ManhattanLife Assurance Company of America

Administrative Office: PO Box 161690, Austin TX 78716 800-845-7519
Home Office: Little Rock, AR

GROUP CANCER AND SPECIFIED DISEASE EXPENSE POLICY

Policyholder: STAFFORD COUNTY PUBLIC SCHOOLS

Policy Number: 2003

Policy Date: 09/01/2021

Anniversary Date: September 1, of each year

MASTER POLICY

This Policy is a legal contract between the Policyholder and Us. To understand the coverage, the Policyholder must read this Policy as a whole.

We agree to insure certain individuals and to pay the benefits provided by this Policy in accordance with its provisions.

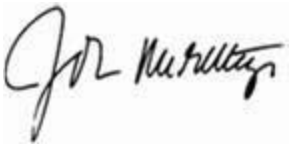
This Policy is issued in consideration of statements made in the application and the payment of premiums by the Policyholder. A copy of the signed application will be attached and made a part of this Policy.

This Policy is effective on the Policy Date. The Policy Date will be the date of issue. The first Policy Year will end on the anniversary date shown above. Each Policy Year after that will end on the same date of each year. All periods will begin and end at 12:01 A.M. Standard Time at the Policyholder's main address.

This Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Signed for ManhattanLife Assurance Company of America:

Dan George
President



John McGettigan
Secretary

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the address and telephone number shown above.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at: P.O. Box 1157 Richmond, VA 23218, 1-800-552-7945 (within Virginia), 804-371-9741 (local number), 1-877-310-6560 (national toll-free number).

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INCORPORATION PROVISION

The provisions of the attached Certificate and all amendments to this Policy after its effective date are incorporated into and made part of this Policy.

The terms used in this Policy have the same meaning given to those terms in the Certificate unless otherwise specifically defined in this Policy.

CERTIFICATE

The Certificates, including the Certificate Schedules, amendments, riders and supplements, if any, are a written statement prepared by Us to set forth a summary of:

- benefits to which a Covered Person is entitled;
- to whom the benefits are payable; and
- limitations or requirements that may apply.

ELIGIBILITY AND EFFECTIVE DATE

Policy Effective Date
Coverage under this Policy begins at 12:01 a.m. Standard Time on the Policy Date shown on page 1 of this Policy.

TERMINATION OF INSURANCE

Termination of This Policy
This Policy can be cancelled:

- by the Policyholder; or
- by Us.

If the premium is not paid when it is due or during the grace period, this Policy will terminate at midnight on the last day of the grace period. The Policyholder must pay all premiums due for the full period each Certificate is in force.

If We cancel this Policy for reasons other than the Policyholder's failure to remit premium, a written notice will be delivered to the Policyholder at least 60 days prior to the cancellation date.

The Policyholder may cancel this Policy by written notice delivered to Us at least 31 days prior to the cancellation date. This Policy can be cancelled on an earlier date if We both agree. Coverage will end at 12:00 midnight Standard Time on the cancellation date.

PREMIUMS

When and Where to Pay Premiums
The premiums for the coverage must be paid to Us at Our home office or to Our administrator when they are due. The premium due dates are based on the effective dates of the coverage shown on the Certificate Schedules.

Each monthly premium will be calculated on the basis of Our record as to the number of Covered Persons in each coverage classification at the time of calculation, at the premiums then in effect.

Our Right to Change Premiums
We have the right to change the premium We charge. If We plan to make a change, We will send the Policyholder a notice at least 60 days in advance.

However, We may change premium rates at any time for reasons which affect the risk assumed, including the reasons shown below:

- a change occurs in the plan design;
- a division, subsidiary, or affiliated company is added or deleted;
- a substantial change occurs in the participation level of employees;
- the number of employees changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this Policy.

Grace Period
The Policyholder is entitled to a grace period of 31 days for the payment of any premium due during which grace period the Policy shall continue in force, unless the Policyholder has given the Company 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 the Company for the payment of a pro rata premium for the time the coverage was in force during such grace period.

Premium Due Dates
The Policy Premium is due and payable on the first day of each month thereafter. This Policy will terminate on the last day of the Grace Period.

PARTICIPATION REQUIREMENTS

The following participation requirements must be met and maintained for coverage to be effective initially and continue in force The Policy may be terminated by Us for the Policyholder's failure to meet participation requirements. The Policyholder agrees that the following participation requirements apply:

For Policies for Which Issue Was Guaranteed

a. For a Policyholder with 100 to 499 or fewer persons in an eligible class, enrollment of at least 25% of such persons as employees under this Policy must be met initially and maintained.
b. For a Policyholder with 500 to 999 or more persons in an eligible class, enrollment of at least 20% of such persons as employees under this Policy must be met initially and maintained.
c. For a Policyholder with more than 1,000 persons in an eligible class, enrollment of at least 15% of such persons as employees under this Policy must be met initially and maintained.

For Policies for Which Issue Was Not Guaranteed

Regardless of the number of persons in an eligible class, enrollment of at least 5 of such persons as employees under this Policy must be met initially and maintained.

POLICYHOLDER NOT OUR AGENT

The Policyholder will not be considered our agent for any purpose under this Policy.

GENERAL PROVISIONS

Coverage Provided by This Policy.
We insure a Covered Person for a loss according to the provisions of this Policy.

Entire Contract; Changes. This Policy, the Policyholder's Application, and any attached Riders or Amendments make up the entire contract. A copy of the employee's Enrollment Form is attached to the employee's Certificate. All statements made on any application or Enrollment Form will be considered representations and not warranties. No written statement made by the employee will be used in any contest unless a copy of the statement is furnished to the employee or his or her personal representative.

No change in this Policy or a Certificate will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to this Policy. No agent may change this Policy or waive any of its provisions. Any change that modifies, limits or excludes an employee's coverage must contain the employee's signature in order for the change to be binding.

Incontestability. This Policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

After two years from the Policy Effective Date, no misstatements made in the Policyholder's Application will be used to contest this Policy. No statement will be used to contest the validity of coverage under the Policy unless such statement is in writing, signed by the Named Insured and a copy of such statement has been provided to the Named Insured or his representative or beneficiary

Physical Examination. We, at Our own expense, have the right and opportunity to examine the person of any individual whose loss is the basis of claim under this Policy when and as often as We may reasonably require during the pendency of the claim.

Legal Actions. No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements. Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes. Any provision of this Policy and any Certificate which, on its Effective Date, is in conflict with the statutes of the state in which this Policy or any Certificate is delivered is hereby amended to conform to the minimum requirements of those statutes.

Clerical Error. Clerical error, whether by the Policyholder or Us, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect or extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

Misstatement of Age. If premiums for the Covered Person are based on age and the Covered Person's age has been misstated, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. We may require satisfactory proof of age before paying any claim.

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.

Information to Be Furnished By the Policyholder.
The Policyholder must keep a record of the employees and the particulars of the insurance on each. The Policyholder must provide Us at regular intervals, on forms acceptable to Us, information relative to persons:
who are eligible to enroll;
who are insured by the coverage; and
whose coverage terminates pursuant to the "Termination Dates" provision.

The Policyholder must also provide Us with any other information about the coverage that may be reasonably required, such as employee on leave of absence.

We have the right to inspect the Policyholder's records which may have a bearing on the insurance provided by this Policy. We may inspect the records at any time while this Policy is in force and within one year after the termination of this Policy.

ManhattanLife Assurance Company of America

Administrative Office: PO Box 161690, Austin TX 78716 800-845-7519
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CERTIFICATE OF GROUP CANCER AND SPECIFIED DISEASE EXPENSE INSURANCE

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 contract between ManhattanLife Assurance Company of America and the Policyholder. It may be changed or ended without Your consent or notice to You.

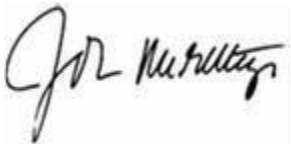
Coverage under the Policy will be administered on behalf of the Company by "the Administrator": Bay Bridge Administrators, LLC

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

The Policy Effective Date is: 09/01/2021

The Policy Anniversary Date is: September 01 of each year.

Signed for ManhattanLife Assurance Company of America.



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CERTIFICATE CONTENTS

CERTIFICATE SCHEDULE

YOUR NAME	[Certificate Holder]
POLICYHOLDER	STAFFORD COUNTY PUBLIC SCHOOLS
POLICY NUMBER	2003
POLICY EFFECTIVE DATE	09/01/2021
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

FAMILY MEMBERS COVERED:
[Dependent Names]

Optional Benefit Level

BENEFIT	MAXIMUM BENEFIT AMOUNT
HOSPITAL CONFINEMENT BENEFIT	$100 PER DAY
COLONY STIMULATING FACTORS	Incurred Expenses up to $500 PER MONTH
SURGICAL	Up to $3,000 per surgery
RADIATION/CHEMOTHERAPY/IMMUNOTHERAPY	Incurred Expenses up to $2,500 PER MONTH
FIRST DIAGNOSIS BENEFIT	$0
WELLNESS BENEFIT	$100 PER CALENDAR YEAR
MISCELLANEOUS DIAGNOSTIC CHARGES BENEFIT	Incurred Expenses up to a lifetime maximum of $10,000
SELF- ADMINISTERED DRUGS BENEFIT	Incurred Expenses up to $4,000 PER MONTH

ADDITIONAL BENEFITS (AS PROVIDED BY RIDER OR AMENDMENT)

WELLNESS BENEFIT AMENDMENT

[INTENSIVE CARE UNIT BENEFIT RIDER]

AMENDMENT RIDER - PAYMENT OF BENEFITS

If more than one Certificate Schedule is attached to this Certificate, the Certificate Schedule with the most recent Certificate Effective Date will be valid.

