CommonSpirit Health

$15,000 Plan

Employee Term Life Coverage

Basic and Optional Plans

Dependents Term Life Coverage

Accidental Death and Dismemberment Coverage

Basic and Optional Plans

Prudential

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176
1-800-524-0542

If Prudential fails to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494

FOR FLORIDA RESIDENTS

The benefits of the policy providing your coverage are governed by the law of a state other than Florida.

FOR IDAHO RESIDENTS

If you need the assistance of the governmental agency that regulates the business of insurance, you can contact the Idaho Department of Insurance by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043

1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
(800) 524-0542

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

Notice: This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's laws.

FOR TEXAS RESIDENTS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

Problems with Your Insurance? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517

Philadelphia, PA 19176
1-800-524-0542

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at *http://oci.wi.gov/*, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Prudential first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Prudential primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certificate of Coverage

Prudential certifies that insurance is provided according to the Group Contract(s) for each Insured Employee. Your Booklet's Schedule of Benefits shows the Contract Holder and the Group Contract Number(s).

Insured Employee: You are eligible to become insured under the Group Contract if you are in the Covered Classes of the Booklet's Schedule of Benefits and meet the requirements in the Booklet's Who is Eligible section. The When You Become Insured section of the Booklet states how and when you may become insured for each Coverage. Your insurance will end when the rules in the When Your Insurance Ends section so provide. Your Booklet and this Certificate of Coverage together form your Group Insurance Certificate.

Beneficiary for Employee Death Benefits: See the Booklet's Beneficiary Rules.

Coverages and Amounts: The available Coverages and the amounts of insurance are described in the Booklet.

If you are insured, your Booklet and this Certificate of Coverage form your Group Insurance Certificate. Together they replace any older booklets and certificates issued to you for the Coverages in the Booklet's Schedule of Benefits. All Benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate.

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

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

THIS CERTIFICATE IS NOT MEDICAL COVERAGE. It does NOT provide any type of medical coverage and is not a substitute for medical coverage or disability insurance.

Foreword

We are pleased to present you with this Booklet. It describes the Program of benefits we have arranged for you and what you have to do to be covered for these benefits.

We believe this Program provides worthwhile protection for you and your family.

Please read this Booklet carefully. If you have any questions about the Program, we will be happy to answer them.

IMPORTANT NOTICE: *This Booklet is an important document and should be kept in a safe place. This Booklet and the Certificate of Coverage made a part of this Booklet together form your Group Insurance Certificate.*

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code.* ***Your Access Code is 49038.***

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

Table of Contents

Schedule of Benefits

Covered Classes: The “Covered Classes" are these Employees of the Contract Holder (and its Associated Companies): Employees classified by the Contract Holder as Employees of one of the facilities noted below and at the following locations:.

Program Date: March 1, 2021. This Booklet describes the benefits under the Group Program as of the Program Date.

- This Booklet and the Certificate of Coverage together form your Group Insurance Certificate. The Coverages in this Booklet are insured under a Group Contract issued by Prudential. All benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate. It alone forms the agreement under which payment of insurance is made.

BASIC EMPLOYEE TERM LIFE COVERAGE

BENEFIT AMOUNTS:

Amount For Each Benefit Class:

Benefit Classes	Amount of Insurance
All Employees	$15,000

Amount Limit Due to Age: When you are age 70 or more, your amount of insurance is limited. It is the Limited Percent (for that Age) of the amount for which you would then be insured if there were no limitation. Each Age and the Limited Percent for that Age are shown below.

Age	Limited Percent
70	50
75	30
80 and more	20

The Limited Percent for an Age takes effect on the day you become insured if you are then that Age. Otherwise, each Limited Percent for an Age takes effect on the first March 1 that occurs while you are that Age.

The Delay of Effective Date section does not apply to this Amount Limit Due to Age provision.

Effect of Option to Accelerate Payment of Death Benefits: Your amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits.

OPTIONAL EMPLOYEE TERM LIFE COVERAGE

You may enroll for one of the options below. The option for which you enroll will be recorded by your Employer and reported to Prudential.

BENEFIT AMOUNTS:

Amount For Each Benefit Class:

Benefit Classes	Amount of Insurance
All Employees	Any multiple of $10,000. Maximum Amount: $750,000 minus your amount of insurance under the Basic Employee Term Life Coverage.

The Definitions section explains what “Earnings" means.

