PLAN DOCUMENT
AND SUMMARY PLAN
DESCRIPTION

Mayo Paid Life

Group Variable Universal Life Insurance
for Voting and Consulting Staff

January 2018
HOW TO USE THIS DOCUMENT

The Table of Contents provides an overview of the detailed information in the Plan.

The glossary provides additional detailed definitions.

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 Group Life Insurance Plan (Employer Paid), which consists of the Employer Paid Life and Mayo Paid Life Group. This document describes the Mayo Paid Life component of the Group Life Insurance Plan (Employer Paid), and is referenced throughout this document as either “Mayo Paid Life” or the “Plan.” A separate document describes the benefits offered under the Employer Paid Life component of the Group Life Insurance Plan (Employer Paid).

Effective January 1, 2018, this document sets forth a summary of the Plan’s death benefit portion of the Face Amount of Insurance for eligible employees and eligible retirees under the Plan, and serves as the Summary Plan Description (“SPD”). The death benefit described in this document is based on your annual salary and consists of the Face Amount of Insurance. This SPD is intended to be easy to use and understand. It contains only highlights of the insurance policy (discussed below), which, together with this SPD, constitute the official plan document for the Plan.

In addition to the death benefit portion of the Face Amount of Insurance that is described in this document, this Plan has an option for you to make additional contributions into an investment account known as the Certificate Fund that is described in the Prospectus and other information already provided to you. You may obtain additional information about the investment options and the Certificate Fund by calling The Prudential Insurance Company of America (Prudential) at 1-800-562-9874 or visiting their website at www.prudential.com/gulgvul.

This death benefit is insured, meaning it is paid from an insurance policy issued to Mayo Clinic by 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 this Plan. This 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 the dispute with Prudential, not Mayo Clinic; and Mayo Clinic will have no role in resolving the 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 46820.

Please review this entire document and all information provided to you by Prudential 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 this Plan. If you have questions, see the contact information in the next section.
CONTACT INFORMATION

For enrollment or general eligibility questions, please contact the Office of Staff Services. The Office of Staff Services is your human resources office for this Plan.

<table>
<thead>
<tr>
<th>General Questions about Enrollment/Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of Staff Services</td>
</tr>
<tr>
<td>200 First Street SW</td>
</tr>
<tr>
<td>Rochester, MN 55905</td>
</tr>
<tr>
<td>507-266-0110 (Rochester)</td>
</tr>
<tr>
<td>480-301-8072 (Arizona)</td>
</tr>
<tr>
<td>904-953-6254 (Florida)</td>
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</tbody>
</table>

For questions about claims, see the sections on *Claim Procedures* and *Claims Administration*.
You may also contact Prudential customer service at 1-800-562-9874 to answer any questions that you may have. For any questions regarding the Certificate Fund and investment options, you should contact Prudential directly or refer to the material and information that Prudential has already provided to you.
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW TO USE THIS DOCUMENT</td>
</tr>
<tr>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>CONTACT INFORMATION</td>
</tr>
<tr>
<td>ELIGIBILITY AND PARTICIPATION</td>
</tr>
<tr>
<td>Effective Date of Coverage</td>
</tr>
<tr>
<td>Evidence of Insurability</td>
</tr>
<tr>
<td>Actively at Work Requirement</td>
</tr>
<tr>
<td>Naming a Beneficiary</td>
</tr>
<tr>
<td>Personal, Disability, USERRA, FMLA, or Parental Leaves of Absence</td>
</tr>
<tr>
<td>When Coverage Ends</td>
</tr>
<tr>
<td>Cost of Coverage</td>
</tr>
<tr>
<td>PLAN BENEFITS FOR MAYO PAID LIFE</td>
</tr>
<tr>
<td>Mayo Paid Life</td>
</tr>
<tr>
<td>Coverage Amount</td>
</tr>
<tr>
<td>Taxable Income</td>
</tr>
<tr>
<td>Eligibility for Retirement Coverage</td>
</tr>
<tr>
<td>Amount of Coverage During Retirement</td>
</tr>
<tr>
<td>When Benefits Are Payable</td>
</tr>
<tr>
<td>Legal Action</td>
</tr>
<tr>
<td>CONVERSION PRIVILEGE</td>
</tr>
<tr>
<td>CONTINUATION OF COVERAGE</td>
</tr>
<tr>
<td>CLAIMS PROCEDURES</td>
</tr>
<tr>
<td>How to Receive Benefits</td>
</tr>
<tr>
<td>Determination of Benefits</td>
</tr>
<tr>
<td>Appeals of Adverse Determination</td>
</tr>
<tr>
<td>CLAIMS ADMINISTRATION</td>
</tr>
<tr>
<td>PLAN ADMINISTRATION</td>
</tr>
<tr>
<td>STATEMENT OF ERISA RIGHTS</td>
</tr>
<tr>
<td>Receive Information About Your Plan and Benefits</td>
</tr>
<tr>
<td>Prudent Actions by Plan Fiduciaries</td>
</tr>
<tr>
<td>Enforce Your Rights</td>
</tr>
<tr>
<td>Assistance with Your Questions</td>
</tr>
<tr>
<td>PLAN INFORMATION</td>
</tr>
<tr>
<td>GLOSSARY</td>
</tr>
</tbody>
</table>
ELIGIBILITY AND PARTICIPATION

