Metropolitan Life Insurance Company
New York, New York

Metropolitan Life Insurance Company ("MetLife"), a stock company, will pay the benefits specified in the Exhibits to this policy subject to the terms and provisions of this policy.

Policyholder: LEE COUNTY SCHOOLS (NC)

Group Policy No.: 1707

EFFECTIVE DATE

This policy will take effect on 04/01/2019.

This policy is a legal contract between MetLife and the Policyholder.

READ THIS POLICY CAREFULLY!

POLICY ANNIVERSARIES

The first Policy Anniversary will be 4/01/2020. Subsequent Policy Anniversaries will be 4/01/2021 and each April 01 thereafter.

PREMIUM PAYMENTS

This policy, and the insurance provided under it, is issued in return for the payment of required Premiums.

Premiums are payable at the home office of MetLife or to its authorized agent. The first Premium is due on and must be paid on or before this policy's Effective Date. Any later Premiums are due monthly in advance on the first day of each Policy Month. These dates are the Premium Due Dates.

MetLife and the Policyholder may agree upon a different frequency for the payment of Premiums. In that case, Premium Due Dates will be adjusted to reflect the agreed upon frequency.

POLICY SITUS

This policy is issued for delivery in and governed by the laws of North Carolina.

IMPORTANT CANCELLATION INFORMAITON: Please read the provision titled "End of Insurance Provided by this Policy" found on page 8.

SEE NEXT PAGE FOR IMPORTANT NOTICES

Signed as of this policy's effective date at MetLife's home office in New York, New York.

Timothy J. Ring
Secretary

Michel Khalaf
President and CEO

GROUP CANCER AND SPECIFIED DISEASE EXPENSE POLICY
NON-DIVIDEND PAYING
This is a Limited Benefit Policy

NOTICE

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS, IF ANY, TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

TABLE OF CONTENTS

Section **Page**

DEFINITIONS

As used in this policy, the terms listed below will have the meanings defined below. When defined terms are used in this policy, they will appear with initial capitalization. The plural use of a term defined in the singular and the singular use of a term defined in the plural will share the same meaning.

Certificateholder means an Employee who is a Covered Person. Unless otherwise specified, the Certificateholder is entitled to exercise the rights and benefits granted under the certificates attached to the policy as Exhibits.

Covered Person means an Employee or Dependent whose life or person is the subject of insurance under the certificates attached to the policy as Exhibits.

Dependent means any person who qualifies as a Dependent under the certificates attached to the policy as Exhibits.

Employee means any person who qualifies as an employee under the certificates attached to the policy as Exhibits.

Employer means the Policyholder shown on the face page of this policy and any subsidiaries, affiliates, divisions, branches or other similar entities of the Policyholder as set forth in the Exhibits to this policy.

Exhibit means any attachment to this policy referred to in the Schedule of Exhibits. Exhibits to this policy include the certificates and any riders attached to such certificates; a Schedule of Initial Premium Rates; and such other attachments as agreed to by MetLife and the Policyholder.

Policy Anniversary means each of the Policy Anniversary dates as set forth in the Policy Anniversaries provision on the policy face page. The Policy Anniversary is also the renewal date of the policy.

Policy Month means the one month period beginning on the Effective Date shown on the face page of this policy. Subsequent Policy Months will begin on the same day of each subsequent month.

Policyholder means the entity listed as the Policyholder on the face page of this policy.

Premium means the amount that must be paid to MetLife for the insurance provided under this policy.

Premium Due Date is defined on is defined on the face page of this policy.

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

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

SCHEDULE OF INSURANCE

The schedules of insurance which apply under this policy are set forth in the Exhibits and certificates attached to this policy as Exhibits.

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

The Eligibility and Effective Dates of Insurance provisions provided under this policy are set forth in the Exhibits to this policy and the appropriate records of MetLife and the Policyholder. Provisions setting forth the conditions, if any, under which MetLife requires a person to furnish evidence of good health satisfactory to MetLife to obtain coverage are also set forth in the Exhibit(s).

PREMIUM RATES

Initial Rates

The initial Premium rates are shown in the Exhibits to this policy.

Computation of Premiums

The Premium due on any Premium Due Date is determined by the total amount of insurance provided under this policy, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable. Premium will be calculated on the basis of the number of Covered Persons in each coverage classification at the time of calculation, at the premiums then in effect.

MetLife may use any reasonable method to compute Premiums due.

Computation of Premiums for Changes in Insurance

Insurance will take effect on the first day of a Policy Month and Premium will be charged from that day. However, if a policy amendment or evidence of good health is required, Premium will be charged as of the date insurance takes effect.

If insurance ends because this policy ends or because insurance for a class of persons ends, Premium for such insurance will be charged to the date it ends. If insurance ends for any other reason, Premium will be charged to the end of the Policy Month in which such insurance ends.

Right to Change Premium Rates

Except as may be required by any Rate Guarantee Period, MetLife may change Premium rates on any date on or after the first Policy Anniversary Date; this will be done no more frequently than every 12 months and only if MetLife notifies the Policyholder, in Writing, at least 60 days before such change.

In addition to the above and notwithstanding any rate guarantee period, MetLife may change Premium rates at any time for changes which materially affect the risk or cost assumed for the insurance provided by this policy, as follows:

1. when this policy is amended or endorsed;

2. when a class of eligible persons is added to or deleted from this policy for any reason including organizational restructuring, acquisition, spin-off or similar situations;

3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including organizational restructuring, acquisition, spin-off or similar situations;

4. when there is a significant change in the geographic distribution of either certificateholders or Covered Persons;

5. when applicable law or regulatory requirements or the administration of such law or regulatory requirements:

    a. requires a change in:

        i. the insurance provided by this policy; and/or
        ii. a class or classes of persons eligible for insurance under this policy;

    b. results in a change in the amount of benefits paid under this policy; or

    c. requires additional tax(es) to be paid;

PREMIUM RATES (Continued)

6. when a Premium Due Date coincides with or next follows a change greater than 10% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed;

7. on any other date agreed to by MetLife and the Policyholder.

New Premium rates will apply only to Premiums that become due on or after the date the rate change takes effect.

MetLife will notify the Policyholder, in Writing, at least **60** days before such a Premium rate change.

In addition, MetLife may change Premium rates:
1. on any date agreed to by MetLife and the Policyholder; or
2. except as may be stated in Exhibit 1, on any date on or after the first Policy Anniversary, subject to the following restrictions:
   a. any such Premium rate change will be made no more frequently than every **12** months;
   b. if such Premium rate change is based on claims experience, it will be based on at least 12 months of claims experience; and
   c. MetLife will notify the Policyholder, in Writing, at least 60 days before such change.

GRACE PERIOD

Each premium due may be paid up to 31 days after its Premium Due Date. This period is known as the grace period. The insurance provided by this policy for which premium has not been paid will stay in effect during the grace period. MetLife will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, such insurance will end at the end of the last day of the grace period. If MetLife fails to give Written notice to the Policyholder by the end of the grace period, such insurance will continue in effect until the date notice is given.

Policyholder's intent to end insurance during a grace period

The Policyholder may notify MetLife in Writing prior to the end of a grace period of its intent to end this policy or insurance coverage provided under it before the end of such grace period. In this case, this policy or such insurance will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

The Written notice to be given by MetLife and required by the first paragraph of this provision will not be necessary if the Policyholder replaces the insurance provided by this policy for which premium has not been paid with other group insurance or the Policyholder notifies MetLife of its intent to end this policy or such insurance.

Grace period extensions

MetLife may extend a grace period by giving Written notice to the Policyholder. Such notice will state the date insurance will end if the Premium remains unpaid.

Premiums must be paid for a grace period, any extension of such period and any period insurance was in effect for which Premium was not paid.

END OF INSURANCE PROVIDED BY THIS POLICY

The Policyholder may end this policy by giving 60 days advance Written notice to MetLife. The policy or such insurance will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

MetLife may end this policy as follows:

1. for non-payment of Premium, as set forth in the Grace Period provisions;

2. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if fewer than 5 Employees are insured by this policy.

3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or

4. on any Policy Anniversary, except during a Rate Guarantee Period for insurance affected by the Rate Guarantee Period, by giving the Policyholder 60 days advance Written notice.

This policy will end on the date on which the last certificate in effect under this policy ends.

If this policy ends, all Premiums due must be paid. If MetLife accepts Premium after the date this policy ends, such acceptance will not act to reinstate the policy. MetLife will refund any unearned Premium.

PORTABILITY OF CERTAIN INSURANCE

Under circumstances described in the Exhibits to this policy, certificateholders may be entitled to elect to port insurance if this policy ends. If on or after the date the policy would otherwise end there are certificates in effect under which one or more certificateholders have elected to port insurance after this policy ends in accordance with the terms and conditions specified in their certificates, this policy will be deemed to continue in effect but only with respect to those certificateholders.

GENERAL PROVISIONS

Entire Contract

The entire contract is made up of the following:

- this policy and its Exhibits including the certificates attached to the policy as Exhibits;
- the Policyholder's application; and
- all amendments and endorsements to this policy, if any.

Policy Changes or Waivers

The terms and provisions of this policy may be changed, either by amendment or endorsement.

1. The policy may be changed by amendment upon the mutual agreement of MetLife and the Policyholder. Such amendment must be in Writing and Signed by an officer of MetLife and by an authorized representative of the Policyholder.
2. The policy may be changed by an endorsement issued by MetLife without the consent of the Policyholder. Such endorsement must be in Writing and Signed by an officer of MetLife. The use of endorsements is limited to:
    a. changes made in response to:
        - applicable local, state or federal law or regulation;
        - a change in applicable local, state or federal law or regulation; or
        - the administration of applicable local, state or federal law or regulation;
    b. reflect changes in MetLife's administrative practices;
    c. reflect policy liberalizations to the extent that they do not increase Premiums;
    d. incorporate provisions agreed upon prior to issuance of this policy; and
    e. reflect the exercise of a right or rights set forth under the terms of the policy.

Changes to the policy may be made without the consent of the certificateholders or anyone else with a beneficial interest in it. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement may be effective retroactively if such retroactivity is not prohibited by applicable law.

An officer of MetLife must approve in Writing any waiver of the terms and provisions of this policy.

A sales representative or other MetLife employee, who is not an officer of MetLife does not have MetLife's authority to approve changes or waivers. A copy of the amendment or endorsement will be provided to the Policyholder for attachment to this policy.

Time Limit on Certain Defenses: Statements Made by the Policyholder

Any statement made by the Policyholder will be considered a representation and not a warranty. MetLife will not use such a statement to contest insurance after such insurance has been in force for 2 years from its effective date. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless it is contained in a Written application.

Time Limit on Certain Defenses: Statements Made by Covered Persons

Any statement made by a Covered Person or a Covered Person's legal representative will be considered a representation and not a warranty. MetLife will not use statements which relate to insurability to contest insurance after such insurance has been in force for 2 years during the Covered Person's life. In addition, MetLife will not use such statements to contest an increase or benefit addition to insurance after the increase or benefit has been in force for 2 years during the Covered Person's life.

Time Limit on Certain Defenses: Statements Made by Covered Persons (continued)

MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. the Covered Person or the Covered Person's legal representative has Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to the Covered Person, the Covered Person's legal representative or the Covered Person's beneficiary.

Certificates

MetLife will issue certificates to the Policyholder or the Policyholder's designee for delivery to each certificateholder, as appropriate. Such certificates will describe the certificateholder's benefits and rights under this policy and are Exhibits to the policy. The term "certificate" includes certificate riders.

Assignment

This policy is not assignable except and to the extent such assignment may be agreed to by MetLife.