Optional Benefit Level

BENEFIT	MAXIMUM BENEFIT AMOUNT
HOSPITAL CONFINEMENT BENEFIT	$100 PER DAY
COLONY STIMULATING FACTORS	Incurred Expenses up to $500 PER MONTH
SURGICAL	Up to $3,000 per surgery
RADIATION/CHEMOTHERAPY/IMMUNOTHERAPY	Incurred Expenses up to $2,500 PER MONTH
FIRST DIAGNOSIS BENEFIT	$2,500
WELLNESS BENEFIT	$100 PER CALENDAR YEAR
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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 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 Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions which may be considered precancerous, including, but not limited to: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or 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.

Certificate Schedule means page(s) so labeled in the Policy and this Certificate.

Chemotherapist - means a person who is:
1. licensed to administer chemotherapy or immunotherapy; and
2. certified by the American Board of Internal Medicine, Radiology, or Hematology.

Child - means Your unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption who is not yet age 26.

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 any of the following:
1. You;
2. any eligible Spouse, or Domestic Partner, or dependent Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective;
3. any eligible Spouse, or Domestic Partner, or dependent Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
4. a newborn child (as described in the Eligibility Section).

Date of Diagnosis - means the later of:
1. the day the tissue specimen is taken; or
2. the day a diagnostic procedure is performed; or
3. the day the Positive Diagnosis of Cancer or Specified Disease is made.

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

Domestic Partner - means a person with whom You maintain a committed relationship and who has registered. Each partner must:
1. be at least 18 years old and competent to contract;
2. be the sole domestic partner of the other person; and
3. not be married.

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.

Evidence of Insurability - means a statement of medical history or condition or other evidence that a person is an acceptable risk for insurance as determined by the Company.

Extended Care Facility - means a licensed nursing facility directed by a Physician. It provides continuous skilled nursing service under the supervision of a graduate 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.

Family Coverage - means coverage that includes You and other Covered Persons, as defined.

Free Standing Hospice Care Center - means a center which is not a Hospital, or a wing or section of a Hospital. It provides 24 hour a day care for the Terminally Ill under the medical direction of a Physician.

Hospital - means an institution which:
1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified Physicians; and
4. provides 24 hour a day nursing service by or under the supervision of registered graduate Nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:
1. a nursing home, convalescent home, or skilled nursing facility;
2. a place for rest, custodial care, or for the aged;
3. a clinic;
4. 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:

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

Hospital Confinement - means admission to a Hospital and confinement as a resident bed patient due to a covered diagnosis. We do not consider confinement to an emergency room, outpatient treatment room, or observation unit with a stay of less than 48 hours as Hospital Confinement.

Incurred Expenses - means the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided. This includes amounts that are a combination of insurance reimbursement amounts paid and expenses paid by You such as deductibles or co-payments.

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 FDA, 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:
1. licensed practical Nurse (L.P.N.); or
2. licensed vocational Nurse (L.V.N.); or
3. graduate 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 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:

1. it does not charge a daily room rate;
2. it does not admit or assign persons to a Hospital bed for a period of 23 hours or longer;
3. clinical services and treatment plans must be evidenced-based and quality improvement-oriented;
4. it must have a formal connection with a Physician or Physician practice; and
5. 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 by the American Board of Pathology to practice Pathological Anatomy.

Physician - means a medical doctor or other person recognized by law or regulation in the state where services are rendered as a Physician. The person must be licensed to practice medicine and prescribe and administer drugs or to perform surgery in the United States.

Physician does not include:
1. You;
2. a person related to You by blood or marriage; or
3. a medical doctor or other person practicing outside of the United States.

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.

Radiologist - means a Physician licensed to administer X-ray therapy, radium therapy, or radioactive isotopes therapy and certified by the American Board of Radiology.

Renewal Date - means the date the renewal premium is due.

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.

Tentative Diagnosis - means a diagnosis by a qualified 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.

Totally Disabled (Total Disability) means that You are:
1. unable to perform the Primary and Essential duties of Your regular occupation;
2. not working in any other occupation; and
3. under the care of a Physician for the Total Disability.

We, Our, Us, or Company – means ManhattanLife Assurance Company of America

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

SECTION II – ELIGIBILITY AND EFFECTIVE DATES

To be eligible for insurance under the Policy You must be a member of an eligible class, as provided on the Certificate Schedule and, submit an Enrollment Form to be received by Us prior to the end of the Initial Enrollment Period in order not to be considered a Late Enrollee and satisfy the waiting period shown on the Policyholder Application and, if required, submit Evidence of Insurability satisfactory to the Company.

Enrollment

An individual who is a member of an eligible class may enroll for coverage during the Initial Enrollment Period, as shown on the Certificate Schedule that follows the later of:

1. the Policy Effective Date;
2. the date the individual first becomes a member of an eligible class;
3. the date the individual completes the waiting period shown on the Policyholder Application and Certificate Schedule, if applicable.

An individual who fails to enroll during the Initial Enrollment Period is a Late Enrollee and may enroll only during the annual Open Enrollment Period shown on the Certificate Schedule, and must submit Evidence of Insurability satisfactory to the Company.

Your Effective Date

Your Effective Date of coverage under the Policy, excluding Late Enrollees, will be determined as follows:

1. If You enroll for coverage when the Policyholder applies for coverage, Your coverage will be effective on the Policyholder's Effective Date.
2. If You become eligible after the Policyholder's Effective Date and enroll during a waiting period or an Initial Enrollment Period, coverage will be effective the first of the month next following the later of the end of any applicable waiting period, Initial Enrollment Period and receipt of the Enrollment Form by Us.
3. The first of the month coinciding with or next following completion of Your Enrollment Form and Our approval of Your Evidence of Insurability.

If You are not Actively-at-Work, the effective date of Your 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 are otherwise Actively-at-Work and performing all of the Primary and Essential duties of Your employment or occupation on the last preceding scheduled work day.

Family Coverage - Eligibility

Family members eligible for coverage are:

1. You;
2. Your Spouse, or Domestic Partner, on the Certificate Effective Date;
3. Your unmarried Dependent Child(ren), as defined.

Newborn Coverage from Birth

If Your coverage does not include a Spouse, or Domestic Partner, a Dependent child or Dependent children, benefits will be payable with respect to Your newly born child from the moment of birth for a 31-day period. Notification of birth of a newly born child must be furnished to Us within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period. Payment of the required premium must be made within thirty (30) days after the mailing by Us of the notice of premium to the Policyholder. If Your coverage includes a Spouse, or Domestic Partner, a Dependent Child and if a child is born to You or Your Spouse or Domestic Partner while coverage under the Policy is in force, the newborn child will become covered by the Policy from the moment of birth. No notification of birth is required.

Adopted Children Coverage

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

1. from the moment of birth if Placement for Adoption or adoption occurs within 31 days after the child's birth; or
2. 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.

Spouse or Domestic Partner and Dependent Child Effective Date

The Effective Date of Spouse or Domestic Partner and Dependent Child's coverage under the Policy, excluding a Late Enrollee, a newborn child, an adopted child, or a child placed for adoption depends on when You enroll the Spouse or Domestic Partner and children. The applicable premium must be paid. The Effective Dates are as follows:

1. If the Spouse or Domestic Partner and children are eligible for coverage when the Policyholder enrolls for coverage, the coverage for the Dependent will become effective on the Policyholder's Effective Date if You enroll the Spouse or Domestic Partner or children for coverage at that time;
2. If You first become eligible after the Policyholder's Effective Date and You enroll the Spouse or Domestic Partner or children during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;
3. If Your Spouse or Domestic Partner is a new Spouse or Domestic Partner who first becomes eligible after the Your Effective Date and You timely enroll the new Spouse or Domestic Partner as described above, coverage will become effective as of the first day of the month next following the date on which We receive the Enrollment Form;
4. If the child is a newborn child who is born after Your Effective Date and You timely enroll the newborn child as described above, coverage will become effective as of the date of birth; or
5. If the child qualifies for any other reason and first meets the definition of Dependent Child after Your Effective Date, coverage will become effective as of the first day of the month next following the date on which We receive the Enrollment Form.

Late Enrollee Effective Date (Employee or Dependent)

An employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period is a Late Enrollee.