You are eligible for coverage under the Plan if you are classified as a Consultant or Voting Staff by the participating employer or are classified as an eligible retiree.

To be eligible as an active employee under the Plan, you must be classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least (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. Allied Health Staff that do not have Voting Staff or Consultant benefits are not eligible.

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.

The Participating Employers section contains a listing of participating employers for Mayo Clinic and Mayo Clinic Health System locations.

To be eligible as a retiree under the Plan, please see “Eligibility for Retirement Coverage.”

Effective Date of Coverage

There is no waiting period to receive Mayo Paid Life. This coverage will be automatically effective on the first day that you are actively at work.

Evidence of Insurability

There is no evidence of insurability required for the Face Amount of Insurance.

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 employer worksite at the request of the employer. If you are not actively at work on the day your 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 during your last normally scheduled work day.

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 the HR Connect page or you may call the Office of Staff Services. In the event of your death, if there is no beneficiary designated, benefits will be paid to the first of the following: Your (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) estate.
If there is more than one beneficiary, but the beneficiary designation does not specify their shares, they will share equally. If a beneficiary dies before you, that Beneficiary’s interest will end. If you have more than one beneficiary and one of them dies before you do, benefits will be divided among the remaining beneficiaries if you do not choose a new beneficiary before your death.

**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.

**When Coverage Ends**

Your coverage under the Plan 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 or eligible retiree
- The day the employer terminates this Plan or its participation in this Plan
- The effective date of an amendment to this 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 Mayo Clinic or You fail to pay when due, any premium required for your coverage
- When you attain age 100

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

- Coverage may be converted to an individual policy as detailed in *Conversion Privilege*
- Coverage when you attain age 100 is limited to the Certificate Fund minus any outstanding loans or charges. There is no Face Value coverage.

**Cost of Coverage**

Your employer pays the required premium of the Mayo Paid Life Plan with respect to the death benefit portion of the Face Value coverage. However, retirees hired or newly eligible for coverage after October 31, 2003 pay the entire required premium directly to Prudential in order to maintain the coverage in retirement. Also, you pay for any contributions you make to the Certificate Fund.
PLAN BENEFITS FOR MAYO PAID LIFE

Mayo Paid Life

Your Mayo Paid Life coverage is based on your **annual salary**, up to a maximum of $1,750,000 of annual salary. Salaries not in even thousands are rounded to the next higher thousand for benefit purposes. Benefits from Mayo Paid Life coverage are payable to your beneficiary in the event of your death from any cause.

Coverage Amount

Mayo Paid Life provides death benefit coverage of three times your annual salary, subject to the maximum annual salary of $1,750,000 noted above. This coverage is the death benefit portion of the Face Value of the insurance coverage.

If you have made contributions to the Certificate Fund pursuant to the terms of the investment options available to you, your beneficiaries will also receive those proceeds, if any, subject to the terms and limitations of the investment component of this Plan. You may contact Prudential for additional information regarding any benefit beyond the death benefit portion of the Face Value of insurance.

Taxable Income

The premium that Mayo pays for this coverage is taxable income to the employee.

Eligibility for Retirement Coverage

If you were enrolled in the Plan prior to November 1, 2003, you are eligible for employer premium contributions towards Mayo Paid Life coverage after you terminate employment if you satisfy the following age and Continuous Service requirements at the time you terminate employment.

If you were hired or enrolled in the Plan after October 31, 2003, you have the option to continue the coverage you had as an active employee by paying premiums directly to Prudential. Your employer does not make any premium contributions for you and you must pay the full cost of the insurance to maintain any coverage in retirement. See Continuation of Coverage section on page 13 for details.

<table>
<thead>
<tr>
<th>Retirement Age</th>
<th>Required Years of Service</th>
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<tbody>
<tr>
<td>62 and over</td>
<td>10 continuous years</td>
</tr>
<tr>
<td>60 and 61</td>
<td>15 continuous years</td>
</tr>
<tr>
<td>55 through 59</td>
<td>20 continuous years</td>
</tr>
<tr>
<td>Any age</td>
<td>30 continuous years</td>
</tr>
</tbody>
</table>

Note that this retiree coverage is subject to Mayo Clinic’s general right to amend, reduce, and/or terminate the Mayo Paid Life Plan.