The assignability of certificates attached as Exhibits to this policy and of the rights and benefits arising under such certificates, is described in the certificates.

Information Needed and Policy Administration

All information necessary to compute Premiums and carry out the terms of this policy will be provided by the Policyholder to MetLife. Such information:

- Must be provided in a timely manner and in a format as agreed to by MetLife and the Policyholder;
- Will be provided, maintained and administered as agreed to in writing by an officer of MetLife and the Policyholder; and
- If maintained by the Policyholder, may be examined by MetLife at any reasonable time.

If MetLife or the Policyholder makes a clerical error in keeping or providing the information, the Premium and/or benefits will be adjusted as warranted, according to the correct information. An error will not end insurance validly in effect, nor will it continue insurance validly ended or create insurance coverage where no coverage existed.

Any act undertaken by the Policyholder that relates to the insurance provided under this policy must be consistent with the terms of such insurance and with MetLife's requirements; including but not limited to the eligibility requirements for coverage as set forth in the certificates to this policy.

Termination of a Covered Person

Upon the termination of coverage of a covered person, the premium under this Policy shall be the applicable premium for the remaining covered persons.

Refund of Unearned Premium

If a covered person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to us within 12 months, or as soon as reasonably possible, after a covered person has died.

Misstatement of Age

If a Covered Person's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, adjust Premiums and/or benefits.

Non-Dividend Paying

This policy does not pay dividends.

Conformity with Law

If the terms and provisions of this policy do not conform to any applicable law, this policy shall be interpreted to so conform.

SCHEDULE OF EXHIBITS

Exhibit Number	Exhibit Type	Applies To	Effective Date
1	Schedule of Initial Premium Rates	All Covered Persons	04/01/2019
2	Certificate Forms and Attachments	Persons Specified In The Listed Forms And Attachments	04/01/2019

EXHIBIT 1

SCHEDULE OF INITIAL PREMIUM RATES

Rate Guarantee Period

Subject to the Right to Change Premium Rates provision, the Premium rates stated below will be in effect from 04/01/2019 to 3/31/2020.

Rates are determined separately for each Employee based on:

- the dependents (if any) that the Employee insures; and:
- the Employee's age as of the 31st day of December of the preceding calendar year

The initial monthly Premium rates for the insurance provided by this policy are as follows:

Benefit	Coverage	Total
Opt1	Employee	$17.65
Opt1	Employee and children	$25.19
Opt1	Employee and Spouse	$35.57
Opt1	Family	$43.10
Opt2	Employee	$23.38
Opt2	Employee and children	$33.20
Opt2	Employee and Spouse	$47.60
Opt2	Family	$57.43
Opt3	Employee	$19.63
Opt3	Employee and children	$27.64
Opt3	Employee and Spouse	$39.44
Opt3	Family	$47.45
Opt4	Employee	$30.89
Opt4	Employee and children	$43.36
Opt4	Employee and Spouse	$62.87
Opt4	Family	$75.34

Date: 04/01/2019

EXHIBIT 2

CERTIFICATE FORMS

The North Carolina certificate(s) listed below are Exhibits to and attached to the policy.

Certificate Number	Certificate Form	Effective Date
1	GCERT18-BB-SD/CAN	04/01/2019

If an employee resides in one of the following states on the date their certificate is initially issued under the policy, a certificate specific to their state of residence will be issued to them:

Alaska, Arkansas, Colorado, Connecticut, Florida, Idaho, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF GROUP CANCER AND SPECIFIED DISEASE EXPENSE INSURANCE

This is a Limited Benefit Certificate.

This Certificate is issued to You under the Policy. This Certificate includes the terms and provisions of the Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Policy is a legal contract between Metropolitan Life Insurance Company ("MetLife") and the Policyholder. It may be changed or ended without Your consent or notice to You.

Coverage under the Policy will be administered on Our behalf by "the Administrator" Bay Bridge Administrators, LLC.

The Policy is on file with the Policyholder and may be examined at any reasonable time. Only an executive officer of MetLife can authorize a change of the Policy or benefits.

The Policy Effective Date is: 04/01/2019

The Policy Anniversary Date is: April 1st of each year.

MetLife Toll Free Number: 1-800-845-7519

MetLife Address
Bay Bridge Administrators LLC on behalf of MetLife:
P.O. Box 161690
Austin, TX 78716

Notice to Buyer: This is cancer and specified disease coverage that provides limited benefits in the event a Covered Person is diagnosed with certain specified diseases or have certain surgical procedures performed. Benefits provided are a supplement, and not a substitute for major medical coverage. You should have major medical coverage when enrolling for this coverage.

IMPORTANT CANCELLATION INFORMATION: Please read the provision titled "Termination Dates" found on page 18.

THIS CERTIFICATE CONTAINS A PRE-EXISTING CONDITION LIMITATION. SEE THE LIMITATIONS SECTION

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS, IF ANY, TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE FOR RESIDENTS OF CALIFORNIA

If You were a resident of California on Your Certificate effective date, this notice applies to You.

READ YOUR CERTIFICATE CAREFULLY TO REVIEW LIMITATIONS. IF YOU ARE AT LEAST 65 YEARS OLD ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN THIS CERTIFICATE TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT. IF YOU RETURN IT WITHIN 30 DAYS, THE CERTIFICATE WILL BE CONSIDERED NEVER TO HAVE BEEN ISSUED. WE WILL REFUND ANY PREMIUM PAID FOR INSURANCE UNDER THIS CERTIFICATE.

NOTICE FOR RESIDENTS OF MAINE

If You were a resident of Maine on Your Certificate effective date, this notice applies to You.

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to Bay Bridge Administrators, LLC. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to Bay Bridge Administrators, LLC. The designation will be effective as of the date MetLife receives the form. Call Bay Bridge Administrators, LLC at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR RESIDENTS OF MARYLAND

The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

NOTICE FOR RESIDENTS OF MASSACHUSETTS

If You were a resident of Massachusetts on Your Certificate effective date and Your insurance under this Certificate is ending as described in Section III – Termination Dates because You cease to be in an eligible class because Your employment has ended, instead of insurance ending on the premium due date that coincides with or next follows the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.

- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

CERTIFICATE CONTENTS

CERTIFICATE SCHEDULE

YOUR NAME	[Certificate Holder]
POLICYHOLDER	LEE COUNTY SCHOOLS (NC)
POLICY NUMBER	1707
POLICY EFFECTIVE DATE	04/01/2019
CERTIFICATE EFFECTIVE DATE	[Date]
CERTIFICATE NUMBER	[Certificate Number]
ELIGIBLE CLASS	CLASS 1 - ALL FULL-TIME EMPLOYEES CLASS 2 - ALL EMPLOYEES WHO HAVE PORTED COVERAGE
DEFINITION OF FULL-TIME	30 HOURS

DEPENDENTS COVERED:
[DEPENDENT NAMES]

Optional Benefit Level

Please refer to Section V for details regarding the benefits and benefit amounts listed below.

BENEFIT	**BENEFIT AMOUNT**
HOSPITAL CONFINEMENT	$100 per Covered Person PER DAY
COLONY-STIMULATING FACTORS	Up to $500 per Covered Person PER CALENDAR MONTH
SURGERY	Up to $3,000 per Covered Person per surgery
RADIATION/CHEMOTHERAPY/IMMUNOTHERAPY	Up to $2,500 PER MONTH per Covered Person
FIRST DIAGNOSIS	$2,500 per Covered Person
WELLNESS	$100 PER CALENDAR YEAR per Covered Person
MISCELLANEOUS DIAGNOSTIC SERVICES	Up to a lifetime maximum of $10,000 per Covered Person
SELF- ADMINISTERED DRUGS	Up to $4,000 PER CALENDAR MONTH per Covered Person

ADDITIONAL BENEFITS (AS PROVIDED BY RIDER)
[INTENSIVE CARE UNIT BENEFIT RIDER]

Optional Benefit Level

Please refer to Section V for details regarding the benefits and benefit amounts listed below.

BENEFIT	**BENEFIT AMOUNT**
HOSPITAL CONFINEMENT	$100 per Covered Person PER DAY
COLONY-STIMULATING FACTORS	Up to $500 per Covered Person PER CALENDAR MONTH
SURGERY	Up to $3,000 per Covered Person per surgery
RADIATION/CHEMOTHERAPY/IMMUNOTHERAPY	Up to $5,000 PER MONTH per Covered Person
FIRST DIAGNOSIS	$5,000 per Covered Person
WELLNESS	$100 PER CALENDAR YEAR per Covered Person
MISCELLANEOUS DIAGNOSTIC SERVICES	Up to a lifetime maximum of $10,000 per Covered Person
SELF- ADMINISTERED DRUGS	Up to $4,000 PER CALENDAR MONTH per Covered Person

ADDITIONAL BENEFITS (AS PROVIDED BY RIDER)
[INTENSIVE CARE UNIT BENEFIT RIDER]

Optional Benefit Level

Please refer to Section V for details regarding the benefits and benefit amounts listed below.

BENEFIT	**BENEFIT AMOUNT**
HOSPITAL CONFINEMENT	$100 per Covered Person PER DAY
COLONY-STIMULATING FACTORS	Up to $500 per Covered Person PER CALENDAR MONTH
SURGERY	Up to $3,000 per Covered Person per surgery
RADIATION/CHEMOTHERAPY/IMMUNOTHERAPY	Up to $2,500 PER MONTH per Covered Person
FIRST DIAGNOSIS	$0 per Covered Person
WELLNESS	$100 PER CALENDAR YEAR per Covered Person
MISCELLANEOUS DIAGNOSTIC SERVICES	Up to a lifetime maximum of $10,000 per Covered Person
SELF- ADMINISTERED DRUGS	Up to $4,000 PER CALENDAR MONTH per Covered Person

ADDITIONAL BENEFITS (AS PROVIDED BY RIDER)
[INTENSIVE CARE UNIT BENEFIT RIDER]

Optional Benefit Level

Please refer to Section V for details regarding the benefits and benefit amounts listed below.

BENEFIT	**BENEFIT AMOUNT**
HOSPITAL CONFINEMENT	$100 per Covered Person PER DAY
COLONY-STIMULATING FACTORS	Up to $500 per Covered Person PER CALENDAR MONTH
SURGERY	Up to $3,000 per Covered Person per surgery
RADIATION/CHEMOTHERAPY/IMMUNOTHERAPY	Up to $5,000 PER MONTH per Covered Person
FIRST DIAGNOSIS	$0 per Covered Person
WELLNESS	$100 PER CALENDAR YEAR per Covered Person
MISCELLANEOUS DIAGNOSTIC SERVICES	Up to a lifetime maximum of $10,000 per Covered Person
SELF- ADMINISTERED DRUGS	Up to $4,000 PER CALENDAR MONTH per Covered Person

ADDITIONAL BENEFITS (AS PROVIDED BY RIDER)
[INTENSIVE CARE UNIT BENEFIT RIDER]

SECTION I - DEFINITIONS

Actively-At-Work – means performing in the customary manner, all the Primary and Essential Duties of Your occupation with the Policyholder, on a Full-Time basis, as indicated on the Certificate Schedule, at Your customary place of employment or business, or at some location to which that employment requires You to travel.

Ambulatory Surgical Center – means a center which provides elective surgical care and admits and discharges each patient within a working day.

Calendar Month – means any of the named months, January through December.

Calendar Year – means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

Cancer – means the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes:

1. Hodgkins Disease;
2. leukemia;
3. lymphoma;
4. carcinoma;
5. sarcoma; or
6. malignant tumor.

It does not include other conditions which may be considered precancerous, including, but not limited to:

1. leukoplakia;
2. actinic keratosis;
3. carcinoid;
4. hyperplasia;
5. polycythemia;
6. nonmalignant melanoma;
7. moles; or
8. similar diseases or lesions.

