
• dividends;
• credits given in connection with the administration of a policy by a group contract holder;
• annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
• unallocated annuity contracts (which give rights to group contract holders, not individuals).
• any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
• an obligation that does not arise under the express written terms of the policy or contract;
• any policy providing Medicare part C and Part D coverage.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association’s website at wyoming.lhiga.com or contact:

Wyoming Life and Health Insurance Guaranty Association          Wyoming Department of Insurance
6700 N. Linder Road, Suite 156,                                106 East 6th Avenue
Box 139                                                       Cheyenne, WY 82002
Meridian, ID 83646                                             Phone: (307) 777-7401
Toll Free: (800) 362-0944                                       Toll Free: (800) 438-5768
Fax: (208) 968-0206                                             Fax: (307) 777-2446
Website: www.wylifega.org                                     Website: doi.wyo.gov
Email: administrator@wylifega.org                               Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming 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 Wyoming law, then Wyoming law will control.