Amount of Coverage During Retirement

In order to be eligible for Mayo Paid Life in retirement, you must have been continuously eligible based on the eligibility requirements outlined in the Eligibility and Participation section as of November 1, 2003 or before. Mayo Paid Life provides death benefit coverage of one times your annual salary as of November 1, 2003 (rounded to the next higher thousand if not in even thousands) on the date you retire, subject to the reductions described below. Annual salary is subject to a maximum of $1,750,000.
Reduction of Mayo Paid Life retiree coverage:

<table>
<thead>
<tr>
<th>Anniversary of Retirement</th>
<th>At least age 60; or, 25 years of service on 11/01/2003</th>
<th>At least age 50, or 15 years of service on 11/01/2003</th>
<th>At least age 40, or 5 years of service on 11/01/2003</th>
<th>Not at least age 40, or 5 years of service on 11/1/2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Year 2</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Year 3</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Year 4</td>
<td>100%</td>
<td>75%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Year 5</td>
<td>100%</td>
<td>75%</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Year 6</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Year 7</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Year 8</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Year 9</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Year 10 and after</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
</tr>
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</table>

You also have the option to continue the coverage you had as an active employee by paying premiums directly to Prudential.

**When Benefits Are Payable**

Mayo Paid Life benefits are payable to your beneficiary after Prudential receives satisfactory written proof of death. Report of a death should be made to the Office of Staff Services. See the *Claims Procedure* section for more information.

If you are an active participant in the Plan, Terminally Ill, and not expected to live beyond twelve months, you are eligible to receive 75 percent of your benefit, not to exceed $50,000 and a portion of your certificate fund. You may take this as a lump sum or in twelve equal installments. You will need to provide proof of terminal illness to Prudential prior to being entitled to this benefit. Upon your death this amount will be deducted from the total benefit paid to your named beneficiary. This option is not available if your coverage has been assigned.

**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.
CONVERSION PRIVILEGE

If your Mayo Paid Life coverage ends for any reason stated in the certificate of coverage and you are not otherwise eligible for Mayo Paid Life coverage in retirement, you may be able to convert the coverage to an individual whole life policy. 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 policy 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 should die within the 31 days after your Mayo Paid Life coverage ends but before any converted coverage is in effect, your life insurance coverage in force before termination of coverage will be payable to your beneficiary, reduced by the amount of any extended death protection which applies.
CONTINUATION OF COVERAGE

If your employment ends for any reason in the certificate of coverage and you are not otherwise eligible for Mayo Paid Life coverage in retirement, your Mayo Paid Life coverage ends on your last day of employment. You may continue your coverage in Mayo Paid Life by electing continuation coverage and paying the full cost of coverage. This continued coverage would if:

- The premium is not paid on time
- You obtain coverage under an individual life insurance policy
- Termination by Mayo of its contract with Prudential and all other group life insurance

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 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.

The premium to continue coverage may be obtained from HR Connect.

Also, upon termination of 18 months of continued coverage, you may elect to convert your Mayo Paid Life to an individual whole life policy. See the section entitled Conversion Privilege for details.
CLAIMS PROCEDURES

How to Receive Benefits

In the event of your death the Office of Staff Services should be contacted as soon as possible. They can provide assistance in filing a claim for benefits, but satisfactory written proof of death must be provided to Prudential by your beneficiary or representative.

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

Appeals 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 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 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 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 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:*

2102 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 this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing this Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by this 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 this 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 annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report 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 plans. The people who operate these plans, called “fiduciaries” of the plans, 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 Claim 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 this 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 claim procedure. If it should happen, that Plan fiduciaries misuse Plan 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 these 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution 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>Group Life Insurance Plan (Employer Paid)</th>
</tr>
</thead>
</table>
| 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 | 503 |
| Type of Administration | The Plan is insured and administered by The Prudential Insurance Company of America (“Prudential”)  
Address all 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 |
<table>
<thead>
<tr>
<th>Sources of Contributions for Mayo Paid Life</th>
<th>This Plan is insured by Prudential. All premiums are paid from the general assets of participating employers, except for retirees hired or newly eligible after October 31, 2003, continuation coverage, or any contributions by participants to Certificate Fund investments.</th>
</tr>
</thead>
</table>
| Participating Employers | Charterhouse  
Franklin Heating Station  
Gold Cross Ambulance Service  
Herman House LLC  
Mayo Clinic  
Mayo Clinic Arizona  
Mayo Clinic Florida (a non-profit corporation)  
Mayo Clinic Health System – Decorah Clinic Physicians  
Mayo Clinic Health System – Fairmont  
Mayo Clinic Health System – Franciscan Medical Center, Inc.  
Mayo Clinic Health System – Lake City Medical Center  
Mayo Clinic Health System – Northwest Wisconsin Region, Inc.  
Mayo Clinic Health System – Pharmacy & Home Medical, Inc.  
Mayo Clinic Health System – Southeast Minnesota Region  
Mayo Clinic Health System – Southwest Minnesota Region  
Mayo Clinic Health System – St. James  
Mayo Clinic Hospital – Rochester  
Mayo Clinic Jacksonville (a non-profit corporation)  
Mayo Collaborative Services, LLC  
Mayo Foundation for Medical Education and Research  
Rochester Airport Company |
GLOSSARY