Certificate – means this Certificate including any riders attached to it.

Certificate Effective Date – means the day on which coverage begins for You and is shown on the Certificate Schedule.

Chemotherapist – means a person who is licensed to administer chemotherapy or immunotherapy.

Colony-Stimulating Factors – means substances that stimulate the production of blood cells. Treatment with colony-stimulating factors can help the blood forming tissue recover from the effects of chemotherapy and radiation therapy. These include granulocyte colony-stimulating factors and granulocyte-macrophage colony-stimulating factors.

Common Carrier - means only the following: commercial airline; passenger train; or bus line between cities. It does not include taxis, city bus lines or private charter planes.

Covered Person – means You and, if insured under the Policy for the insurance described in this Certificate, Your Dependents.

Date of Diagnosis – means the later of:
(a)the day the tissue specimen is taken; or
(b)the day a diagnostic procedure is performed; or
(c)the day the Positive Diagnosis of Cancer or Specified Disease is made.

Dependent means Your Spouse, and/or Dependent Child. No person can be insured under the Policy as both an employee and a Dependent.

Dependent Child – means the following:
- Your biological child, while such child is younger than the Dependent Child Age Limit, and unmarried;
- Your adopted child who was under age 18 when adopted by You, while such child is younger than the Dependent Child Age Limit, and unmarried;
- Your Foster Child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, including a child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit, and unmarried;
- A child for whom You are required to provide health insurance pursuant to a court or administrative order, while such child is under the Dependent Child Age Limit.
- A child for whom You or Your Spouse are appointed legal guardian, while such child is under the Dependent Child Age Limit, unmarried and subject to the legal guardianship of You or Your Spouse.

The term Dependent Child does not mean an unborn or stillborn child.

A person cannot be insured for Cancer and Specified Expense Disease Insurance as a Dependent Child of more than one employee under the Policy.

Dependent Child Age Limit – means the end of the Calendar Month in which the Dependent Child reaches age 26.

Domestic Partner –means each of two people, one of whom is an employee of the Policyholder, who:
(a) have registered as each other's domestic partner, civil union partner with a government agency where such registration is available; or
(b) are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
- 18 years of age or older;
- unmarried;
- the sole domestic partner of the other;
- sharing a Primary Residence with the other; and
- not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and signed by the employee.

Effective Date/Effective Date of Insurance – means the Certificate Effective Date for You, and the date Your Spouse and /or Dependent Children are added to the coverage according to Section II – Eligibility and Effective Dates.

Employer – means Your Employer.

Enrollment Form – means the form designated by Us that a person in an Eligible Class must complete and submit in order to request enrollment in the Policy. Enrollment Forms are available from the Policyholder and must be submitted to the Policyholder to be forwarded to Us.

Extended Care Facility – means a licensed nursing facility directed by a Physician. It provides continuous skilled nursing service under the supervision of a Registered Nurse (R.N.). It maintains daily medical records of each patient. It does not include any institution, or part of one, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

Foster Child means a child placed with You with the intent that such child will reside with You on more than a temporary or short-term basis, for whom You assume the legal obligation for total or partial support, and for whom You are:

- appointed guardian of such child; or
- given primary or sole custody of such child by order of a court of competent jurisdiction.

Government or Charity Hospital or Outpatient Clinic – means

- a Hospital or Outpatient Clinic operated by or for the United States Government (including the Veteran's Administration); or
- a Hospital or Outpatient Clinic that does not charge for the services it provides (charity).

For the purposes of this definition, the term Outpatient Clinic means a healthcare facility that cares for outpatients and meets all of the following conditions:

- it does not charge a daily room rate;
- it does not admit or assign persons to a Hospital bed for a period of 23 hours or longer;
- clinical services and treatment plans must be evidenced-based and quality improvement-oriented;
- it must have a formal connection with a Physician or Physician practice; and
- it must be duly licensed by the state or regulatory agency responsible for such licensing.

The term Outpatient Clinic shall also include an institution that otherwise meets the required conditions, referring to itself as a convenience clinic or any such other facility.

Hospice Facility - means a facility, unit of a facility, public or private agency, or unit of a public or private agency that

- is separate from a Hospital or is a separately designated unit within a Hospital; and
- meets federal certification requirements as a hospice, or is comparably licensed under the laws where it is located, to provide care or management of persons who are diagnosed with a Terminal Illness.

Hospital Confined or **Hospital Confinement** means the assignment to a bed as a resident inpatient in a Hospital on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Hospital – means an institution which:

- operates pursuant to law;
- primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
- operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified Physicians or is a state tax-supported institution; and
- provides 24 hour a day nursing service by or under the supervision of registered Nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

- a nursing home, convalescent home, or skilled nursing facility;
- a place for rest, custodial care, or for the aged;
- a clinic;
- a place for the treatment of mental illness, alcoholism, or drug addiction.

However, a place for the treatment of mental, nervous or emotional disorders will be regarded as a Hospital if:

- it is part of an institution that meets the above requirements; and
- it is listed in the American Hospital Association Guide as a general hospital.

Incurred Expenses – means charges that are solely Your responsibility, or expenses that are a combination of insurance reimbursement and Your responsibility such as deductibles or co-payment. The fee negotiated between Your major medical insurer and medical providers, as reflected on an explanation of benefits from such insurer, would be considered the Incurred Expense.

Initial Enrollment Period – means the period of time during which You are first eligible to enroll under the Policy.

Late Enrollee – means an employee who does not send an Enrollment Form during the Initial Enrollment Period.

Local – means within 60 miles of the Covered Person's home.

New and Experimental Treatment – New and experimental treatment means treatment that is not generally accepted by the medical community as effective and proven, is not approved by the Federal Drug Administration, and/or is in clinical trials.

Non-Local – means more than 60 miles and less than 700 miles.

Nurse – means any one of the following who is not a member of Your immediate family:
- licensed practical Nurse (L.P.N.);or
- licensed vocational Nurse (L.V.N.);or
- licensed registered Nurse (R.N.).

With respect to the benefits provided under the Policy, Nurse will not include an L.P.N., L.V.N. or R.N. who is employed by the Hospital where the Covered Person is Hospital Confined.

Oncologist – means a Physician certified to practice in the field of Oncology.

Outpatient Clinic – means a healthcare facility that cares for outpatients and meets all of the following conditions:
- it does not charge a daily room rate;
- it does not admit or assign persons to a Hospital bed for a period of 23 hours or longer;
- clinical services and treatment plans must be evidenced-based and quality improvement-oriented;
- it must have a formal connection with a Physician or Physician practice; and
- it must be duly licensed by the state or regulatory agency responsible for such licensing.

The term shall also apply to an institution which otherwise meets the required conditions, referring to itself as a convenience clinic or any such other facility.

Pathologist – means a Physician certified to practice pathological anatomy.

Physician – means:
- a person licensed to practice medicine in the United States who is acting within the scope of such license; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Policy, who is practicing in the United States. Each such person must be licensed, certified or registered, as required, in the United States jurisdiction where the service is performed and must act within the scope of such license, certification or registration.

Physician does not include:
- You;
- Your Spouse; or
- Any member of Your immediate family including Your and/or Your Spouse's parents, children (natural, step or adopted); siblings; grandparents; or grandchildren.

Policy – means the policy of insurance issued by Us to the Policyholder under which this Certificate is issued.

Policyholder – means the entity, in whose name the Policy is issued, as specified on the Certificate Schedule.

Positive Diagnosis (of Cancer) – means a diagnosis by a Pathologist. Diagnosis is based on a microscopic examination of fixed tissue or preparation from the hemic system (except for skin Cancer). If a pathological diagnosis is not made, We will accept clinical diagnosis of Cancer as evidence that Cancer existed. The evidence must substantially document the diagnosis and the Covered Person must receive definitive treatment.

Positive Diagnosis (of Specified Disease) – means a diagnosis by a qualified Physician. This is based on generally accepted diagnostic procedures and criteria.

Primary and Essential Duties – means those duties that are generally and regularly required in the performance of an occupation and which cannot be reasonably changed, accommodated or omitted.

Proof – means Written evidence satisfactory to Us that a Covered Person has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:

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

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

Radiologist – means a Physician licensed to administer X-ray therapy, radium therapy, or radioactive isotopes therapy.

Specified Disease – means any of the following: Addison's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Diphtheria, Encephalitis, Epilepsy, Hansen's Disease, Legionnaire's Disease, Lupus Erythematosus, Lyme Disease, Malaria, Meningitis(epidemic cerebrospinal), Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Tuberculosis, Tularemia, Typhoid Fever, Undulant Fever, Whipple's Disease.

Spouse – means Your lawful Spouse or Your Domestic Partner.

Tentative Diagnosis – means a diagnosis by a Physician, based on the Physician's experience, training and expertise, when a Positive Diagnosis cannot be made due to medical reasons.

Terminally Ill – means the Covered Person has a life expectancy of 12 months or less.

We, Our, Us, or Company – means Metropolitan Life Insurance Company.

You and Your – means an employee who is insured under the Policy for the insurance described in this Certificate.

Write, Written or Writing – means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

SECTION II – ELIGIBILITY AND EFFECTIVE DATES

Eligibility – For You

To be eligible for insurance under the Policy You must be a member of an eligible class, as provided on the Certificate Schedule.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable waiting period set by the Policyholder.

If You enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable waiting period set by the Policyholder.

Enrollment

If You are eligible for insurance, You may enroll by submitting an Enrollment Form which must be received by Us prior to the end of the Initial Enrollment Period, or, if a new hire, upon satisfying any applicable waiting period.

An individual who fails to enroll during the Initial Enrollment Period is a Late Enrollee and may only enroll during the annual open enrollment period.

Your Effective Date of Insurance

Your Effective Date of Insurance is the Certificate Effective Date shown on the Certificate Schedule.

If You are not Actively-at-Work in an eligible class on the date insurance under this Certificate would otherwise take effect, Your Effective Date of Insurance will be delayed until the date You return to being Actively-at-Work. However, should the effective date be a non-work day, insurance will still become effective on that date if You were Actively-at-Work on Your last preceding scheduled work day.

Eligibility – For Your Dependents

If You are in an eligible class of employees who are eligible for Dependent insurance on the date Your insurance takes effect, You will be eligible for Dependent insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter an eligible class of employees who are eligible for Dependent insurance after the date Your insurance takes effect, You will be eligible for Dependent insurance on the later of the following:

- the date You enter a class eligible for Dependent insurance; and
- the date an individual becomes Your first Dependent.

Newborn Coverage from Birth

If coverage is not already in effect for at least one Dependent Child, a Dependent Child born to You or Your Spouse while coverage is in effect under this Certificate will be covered from the moment of birth. Notification of birth of a newborn child must be furnished to Us within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period. Payment of the required premium must be made within 30 days after the mailing by Us of the notice of premium to the Policyholder.

If coverage is in effect for at least one Dependent Child a Dependent Child born to You or Your Spouse while coverage is in effect under this Certificate, the child will be covered from the moment of birth. No notification of birth is required.

Adopted Children Coverage from Date Placed for Adoption

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if Placement for Adoption or adoption occurs within 31 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 31 days after the child's birth.

The child does not need to be enrolled if coverage is already in effect for at least one other Dependent Child. If Dependent coverage is not already in effect for at least one other Dependent Child, to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's adoption or Placement for Adoption. You must do this within 31 days after the date the child is adopted by You or Placed for Adoption with You. Payment of the required premium must be made within 30 days after the mailing by Us of the notice of premium to the Policyholder. Coverage will end if the child's placement is disrupted prior to legal adoption.