Non-medical Limit on Amount of Insurance: There is a limit on the amount for which you may be insured without submitting evidence of insurability. This is called the Non-medical Limit.

If the amount of insurance for your Class and age at any time is more than the Non-medical Limit, you must give evidence of insurability satisfactory to Prudential before the part over the Limit can become effective.

This requirement applies: when you first become insured; when your Class changes; if you request an increase in your Amount of Insurance; or if the amount for your Class is changed by an amendment to the Group Contract. Even if you are insured for an amount over the Limit, you will still have to meet this evidence requirement before any increase in your amount of insurance can become effective. The amount of your insurance will be increased to the amount for your Class and age when Prudential decides the evidence is satisfactory and you meet the Active Work Requirement.

Non-medical Limit: The lesser of (1) 300% of your annual Earnings and (2) $500,000. If the Amount Limit for this Coverage applies at any time to your amount of insurance, that Limit will also apply to the Non-medical Limit as if it were an amount of insurance.

The Delay of Effective Date section does not apply to this Non-medical Limit on Amount of Insurance provision.

Note: The Non-medical Limit does not apply to any amount of insurance for which you were insured under another group contract providing employee term life coverage for Employees of the Employer on the day prior to the Program Date.

Increases and Decreases: You may elect to have your amount of insurance under the Coverage changed. You must do this on a form approved by Prudential and agree to make any required contributions.

If you request an increase, you must give evidence of insurability. The amount of your insurance will be increased when Prudential decides the evidence is satisfactory and you meet the Active Work Requirement.

If you request a decrease, the amount of your insurance will be decreased on the date of your written request.

Amount Limit Due to Age: When you are age 70 or more, your amount of insurance is limited. It is the Limited Percent (for that Age) of the amount for which you would then be insured if there were no limitation. Each Age and the Limited Percent for that Age are shown below.

Age	Limited Percent
70	50
75	30

80 and more	20

The Limited Percent for an Age takes effect on the day you become insured if you are then that Age. Otherwise, each Limited Percent for an Age takes effect on the first March 1 that occurs while you are that Age.

The Delay of Effective Date section does not apply to this Amount Limit Due to Age provision.

Effect of Option to Accelerate Payment of Death Benefits: Your amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits.

OPTIONAL DEPENDENTS TERM LIFE COVERAGE

The amount of insurance is the amount for your Benefit Class. You may enroll your Qualified Dependents for the plan shown below. If you may choose the amount of insurance or if there are options from which to select, the amount for which you enroll will be recorded by your Employer and reported to Prudential. Your Benefit Class is determined by the classification of your dependents and the amount for which you enroll as shown in this table.

Qualified Dependents Classification	**Amount of Insurance**
Your Spouse or Domestic Partner	Any multiple of $10,000. Maximum Amount: $200,000.
Your Children, according to attained age:	
14 days or over but less than 6 months	$ 100
6 months or over	$2,000

Non-medical Limit on Amount of Insurance for Your Spouse or Domestic Partner: There is a limit on the amount for which your Spouse or Domestic Partner may be insured without submitting evidence of insurability. This is called the Non-medical Limit.

If you elect an amount of Dependents Term Life Coverage for your Spouse or Domestic Partner above the Non-medical Limit, you must give evidence of insurability for your Spouse or Domestic Partner satisfactory to Prudential before the part over the Limit can become effective. The amount of your Spouse's or Domestic Partner's insurance will be increased when Prudential decides the evidence is satisfactory and your Spouse or Domestic Partner is not home or hospital confined for medical care or treatment. This requirement applies: when your Spouse or Domestic Partner first becomes insured, or if you elect to have your Spouse's or Domestic Partner's amount of Dependents Term Life Coverage increased.

Non-medical Limit: $50,000. If the Amount Limit for this Coverage applies at any time to your Spouse's or Domestic Partner's amount of insurance, that Limit will also apply to the Non-medical Limit as if it were an amount of insurance.

The Delay of Effective Date section does not apply to this Non-medical Limit on Amount of Insurance for Your Spouse or Domestic Partner provision.

Note: The Non-medical Limit for your Spouse or Domestic Partner does not apply to any amount of insurance for which you were insured under another group contract providing dependents term life coverage for dependents of Employees of the Employer on the day prior to the Program Date.

Increases and Decreases: You may elect to have the amount of insurance on your Spouse or Domestic Partner changed. You must do this on a form approved by Prudential and agree to make any required contributions.