For Late Enrollees, the Effective Date of coverage under the Policy will be the first day of the month next following the date we approve Evidence of Insurability and the applicable premium is paid.

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:

1. the date that the Policy terminates.
2. The date of termination of any section or part of the Policy with respect to insurance under such section or part.
3. the premium due date coinciding with or next following the date that the employee ceases to be a member of an eligible class.
4. at the end of the Grace Period, if premium remains unpaid at the end of the grace period.
5. The date the Policyholder no longer meets participation requirements.

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:
1. the date employment is formally terminated; or
2. 12 months after the leave of absence began.

If any change in benefits or coverage is requested, that change shall become effective as of the date of the Company's approval of that change. If that change operates to increase benefits or coverage, then the effective date of the change will be delayed if You are not Actively-at-Work until the date You return to Active Work. Should the effective date be a non-work day, insurance will still become effective on that date if You are Actively-at-Work on the last preceding scheduled work day.

Termination of coverage will not affect a claim for a covered loss that occurred while coverage was in force under the Policy.

Spouse or Domestic Partner and Dependent Child Termination: If Your Spouse or Domestic Partner or child is a Covered Person, his or her coverage will end:
1. with respect to a covered Spouse, on the date he or she is divorced from You; or
2. with respect to a covered Domestic Partner, on the date he or she is no longer in a Domestic Partnership with You; or
3. on the date You die, unless continued under the Widow or Widower's Continuation provision; or
4. at the end of the Grace Period, if premium remains unpaid at the end of the Grace Period; or
5. with respect to a covered Dependent Child, on the Policy anniversary following the date the Dependent Child no longer qualifies as a Dependent Child, as defined, unless continued under the Incapacitated Child Continuation provision.

Widow or Widower's Continuation: If You die while Your Spouse or Domestic Partner is covered under the Policy, the Spouse or Domestic Partner may continue his or her coverage; and coverage of any Dependent Children who were covered by the Policy on the date of Your death by exercising the Portability provision.

We must receive the Spouse or Domestic Partner's request and required premium to continue the coverage within 31 days of the premium due date next following Your death. Solely for the purpose of continuing the coverage, the Spouse or Domestic Partner will be considered a Covered Person. However, this will not continue the Spouse or Domestic Partner's coverage beyond a date the coverage would normally cease under the Portability provision. Any coverage continued by this Widow/er's Continuation provision will terminate on the premium due date on or next following the date the Spouse or Domestic Partner remarries.

Incapacitated Child Continuation: If, on the date a Dependent Child reaches age 26, he or she is covered under the Policy as an Incapacitated Child as defined, his or her coverage will not terminate solely due to age. But You must give us notice of the incapacity within sixty (60) days of the termination date. The Dependent Child's coverage will continue as long as the Dependent Child qualifies as an Incapacitated Child and the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

Incapacitated Child - means Your or Your Spouse or Domestic Partner's Dependent Child who has an intellectual disability or is physically handicapped and incapable of earning his or her own living, 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 the Company 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 the Company for the payment of a pro rata premium for the time the coverage was in force during such grace period.

SECTION IV - PAYMENT OF BENEFITS

We will pay the benefits described in Section V for the necessary treatment of a Covered Person's Cancer or Specified Disease provided he or she is covered under the Policy. Payment will be made in accordance with all applicable Policy provisions. Benefits are payable for a Positive Diagnosis that begins after the Certificate Effective Date, unless coverage replaces a prior plan of similar coverage that was in force when the Policy was issued or coverage is for a Covered Person who enrolled during the Initial Enrollment Period, and while the Certificate has remained in force. The Positive Diagnosis must be for Cancer or Specified Disease, as they are defined in the Policy. All benefits are subject to the terms of the Policy.

If Cancer or a Specified Disease is diagnosed while You or any Covered Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the Date of Diagnosis if this is more favorable to You. Admission to the Hospital must begin after the Certificate Effective Date.

If a Positive Diagnosis is made for Cancer or Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis after the Certificate Effective Date. If the Positive Diagnosis of Cancer or Specified Disease can only be confirmed post-mortem, then We will pay benefits beginning on the first day of confinement for the terminal admission for up to 45 days.

1. With respect to the Wellness Benefit, on the date the expense is incurred.
2. Subject to the Maximum Benefit Amount stated across from each Benefit.

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.

	BENEFITS	MAXIMUM AMOUNT
1.	**Wellness Benefit.** We will pay the amount shown on Certificate Schedule 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.	See Certificate Schedule.
2.	**Positive Diagnosis Test.** We will pay the benefit for one diagnostic test that leads to Positive Diagnosis of Cancer or Specified Disease within 90 days of such test. This benefit is not payable if the same Cancer or Specified Disease recurs.	The actual billed charges up to $300 per Calendar Year.
3.	**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 Certificate Effective Date. This benefit is payable only once for each Covered Person.	See Certificate Schedule.
4.	**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 a Board Certified internist or a Board Certified Specialist in the appropriate specialty, who is not affiliated with the Physician performing the surgery.	Incurred Expenses.
5.	**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 payable if the Covered Person's treatment is not available Locally and is available Non-Locally.	(a) The actual billed charges for a Common Carrier fare; 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.

	BENEFITS	MAXIMUM AMOUNT
6.	**Adult Companion Lodging and Transportation.** If a Covered Person is confined in a Non-Local Hospital for Cancer or Specified Disease treatment, We will pay lodging and transportation expenses for one adult companion to stay with the Covered Person.	(a) Not more than $75 per day for a single room in a motel, hotel, or other accommodations, to a maximum stay of 60 days. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. (b) We will pay the actual billed charges for a round trip coach fare on a Common Carrier or a personal vehicle allowance of 50 cents per mile. Mileage is measured from the visiting adult companion's home to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. If We pay for personal vehicle mileage under Item 5, We will pay personal vehicle mileage under this benefit only if the adult companion lives in another town other than where the Covered Person lives.
7.	**Ambulance.** We will pay the ambulance service if the Covered Person is taken to the Hospital by a licensed or Hospital-owned ambulance and is admitted as an inpatient.	Incurred Expenses.
8.	**Surgery.** We will pay the surgeon's fee for an operation 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: (a) the amount listed on the Surgical Schedule* for the applicable surgery; and (b) 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: (a) the surgeon's actual billed charges; or (b) 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.
9.	**Donor Benefit Bone Marrow and Stem Cell Transplant.** We will pay the following benefits for a Covered Person and his or her live donor: (a) two times the Hospital Confinement Benefit chosen by You for medical expenses (b) charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or (c) personal automobile expense (d) lodging and meals expense for donor to remain near Hospital.	(a) See Certificate Schedule. (b) The actual billed charges. (c) We will pay a 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. (d) The actual billed charges up to $50 per day.

	BENEFITS	MAXIMUM AMOUNT
10.	**Bone Marrow and Peripheral Stem Cell Transplant.** We will pay the benefit per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant.	Incurred Expenses to a combined lifetime maximum of $15,000.
11.	**Anesthesia.** We will pay for the services of an anesthesiologist in connection with the Covered Person's surgery. For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma.	25% of the amount paid for surgery. $100
12.	**Ambulatory Surgical Center.** We will pay for surgery performed at an Ambulatory Surgical Center.	$250
13.	**Drugs and Medicine.** We will pay drugs and medicine while the Covered Person is confined in a Hospital.	$25 for each day of confinement to a Calendar Year maximum of $600.
14.	**Outpatient Anti-Nausea Drugs.** We will pay for drugs prescribed by a Physician and which are used for suppressing nausea during Cancer or Specified Disease treatment.	The actual billed charges Up to $250 per calendar year.
15.	**Radiation Therapy, Radioactive Isotopes Therapy; Chemotherapy; or Immunotherapy.** We will pay for: (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.	We will pay the Incurred Expenses up to the amount shown on the Certificate Schedule.

	BENEFITS	MAXIMUM AMOUNT
16.	**Miscellaneous Diagnostic Charges.** We will pay for the following services: (a) laboratory work and its interpretation; (b) routine or diagnostic X-rays, scans, and their interpretations. Service must be performed while receiving treatment(s) in Item 15 or within 30 days following a covered treatment.	We will pay the Incurred Expenses up to the amount shown on the Certificate Schedule.
17.	**Self- Administered Drugs.** We will pay for 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.	We will pay the Incurred Expenses up to the amount shown on the Certificate Schedule.
18.	**Colony-Stimulating Factors.** We will pay the Incurred Expenses for (a) 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.	We will pay the Incurred Expenses up to the amount shown on the Certificate Schedule.
19.	**Blood, Plasma, and Platelets.** We will pay the expenses a Covered Person incurs for: (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.	Incurred Expenses up to $200 per day.
20.	**Physician's Attendance.** We will pay for one visit per day by a Physician while the Covered Person is confined in a Hospital.	$35 per day.
21.	**Private Duty Nursing Services.** We will pay for private nursing care by a Nurse provided: (a) nursing services are required and ordered by the attending Physician; and (b) the Covered Person is confined in a Hospital. We will not pay for nursing services in a facility other than a Hospital.	$100 per day.