Placed for Adoption or **Placement for Adoption** means the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child.

Foster Children

A Dependent Child who becomes Your Foster Child while insurance is in effect under the Certificate will be covered as soon as the guardian or custodian has been appointed by the clerk of superior court of any county in North Carolina.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's Placement In Your Home as a Foster Child and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the Foster Child. The premium must be paid to Us for that period of coverage. You must do this within 31 days of the date the child is Placed In Your Home as a Foster Child.

Placed In Your Home as a Foster Child or Placement In Your Home as a Foster Child means:

- the child is physically residing with You;
- You are appointed as guardian or custodian of the child; and
- You have assumed the legal obligation for total or partial support of the Foster Child with the intent that the Foster Child reside with You on more than a temporary or short-term basis.

A Child Covered Pursuant to a Court or Administrative Order

A child for whom You are required to provide insurance pursuant to a court or administrative order that is entered while insurance is in effect under the Certificate will be covered from the date specified in the order.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of Your obligation to cover the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the child. The premium must be paid to Us for that period of coverage. You must do this within 31 days of the date You become obligated to cover the child.

Custodial Parent

If You do not have custody of Your Dependent Child who is insured under this Certificate, We may provide such information to the custodial parent of such Dependent Child as may be necessary for such Dependent Child to obtain benefits under this Certificate.

Spouse and Dependent Child Coverage Effective Date

The Effective Date of Insurance for Your Spouse and Dependent Child, depends on when You enroll the Spouse and Dependent Child. The applicable premium must be paid.

The Effective Date of Insurance is determined as follows:

- If You enroll Your Dependents when You are first eligible for Dependent insurance, coverage for Your Dependents will be effective on Your Effective Date of Insurance.
- If You enroll Your Spouse within 31 days from when Your Spouse becomes Your Dependent, coverage for Your Spouse will be effective as of the first day of the Calendar Month next following the date on which We receive the Enrollment Form for Your Spouse.
- If the Dependent Child is a newborn child or a newly adopted child, the Effective Date of Insurance for such child will be determined in accordance with the above provisions regarding newborn and adopted children.
- If a child, other than a newborn or newly adopted child, becomes Your Dependent Child after Your Effective Date of Insurance, coverage for such child will be effective as of the first day of the Calendar Month next following the date We receive the Enrollment Form.

Benefit Changes

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Policyholder. Please contact Us or the Policyholder for more information.

If a change to Your insurance operates to increase benefits or coverage, then You must be Actively-at-Work on the Effective Date of the change in order for the change to take effect. If You are not Actively-at-Work on that date, the Effective Date of the change will be delayed until the date You return to being Actively-at-Work. Should the Effective Date be a non-work day, the change in Your insurance will still become effective on that date if You are Actively-at-Work on the last preceding scheduled work day.

SECTION III – TERMINATION DATES

Termination of a Full-Time Employee's Coverage

A Full-Time employee's insurance under the Policy will automatically terminate on the earliest of the following dates:

- the date that the Policy terminates;
- the date of termination of any section or part of the Policy with respect to insurance under such section or part;
- the premium due date that coincides with or next follows the date that You cease to be a member of an eligible class; or
- the end of the grace period following the period for which the last full premium has been paid for Your insurance.

If You are no longer Actively-at-Work due to an authorized leave of absence, You may continue to be covered under the Policy until the earlier of:

- the date employment is formally terminated; or
- 12 months after the leave of absence began.

Termination of coverage will not affect a claim that was incurred while coverage was in force under the Policy.

Termination of Spouse and Dependent Child Coverage

A Spouse's coverage under this Certificate will end on the earliest of:

- the date of divorce; or
- the date You die, unless coverage is continued under the Widow or Widower's Continuation provision; or
- the end of the grace period following the period for which the last full premium has been paid for the Spouse.

A Dependent Child's coverage under this Certificate will end on the earlier of:

- the Policy Anniversary that coincides with or next follows the date the child reaches the Dependent Child Age Limit, unless coverage is continued under the Incapacitated Child Continuation provision; or
- the premium due date for any required premium for the Dependent Child that remains unpaid by the end of the grace period.

Widow or Widower's Continuation

If You die while Your Spouse is covered under the Policy, Your Spouse may elect to continue coverage through the Portability provision for themselves and any Dependent Children who are covered by the Policy on the date of Your death.

In order to continue coverage under this provision, We must receive the Spouse's request to continue coverage and the required premium within 31 days of the premium due date next following Your death, subject to the following:

- for the purpose of continuing coverage under this provision, the Spouse will continue to be considered a Covered Person;
- coverage continued under this provision for a Spouse will terminate on the premium due date on or next following the earliest of the following dates:
    - date the Spouse remarries;
    - the date the Spouse's coverage would otherwise end under the Portability provision;
    - the premium due date for any required premium for the Spouse that remains unpaid by the end of the grace period; or

- coverage for a Dependent Child being continued under this provision will end on the earliest of the following dates:
    - the date coverage for the Spouse ends;
    - the premium due date for any required premium that remains unpaid for the Dependent Child by the end of the grace period; or
    - the date the child no longer qualifies as a Dependent Child.

Incapacitated Child Continuation

If, on the date a Dependent Child reaches the Dependent Child Age Limit, the Dependent Child is an Incapacitated Child, coverage will not terminate solely due to age. Proof of such incapacity must be furnished to Us within 60 days after the Dependent Child reaches the Dependent Child Age Limit and subsequently as may be required by Us, but not more frequently than annually after the Dependent Child reaches the Dependent Child Age Limit.

Except as stated in the Spouse and Dependent Child Coverage Termination provision, coverage will continue as long as:

- the Dependent Child remains an Incapacitated Child; and
- the required premium is paid.

Incapacitated Child - means Your or Your Spouse's Dependent Child who has an intellectual disability or is physically handicapped and incapable of earning his or her own living and unmarried and primarily dependent on You for support and maintenance.

Grace Period

The Policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period coverage under the Policy shall continue in force, unless the Policyholder has given Us Written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Policyholder shall be liable to Us for the payment of a pro rata premium for the time the coverage was in force during such grace period.

SECTION IV – BENEFITS

We will provide coverage to a Covered Person for the benefits and services shown in the Certificate Schedule and the Schedule of Benefits up to any maximums indicated while insurance under the Policy is in force, subject to all applicable terms, conditions, provisions and exclusions.

Cancer and Specified Disease Benefits will only be paid for a Positive Diagnosis made after the Covered Person's Effective Date of Insurance, except as provided in Section VII – Replacement of Prior Group Policy.

If Cancer or a Specified Disease is diagnosed while any Covered Person is Hospital Confined, benefits will begin on the day of admission or 10 days prior to the Date of Diagnosis if this is more favorable, subject to the Pre-Existing Condition Limitation provision in this Certificate. Admission to the Hospital must begin after the Covered Person's Effective Date of Insurance.

If a Positive Diagnosis is made within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis, subject to the Pre-Existing Condition Limitation provision in this Certificate. If the Positive Diagnosis can only be confirmed post-mortem following a Hospital Confinement, We will pay benefits for the confinement beginning on the first day of confinement for up to 45 days.

We will pay benefits for unrelated cancer diagnosed after the Certificate Effective Date.

SECTION V – SCHEDULE OF BENEFITS

The benefits listed below, other than the Wellness Benefit, are only payable for Cancer or a Specified Disease covered under the policy and subject to the requirements of Section IV above. For all benefits, other than the Wellness, First Diagnosis and Government or Charity Hospital or Outpatient Clinic benefits, We will only pay the applicable benefit amount if there was an actual billed charge or Incurred Expense for the service or treatment.

BENEFIT	BENEFIT AMOUNT
Wellness. We will pay a benefit if a Covered Person has a Cancer screening test, including but not limited to: (a) Mammogram; (b) Flexible Sigmoidoscopy; (c) Pap Smear; (d) Chest X-ray; (e) Hemoccult Stool Specimen; (f) Prostate Screen.	The amount shown on the Certificate Schedule
Positive Diagnosis Test. We will pay a benefit for one diagnostic test that leads to a Positive Diagnosis of Cancer or Specified Disease within 90 days of such test. This benefit is only payable for one test per Covered Person per Calendar Year and is not payable if the same Cancer or Specified Disease recurs.	The provider's actual billed charge, up to $300 per Covered Person per Calendar Year
First Diagnosis Benefit. We will pay a one-time benefit when a Covered Person is first diagnosed with Cancer (other than skin Cancer that is not invasive melanoma) or a Specified Disease. The first diagnosis must occur after the Effective Date of Insurance. This benefit is payable only once per lifetime for each Covered Person.	The amount shown on the Certificate Schedule
Second and Third Surgical Opinions. We will pay for a Written second or third surgical opinion as to the need for the surgical procedure. These charges must be incurred: (a) after a Positive Diagnosis and before surgery; and (b) given by an internist or a Specialist in the appropriate specialty, who is not affiliated with the Physician performing the surgery.	The Incurred Expense for the opinion
Non-Local Transportation. We will pay for a Covered Person's Non-Local travel to a Hospital (inpatient or outpatient); radiation therapy center; chemotherapy or oncology clinic; or any other specialized treatment. This benefit is only payable if the Covered Person's treatment is not available Locally and is available Non-Locally.	(a) The actual billed charges for round trip coach fare on a Common Carrier; or (b) 50 cents per mile for round-trip personal vehicle transportation for round trips over 60 miles. Mileage is measured from the Covered Person's home to the nearest treatment facility as described above. We will pay for up to 700 miles per treatment.

BENEFIT	BENEFIT AMOUNT
Adult Companion Lodging and Transportation. If a Covered Person is Hospital Confined in a Non-Local Hospital for Cancer or Specified Disease treatment, We will pay for lodging and round trip transportation for one adult companion to stay with the Covered Person. This benefit is not payable for actual billed charges for lodging incurred more than 24 hours before the treatment nor for actual billed charges for lodging incurred more than 24 hours following treatment. If We pay for personal vehicle mileage under the Non Local Transportation Benefit, We will pay personal vehicle mileage under this benefit only if the adult companion lives in a town other than where the Covered Person lives.	(a) For lodging: The actual billed charges up to $75 per day for a single room in a motel, hotel, or other accommodations, to a maximum stay of 60 days. (b) For transportation: • the actual billed charges for a round trip coach fare on a Common Carrier; or • a personal vehicle allowance of 50 cents per mile for up to 700 miles per Hospital stay. Mileage is measured from the visiting adult companion's home to the Hospital in which the Covered Person is staying.
Ambulance. We will pay a benefit for ambulance services if a Covered Person is taken to the Hospital by a licensed ambulance and is admitted as an inpatient.	The Incurred Expense for the ambulance service.
Surgery. We will pay a benefit for the surgeon's fee for an operation on a Covered Person and for care by the surgeon after the operation. If more than one operation is performed through the same incision, payment will be made for the one operation providing the largest benefit. Payment will not include charges by an assistant or co-surgeons.	For inpatient surgery: The lesser of: • the amount listed on the Surgical Schedule* for the applicable surgery; and • the surgeon's actual billed charges for the surgery. *If a surgical procedure is performed that is not listed in the Surgical Schedule, the benefit amount payable under the Policy will be the lesser of: • the surgeon's actual billed charges; or • the fee for the procedure shown in the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule which appears at www.cms.gov. For outpatient surgery: 150% of the Surgery benefit payable for inpatient surgery. However, We will not pay an amount which exceeds the surgeon's actual billed charges for the surgery.