If you request an increase, you must give evidence of insurability for your Spouse or Domestic Partner. The amount of insurance on your Spouse or Domestic Partner will be increased when Prudential decides the evidence is satisfactory and your Spouse or Domestic Partner is not home or hospital confined for medical care or treatment.

If you request a decrease, the amount of insurance on your Spouse or Domestic Partner will be decreased on the date of your written request.

Amount Limit Due to Age: When you are age 70 or more, your Spouse's or Domestic Partner's amount of insurance is limited. It is the Limited Percent (for that Age) of the amount for which your Spouse or Domestic Partner would then be insured if there were no limitation. Each Age and the Limited Percent for that Age are shown below.

Age	Limited Percent
70	50
75	30
80 and more	20

The Limited Percent for an Age takes effect on the day you become insured if you are then that Age. Otherwise, each Limited Percent for an Age takes effect on the first March 1 that occurs while you are that Age.

The Delay of Effective Date section does not apply to this Amount Limit Due to Age provision.

Effect of Option to Accelerate Payment of Death Benefits for your Spouse or Domestic Partner: The amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits with respect to the dependent.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

BENEFIT AMOUNTS UNDER EMPLOYEE INSURANCE:

Amount For Each Benefit Class: An amount equal to the amount for which you are insured under the Basic Employee Term Life Coverage. For this purpose only, that amount will be the amount as determined above, except that if your Basic Employee Term Life Coverage is reduced by any amount paid under the Option to Accelerate Payment of Death Benefits, that reduction will not apply to this Coverage.

ADDITIONAL BENEFITS UNDER EMPLOYEE INSURANCE:

For the purposes of determining benefits under the Coverage, Amount of Insurance does not include any additional amount payable as shown below.

Additional Amount Payable for Loss of Life as a Result of an Accident in an Automobile While Using a Seat Belt: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

Additional Amount Payable for Loss of Life as a Result of an Accident in an Automobile While Using an Air Bag: An amount equal to the lesser of:

(1) 5% of your Amount of Insurance; and

(2) $5,000.

Additional Amount Payable for Return of Remains: An amount equal to the lesser of:

(1) the amount of Return of Remains Expenses; and

(2) $2,500.

Additional Amount Payable for Loss as a Result of Felonious Assault: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

Additional Amount Payable for Bereavement and Trauma Counseling: An amount equal to the lesser of:

(1) the actual cost charged for counseling sessions; and

(2) $100.

This benefit is payable for up to 20 sessions per person.

Additional Amount Payable for Emergency or Disaster Response Team Member Benefit: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

Additional Amount Payable for Home Alteration and Vehicle Modification: An amount equal to the least of:

(1) the actual cost charged for the alteration or modification;

(2) 10% of your Amount of Insurance; and

(3) $10,000.

Additional Monthly Amount Payable for Medical Premium: An amount equal to the lesser of:

(1) 1% of your Amount of Insurance; and

(2) $250.

This benefit will be paid monthly until the first of these occurs:

(1) Your continued membership in your Employer's medical plan ends.

(2) You become covered under any other group medical plan.

(3) The benefit has been paid for 12 consecutive months.

Additional Monthly Amount Payable for Rehabilitation Expense: An amount equal to the lesser of:

(1) 1% of your Amount of Insurance; and

(2) $250.

This benefit will be paid monthly until the first of these occurs:

(1) A Doctor determines that you no longer need rehabilitation.

(2) You fail to furnish any required proof of your continuing need for rehabilitation.

(3) You fail to submit to a medical exam by Doctors named by Prudential, at Prudential's expense, when and as often as Prudential requires.

(4) The benefit has been paid for 12 consecutive months.

Additional Amount Payable for Critical Burns: An amount equal to the lesser of:

(1) 25% of your Amount of Insurance; and

(2) $25,000.

Additional Monthly Amount Payable for Occupational HIV or Hepatitis: A monthly amount equal to the lesser of:

(1) 3% of your Amount of Insurance; and

(2) $1,000.

This benefit will be paid monthly until the first of these occurs:

(1) You recover from Hepatitis if the benefit is being paid for that disease.

(2) The benefit has been paid for 24 consecutive months.

To Whom Payable: The benefits are payable to you. But benefits for your Losses that are unpaid at your death or become payable on account of your death will be paid to your Beneficiary or Beneficiaries. (See Beneficiary Rules.)