	BENEFITS	MAXIMUM AMOUNT
22.	**National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit.** We will pay the actual billed charges if a Covered Person is diagnosed with Internal Cancer and seeks 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 the transportation and the actual billed charges for lodging expenses incurred. 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 Benefits of the policy.	The actual billed charges limited to a lifetime maximum up to $750 for evaluation. The actual billed charges limited to a lifetime maximum up to $350 for transportation and lodging.
23.	**Breast Prosthesis.** We will pay the expense incurred for: (a) a prosthesis to restore body contour lost due to breast Cancer; (b) the implantation of the prosthesis.	Incurred Expenses.
24.	**Artificial Limb or Prosthesis.** When an amputation is performed, We will pay the following benefits for the Covered Person: (a) an artificial limb or prosthesis; (b) the procedure to affix or implant it.	The actual billed charges up to $1,500 lifetime maximum per Covered Person per amputation.
25.	**Physical Therapy or Speech Therapy.** We will pay for one session of physical or speech therapy per day for restoration of normal bodily function.	$35
26.	**Extended Benefits.** If a Covered Person is confined in a Hospital for more than 60 continuous days, We will pay a benefit. Payment will begin on the 61st day of continuous Hospital Confinement. This benefit is payable in lieu of the Hospital Confinement Benefit.	3 times the Hospital Confinement Benefit shown on the Certificate Schedule.
27.	**Extended Care Facility.** We will pay a benefit for a Covered Person who is confined in an Extended Care Facility. Confinement must: (a) be at the direction of the attending Physician; and (b) begin within fourteen days after a Hospital confinement.	$50 per day, up to the number of days that the Hospital Confinement Benefit was paid.
28.	**At Home Nursing.** We will pay a benefit for a Covered Person for 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.	$100 per day, up to the number of days that the Hospital Confinement Benefit was paid.

	BENEFITS	MAXIMUM AMOUNT
29	**New or Experimental Treatment.** We will pay the benefit for a Covered Person for new or Experimental Treatment: (a) judged necessary by the attending Physician; and (b) received in the United States or in its territories.	The actual billed charges up to $7,500 per Calendar Year.
30.	**Hospice Care.** If a Covered Person elects to receive hospice care, We will pay the benefit for care received in a Free Standing Hospice Care Center 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.	$50 per day.
31.	**Government or Charity Hospital.** If the Covered Person is confined in or treated at: (a) a Hospital or Outpatient Clinics operated by or for the United States Government (including the Veteran's Administration); or (b) a Hospital that does not charge for the services it provides (charity); We will pay a daily benefit in lieu of all other benefits provided in the Policy.	$200 per day.
32.	**Hairpiece.** We will pay the benefit per Covered Person for a hairpiece when hair loss is the result of Cancer treatment.	The actual billed charges up to lifetime maximum of $150.
33.	**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	Incurred Expenses up to $1,500 per Calendar Year.

	BENEFITS	MAXIMUM AMOUNT
34.	**Waiver of Premium.** We will waive premiums starting on the first premium due date following a 60 day period of 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 means that You are: (a) unable to work at any job for which he or she is qualified by education, training or experience; and (b) under the care of a Physician for the treatment of internal Cancer or a Specified Disease.	
35.	**Hospital Confinement Benefit.** 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. For Dependent Children under the age of 21 the benefit is two (2) times the daily Hospital Confinement Benefit.	See Certificate Schedule.
36.	**Surgical Schedule.**	

Optional Benefit Level

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

Optional Benefit Level

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

During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. During the first 12 months following the date a Covered Person makes a change in coverage that increases his or her benefits, the increase will not be paid for Pre-Existing Conditions. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

A Pre-Existing Condition means Cancer or a Specified Disease, 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 Certificate Effective Date of coverage for each Covered Person.

If coverage under the Policy replaces a prior plan of similar coverage, a person who is otherwise a member of an eligible class under the Policy shall be covered without regard to any Actively-at-Work or Evidence of Insurability requirement if:

1. such person was validly covered under the prior plan on the Policyholder's Effective Date;
2. the applicable premium is paid; and
3. the prior coverage is terminated upon issuance of this coverage.

Credit shall be given for the number of years that the prior plan of similar coverage was in effect.

Benefits will be the lesser of:

1. benefits under the Policy without application of the pre-existing conditions limitation; or
2. 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 VII - EXCEPTIONS AND OTHER LIMITATIONS

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

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
   a. Specified Disease or Specified Disease treatment; or
   b. Cancer or Cancer treatment, or unless otherwise defined in the Policy
4. care and treatment received outside the United States or its territories;
5. treatment not approved by a Physician as medically necessary; and
6. Experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

SECTION VIII - CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to Us within 30 days after a Covered Person's loss, or as soon thereafter as reasonably possible. Written notice given by or on behalf of the claimant to Us with information sufficient to identify the Covered Person, is deemed notice to Us.

Claim Forms. We will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not furnished within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, Written proof describing and documenting the occurrence, the character and the extent of the loss for which claim is made. The written notice should include the Covered Person's name, the Policy number and the Certificate number.

Proof of Loss. Written proof of loss must be furnished to Us within 90 days after the date of the loss. Proof of loss includes any documentation necessary to determine if a benefit is payable. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Payment of Claims. Upon receipt of due written proof of loss, payments for all losses will be made to the Covered Person. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to the Covered Person's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at Our option, to any relative by blood or connection by marriage of the payee, who has submitted reliable documentary evidence and, in Our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment We make in good faith fully discharges Our liability to the extent of the payment made.

If the Covered Person provides Us with a written release to do so, we may, at Our option, pay benefits directly to the institution or person rendering treatment or services covered under the Policy.

Time of Payment of Claims. Benefits payable under the policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within thirty (30) days upon Our receipt of due written proof of the loss. Subject to Our receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which We are liable and any balance remaining unpaid upon termination of liability will be paid upon receipt of such proof.

SECTION IX - GENERAL PROVISIONS

Entire Contract; Changes. The Policy, the Policyholder Application, and any attached Riders or Amendments make up the entire contract. All statements made on any Application will be considered representations and not warranties. No Written statement made by You will be used in any contest unless a copy of the statement is furnished to You or Your representative.

No change in the Policy or a Certificate will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to the Policy. No agent may change the Policy or waive any of its provisions. Any change that modifies limits or excludes coverage must contain the Your signature in order for the change to be binding.

Incontestability. The validity of coverage under the Policy will not be contested after it has been in force for two year(s) from the Certificate Effective Date, except for nonpayment of premiums.

After two years from the Certificate Effective Date, no misstatements made in Your Evidence of Insurability will be used to contest a claim under the Policy. We may only contest coverage if the misstatement is made in a written instrument containing Your signature and a copy is given to You.

Physical Examination. We, at Our own expense, have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as We may reasonably require during the pendency of the claim.

Legal Actions. No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements. Any express waiver by Us of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes. Any provision of the Policy and this Certificate which, on its Policy and Certificate Effective Date, is in conflict with the statutes of the state in which the Policy or Certificate is delivered is hereby amended to conform to the minimum requirements of those statutes.

Clerical Error. Clerical error, whether by You or Us, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect or extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

Assignment. You may assign all of Your rights, privileges and benefits under the Policy to the institution or person rendering the service as allowed in the Payment of Claims provision. We are not bound by an assignment until We receive and file a copy of the assignment containing Your signature. We are not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

Misstatement of Age. If premiums for the Covered Person are based on age and the Covered Person's age has been misstated, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. We may require satisfactory proof of age before paying any claim.

Termination of a Covered Person. Upon the termination of coverage of a Covered Person, the premium under the 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.

SECTION X - PORTABILITY

Portability allows You to keep the Policy's Benefits at certain times when Your coverage would otherwise end. This is subject to the Benefit Conditions, Limitations and Exclusions.

Coverage is provided under the terms and conditions of the Policy.

When Portability is Available

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

1. have been continuously covered by the Policy for at least 6 months;
2. are less than Age 70;
3. are not Totally Disabled; and
4. are no longer Actively At Work.

How to Exercise Portability

You must, within 46 days after the date that Your coverage would end:

1. submit written application on a form approved by the Company; and
2. 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 the Company 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 month that coverage began. Coverage remains in effect during the Grace Period.

The Premium rate and Premium changes applicable to a Class will apply to former Class members who have ported.

We may add a billing fee to the Class rate applicable to ported Certificates.

If You port and Premiums for a Class change, We will provide You at least a 60-day advance written notice of the change.

Amount of Insurance

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

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.

When insurance decreases or ends for a Class, the decrease or termination will apply to former members of the Class who have ported.

Termination of Ported Insurance

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

1. when You request termination;
2. at the end of the Grace Period, if the Premium is not paid;
3. for a Spouse or Domestic Partner or Dependent Child, when He or She no longer meets the Policy's definition of Spouse or Dependent Child;
4. for a Spouse or Domestic Partner, Age 70;
5. for a Dependent Child, Age 26;
6. on the next premium due date upon Your death.