BENEFIT	BENEFIT AMOUNT
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay benefits for the Covered Person and his or her live donor. This benefit is in lieu of the Hospital benefit for each day both the Covered Person and the donor are hospitalized for the transplant. This benefit is in lieu of the Non-Local Transportation benefit, which will not be payable. A donor will not qualify for the Adult Companion Lodging and Transportation benefit while the Covered Person is hospitalized for the transplant.	(a) Two times the Hospital Confinement benefit shown on the Certificate Schedule for each day both the Covered Person and the donor are hospitalized for the transplant. (b) For transportation: • actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or • personal vehicle allowance of 50 cents per mile. Mileage is measured from the home of the donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay; and (c) actual billed charges for lodging and meals for the donor to remain near Hospital up to $50 per day.
Bone Marrow and Peripheral Stem Cell Transplant. We will pay a benefit for surgical and anesthetic charges associated with a Covered Person's bone marrow transplant and/or peripheral stem cell transplant. This benefit is in lieu of the Surgery and Anesthesia benefits, which will not be payable.	The Incurred Expense up to a combined lifetime maximum per Covered Person of $15,000
Anesthesia. We will pay a benefit for anesthesia provided during a surgical procedure.	(a) For anesthesia for skin Cancer that is not invasive melanoma: $100 per Covered Person. (b) For anesthesia for all other surgery: 25% of the amount paid by Us for the surgery.
Ambulatory Surgical Center. We will pay a benefit for facility charges for surgery performed on a Covered Person in an Ambulatory Surgical Center.	$250 per Covered Person
Drugs and Medicine. We will pay a benefit for drugs and medicine provided to a Covered Person while Hospital Confined.	$25 per day per Covered Person for each day of confinement for a Calendar Year maximum per Covered Person of $600.
Outpatient Anti-Nausea Drugs. We will pay for drugs prescribed by a Physician and which are used by a Covered Person while an outpatient, for suppressing nausea during Cancer or Specified Disease treatment.	The actual billed charges, up to $250 per Covered Person per calendar year.

BENEFIT	BENEFIT AMOUNT
Radiation/Chemotherapy/Immunotherapy. We will pay a benefit for the following provided to a Covered Person: (a) teleradio therapy using either natural or artificially propagated radiation; (b) interstitial or intracavity application of radium or radioactive isotopes in sealed or non-sealed sources; (c) chemical substances and their administration including hormonal therapy; (d) antigenic preparation or immunosuppressive techniques; on an inpatient or outpatient basis. Treatment must be: (a) administered by a Radiologist, Chemotherapist, or Oncologist; or (b) used to modify or destroy cancerous tissue. Unless specified elsewhere in the Policy, We will not pay for: (a) treatment room charges; (b) dressings; (c) medications other than chemotherapeutic drugs; (d) emergency room charges; (e) medical supplies; (f) x-rays, scans and their interpretations.	The Incurred Expenses up to the amount shown on the Certificate Schedule for this benefit, per Covered Person.
Miscellaneous Diagnostic Services. We will pay a benefit for the following diagnostic services for a Covered Person: (a) laboratory work and its interpretation; (b) routine or diagnostic X-rays, scans, and their interpretations. Diagnostic service must be performed while receiving treatment(s) covered under the Radiation/Chemotherapy/Immunotherapy Benefit or within 30 days following a treatment covered under the Radiation/Chemotherapy/Immunotherapy Benefit.	The Incurred Expenses up to the amount shown on the Certificate Schedule for this benefit, per Covered Person.
Self- Administered Drugs. We will pay a benefit for a Covered Person's self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment.	The Incurred Expense up to the amount shown on the Certificate Schedule for this benefit, per Covered Person.

BENEFIT	BENEFIT AMOUNT
Colony -Stimulating Factors. We will pay a benefit for a Covered Person for: (a) the cost of the chemical substances; and (b) their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist.	The Incurred Expense up to the amount shown on the Certificate Schedule for this benefit, per Covered Person.
Blood, Plasma, and Platelets. We will pay a benefit for the following for a Covered Person: (a) blood, plasma, and platelets; (b) transfusions; (c) the administration of items (a) and (b) above; (d) processing and procurement costs; (e) cross matching. We will not pay for blood replaced by donors.	The Incurred Expense up to $200 per Covered Person per day.
Physician's Attendance. We will pay a benefit for one visit per day by a Physician while the Covered Person is Hospital Confined.	$35 per Covered Person per day.
Private Duty Nursing Services. We will pay a benefit for private nursing care by a Nurse provided to a Covered Person if: (a) nursing services are required and ordered by the attending Physician; and (b) the Covered Person is Hospital Confined. We will not pay for nursing services provided in a facility other than a Hospital.	$100 per Covered Person per day.
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay a benefit if a Covered Person is diagnosed with Cancer, other than skin Cancer that is not invasive melanoma, and receives an evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay a benefit for transportation and lodging. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation benefit.	(a) For the evaluation: The actual billed charges, up to a lifetime maximum per Covered Person up to $750 (b) For transportation and lodging: The actual billed charges, up to a lifetime maximum per Covered Person up to $350

BENEFIT	BENEFIT AMOUNT
Breast Prosthesis. We will pay for: (a) a prosthesis to restore body contour lost due to breast Cancer; (b) the implantation of the prosthesis - the benefit for the surgical procedure for implantation of the prosthesis is in lieu of the Surgery benefit; and (c) a mastectomy bra.	The Incurred Expenses.
Artificial Limb or Prosthesis. When an amputation is performed, We will pay a benefit for: (a) an artificial limb or prosthesis; (b) the procedure to affix or implant it – the benefit for the procedure to affix or implant the artificial limb or prosthesis is in lieu of the Surgery benefit.	The actual billed charges, up to $1500 lifetime maximum per Covered Person per amputated limb.
Physical Therapy or Speech Therapy. We will pay a benefit for one session of physical or speech therapy per day for restoration of normal bodily function.	$35 per Covered Person per day
Extended Benefits. Payable if a Covered Person is Hospital Confined for more than 60 continuous days. Payment will begin on the 61st day of continuous Hospital Confinement. This benefit is payable in lieu of the Hospital Confinement benefit.	Three times the Hospital Confinement benefit shown on the Certificate Schedule.
Extended Care Facility. We will pay a benefit if a Covered Person is confined in an Extended Care Facility : (a) at the direction of the Covered Person's attending Physician; (b) beginning within fourteen days after a Hospital confinement for which a Hospital benefit was paid.	$50 per Covered Person per day, not to exceed the number of days that the Hospital Confinement benefit was paid.
At Home Nursing. We will pay a benefit for a Covered Person's private nursing care and attendance by a Nurse at home. Nursing services must be: (a) required and authorized by the attending Physician; and (b) immediately following confinement in a Hospital for which a Hospital benefit was paid.	$100 per day per Covered Person, not to exceed the number of days that the Hospital Confinement Benefit was paid.
New and Experimental Treatment. We will pay a benefit for New and Experimental Treatment provided to a Covered Person: (a) prescribed by the attending Physician; and (b) received by the Covered Person in the United States or in its territories.	The actual billed charges, up to $7,500 per Covered Person per Calendar Year

BENEFIT	BENEFIT AMOUNT
Hospice Care. We will pay a benefit for care received by a Covered Person in a Hospice Facility or at home. The Covered Person must have been diagnosed as Terminally Ill and: (a) the attending Physician must approve such stay or care; and (b) the Covered Person must be admitted or have at home care begin within fourteen (14) days after a Hospital stay. Benefits payable for hospice centers that are designated areas of Hospitals will be paid the same as inpatient Hospital stays. We will not pay for food services or meals other than dietary counseling; services related to well-baby care; services provided by volunteers; or support for the family after the death of the Covered Person. If this benefit is payable for the same day as the At Home Nursing benefit, it will be paid in lieu of the At Home Nursing benefit.	$50 per Covered Person per day.
Government or Charity Hospital or Outpatient Clinic. If the Covered Person is confined in or treated at a Government or Charity Hospital or Outpatient Clinic, We will pay a daily benefit in lieu of all other benefits other than the Wellness and First Diagnosis Benefits.	$200 per Covered Person per day.
Hairpiece. We will pay a benefit for a hairpiece for a Covered Person when hair loss is the result of Cancer treatment.	The actual billed charges up to the lifetime maximum of $150 per Covered Person.
Rental or Purchase of Durable Goods. We will pay for the rental or purchase of the following pieces of durable medical equipment: (a) a respirator or similar mechanical device; (b) brace; (c) crutches; (d) hospital bed; or (e) wheelchair.	The Incurred Expenses up to $1500 per Covered Person per Calendar Year.

BENEFIT	BENEFIT AMOUNT
Waiver of Premium. We will waive premiums starting on the first premium due date following a 60 day period of Your Disability due to Cancer or Specified Disease. You must: (a) be receiving treatment for such Cancer or Specified Disease for which benefits are payable under the Policy; and (b) remain Disabled for 60 consecutive days. We will waive premiums for as long as You remain Disabled. Premiums waived will be in accordance with the mode of payment in effect when treatment began. Disabled or Disability means that You are: (a) unable to work at any job for which You are qualified by education, training or experience; and (b) under the care of a Physician for the treatment of Cancer, other than skin Cancer that is not invasive melanoma, or a Specified Disease.	
Hospital Confinement. We will pay a daily benefit for each day a Covered Person is charged the daily room rate by a Hospital. This benefit is payable up to 60 days for one period of continuous stay.	The daily benefit amount shown on the Certificate Schedule for this benefit. For Dependent Children under the age of 21 the benefit is two (2) times the daily Hospital Confinement benefit.

SURGICAL SCHEDULE
$3,000 Maximum

SURGICAL PROCEDURE	SURGICAL CODE	SURGICAL BENEFIT
ABDOMEN		
Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49083	$55
Excision or destruction, open, intra-abdominal or retroperitoneal tumors or cysts or endometriomas	49203	$1,010
BLADDER		
Cystotomy; for excision of bladder tumor	51530	$1,010
Cystectomy, prostatectomy, and urethrectomy, male with bilateral pelvic lymphadenectomy	51595	$3,000
Cystourethroscopy	52000	$71
Transurethral surgery with fulguration and/or resection of medium tumors (2.0 – 5.0 cm)	52235	$780
BONE		
Biopsy, bone, trochar, superficial	20220	$88
BRAIN		
Excision brain tumor, supratentorial	61510	$2,196
Craniectomy for excision of brain tumor, infratentorial or posterior fossa	61518	$2,635
Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma	61519	$3,000
Excision choroid plexus for craniopharyngioma	61544	$1,867
Craniotomy for hypophysectomy or excision of pituitary tumor	61546	$2,141
BREAST		
Biopsy of breast, needle (independent procedure)	19100	$44
Mastectomy, partial (quadrectomy or more)	19301	$428
Mastectomy, simple, complete	19303	$571
Mastectomy, radical including pectoral muscles, axillary lymph nodes	19305	$1,318
Mastectomy, Including internal mammary lymph nodes	19306	$1,812
CHEST		
Bronchoscopy with biopsy	31625	$351
Thoracentesis for biopsy	32421	$49
Pneumonectomy, total	32440	$1,976
Lobectomy, total or segmental	32480	$1,702
Excision of mediastinal tumor	39220	$1,318
EAR		
Excision, external ear, partial	69110	$209