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

BENEFIT AMOUNTS UNDER EMPLOYEE INSURANCE:

Amount For Each Benefit Class: An amount equal to the amount for which you are insured under the Optional Employee Term Life Coverage. For this purpose only, that amount will be the amount as determined above, except that if your Optional Employee Term Life Coverage is reduced by any amount paid under the Option to Accelerate Payment of Death Benefits, that reduction will not apply to this Coverage.

ADDITIONAL BENEFITS UNDER EMPLOYEE INSURANCE:

For the purposes of determining benefits under the Coverage, Amount of Insurance does not include any additional amount payable as shown below.

Additional Amount Payable for Loss of Life as a Result of an Accident in an Automobile While Using a Seat Belt: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

Additional Amount Payable for Loss of Life as a Result of an Accident in an Automobile While Using an Air Bag: An amount equal to the lesser of:

(1) 5% of your Amount of Insurance; and

(2) $5,000.

Additional Amount Payable for Tuition Reimbursement for Your Dependent Spouse or Domestic Partner: An amount equal to the least of:

(1) the actual annual tuition charged for the program;

(2) 5% of your Amount of Insurance; and

(3) $5,000.

This benefit is payable for only one year.

Additional Amount Payable for Tuition Reimbursement for Your Dependent Child: An amount equal to the least of:

(1) the actual annual tuition, exclusive of room and board, charged by the School;

(2) 10% of your Amount of Insurance; and

(3) $10,000.

This benefit is payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 25.

Additional Amount Payable for Child Care Expenses for Your Dependent Child: An amount equal to the least of:

(1) the actual cost charged by such Child Care Center per year;

(2) 5% of your Amount of Insurance; and

(3) $5,000.

This benefit is payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 13.

To Whom Payable: The benefits are payable to you with these exceptions:

(1) Benefits for tuition reimbursement for your Spouse or Domestic Partner will be paid to:

  (a) your Spouse or Domestic Partner, if living; or

  (b) your Spouse's or Domestic Partner's estate.

(2) Benefits for child care expenses or tuition reimbursement for your dependent children will be paid to the person or institution appearing to Prudential to have assumed the main support of the children.

(3) Benefits for any other of your Losses that are unpaid at your death or become payable on account of your death will be paid to your Beneficiary or Beneficiaries. (See Beneficiary Rules.)

OTHER INFORMATION

Contract Holder: COMMONSPIRIT HEALTH

Group Contract No.: G-49038-CO

Associated Companies: Associated Companies are employers who are the Contract Holder's subsidiaries or affiliates and are reported to Prudential in writing for inclusion under the Group Contract, provided that Prudential has approved such request.

Cost of Insurance: Insurance under the Coverage(s) listed below is Non-Contributory Insurance.

Basic Employee Term Life Coverage

Basic Accidental Death and Dismemberment Coverage

Insurance under the other Coverage(s) in this Booklet is Contributory Insurance. You will be informed of the amount of your contribution when you enroll. Any contribution due but unpaid at your death will be deducted from the death benefit.

Prudential's Address:

The Prudential Insurance Company of America
80 Livingston Avenue
Roseland, New Jersey 07068

WHEN YOU HAVE A CLAIM

Each time a claim is made, it should be made without delay. Use a claim form, and follow the instructions on the form.

If you do not have a claim form, contact your Employer.

Who is Eligible to Become Insured

FOR EMPLOYEE INSURANCE

You are eligible to become insured for Employee Insurance while:

- You are a full-time or part-time Employee of the Employer; and
- You are in a Covered Class; and
- You have completed the Employment Waiting Period, if any. You may need to work for the Employer for a continuous full-time or part time period before you become eligible for the Coverage. The period must be agreed upon by the Employer and Prudential. Your Employer will inform you of any such Employment Waiting Period for your class.

You are full-time if you are regularly working for the Employer at least the number of hours in the Employer's normal full-time work week for your class, but not less than 30 hours per week. **You are part-time** if you are regularly working for the Employer at least the number of hours in the Employer's normal part-time work week for your class, but not less than 1 hours per week. If you are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

Your class is determined by the Contract Holder. This will be done under its rules, on dates it sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under a Coverage. “Class" means Covered Class, Benefit Class or anything related to work, such as position or Earnings, which affects the insurance available.