Termination of the Policy

If the Policy terminates, Covered Persons will be eligible to exercise the Portability Privilege on the termination date of the Policy. Portability coverage may continue beyond the termination date of the Policy, subject to timely payment of premiums. Benefits for portability coverage will be determined as if the Policy had remained in full force and effect.

Portability Benefit Conditions and Limitations

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

You are not eligible to use this Benefit if Totally Disabled.

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

GROUP CANCER AND SPECIFIED DISEASE INSURANCE COVERAGE

ManhattanLife Assurance Company of America
P.O. Box 161690, Austin TX 78716

Please read Your Certificate. If there is anything in the Certificate You do not understand, We urge You to write Us. We will answer Your questions.

When writing to the Home Office, please give Us the number of Your Policy and Certificate.

ManhattanLife Assurance Company of America

Administrative Office: PO BOX 161690, AUSTIN, TX 78716 800-845-7519
Home Office: Little Rock, AR

Amendment Rider

Certificate: [Certificate Number]
Insured: [Certificate Holder]

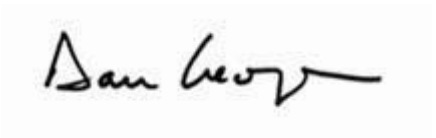
The certificate to which this rider is attached is hereby amended as follows:

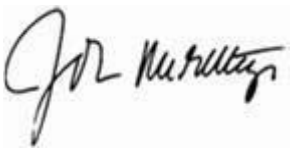
SECTION V – SCHEDULE OF BENEFITS, Wellness Benefit is deleted in its entirety and replaced with the following:

1.	**Wellness Benefit.** We will pay the amount shown on the Certificate Schedule if a Covered Person has a screening test, including, but not limited to: a) Mammogram; b) Flexible Sigmoidoscopy; c) Pap Smear; d) Chest X-ray; e) Hemocult Stool Specimen; f) Prostate Screen. g) Blood test for triglycerides h) Bone marrow testing (can be done for many reasons, if we received something stating it was specifically for cancer testing, we would cover) i) Doppler screening for carotids j) Doppler screening for peripheral vascular disease k) Echocardiogram l) EKG (electrocardiogram) m) HPV vaccination n) Lipid panel o) Stress test on bike or treadmill	See Certificate Schedule.

This rider is subject to all of the provisions of the Policy as long as it does not amend them. This rider will terminate on the same date as the certificate to which it is attached terminates.

Signed for by ManhattanLife Assurance Company of America at its Home Office on the Policy Effective Date





Dan George
President

John McGettigan
Secretary

M-W101

Optional Rider

ManhattanLife Assurance Company of America

Administrative Office: PO Box 161690, Austin TX 78716 800-845-7519
Home Office: Little Rock, AR

INTENSIVE CARE UNIT BENEFIT RIDER

This Rider forms a part of the Policy and Certificate to which it is attached and is effective on the Policy Effective Date and the effective date shown on the Schedule of the Certificate to which it is attached. In consideration of the additional premium, the Policy and Certificate are hereby amended by the addition of the following benefit:

Definitions

Common Carrier Injury - means an accidental bodily injury sustained directly and independently of all other causes from an accident which occurs while the Covered Person is covered under this benefit of the Policy and 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.

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.

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 facilities 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 Nurses assigned just 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. This guide lists three types of facilities that meet this definition:

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

These 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 Intensive Care Unit as defined.

Period of Confinement - means an interval of time during which a Covered Person is confined as an inpatient in the Intensive Care Unit of a Hospital. A Period of Confinement begins on the date the Covered Person is admitted to the ICU of the Hospital. Successive confinements due to the same or related causes and separated by less than 30 days are part of the same Period of Confinement.

A new Period of Confinement begins when the Covered Person is readmitted to the ICU of the Hospital for a new sickness or injury unrelated to the causes of a prior confinement; or after he or she has been free of confinement in the ICU of the Hospital for 30 days or more.

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

Benefit Schedule

The Covered Person's daily benefit amount under this Rider will be as elected on his or her application and shown on the Certificate Schedule. The election must be in accordance with the terms of the Policy and Certificate to which this Rider is attached.

We will pay the daily benefit amount for each day of a Covered Person's Period of Confinement in an ICU. The Period of Confinement must be due to sickness or injury and begin while the Covered Person is covered under the Policy. Benefits are payable from the first day of ICU confinement.

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 or Specified Disease or 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 Common Carrier Injury. 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 Covered Person is transferred directly to the ICU of a Hospital that has an ICU.	ICU Daily Benefit Amount per Day of Confinement

Reduction in Amount of Insurance. On the Certificate Renewal Date on or next following the date a Covered Person attains age 75, his or her daily benefit amount payable for ICU confinement will be reduced to one-half of that which applied to him or her on the day preceding the date he or she attained age 75.

Exceptions and Other Limitations. This benefit does not cover ICU or Step Down Unit confinements which occur during a Period of Confinement that began before the Certificate Effective Date.

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:

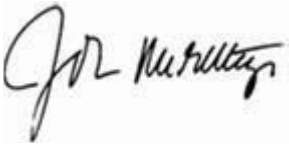
- an intentionally self-inflicted injury or suicide attempt.

- the Covered Person's 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.

In all other respects, the Policy and Certificate remains the same.

Signed for by ManhattanLife Assurance Company of America at its Home Office on the Policy Effective Date.

Dan George
President



John McGettigan
Secretary

ManhattanLife Assurance Company of America

Administrative Office: PO BOX 161690, AUSTIN, TX 78716 800-845-7519
Home Office: Little Rock, AR

Amendment Rider

Certificate [CERTIFICATE NUMBER]

Insured: [CERTIFICATE HOLDER]

The certificate to which this rider is attached is hereby amended as follows:

SECTION IV - PAYMENT OF BENEFITS is deleted in its entirety and replaced with the following

SECTION IV - PAYMENT OF BENEFITS
We will pay the benefits described in Section V for the necessary treatment of a Covered Person's Cancer or Specified Disease provided he or she is covered under the Policy. Payment will be made in accordance with all applicable Policy provisions. Benefits are payable for a Positive Diagnosis, that begins after the Certificate Effective Date, unless coverage replaces a prior plan of similar coverage that was in force when the Policy was issued or coverage is for a Covered Person who enrolled during the Initial Enrollment Period,, and while the Certificate has remained in force. The Positive Diagnosis must be for Cancer or Specified Disease, as they are defined in the Policy. All benefits are subject to the terms of the Policy.

If Cancer or a Specified Disease is diagnosed while You or any Covered Person is confined in the Hospital, benefits will begin on the day of admission or 10 days prior to the Date of Diagnosis if this is more favorable to You. Admission to the Hospital must begin after the Certificate Effective Date.

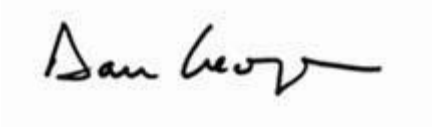
If a Positive Diagnosis is made for Cancer or Specified Disease within 12 months after a Tentative Diagnosis, benefits will be paid from the date of the Tentative Diagnosis after the Certificate Effective Date. If the Positive Diagnosis of Cancer or Specified Disease can only be confirmed post-mortem, then We will pay benefits beginning on the first day of confinement for the terminal admission for up to 45 days.

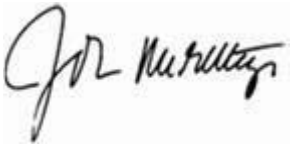
1. With respect to the Wellness Benefit, on the date the expense is incurred.
2. Subject to the Maximum Benefit Amount stated across from each Benefit.

This rider is subject to all of the provisions of the Policy as long as it does not amend them. This rider will terminate on the same date as the [policy/certificate] to which it is attached terminates.

In all other respects, the Policy and Certificate remains the same.

Signed for by ManhattanLife Assurance Company of America at its Home Office on the Policy Effective Date.





Dan George
President

John McGettigan
Secretary

HIPAA PRIVACY NOTICE

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 terms of this Notice of Privacy Practices – Protected Health Information ("Notice") applies to Protected Health Information (defined below) associated with Health Plans (defined below) issued by or coinsured by the following companies: ManhattanLife Assurance Company of America, The Manhattan Life Insurance Company, Family Life Insurance Company, and Western United Life Assurance Company, hereafter referred to as ("the Company"). This Notice describes how the Company may use and disclose Protected Health Information to carry out payment and health care claims and/or operations and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide our policyholders with notice of our legal duties and privacy practices concerning Protected Health Information. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as set forth below; we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, we will mail copies of revised notices to all policyholders then covered by a Health Plan. Copies of our current Notice may be obtained by contacting the Company at the telephone number or address below, or on our Web site at www.manhattanlife.com.

DEFINITIONS

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by the Company and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the policy or the policy itself.