SURGICAL PROCEDURE	SURGICAL CODE	SURGICAL BENEFIT
ESOPHAGUS		
Excision local lesion with primary repair, cervical approach	43100	$1,098
Excision local lesion with primary repair, thoracic approach	43101	$1,427
Esophagectomy and gastric anastomosis	43118	$2,086
Partial esophagectomy, Lower 1/3 with combined thoraco-abdominal vagotomy and pyloroplasty, one or two stages	43121	$1,922
EYE		
Enucleation of eye	65101	$615
Exenteration of orbit	65110	$1,208
HEART		
Excision intracardiac tumor, resection with bypass	33120	$2,416
INTESTINES		
Enterectomy, resection of small intestine with anastomosis	44120	$1,208
Colectomy, total, abdominal; without proctectomy; with ileostomy or ileoproctostomy	44150	$1,812
Colectomy, total, abdominal, with proctectomy; with ileostomy	44155	$2,416
Proctectomy, complete, combined abdominoperineal with colostomy	45110	$1,702
KIDNEY		
Renal biopsy, Percutaneous, by trochar or needle	50200	$176
Renal biopsy, by surgical exposure of kidney	50205	$516
Nephrectomy, radical, with regional lymphadenectomy	50230	$1,647
Nephrectomy, partial	50240	$1,537
LIVER		
Needle biopsy, percutaneous	47000	$99
Wedge biopsy (independent procedure)	47100	$714
Hepatectomy, partial lobectomy	47120	$1,373
LYMPHATIC SYSTEM		
Biopsy or excision of lymph node(s), open, deep cervical node(s)	38510	$242
Cervical lymphadenectomy (complete)	38720	$1,373
MOUTH		
Excision of lip	40510	$747
Glossectomy; Hemiglossectomy	41130	$856
Glossectomy, partial, with unilateral radical neck dissection	41135	$1,537
Glossectomy, total, with unilateral radical neck dissection	41145	$1,812
OVARY		
Wedge resection or bisection of ovary, unilateral or bilateral	58920	$824
PANCREAS		
Biopsy of pancreas	48100	$1,010
Pancreatectomy	48150	$2,416
PAROTID		
Excision parotid tumor, lateral lobe, without nerve dissection	42410	$417

SURGICAL PROCEDURE	SURGICAL CODE	SURGICAL BENEFIT
Excision parotid tumor, with radical cervical lymphadenectomy, unilateral	42426	$1,922
PENIS		
Amputation of penis, partial	54120	$637
Amputation of penis, complete	54125	$1,263
Amputation of penis, radical with bilateral inguino-femoral lymphadenectomy	54130	$1,812
PROSTATE		
Biopsy, incisional, any approach	55705	$516
Prostatectomy, perineal, subtotal	55801	$1,263
SINUS		
Maxillectomy with orbital exenteration	31230	$2,086
SPINE		
Partial resection of vertebral component for cervical tumor	22100	$878
STOMACH		
Gastric biopsy by laparotomy	43605	$856
Local excision of tumor	43610	$1,032
Total gastrectomy including intestinal anastomosis	43620	$1,812
Hemi-gastrectomy with vagotomy	43635	$1,427
TESTIS		
Biopsy, incisional, unilateral (independent procedure)	54505	$198
Orchiectomy, radical, for tumor, inguinal approach	54530	$582
Orchectomy, with abdominal exploration	54535	$780
THROAT		
Laryngectomy, total, without radical neck dissection	31360	$1,867
Laryngectomy, with radical neck dissection	31365	$3,000
Laryngoscopy, direct operative, with biopsy	31535	$296
UTERUS		
Colposcopy with biopsy	57452	$60
Dilation and curettage with biopsy	58120	$296
Radical abdominal hysterectomy	58210	$2,196
URINARY		
Ureterectomy, with bladder cuff (independent procedure)	50650	$1,263
Ureterectomy, total, ectopic; combination abdominal, vaginal, and/or perineal approach	50660	$1,427
Ureteral endoscopy with biopsy	50974	$99
VULVA		
Vulvectomy, simple	56625	$1,010
Vulvectomy, radical	56630	$1,208
Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	56640	$2,196

SECTION VI – PRE-EXISTING CONDITION LIMITATION

Pre-Existing Condition - means a medical condition, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Effective Date of Insurance for each Covered Person or during the 12 months immediately preceding an increase in benefits for each Covered Person under this Certificate.

During the first 12 months that coverage under this Certificate is in effect for a Covered Person no benefits will be payable for a loss due to a Pre-Existing Condition. During the first 12 months following the date You make a coverage change that increases benefits set forth in this Certificate, the benefit increase will not be payable for a loss due to a Pre-Existing Condition.

SECTION VII – REPLACEMENT OF PRIOR GROUP POLICY

If coverage under the Policy replaces a prior plan of similar coverage, if You are otherwise a member of an eligible class under the Policy, You and Your eligible Dependents will be covered under the Policy without regard to any Actively-at-Work requirement if:

- such person was validly covered under the prior plan on the last day that the group policy for the prior plan was in effect;
- the applicable premium is paid; and
- the prior coverage is terminated upon issuance of this Certificate.

If the requirements set forth above are met, benefits will be payable under the Policy, and as described in this Certificate, for a Covered Person's losses incurred on or after their Effective Date of Insurance for a Positive Diagnosis made under a prior plan of similar coverage.

If the Pre-Existing Condition limitation under the Policy has not yet been satisfied, credit shall be given for the time that the prior plan of similar coverage was in effect for the Covered Person on the date it ended in determining how long the Covered Person was insured under the Policy for purposes of satisfying the Pre-Existing Condition limitation. In this case, benefits payable will be the lesser of:

- benefits under the Policy without application of the Pre-Existing Conditions limitation; or
- benefits of the prior plan.

An individual policy does not meet the criteria of a prior plan of group cancer and specified disease insurance.

SECTION VIII – EXCEPTIONS AND OTHER LIMITATIONS

The Policy pays benefits only for diagnoses, treatment and services resulting from Cancer or Specified Diseases, as defined in the Policy. It does not cover:

- any other disease or sickness;
- injuries;
- unless otherwise defined in this Certificate, any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
  - Specified Disease or Specified Disease treatment; or
  - Cancer or Cancer treatment;
- care and treatment received outside the United States or its territories;
- treatment not prescribed by a Physician; or
- experimental treatment by any program that does not qualify as New and Experimental Treatment as defined in the Policy.

SECTION IX – CLAIM PROVISIONS

Notice of Claim
You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss. You may also give notice of a claim under this Certificate to any authorized agent of MetLife.

Claim Form
When We receive notice of a claim under this Certificate, We will provide You or the claimant with a claim form. If We do not provide the claim form within 15 days from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

Proof of Loss
Proof must be provided to Us not later than 180 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 1 year from the date of the loss.

Time of Payment Of Claims
When We receive the claim form and Proof, We will review the claim and, if We approve it, We will immediately pay benefits subject to the terms and provisions of this Certificate and the Policy.

Payment of Claims

Unless You have assigned this insurance, all benefits to be paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay any benefits in accordance with the provision below titled Your Beneficiary.
- If benefits are payable to Your estate or You are not legally competent to claim or receive the benefits, We may pay up to $3,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

Your Beneficiary
A beneficiary may be named by You to receive any benefit that becomes payable to You under this Certificate that You are not alive to receive.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

- Your Spouse, if alive;
- Your child(ren), if there is no surviving Spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

Change of Beneficiary
You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The consent of the beneficiary or beneficiaries shall not be required to terminate coverage under this Certificate or to make any change of beneficiary or beneficiaries or to make any other changes to this Certificate. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

Authorizations
We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

Physical Examination and Autopsy
During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

Legal Actions
A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

Refund To Us For Overpayment of Benefits
If, at any time, We determine that the benefits paid under this Certificate were more than the benefits due:

- You, or any other person, entity or health care provider to whom We over paid benefits have the obligation to reimburse Us for the amount of such overpayment; and
- We have the right to recover the amount of such overpayment from You, or any other person, entity or health care provider to whom We over paid benefits, including offsetting future benefits payable to You or such other person, entity or health care provider by an amount equivalent to the overpayment.

This provision will not be interpreted to create a right of subrogation by Us

SECTION X – GENERAL PROVISIONS

Entire Contract
Your insurance is provided under a contract of group insurance with the Policyholder. The Policy, the Policyholder's Application, the Enrollment Form, if any, and any attached Riders or Amendments make up the entire contract.

Statements Made By You
Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have signed the form; and
- a copy of the form has been given to You or Your beneficiary.

Time Limit on Certain Defenses
We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years. In addition, We will not use such statements to contest a benefit increase after the benefit increase has been in force for 2 years.

Misstatements
If a Covered Person's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Assignment
The benefits under the Policy are not assignable prior to a claim, except as required by law.

Conformity with Law
Any provisions of this Certificate which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirement of such statutes.

Standard of Time
All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.

Changes in Standards
This Certificate refers to classification standards for disease that have been developed by independent third parties. If those independent third parties change the classification standards, or if new standards are developed that become generally accepted in the medical community in the United States, We will interpret this Certificate in a manner that recognizes such changed or new standards when We determine it is appropriate to do so.

SECTION XI – PORTABILITY

Portability allows You to keep the Policy's coverage in force at certain times when Your coverage would otherwise end. Coverage under this Portability provision is subject to the terms and conditions of the Policy and this Certificate.

When Portability is Available

Subject to the Portability Benefit Conditions and Limitations, You may port benefits when You:

- have been continuously covered by the Policy for at least 6 months; and
- are no longer Actively At Work in an eligible class as an employee of the Policyholder.

How to Exercise Portability

You must, within 30 days after the date that Your coverage would end:

- submit Written application on a form approved by Us; and
- pay the first premium for ported coverage.

Effective Date of Ported Insurance

When the first premium for ported insurance is paid, coverage will start on the date that coverage under the Policy would have ended.

Premiums and Premium Due Dates

You must pay premiums to Us by mode of premium payment that We approve.

After insurance is effective there is a 31 day grace period for each premium due. If the premium due is not paid, the grace period begins on the day of the Calendar Month that coverage began. Coverage remains in effect during the grace period.

Premium rates may change as follows if coverage is ported:

- a premium rate change applicable to a class of employees in accordance with the terms of the Group Policy may also apply to former members of that class who have ported coverage; and
- premium rates applicable to the class of employees who have ported coverage, may change specifically for that class.

If You port and premium rates change, We will provide You at least a 60 day advance Written notice of the change.

We may add a billing fee for ported Certificates.

Amount of Insurance

Subject to the Changes to Amount of Ported Coverage provision, insurance provided will be 100% of that which was in effect on the day prior to the Effective Date of ported insurance.

Changes to Amount of Ported Coverage

Benefits provided under the Portability provision cannot be increased.

If You decrease or end a ported benefit, any change in premium will take place on the first day of the Calendar Month after We receive the request.

Termination of Ported Insurance

Ported insurance for You and Your covered Dependents ends on the earliest of the following dates:

- when You request termination;
- at the end of the grace period, if the premium is not paid;
- for a Spouse or Dependent Child, when he or she no longer meets the Policy's definition of Spouse or Dependent Child; or
- on the next premium due date upon Your death.

Portability Benefit Conditions and Limitations

Unless stated, any changes to the Policy apply to ported insurance.

You are not eligible to port while Policy coverage is continued based on a state or federal law, regulation or rule.

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

Certificate Rider

Group Policy No.: 1707

Policyholder: LEE COUNTY SCHOOLS (NC)

Rider Effective Date: 04/01/2019

Your Certificate is changed as follows:

The provision titled Conformity with Law that appears in the General Provisions section of the Certificate, is deleted and replaced with the following:

CONFORMITY WITH LAW

If any terms or provisions of this Certificate on its effective date, are in conflict with the applicable laws of North Carolina, the conflicting terms or provisions are hereby amended to conform to the minimum requirement of such laws.