This applies if you are an Employee of more than one subsidiary or affiliate of an employer included under the Group Contract: For the insurance, you will be considered an Employee of only one of those subsidiaries or affiliates. Your service with the others will be treated as service with that one.

The rules for obtaining Employee Insurance are in the When You Become Insured section.

FOR DEPENDENTS INSURANCE

You are eligible to become insured for Dependents Insurance while:

- You are eligible for Employee Insurance; and
- You have a Qualified Dependent.

Qualified Dependents:

These are the persons for whom you may obtain Dependents Insurance:

- A person who is your Spouse or Domestic Partner prior to their enrollment for Dependents Insurance.

  Your Spouse means your lawful Spouse.

Your Domestic Partner is a person of the same or opposite sex who satisfies the requirements for being a domestic partner, registered domestic partner or party to a civil union under the law of your jurisdiction of residence.

Either a Spouse or a Domestic Partner may be a Qualified Dependent under the Program at any one time, but not both at the same time.

- Your children from 14 days to 26 years old.

Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, Domestic Partner's children and foster children. A child placed with you for adoption prior to legal adoption is considered your Qualified Dependent from the date of placement for adoption, and is treated as though the child was your newborn child.

Exceptions:

Your Spouse, Domestic Partner or child is not your Qualified Dependent while:

(1) on active duty in the armed forces of any country; or

(2) insured for life coverage under the Group Contract as an Employee; or

(3) the Spouse, Domestic Partner or child continues to have life insurance coverage under the Group Contract under a coverage continuation provision such as the Extended Death Benefit and Waiver of Premiums During Total Disability provision of the Employee Term Life Coverage.

A child will not be considered the Qualified Dependent of more than one Employee. If this would otherwise be the case, the child will be considered the Qualified Dependent of the Employee named in a written agreement of all such Employees filed with the Contract Holder. If there is no written agreement, the child will be considered the Qualified Dependent of:

(1) the Employee who became insured under the Group Contract with respect to the child, while the child was a Qualified Dependent of only that Employee; and otherwise

(2) the Employee who has the longest continuous service with the Employer, based on the Contract Holder's records.

The rules for obtaining Dependents Insurance are in the When You Become Insured section.

When You Become Insured

FOR EMPLOYEE INSURANCE

Your Employee Insurance under a Coverage will begin the first day on which:

- You have enrolled, if the Coverage is Contributory; and
- You are eligible for Employee Insurance; and
- You are in a Covered Class for that insurance; and

- You have met any evidence requirement for Employee Insurance; and
- Your insurance is not being delayed under the Delay of Effective Date section below; and
- That Coverage is part of the Group Contract.

For Contributory Insurance, you must enroll on a form approved by Prudential and agree to pay the required contributions. Your Employer will tell you whether contributions are required and the amount of any contribution when you enroll.

At any time, the benefits for which you are insured are those for your class, unless otherwise stated.

When evidence is required: In any of these situations, you must give evidence of insurability. This requirement will be met when Prudential decides the evidence is satisfactory.

(1) For Contributory Insurance, you enroll more than 31 days after you could first be covered.

(2) You enroll after any of your insurance under the Group Contract ends because you did not pay a required contribution.

(3) You wish to become insured for life insurance and have an individual life insurance contract which you obtained by converting your insurance under a Coverage of the Group Contract.

(4) You have not met a previous evidence requirement to become insured under any Prudential group contract for Employees of the Employer.

FOR DEPENDENTS INSURANCE

Your Dependents Insurance under a Coverage for a person will begin the first day on which all of these conditions are met:

- You have enrolled for the person for Dependents Insurance under the Coverage, if the Coverage is Contributory.
- The person is your Qualified Dependent.
- You are in a Covered Class for that insurance.
- To be insured for a Qualified Dependent under the Optional Dependents Term Life Coverage, you must be insured under the Basic Employee Term Life Coverage of the Group Contract.
- Any evidence requirement for that Qualified Dependent has been met.
- Your insurance for that Qualified Dependent is not being delayed under the Delay of Effective Date section below.
- Dependents Insurance under that Coverage is part of the Group Contract.

For Contributory Insurance, you must enroll your Qualified Dependent on a form approved by Prudential and agree to pay the required contributions. Your Employer will tell you whether contributions are required and the amount of any contribution when you enroll your Qualified Dependent.

At any time, the Dependents Insurance benefits for which you are insured are those for your class, unless otherwise stated.