Uses and Disclosures for Payment – We may make requests, uses and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or another Health Plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include underwriting, premium rating or other activities relating to the creation, renewal, or replacement of a Health Plan, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our Professional judgment to disclose PHI with your spouse concerning the processing of a claim. If you do not wish the Company to share PHI with your spouse or others, you may exercise your right to request a restriction on the Company's disclosures of your PHI (see below).

Business Associates – Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents and vendors that help us process your claims. At times it may be necessary for us to provide certain aspects of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Health Plan coverage, and about health-related products and services that may add value to your Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, the Company may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaver organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose your PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

RIGHTS THAT YOU HAVE

Access to your PHI – You have the right to copy and/or inspect your PHI that we maintain. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from the Company at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from the Company at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from the Company at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we do not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request, but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. By contacting the Company at the telephone number or address below you may make requests for a restriction (or termination of an existing restriction).

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to the Company at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting the Company at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with the Company in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the Company by writing to or by calling:

10777 Northwest Freeway
Houston, TX 77092
1-800-669-9030

EFFECTIVE DATE - This Notice is effective September 1, 2003.

ManhattanLife
Since 1850

PRIVACY POLICY

A Commitment to Protecting, Preserving, and Respecting Your Privacy

Your privacy is important to us. This Privacy Policy ("Policy") describes the standards we follow in handling information about you that is not publicly available, herein called "nonpublic personal information". This Privacy Policy applies to the following: Manhattan Life Insurance Company, ManhattanLife Assurance Company of America, Western United Life Assurance Company, Family Life Insurance Company, and all coinsurance and assumption reinsurance treaties administered and/or assumed.

This Privacy Policy is provided to you for informational purposes only. You do not need to call or take any action in response to this notice. We recommend that you read and retain this Privacy Policy with your insurance papers.

A Summary of the Guidelines for Manhattan Life Insurance Company ManhattanLife Assurance Company of America Western United Life Assurance Company and Family Life Insurance Company ("The Companies")

- We collect nonpublic personal information to process and administer our customers' business and to ensure that we are satisfying their financial and insurance needs.
- We do not share any nonpublic personal information about our customers to anyone, except as permitted by law.
- We use our customers' information responsibly to provide them with benefits and improved products and services.
- We have policies and procedures in place to protect our customers' nonpublic personal information.
- We hold our employees to the highest standards of conduct in ensuring this confidentiality.
- We comply with federal and state privacy laws and regulations.
- Our privacy policy applies to customers with a current or former relationship.

Types of Nonpublic Personal Information We Collect and How We Use It

As part of our insurance business, employees, representatives, agents and selected third parties may collect nonpublic personal information about our customers. This includes the following:

- Information we have received from you on applications or other forms.
- Information about transactions with us, our affiliates or third parties.
- Information from others, such as credit reporting agencies, employers, and federal and state agencies.
- Nonpublic personal health information, like medical reports, for certain types of insurance polices in order to underwrite the policy, administer claims or perform other insurance or insurance related functions.
- Examples of nonpublic personal information we may collect are your name, address, social security number, date of birth, gender, medical history, account activity, account balances, income, assets, marital status, payment history, insurance premiums, and information received from a consumer and/or credit reporting agency.
- Please note: There may be instances when the agents and representatives referred to above may not be acting on behalf of "The Company", in which case they may collect nonpublic personal information on their own behalf or on behalf of another. In these instances, "The Companies" Privacy Policy would not apply.

Types of Nonpublic Personal Information We Share and with Whom We Disclose

- We do not share nonpublic personal information about our customers with anyone, except as permitted by law. We may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business to: (1) affiliated companies, employees, agents, representatives and third parties that administer and service customer accounts on our behalf and that market our services; or (2) other insurance and/or financial institutions with which we have joint marketing agreements.
- Examples of the types of companies and individuals with whom we disclose nonpublic personal information are attorneys, trustees, third-party administrators, insurance agents, registered brokers/dealers, insurance companies, insurance support organizations, banks, credit reporting agencies, medical professionals, auditors, federal and state regulators, transfer agents, and reinsurers.
- If medical information is collected in the course of providing insurance services to you, this personally identifiable health information will not be used for any purpose, unless the customer or the applicable law authorizes further sharing.
- We do not sell nonpublic personal information about our customers to other companies so they may solicit you.
- We disclose this nonpublic personal information outside the company only as authorized by you or for a specific business purpose.

Our Safeguards to Protecting Nonpublic Personal Information

- We restrict access to nonpublic personal information to authorized individuals who need to know the information to provide benefits and improved products and services to our customers.
- We have guidelines in place that inform and give direction to our employees, agents, and representatives acting on our behalf on how to protect and use nonpublic personal information.
- We maintain physical, electronic, and procedural safeguards that protect nonpublic personal information.
- We will continue to enhance our security procedures, as new technologies become available.

Additional Privacy Policy Information

- This Policy is provided to you in accordance with the privacy provisions in Title V of the Gramm-Leach-Bliley Act. We may change this policy and/or related procedures at any time, in accordance with applicable federal and state laws. Customers with a continuing relationship will receive appropriate notice if our Policy changes.
- **Our Policy will be available to all interested parties on our web site at www.manhattanlife.com.**

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

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 - 21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, 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 governmental 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, AK 99522-0207
(907) 243-2311

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

ALABAMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT
Effective October, 1 2013

Residents of Alabama 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 Alabama 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 Alabama Life and Health Insurance Guaranty association may not provide coverage for a policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in Alabama. 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 provides for this safety-net coverage is called the Alabama Life and Health Insurance Guaranty Association. Below is a brief summary of this law's current coverages, exclusions and limits. The summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the association. **Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance, at the applicable address listed below, to allege a violation of any provision of the Alabama Life and Health Insurance Guaranty Association Act.**

The Alabama Life and Health Insurance Guaranty Association
Po Box 303351
Montgomery, Alabama 36130-3351

Commissioner of Insurance, State of Alabama
Division of Insurance
502 Montgomery HWY Suite 102
Birmingham, Alabama 35216
Phone: (205) 823-4042

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

- They are eligible for protection under the law of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured's who live outside the state);
- the insurer was not authorized to do business in this state;
- their policy was insured by a nonprofit hospital or medical service organization, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a

mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

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

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than annuity owned by a governmental retirement plan established under section 401, 403 (b) or 457 of the Internal revenue Code 26 U.S.C && 401, 403 (b) and 457, respectively, or trustees of such a plan; or
- Medicare or Medicare Advantage contracts

LIMITS ON AMOUNT OF COVERAGE

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

With respect to life insurance policies on any one insured life, the Association will pay a maximum of $300,000, regardless of how many policies and contracts there are with the same company, and even if they provide different types of coverage. Within this overall $ 300,000 limit, the Association will not pay more than $100,000 in cash surrender values, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to annuities, the Association will not pay more than $250,000 in the present value of benefits, including net cash surrender and withdrawal.

With respect to health insurance for any one life, the Association will not pay more than: 1) $100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; 2) $300,000 for disability insurance or long term care insurance; or 3) $500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $250.000 in present values of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

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

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

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

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

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

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

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

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

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

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

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

COVERAGE

- **Persons Covered**

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

- **Amounts of Coverage**

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

- **Life Insurance, Annuities and Structured Settlement Annuities**

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

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

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

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

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a 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 1067.02(b)(2)(C)

NOTICE

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

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

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

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

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

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

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

The basic protections provided by the Association are:

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

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

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

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 this 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 § 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;

$100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net

cash withdrawal values.

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

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner 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
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

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

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of statutory 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 right established in any policy or contract, or under the Act.

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, HI 96813

Department of Commerce & Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance **Guaranty Association** Act. 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 insurer of the **Guaranty Association.** A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

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

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

LIMITS ON AMOUNT OF COVERAGE
The act also limits the amount the Guaranty Association is obligated to payout. The basic protections provided by the Association are:

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

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

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

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

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

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 in basic hospital, medical-surgical or major medical insurance benefits
  - $300,000 in disability income protection insurance benefits
  - $300,000 in long-term care insurance benefits
  - $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
Two Ruan Center
601 Locust Street, 4th Floor
Des Moines, IA 50309
(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 state 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 shall control.

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

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

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

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

This information is provided by:

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

Idaho Department of Insurance
700 west State Street
P.O. Box 83720
Boise, Idaho 83720-0043
208-334-4250
1-800-721-3272
www.doi.idaho.gov

(continued on next page)

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

COVERAGE:

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

EXCLUSIONS FROM COVERAGE:

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

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

The Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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 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 W. 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. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

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

GENERAL PURPOSES AND LIMITATIONS OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION K.S.A. 40-3001, et. seq.