This Certificate Rider is to be attached to and made a part of the Certificate.

Metropolitan Life Insurance Company
New York, New York

INTENSIVE CARE UNIT BENEFIT RIDER

Policyholder Name: LEE COUNTY SCHOOLS (NC)

Policy Number: 1707

Certificate Number: [Certificate Number]

Rider Effective Date: [Date]

This Rider is part of Your Certificate if it is listed on the Certificate Schedule of Your Certificate. This rider takes effect on the Rider Effective Date shown above.

This Rider is subject to the terms and provisions of the Policy and Your Certificate. If there is a conflict between the terms of the Policy, Certificate and this Rider, the provisions of this Rider will control. In all other respects, the provisions and conditions set forth in Your Certificate remain the same. This Rider is to be attached to and made a part of Your Certificate.

I. DEFINITIONS

Accident or Accidental - means a sudden, unexpected, violent and external event that causes bodily Injury to a Covered Person.

Common Carrier Injury - means an Accidental Injury sustained as a result of being struck by an automobile, bus, truck, motorcycle, train or airplane, or being involved in an Accident where the Covered Person was an operator or a passenger in such vehicle. The Accident must occur while the Covered Person is covered under the ICU Benefit Rider.

Day of Confinement – means a 24-hour period. If a Covered Person is confined to an ICU for only part of a day, a pro-rata portion of the ICU Daily Benefit amount will be paid.

Injury - means the bodily harm resulting directly from an Accident and independently of all other causes.

Intensive Care Unit (ICU) - means a specifically designated portion a Hospital that provides the highest level of medical care and is restricted to patients whose condition requires such level of care. The Hospital units must be apart from the surgical recovery room and from private or semi-private rooms. The ICU must be permanently equipped with special life-saving equipment for the care of the critically ill or injured. The patients must be under constant and continuous care of specially trained Nurses assigned exclusively to the ICU. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. The following are typical types of Hospital units that satisfy the definition of an ICU:

(a) Intensive Care Unit;

(b) Cardiac Intensive Care Unit; and
(c) Infant (neonatal) Intensive Care Unit.

The ICU Hospital units do not include surgical recovery rooms, progressive care, intermediate care, private monitored rooms, observation units, telemetry units, or other facilities which do not meet the standards for an ICU as defined.

Period of Confinement - means an interval of time during which a Covered Person is confined as an inpatient in the ICU Unit of a Hospital. A Period of Confinement begins on the date of admission to the ICU. If the Covered Person is discharged or transferred out of the Intensive Care Unit and, within 30 days, is again confined to the Intensive Care Unit due to the same or related causes, We will treat the subsequent confinement as the same Period of Confinement.

A new Period of Confinement begins when the Covered Person is readmitted to the ICU:
- For a new Sickness or Injury unrelated to the causes of a prior confinement; or
- When more than 30 days separates each ICU confinement.

Step Down Unit - means a specially designed area of the Hospital that provides medical care restricted to those patients whose condition requires an intermediate level of care between the ICU and the general medical-surgical Hospital units. A Step Down Unit includes: progressive care units; subacute intensive care units; and intermediate care units. A Step Down Unit does not include treatment units such as: private or semi-private rooms; private monitored rooms; observation units; or surgical recovery units.

II. INTENSIVE CARE UNIT BENEFIT RIDER SCHEDULE

The maximum benefit period for which benefits under this rider are payable is 45 Days of Confinement per Period of Confinement.

Benefit	Benefit Amount
ICU Daily Benefit Amount	[Amount] per Covered Person per Day of Confinement.
For confinement in an ICU for treatment other than for Cancer, Specified Disease or a Common Carrier Injury	ICU Daily Benefit Amount per Day of Confinement
For confinement in an ICU for treatment of Cancer or Specified Disease	2 times the ICU Daily Benefit Amount per Day of Confinement
For confinement in an ICU for treatment of a Common Carrier Injury. The Period of Confinement must begin within 48 hours of the Common Carrier Injury.	Initial ICU Confinement: 2 times the ICU Daily Benefit Amount per Day of Confinement Subsequent ICU Confinements due to the same Common Carrier Injury: ICU Daily Benefit Amount per Day of Confinement
For confinement in a Step Down Unit	One-half the ICU Daily Benefit Amount per Day of Confinement
For Emergency Confinement and Transfer to an ICU: (a) the Covered Person must be admitted to a Hospital on an emergency basis; and (b) the Covered Person is receiving the highest level of care available in a Hospital that does not have an Intensive Care Unit; and (c) within 48 hours of the Hospital admission, the	ICU Daily Benefit Amount per Day of Confinement

Covered Person is transferred directly to the ICU of a Hospital that has an ICU.	

III. BENEFIT REDUCTION DUE TO AGE

On the date a Covered Person attains age 75, the Covered Person's ICU Daily Benefit Amount will be reduced to one-half of that which applied to the Covered Person on the day preceding the date the Covered Person attained age 75.

IV. BENEFIT LIMITATIONS AND EXCLUSIONS

Payment of benefits under this Rider is subject to the Pre-Existing Condition Limitation provisions of the Certificate.

We will not pay benefits for any Period of Confinement that began before the Covered Person's Effective Date of Insurance.

We will not pay benefits under the Intensive Care Unit Benefit Rider for a Period of Confinement for a Covered Person's confinement caused or contributed to by:

- an intentionally self-inflicted Injury or suicide attempt; or
- the Covered Person being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a Physician and taken according to the Physician's advice. The term "intoxicated" refers to that condition as defined by law or the legal decisions of the jurisdiction in which the Accident, or the cause of the loss or losses occurred.

V. TERMINATION

This Rider will terminate on the earliest of the following dates:

- the Policy Anniversary Date that coincides with or next follows the date You elect to end this Rider;
- the date the Policyholder discontinues this Rider; or
- the date Your coverage under the Policy ends.

HIPAA Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company or a member of the MetLife, Inc. family of companies, which includes SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, and Delaware American Life Insurance Company (collectively, "**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental, Vision, Long-Term Care, Cancer and Specified Disease Expense Insurance, or Health coverage with us (your "**Coverage**"). MetLife strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, **www.metlife.com**. You may submit questions to us there or you may write to us directly at MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may **use** and **disclose** PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);

- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We **protect** your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

Except in the case of Long-Term Care Coverage, we will **not use or disclose** PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums or contribution amounts under your Coverage.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage.

The main reasons we may **use** and **disclose** your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.
- **For Health Care Operations:** We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.
- **To Affiliates and Business Associates:** We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health information organizations, e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.
- **To Plan Sponsors:** We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.
- **To Individuals Involved in Your Care:** We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.
- **Where Required by Law or for Public Health Activities:** We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.
- **To Avert a Serious Threat to Health or Safety:** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- **For Health-Related Benefits or Services:** We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of

interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **PHI about Deceased Individuals:** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.

- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

  - is accurate and complete;
  - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - is not part of the PHI kept by or for us; or
  - is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on PHI we

use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing *and* specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

MetLife or SafeGuard Dental & Vision
P.O. Box 14587
Lexington, KY 40512-4587

MetLife LTC Privacy Coordinator
1300 Hall Boulevard, 3rd Floor
Bloomfield, CT 06002

Delaware American Life Insurance Company
MetLife Worldwide Benefits
P.O. Box 1449
Wilmington, DE 19899-1449

Cancer and Specified Disease Expense Insurance
c/o Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at HIPAAprivacyAmericasUS@metlife.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at telephone number (212) 578-0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

Effective Date: 02012019

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Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company
MetLife Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

1.Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

2.Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

3.Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

4.How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at www.mib.com.

5.Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

6.Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

7.HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

8.Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

9.Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully. The privacy of your personal and health information is important.

This requires no action on your part unless you have a request or complaint.

■ Bay Bridge Administrator's Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for administration purposes. This notice applies to all of the medical records we maintain.

Both under law, The Health Insurance Portability and Accountability Act (HIPAA) and our policy, Bay Bridge Administrators, LLC (BBA) has a responsibility to protect the privacy of your personal and health information, which is legally known as Protected Health Information (PHI). We:

- protect your privacy by limiting who may see your PHI;
- limit how we may use or disclose your PHI;
- inform you of our legal duties with respect to your PHI;
- explain our privacy policies; and
- strictly adhere to the policies currently in effect.

This notice takes effect on 4/14/2003 and will remain in effect until we replace it and provide you notice of such changes.

■ BBA's Uses and Disclosures of Plan Member's PHI

As a Plan member, BBA may use and disclose your PHI, without your consent/authorization, in the following ways:

Treatment: We may disclose your PHI to a doctor, a hospital or other entity that asks for it in order for you to receive medical treatment.

Payment: We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations: We may use and disclose medical information about you for Plan operations that are necessary to run the Plan. We may use medical information in connection with: conducting quality assessment and improvement activities, medical review, legal services, audit services, fraud and abuse detection programs; business planning and development, such as cost and business management and other general Plan administrative activities or other activities relating to Plan coverage such as enrollment, changes or disenrollment in Plan.

Disclosure to Health Plan Sponsor: Information may be disclosed to another health plan maintained by your employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to your employer solely for purposes of administering the Plan.

Disclosure to Business Associates: We will share your PHI with third party "business associates" that perform various activities for the Plan. Whenever an arrangement between BBA and a business associate involves the use or disclosure of your PHI, BBA will have a written contract that contains terms that will protect the privacy of your PHI.

Required by Law: We must use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

Process and proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose limited information to law enforcement officials concerning the PHI of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution.

Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

■ Authorizing Use and Disclosure of Plan Member's PHI

BBA will request written authorization from you to use your PHI or to disclose it to anyone for any purpose or situation not included in this document. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your PHI for any reason except those described in this notice without your written authorization.

■ Individual Rights for All Plan Members

As a Plan member, the following are your rights concerning your PHI:

Access: You have the right to review or obtain copies of your PHI, with certain exceptions. If you request copies, BBA may charge you a fee for each page, and a per hour charge for staff time to locate and copy your PHI, and postage to mail it.

Disclosure Accounting: You have the right to request in writing a list of instances in which BBA or our subcontractors disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities. Your request must state a time period no longer than six years and not before April 14, 2003. If you request this list more than once in a 12-month period, BBA can charge you a fee.

Amend: You have the right to request in writing that we amend your PHI if you feel the information we have about you is incorrect or incomplete. You must explain why the information should be amended. We may deny your request if we did not create the information you want amended, in the first place or we do not even maintain or keep the information in question, or the information is in fact accurate and complete.

Restriction Request: You have the right to ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Alternate Confidential Communications: We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

If You Have a Complaint: If you are concerned that BBA may have violated your privacy rights, you may file a complaint. You may also submit a written complaint to the Secretary of the Department of Health and Human Services. BBA will not retaliate in any way if you choose to file a complaint. If you want more information regarding our privacy practices or would like to request a form, you may contact us in the following ways:

- Access us at:
  www.baybridgeadministrators.com
- Bay Bridge Administrators, LLC
  P.O. Box 161690
  Austin, TX 78716
- Phone: (800) 845-7519
- Fax: (512) 329-5463

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. A current copy of this notice will e posted on the BBA website.

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

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

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

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 – 21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The association does not provide coverage for:

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;
- a credit 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;
- 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;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

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

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

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

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

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

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

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

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization 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 the State of Arkansas. Other conditions may also preclude coverage.

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

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

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

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, *et. seq.* Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty 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; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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 October 1, 2016, is $554,556. 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.