When evidence is required: In any of these situations, evidence of insurability must be given for a

Qualified Dependent Spouse or Domestic Partner. This requirement will be met when Prudential decides the evidence is satisfactory. Evidence is not required for a Qualified Dependent child.

(1) For Contributory Insurance, you enroll for Dependents Insurance under a Coverage more than 31 days after you are first eligible for Dependents Insurance.

(2) You enroll for Dependents Insurance after any insurance under the Group Contract ends because you did not pay a required contribution.

(3) The Qualified Dependent Spouse or Domestic Partner is a person for whom a previous requirement for evidence of insurability has not been met. The evidence was required for that person to become covered for an insurance, as a dependent or an Employee. That insurance is or was under any Prudential group contract for Employees of the Employer.

Change in Family Status: It is important that you inform the Employer promptly when you first acquire or lose a Qualified Dependent. You should also inform the Employer if your Dependents Insurance status changes from one to another of these categories:

- No Qualified Dependents.
- Qualified Dependent Spouse or Domestic Partner only.
- Qualified Dependent Spouse or Domestic Partner and children.
- Qualified Dependent children only.

If you are insured under a Coverage for one or more children, you need not report additional children. Forms are available for reporting these changes.

Delay of Effective Date

FOR EMPLOYEE INSURANCE

Your Employee Insurance under a Coverage will be delayed if you do not meet the Active Work Requirement on the day your insurance would otherwise begin. Instead, it will begin on the first day you meet the Active Work Requirement and the other requirements for the insurance. The same delay rule will apply to any increase in your insurance that is subject to this section. If you do not meet the Active Work Requirement on the day that an increase would take effect, it will take effect on the day you meet that requirement.

FOR DEPENDENTS TERM LIFE COVERAGE

A Qualified Dependent may be confined for medical care or treatment, at home or elsewhere. If a Qualified Dependent is so confined on the day that your Dependents Insurance under a Coverage for that Qualified Dependent, or any increase in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or increase will take effect upon the Qualified Dependent's final medical release from all such confinement. The other requirements for the insurance or increase must also be met.

Newborn Child Exception: This section does not apply to a child of yours if the child is born to you and either:

(1) is your first Qualified Dependent; or

(2) becomes a Qualified Dependent while you are insured for Dependents Insurance under that Coverage for any other Qualified Dependent.

Also, this section does not apply to any age increase in the amount of insurance for a child under the Dependents Term Life Coverage.

Basic Employee Term Life Coverage

FOR YOU ONLY

A. DEATH BENEFIT WHILE A COVERED PERSON.

If you die while a Covered Person, the amount of your Employee Term Life Insurance under this Coverage is payable when Prudential receives written proof of death.

B. DEATH BENEFIT DURING CONVERSION PERIOD.

A death benefit is payable under this Section B if you die:

(1) within 31 days after you cease to be a Covered Person; and

(2) while entitled (under Section C) to convert your Employee Term Life Insurance under this Coverage to an individual contract.

The amount of the benefit is equal to the amount of Employee Term Life Insurance under this Coverage you were entitled to convert. It is payable even if you did not apply for conversion. It is payable when Prudential receives written proof of death.

C. CONVERSION PRIVILEGE.

If you cease to be insured for the Employee Term Life Insurance of the Group Contract for one of the reasons stated below, you may convert all or part of your insurance under this Coverage, which then ends, to an individual life insurance contract. Evidence of insurability is not required. The reasons are:

(1) Your employment ends or you transfer out of a Covered Class.

(2) All term life insurance of the Group Contract for your class ends by amendment or otherwise. But, on the date it ends, you must have been insured for five years for that insurance (or for that insurance and any Prudential rider or group contract replaced by that insurance).

Any such conversion is subject to the rest of this Section C.

Availability: You must apply for the individual contract and pay the first premium by the later of:

(1) the thirty-first day after you cease to be insured for the Employee Term Life Insurance; and

(2) the fifteenth day after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the ninety-second day after you cease to be insured for the Employee Term Life Insurance.

Individual Contract Rules: The individual contract must conform to the following:

Amount: Not more than your Employee Term Life Insurance under this Coverage when your insurance ends. But, if it ends because all term life insurance of the Group Contract for your class

ends, the total amount of individual insurance which you may get in place of all your life insurance then ending under the Group Contract will not exceed the lesser of the following:

(1) The total amount of all your life insurance then ending under the Group Contract reduced by the amount of group life insurance from any carrier for which you are or become eligible within the next 31 days.