DISCLAIMER

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

Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

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 happen, 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, LA 70821

Department of Insurance
P. O. Box 94214
Baton Rouge, LA 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 direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons 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 OF COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA, 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, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as 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 C coverage" or "Medicare Part D coverage" 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 an 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 or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits; and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

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

Or,

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

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

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

If the insurer 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 & Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, Minnesota 55110
(651) 407-3149

The maximum amount the Guaranty Association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, 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 PROTECTION PROVIDED BY MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

The basic protections provided by the Association are as follows:

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

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

  or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

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

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

Missouri Life and Health
Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Ph.: 573-634-8455
Fax: 573-634-8488

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

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

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

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

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

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

Life Insurance

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

Health Insurance

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

Annuities

- $250,000 in net cash surrender and net cash withdrawal values

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

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

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

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

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

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

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

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

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

The basic protections provided by the Association are:

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

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to hospital, medical, and surgical insurance benefits.

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website 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

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.

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.

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

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

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

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

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

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

SUMMARY OF THE 1996 NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (RSA 408-B) AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

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

IMPORTANT DISCLAIMER

The New Hampshire Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Hampshire. Other conditions may preclude coverage.

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

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

This information is provided by:

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

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

SUMMARY:

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

COVERAGE:

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

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

EXCLUSIONS FROM COVERAGE:

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

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

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with an insurance policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;
- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery; or

- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.
- a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date of the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of subchapter XVIII, chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C and D, or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE:

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

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

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

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

ADDITIONAL INFORMATION:

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

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

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 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.

New Jersey Life and Health Insurance Guaranty Association
11 Wharf Avenue, Suite One
Red Bank, NJ 07701
732-345-5204

State of New Jersey Department of
Banking and Insurance
20 West State Street, Trenton, NJ 08625
609-292-7272

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, or if they are insured under a group insurance contract, issued by a member insurer.

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

NOTICE OF
PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

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

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

The basic protections provided by the Association are:

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

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

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

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

To learn more about the above protections, please visit the Association's website 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.

NEVADA LIFE AND HEALTH INSURANCE

GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT

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

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

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

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

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. Below is a brief summary of this law's coverages, exclusions and limits. The summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association. **Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance, at the applicable address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.**

The Nevada Life and Health Insurance Guaranty Association
4600 Kietzke Lane, Suite O-269
Reno, Nevada 89502

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) and
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code 26 U.S.C. && 401, 403(b) and 457, respectively, or trustees of such a plan, and
- Medicare or Medicare Advantage contracts

LIMITS ON AMOUNT OF COVERAGE

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

With respect to life insurance policies and annuities, on any one insured life, the Association will pay a maximum of $300,000, regardless of how many policies and contracts there are with the same company, and even if they provide different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, $100,000 in present values of an annuity, or $300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to health insurance for any one natural person, the Association will not pay more than: 1) $100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal; 2)

$300,000 for disability insurance; 3) $500,000 for basic hospital, medical and surgical insurance or major medical insurance; or 4) $300,000 for Long Term Care insurance.

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

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of $300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate of $500,000 in benefits, including 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 coverage allowed is an aggregate of $250,000, regardless of the number of contracts issued by anyone member company.

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

www.nvlifega.org

New York State
Department of Financial Services

Policyholder Protection

Provided by the Life Insurance Company Guaranty Corporation of New York

It is illegal for any person, including an insurer, agent or affiliate of an insurer to use this brochure for the purpose of selling insurance, or soliciting or inducing the purchase of insurance.

As an insurance consumer, you should select your insurance company carefully. Although the Life Insurance Company Guaranty Corporation provides broad protection, there are limitations on coverage. You should not ignore a company's financial condition on the assumption that you will be fully protected if the company fails to meet its obligations.

ANDREW M. CUOMO
Governor

BENJAMIN LAWSKY
Superintendent
Department of Financial Services

OVERVIEW

This brochure summarizes protections provided by the Life Insurance Company Guaranty Corporation of New York (LICGC) to New York policyholders in the event of the financial insolvency of any New York-licensed life insurance company owing benefits under outstanding life insurance policies, annuity contracts or accident and health insurance policies.

This brochure responds to some of the most frequently asked questions concerning the LICGC and should not be considered a legal opinion of either the New York State Department of Financial Services or the Life Insurance Company Guaranty Corporation of New York.

If you have questions after reviewing the brochure, you may write to the LICGC in care of the New York State Department of Financial Services Life Insurance Bureau, 25 Beaver Street, New York, NY 10004.

The LICGC is a not-for-profit New York corporation created under a special statute enacted in 1985, *The Life Insurance Company Guaranty Corporation of New York Act.* Every life insurance company licensed to do business in the State of New York must be a member of the LICGC as a condition of transacting an insurance business in the State. A Board of Directors, consisting of representatives of member insurers and the Superintendent of Financial Services, manages the operations of the LICGC.

One of the Department of Financial Services' most important responsibilities is regulating the activities of life insurers doing business in the State to ensure that the promises made in insurance policies are fulfilled. Therefore, each life insurer licensed in New York submits comprehensive annual and quarterly reports on its financial condition.

In addition, the Department's insurance examiners conduct regular on-site examinations of all **domestic life insurers** (those insurers incorporated in New York) to evaluate their financial condition, as well as their underwriting and claims-handling practices. Out-of state life insurers doing business in New York are subject to on-site examinations by their home state insurance departments.

The Department's record in regard to life insurer solvency is an excellent one. With the creation of the Life Insurance Guaranty Corporation in 1941, New York became the first state in the country to provide consumers with a measure of protection against life insurer insolvency. Since those original guaranty fund protections were established, the fund has been needed only three times to pay policyholder claims.

Q: How does the LICGC work?

A: The LICGC is required by law to provide funds to protect **New York resident policyholders** in the event of the insolvency of a **licensed life insurer**.

The LICGC is funded through assessments against member insurers made after a member insurer is declared insolvent by a court of law. Such funds are used to pay valid claims as well as administrative expenses.

In addition, insurance policies and annuity contracts issued by **domestic life insurers** prior to August 2, 1985 may also have protection provided by a separate fund, administered by the Life Insurance Guaranty Corporation, which was established before the LICGC was created in 1985.

Q: What types of insurance policies are protected by the LICGC?

A: The LICGC protects life insurance policies as well as annuity contracts and accident and health insurance policies issued by licensed life insurers, subject to certain limitations. Limited protection is also available for other types of contracts as discussed below.

Q: Are there any limits on the protection afforded by the LICGC?

A: The LICGC will provide up to $500,000 of coverage to a life insurance policyholder/beneficiary, an individual annuity (such as a Single Premium Deferred Annuity) contract holder or an **individual** accident and health insurance policyholder. In addition, the full benefits of **group** accident and health insurance policies issued by licensed life insurers are protected for a minimum of six months.

Also, limited coverage is afforded to funding agreements and group annuity contracts. Both group annuity contracts, including guaranteed interest contracts, and funding agreements, are frequently used for the investment of the assets of pension, profit-sharing and salary reduction type plans. Most often it is the plan trustee or sponsor who makes the investment. The extent of LICGC protection for an individual participant depends on the insurer's obligation as set forth in the contract.

If the contract does not guarantee annuity benefits with respect to any specific individual identified in the contract, the LICGC will provide coverage for the total invested with the insurer, up to $1 million. However, if the contract does guarantee annuity benefits with respect to specific individuals identified in the contract, then the LICGC will provide up to $500,000 of coverage to such individuals who are New York residents.

With respect to funding agreements that do not fund benefits under employee benefit plans, the LICGC provides aggregate coverage of up to $500,000. For more specific information about the type of contract through which your protection is provided, you should contact your employer's personnel office.

Q: My insurance company's home office is in another state, but the company is licensed in New York. Am I protected by the LICGC?

A: You are protected if you were a resident of New York State when you purchased the policy or are a resident at the time your insurance company becomes insolvent. Policies purchased from domestic life insurers prior to August 2, 1985 may have additional protection through the separate Life Insurance Guaranty Corporation, regardless of residency.

Q: I bought my life insurance policy when I lived in New York but now I live in Florida. Am I protected?

A: As long as you were a resident of this State at the time of purchase and your insurer was licensed here, you are protected. You may also have protection in your current state of residence.

Q: I have a separate account variable annuity contract, i.e., my funds are invested separately from those of the company and I bear all the risk of gains and losses. What kind of protection do I have?

A: The LICGC provides no protection under the contract described above. As noted, you bear the entire risk under the contract. However, there are some separate accounts in which individuals do not bear the full amount of the risk and some protection would be available for these kinds of contracts. Assets in such separate accounts would normally retain their separate status in the event of the insolvency of the issuing insurer and could not be used to pay that insurer's other debts and obligations that do not arise out of the business of the separate account.

Q: My separate account annuity guarantees a minimum return. Am I protected by the LICGC?

A: You are protected, but only for the portion of the contract that is guaranteed. Presumably, most of this guaranteed amount would be payable from the assets of the separate account. The LICGC would come into play only in the event of a shortfall as to the guaranteed amount.

Q: I have a 401(k) plan with my employer. I have selected a fixed interest option funded by a guaranteed investment contract (GIC) issued by a life insurance company to my employer. Will my invested funds be protected?