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 charitable 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 with of the following:

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

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

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

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

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

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

The basic protections provided by the Association are:

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

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

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

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

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

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

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

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

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

Coverage Limitations

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

* The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or

* With respect to any one life, regardless of the number of policies, contracts, or certificates:
    - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
    - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
    - $300,000 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 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. 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
1050 First St NE #801
Washington, DC 20002
Ph: (202) 727-8000
Fax: (202) 354-1085

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
Ph: (202) 434-8771
Fax: (202) 347-2990

Pursuant to the Act (D.C. Official Code Section 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 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

HAWAII

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION 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, Hawaii 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. 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 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 policyholder 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
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 which determines who and what is covered and the amounts of coverage.

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

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for 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 health benefit plan 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 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 these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62767

Insurance companies, health maintenance organizations 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 or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

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

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

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

Basic Protections Currently Provided by ILHIGA

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

Life Insurance

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

Health Insurance

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

Annuities

* $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

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

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

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

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

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

To learn more 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

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 or HMO coverage. (IC27-8-8-18(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.

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 and major medical 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 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.

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
3745 SW Wanamaker Road, Suite C
Topeka, KS 66610

Kansas Insurance Department
420 SW 9th Street
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.

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

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

Disclaimer

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

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

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

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

LLHIGA
P.O. Box 3337
Baton Rouge, Louisiana 70821

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 Law), and is set forth at R.S. 22:2081 *et seq*. 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 Law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a covered life, health, or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the Law are applicable.

EXCLUSIONS FROM COVERAGE

A person who holds a covered life, health, or annuity policy, plan or contract is not protected by LLHIGA if:

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

LLHIGA 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 or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
(4) Dividends, premium refunds, or similar fees or allowances described under the Law;
(5) Credits given in connection with the administration of a policy by a group contract holder;
(6) Employers', associations' or similar entities' 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;
(7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States *Internal Revenue Code* (26 U.S.C. §403(b)).
(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the Law;
(9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part A Coverage", "Medicare Part B Coverage", "Medicare Part C Coverage", "Medicare Part D Coverage" or "Medicaid" and any regulations issued pursuant to those parts;
(10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

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

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

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

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
  - $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 and 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, 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
8817 Belair Road, Suite 208
Perry Hall, Maryland 21236
410-248-0407

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

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

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
200 Park Avenue
New York, New York 10166
1-800-638-5433

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

If the insurer who 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
3300 Wells Fargo Center
90 South 7th Street
Minneapolis, MN 55402
Phone: 612-322-8713
Fax: 402-474-5393

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.

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

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

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

The basic protections provided by the Association are:

Life Insurance

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

Health Insurance

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

Annuities

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

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

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

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

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

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

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

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

EN-GUAR-12-20 MS

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 MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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. (For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs).) The basic protections provided by the Association are as follows:

* Life Insurance
* $300,000 in death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values
* Health Insurance
* $500,000 for health benefit plans
* $300,000 in disability insurance benefits
* $300,000 in long-term care insurance benefits
* $100,000 in other types of health insurance benefits
* Annuities
* $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal 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 health benefit plans

* $500,000 in aggregate for health benefit plans

* $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

“Health benefit plan” is defined in section 376.718, RSMo.

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.

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

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

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

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

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

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 (Association) and the protection it provides for policyholders.

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

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

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

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

Note: <u>Other restrictions to coverage apply.</u> 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:

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

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

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

NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT

Effective January 1, 2020

Residents of Nevada who purchase life insurance, annuities, health insurance or Health Maintenance Organization (HMO) insurance should
know that the insurance companies licensed in this 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 and becomes insolvent. 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. This valuable extra protection provided by these insurers through the Association is not unlimited, however, as noted in the **bold** written information 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 certain types of policies, however, 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 Nevada 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.

The Nevada Life and Health Insurance Guaranty Association
4600 Kietzke Lane, Suite O-269
Reno, Nevada 89502
(Business and Mailing address)

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

Generally, individuals will be protected by the Association if they live in this State and hold a life, health or HMO 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 if they live in another state.

MAXIMUM BENEFIT LIMITS
(For any one policyholder per company no matter how many policies you have)

Life Insurance: $300,000 or $100,000 for cash surrenders
Annuities: $250,000 or $250,000 for cash surrenders, including Structured settlement annuities.
Disability Income Insurance: $300,000 **Long Term Care:** $300,000
Basic Hospital, Medical and Surgical Insurance or Major Medical Insurance and HMOs (Known as Health Benefit Plans as defined in NRS 687B.470): For any one person: $100,000, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or an aggregate of $500,000 in benefits, including benefit 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.

With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in NRS 686C, the maximum allowed is an aggregate of $250,000 regardless of the number of contracts issued by any one member company.

EXCLUSIONS FROM COVERAGE

Not covered by the Nevada Guaranty Association:

If they are eligible for protection under the law by another State Guaranty Association;
The insurer is not authorized to do business in the State of Nevada;
If the policy was insured by a fraternal benefit society, a mandatory state pooling plan, or 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 member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
Where interest rate yields exceed an average rate;
Credits given in connection with the administration of a policy by a group contract holder;
Any dividends;
Employers' plans to the extent they are self-funded (that is, not insured by an insurance company or administered by an insurance company;
Unallocated annuity contracts (which gives rights to group contract holders and not to individuals) other than annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code and the Nevada Revised Statute 686C.130; or
Medicare or Medicare Advantage contracts.

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

www.nvlifega.org

SUMMARY OF THE NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT of 2019 (RSA 408-F) (the Act) AND **NOTICE CONCERNING COVERAGE AND LIMITATIONS**

SUMMARY:

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

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 Hampshire law, with funding from assessments paid by other insurance companies, including health maintenance organizations (HMOs).

DISCLAIMER:

The Association may not cover your policy or contract or, if coverage is available, it may be subject to substantial limitations and exclusions and conditioned on continued residence in the state.

This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable and consumers should not rely on coverage under this Act when selecting an insurer or HMO. The valuable protection through the Guaranty Association is not unlimited.

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 2020, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

BASIC LIMITS ON AMOUNT OF COVERAGE:

The Act 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.

The basic protections provided by the Association are limited to:

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

- **Health Insurance**
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability (income) insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- **Annuities**
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

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.

"Health benefit plan" is defined in RSA 408-F:4,VI and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

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

NOTE: Certain policies and contracts may not be covered or may not be fully covered. For example, coverage does not extend to a 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.

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
www.nhlifega.org

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261
www.nh.gov/insurance/

February 2020

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 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 had 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
521 Newman Springs Road, Suite 22
Lincroft, NJ 07738

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

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

COVERAGE

The following is a brief summary of 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.

NEW MEXICO

NOTICE OF
PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

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

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

The basic protections provided by the Association are:

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

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

Annuities
- $250,000 in present value of annuity benefits

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

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

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law.
To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance Guaranty Association PO Box 2880 Santa Fe, NM 87504-2880 505-820-7355	Insurance Division Public Regulation Commission PO Box 1269 Santa Fe, NM 87504-1269 888-427-5772

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

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

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

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

Coverage is NOT provided for your policy or 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 27605-0218

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

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the 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 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 or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects 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 mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange;
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' 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, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

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

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per 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 a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

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

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

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

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

1. Life Insurance

    a. $300,000 in death benefits

    b. $100,000 in cash surrender or withdrawal values

2. Health Insurance

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

    b. $300,000 in disability income insurance benefits

    c. $300,000 in long-term care insurance benefits

    d. $100,000 in other types of health insurance benefits

3. Annuities

    a. $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal 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 health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTCI).

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

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, ND 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 or HMO coverage. 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.

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act

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

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

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

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

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive, Suite 200
Columbus, 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. 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 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, DA Cs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§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 as noted above. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

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

As of 11/15/2018

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. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
    - o $300,000 in death benefits
    - o $100,000 in cash surrender or withdrawal values
- Health Insurance
    - o $500,000 for health benefit plans (see definition below)
    - 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 the present value of annuity benefits, including net cash surrender and net cash withdrawal values

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

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

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

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

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

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

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

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

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

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

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

COVERAGE

Persons Covered

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

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
o Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
o Up to $500,000 for health benefit plans, with some exceptions.
o Up to $300,000 for disability income benefits.
o Up to $300,000 for long-term care insurance benefits.
o Up to $100,000 for all other types of health insurance.

Individual annuities
o Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;

- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

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

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company

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
(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. §§401, 403(b), or 457 covered by an unallocated annuity contract, or the beneficiaries of 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.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association
Attention: Executive Director
P.O. Box 8625
Columbia, SC 29202

South Carolina Department of Insurance
Attention: Office of Consumer Services
1201 Main Street, Suite 1000
Columbia, SC 29201
Electronic complaint submission via
www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are r1ot protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by *the* member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or Dor Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy owners, contract owners, and certificate owners 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 or contract. 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 or contract.

Coverage is NOT provided for your policy or contract for 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 or contract.

South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

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

(**please see next page**)

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 or contracts 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 an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy owner, contract owner, or certificate 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 of a policy or contract 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 or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract 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 benefit plans, not more than $500,000, but 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 health benefit plans, 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.

(**please see next page**)

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted 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 coverage, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by 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).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000

- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000

- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000

- health insurance benefits for companies declared insolvent on or after January 1, 2010:

    - $100,000 for limited benefits and supplemental health coverages

    - $300,000 for disability and long term care insurance

    - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

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NOTE

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

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

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

Tennessee Life and Health Insurance Guaranty Association
P.O. Box 190434

Nashville, TN 37219
Website: www.tnlifega.org

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

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How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

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

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The 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, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - $500,000 for health benefit plans
  - $500,000 in disability income insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain 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 Utah law.

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

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

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South, #150
Salt Lake City, UT 84101
(801) 320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

NOTICE OF
PROTECTION PROVIDED BY
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 accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other 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 and withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

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

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

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

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

SUMMARY OF THE
WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT
(Effective July 1, 2019)

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

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

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

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

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

West Virginia Insurance Commissioner
Consumer Services Division
900 Pennsylvania Avenue
P. O. Box 50540
Charleston, West Virginia 25305 0540
(304) 558-3386
Toll Free 1-888-879-9842
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called 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,r health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- The policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contract holder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
    i. multiple employer welfare arrangement;
    ii. minimum premium group insurance plan;
    iii. stop loss group insurance plan; or
    iv. administrative services only contract;
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;
- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials, claims based on side letters or riders not approved by the Commissioner, misrepresentations regarding policy benefits, extracontractual claims or claims for penalties or consequential or incidental damages;
- A contractual agreement that establishes the member insurer’s obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;

- Structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(10)); and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long term care insurance, or health benefit plans.

Also for any one insured life, the Guaranty Association will only pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company - for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

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

NOTICE 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 or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association are:

* Life Insurance

    - $300,000 in death benefits

    - $100,000 in cash surrender or withdrawal values

* Health Insurance

    - $300,000 in health benefit plan benefits

    - $300,000 in disability insurance benefits

    - $300,000 in disability income insurance

    - $300,000 in long-term care insurance benefits

    - $100,000 in other types of health insurance benefits

* Annuities

    - $250,000 in present value of benefits including net 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 or health maintenance organization 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

Policy owners, contract owners, policy holders, certificate holders and enrollees 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 or health maintenance organization was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer or health maintenance organization 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, by an insurance exchange, or by an entity similar to those listed here.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;
- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy or contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- experience rating credits given in connection with the administration of a policy to 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 benefits under Medicare Part C, Medicare Part D, or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

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 www.wylifega.org or contact:

Wyoming Life and Health
Insurance Guaranty Association
6700 N. Linder Rd, 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.