Annual Salary
Your basic salary—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, as determined by your Employer, for the year in which your death occurs.

Beneficiary
Your beneficiary 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. You can update your beneficiary by accessing the Employee Self-Service tool found on the HR Connect page by or you may call the Office of Staff Services.

Certificate Fund
The investment component of the Plan that consists of the contributions you make to the investment options that are available to you. The value may increase or decrease daily depending on the contributions, investment experience and any applicable deductions described in other documents provided to you by Prudential. There is a Certificate Fund Tax of 2.64% that is deducted from each fund contribution at the time the money is deposited into the account. This fee is to cover taxes attributable to premium.

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, transfer to a non-regular classification, or 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.

Death Benefit
The greater of (a) the Face Amount of Insurance plus, if you make contributions to a Certificate Fund, your beneficiaries will also receive the value of your Certificate Fund on the date of your death, minus any applicable debt and charges; or (b) the Certificate Fund times the percent for the person’s attained age in the Table of Corridor Percentages as defined in your Group Insurance Certificate.

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.
**Group Contract**
The contract is between The Prudential Insurance Company of America and the Trustee of the Prudential Life Insurance Trust. Mayo Clinic participates in the trust in order to provide GVUL benefits.

**Mayo Clinic Health System**
A family of clinics, hospitals and health care facilities serving over 70 communities in Iowa, Wisconsin and Minnesota.

**Terminally Ill**
An actively at work Employee whose life expectancy is six months or less.
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.
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 contract holders, not individuals);
- Unallocated annuity contracts issued to/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:

<table>
<thead>
<tr>
<th>California Life and Health Insurance Guarantee Association</th>
<th>California Department of Insurance Consumer Communications Bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O Box 16860</td>
<td>300 South Spring Street</td>
</tr>
<tr>
<td>Beverly Hills, CA 90209-3319</td>
<td>Los Angeles, CA 90013</td>
</tr>
<tr>
<td>(323) 782-0182</td>
<td>(800) 927- 4357</td>
</tr>
</tbody>
</table>

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
  • $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 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
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.
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 insolvency 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.

KS-SD (Ed. 5-11)
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
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:

**Missouri Life and Health Insurance Guaranty Association**

994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Fax: 573-634-8488

**Missouri Department of Insurance, Financial Institutions and Professional Registration**

301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph.: 573-522-6115

Insurance companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. 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:

<table>
<thead>
<tr>
<th>Mississippi Life and Health Insurance Guaranty Association</th>
<th>Mississippi Insurance Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>330 North Mart Plaza</td>
<td>Woolfolk Building</td>
</tr>
<tr>
<td>Jackson, MS. 39206-5327</td>
<td>501 N. West Street. Suite 1001</td>
</tr>
<tr>
<td>601-981-0755</td>
<td>Jackson, MS 39201</td>
</tr>
</tbody>
</table>

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 State Auditor's Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 951, 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.
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
NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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 | Insurance Division |
| PO Box 2880 | Public Regulation Commission |
| Santa Fe, NM 87504-2880 | PO Box 1269 |
| 505-820-7355 | 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.
NOTICE OF PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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.
SUMMARY

COVERAGE, LIMITATIONS and EXCLUSIONS UNDER
RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (“Act”)

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

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

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

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited 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 is 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.
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.
NOTICE OF
PROTECTION PROVIDED BY
VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

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

The Association was established to provide protection in the unlikely event that 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:
VIRGINA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218
804-371-9741
Toll Free Virginia only: 1-800-552-7945

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.
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.

WA-SD (Rev 11-09)
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.
SUMMARY OF THE WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS
(Effective July 10, 2009)

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 contractholder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  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
  o $300,000 in death benefits
  o $100,000 in cash surrender or withdrawal values

• Health Insurance
  o $300,000 in hospital, medical and surgical insurance benefits or major medical insurance
  o $300,000 in disability insurance benefits
  o $300,000 in disability income insurance
  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 $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
6700 N. Linder Road, Suite 156, Box 139
Meridian, ID 83646
Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002
Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
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.