A: A 401(k) plan is a retirement savings plan in which employees contribute through payroll deductions to a fund to be used for retirement. If the guaranteed interest contract guarantees annuity benefits with respect to specific individuals identified in the contract, then such individual is protected by the LICGC up to a maximum of $500,000.

However, if the guaranteed interest contract does not guarantee annuity benefits with respect to any specific individual identified in the contract, the contract is protected up to a maximum of $1 million in the aggregate for all claims made under that contract.

Q: My husband and I each have an annuity contract worth $300,000. Does the $500,000 cap apply to us jointly?

A: No, the LICGC puts the aggregate limit of $500,000 on any one life. Therefore, the limit would apply to you and your husband separately.

Q: How can I find out if my insurer is licensed in New York State?

A: The New York Department of Financial Services maintains a list of all companies currently licensed in New York State. The list is located on the Department's Web site, **www.dfs.ny.gov** – click on "Insurance Industry" to locate the link for the "Insurance Company Search."

Q: What happens when an insurance company experiences financial difficulty?

A: The Insurance Law provides that the Superintendent may seek an order from the New York State Supreme Court to allow him or her to take over a domestic insurer's operations if any of a variety of circumstances exist, including situations that affect a company's financial stability.

This supervision of a company may take either of two forms: rehabilitation or liquidation. The essential difference is that under rehabilitation, the Superintendent attempts to return the company to a financially stable condition, whereas under liquidation, steps are taken toward the eventual dissolution of the company. Both are designed to enable the Superintendent to protect the insurer's policyholders and other creditors.

If a company is domiciled in another state that has placed it in rehabilitation or liquidation, the Superintendent may seek a court order allowing him or her to take control of the company's assets in New York. The LICGC is available to pay policyholder claims after a court declares any licensed insurer insolvent. This declaration is typically found in a court order of rehabilitation or liquidation.

Q: Will I have to wait for payments once my insurer is taken over by the Superintendent?

A: When your insurer is initially taken over by the Superintendent, payments to you from your insurer may be suspended. Delays could be necessary to allow the Superintendent time to sort out the affairs of the financially troubled insurer. As a result, in some cases, you may have to wait many months before receiving payments; in other cases, benefits may not be delayed at all.

Q: How will I know if my insurer is taken over by the Superintendent?

A: Once the Superintendent of Financial Services steps in to take over an insurer, official notice is sent to all policyholders explaining the circumstances that made the action necessary. In addition, notices are published in the newspapers.

The Life Insurance Company Guaranty Corporation was created to provide protection for New York life insurance policyholders in the event of insurer insolvency. However, the best protection for consumers is care in selecting an insurer and a policy.

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
1840 Mackenzie Drive
Columbus, OH 43220

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

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. 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 in which the policyholder is subject to future assessments, or by an insurance exchange.

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

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

LIMITS ON AMOUNT OF COVERAGE

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

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§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.

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

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

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

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

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

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

SUMMARY OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS

INTRODUCTION

Residents of Pennsylvania 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 Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. 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:

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

SUMMARY

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

Coverage. Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, 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. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;

- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;

- their policy was issued by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;

- any policy of reinsurance (unless an assumption certificate was issued);

- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);

- interest rate yields that exceed an average rate;

- dividends;

- experience rating credits;

- credits given in connection with the administration of a policy or contract;

- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;

- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;

- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;

- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;

- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the over-all $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits, but not more that $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits, or $100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to $300,000, including any net cash surrender or withdrawal benefits.

MANHATTANLIFE ASSURANCE COMPANY OF AMERICA
10777 Northwest Freeway, Houston, TX 77092

SUMMARY

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

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

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

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

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

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

Rhode Island Life and Health Insurance Guaranty Association
235 Promenade Street, #426
Providence, RI 02908
Tel. (401) 273-2921

Rhode Island Division of Insurance
1511 Pontiac Avenue
Cranston, RI 02920
Tel. (401) 462-9520

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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

(Continued on next page)

policies or contracts were in force with the same insurer, the Association will pay no more than:

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

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws section 27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.

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

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

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

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

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, SD 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

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

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

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

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

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

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than $500,000 for basic hospital, medical and surgical insurance, not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

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

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in 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 coverages, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. **This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

The 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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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
150 Third Avenue South, Suite 1600
Nashville, TN 37201

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

NOTICE

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 Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

COVERAGE is NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

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

Tennessee Life and Health Insurance Guaranty Association
150 Third Avenue South, Suite 1600
Nashville, TN 37201

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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

(For insurers declared insolvent or impaired on or after September 1, 2011)

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

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

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

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

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

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

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

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

The basic protections provided by the Association are:

- Life Insurance
    - $500,000 in death benefits
    - $200,000 in cash surrender or withdrawal values
- Health Insurance
    - $500,000 in hospital, medical and surgical insurance benefits
    - $500,000 in long-term care insurance benefits
    - $500,000 in disability income insurance benefits
    - $500,000 in other types of health insurance benefits
- Annuities
    - $250,000 in withdrawal and cash values

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

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

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

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

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

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

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

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

The Association was established to provide protection in the unlikely event that a life, annuity or 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
  - o $300,000 in death benefits
  - o $100,000 in cash surrender and withdrawal values

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

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

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

PROTECTION FOR YOU AND YOUR INSURANCE POLICY
THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

PREFACE

This brochure briefly describes the coverage provided through the Washington Life & Disability Insurance Guaranty Association ("Association").

The Association is a nonprofit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48.32A RCW ("Act"). Every life and disability insurance company authorized to do business in Washington is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex officio, oversee the operation of the Association.

The expenses of the Association are paid by assessments made against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the limitations and exclusions provided by the Act.

The purpose of this brochure is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contact either the Association or the Office of the Insurance Commissioner.

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

Company Supervision Division
Office of the Insurance Commissioner
P.O. Box 40259
Olympia, WA 98504-0259
360-725-7212

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

   The Act applies to life insurance policies, disability insurance policies, and annuity contracts issued by an insurance company authorized to do business in Washington. The term "disability insurance," as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance" (which includes long term care policies). Together, all of these policies and contracts are sometimes referred to as "covered policies," a term used in this brochure.

2. ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

   The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued in Washington by an insurer at a time when the insurer was not licensed or did not have a certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

   The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, self funded multiple employer welfare arrangements, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities.

3. WHO IS PROTECTED UNDER THE ACT?

   You are covered by the Act if you are an owner of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity), and:

   - You are a Washington resident; or
   - You are not a Washington resident, but only if: the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or
   - You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident; or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is generally determined at the time of entry of an order of liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

4. HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. The association may also directly provide benefits and coverage as authorized by the Act. The Association has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

5. WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all life and disability insurance companies doing business in Washington. The funds collected from an assessment are used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

6. DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

The Association generally cannot make an assessment for covered policies issued by a company until after an order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

7. WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits $500,000

Disability Benefits and Health Benefits (including Long Term Care Benefits) $500,000

Present Value of Individual Annuities $500,000

Unallocated Annuity Contracts, other than certain government retirement plans (limit is per contract owner or plan sponsor) $5,000,000

Government Retirement Plans in Unallocated Annuities established under Internal Revenue Code § § 401, 403(b), or 457 (limit is per participant) $100,000

This protection becomes effective at the time of entry of a Court order of liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim.

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

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

9. WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT IT'S POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

   Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be covered under the Act.

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

10. WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

    Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently, will generally not discuss the subject of a guaranty act with clients.

11. WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

    You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

CONCLUSION

This brochure has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public in a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in Washington. The Association does not, by this brochure, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

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

SUMMARY OF THE WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERTNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this association is to assure that 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 West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

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

Insurance companies or their agents are required by law to give or send you this notice.

However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

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

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

West Virginia Insurance Commissioner
Consumer Services Division
1124 Smith Street, Rm. 309
P. O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386
Toll Free 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 or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group life, health or annuity insurance contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code § 33-24) and health care corporations (W. Va. Code § 33-25). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

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

The association also does not provide coverage for:

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

A contractual agreement that establishes the member insurer's obligation to provide a book value guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, regardless of the number of policies or contracts, the association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for basic major hospital medical and surgical insurance or major medical insurance, and;
- $100,000 for all other types of accident and sickness insurance than those listed above (disability, long term care, and major medical).

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

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

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

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

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

The basic protections provided by the Association are:

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000.

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

EXCLUSIONS FROM COVERAGE

Persons holding such policies are *not* protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;

- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy of contract);

- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;

- dividends;

- credits given in connection with the administration of a policy by a group contract holder;

- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;

- unallocated annuity contracts (which give rights to group contract holders, not individuals);

- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;

- an obligation that does not arise under the express written terms of the policy or contract;

- Medicare supplement plans.

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

Wyoming Life and Health
Insurance Guaranty Association
P.O. Box 36009
Denver, CO 80236-0009
Phone: (303) 292-5022
Toll Free: (888) 959-4091
Fax: (303) 292-4663
Website: *wyoming.lhiga.com*
Email: *jkelldorf@aol.com*

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.