(2) $10,000.

Form: Any form of a life insurance contract that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

This does not include term insurance or a contract with disability or supplementary benefits.

Premium: Based on Prudential's rate as it applies to the form and amount, and to your class of risk and age at the time.

Effective Date: The end of the 31 day period after you cease to be insured for the Employee Term Life Insurance.

Any death benefit provided under a section of this Coverage is payable according to that section and the Beneficiary and Mode of Settlement Rules.

Optional Employee Term Life Coverage

FOR YOU ONLY

A. DEATH BENEFIT WHILE A COVERED PERSON.

If you die while a Covered Person, the amount of your Employee Term Life Insurance under this Coverage is payable when Prudential receives written proof of death. But, all or part of the death benefit is not payable if it is excluded under Section E.

B. DEATH BENEFIT DURING CONVERSION PERIOD.

A death benefit is payable under this Section B if you die:

(1) within 31 days after you cease to be a Covered Person; and

(2) while entitled (under Section D) to convert your Employee Term Life Insurance under this Coverage to an individual contract.

The amount of the benefit is equal to the amount of Employee Term Life Insurance under this Coverage you were entitled to convert. It is payable even if you did not apply for conversion. It is payable when Prudential receives written proof of death. But, all or part of the death benefit is not payable if it is excluded under Section E.

C. EXTENDED DEATH BENEFIT AND WAIVER OF PREMIUMS DURING TOTAL DISABILITY.

If you meet the conditions below, your death benefit protection will be extended while you are Totally Disabled, and from the date Prudential receives proof as described below, premiums for your Employee Term Life Insurance under this Coverage will be waived while your death benefit protection is extended. The “Extended Death Benefit" is the benefit described in this Section C.

The conditions referred to above are:

(1) You become Totally Disabled while you are a Covered Person.

(2) You are less than age 60 when your Total Disability starts.

Total Disability: You are “Totally Disabled" when:

(1) You are not working at any job for wage or profit; and

(2) Due to Sickness, Injury or both, you are not able to perform for wage or profit, the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience.

The extension ends one year after your Total Disability started, unless, within that year, you give Prudential written proof that:

(1) You have met the above conditions; and

(2) You are still Totally Disabled; and

(3) Your Total Disability has continued for at least 6 months.

Prudential will then further extend your death benefit protection for successive one year periods. The first of these periods will start on the date Prudential receives this proof. After that first period, you must give written proof when and as required by Prudential once each year that your Total Disability continues.

If you die while your death benefit protection is being extended, the Extended Death Benefit is payable when Prudential receives written proof that:

(1) Your Total Disability continued until your death; and

(2) All of the above conditions have been met.

But, all or part of the death benefit is not payable if it is excluded under Section E.

If you die within one year after your Total Disability started and before you give Prudential proof of Total Disability, written notice of your death must be given to Prudential within one year after your death.

Your extension protection ends if and when:

(1) Your Total Disability ends; or

(2) You reach age 65; or

(3) You fail to furnish any required proof that your Total Disability continues; or

(4) You fail to submit to a medical exam by Doctors named by Prudential when and as often as Prudential requires. After two full years of this protection, Prudential will not require an exam more than once a year.

If your extension protection ends after you have given the first proof of continued Total Disability, you have the same rights and benefits under Sections B and D as if you ceased to be a member of the Covered Classes for the insurance. But this does not apply if you become a Covered Person within 31 days after this protection ends.

Amount of Extended Death Benefit: This amount is determined as if you had remained a Covered Person until death. But it is reduced by any amount payable under Sections A or B above or any Prudential group life insurance that replaces this Coverage for a class of Employees.

Effect of Conversion: An individual contract issued under Section D will be in place of all rights under this Section C. But if you have met all the requirements of this Section C, you can obtain these rights in exchange for all benefits of the individual contract. Premiums paid under the individual contract will be refunded. Your choice of Beneficiary in the individual contract, if different than for this Coverage, will be considered notice of change of Beneficiary for any claim under this Section C.

D. CONVERSION PRIVILEGE.

If you cease to be insured for the Employee Term Life Insurance of the Group Contract for one of the reasons stated below, you may convert all or part of your insurance under this Coverage, which then ends, to an individual life insurance contract. Evidence of insurability is not required. The reasons are:

(1) Your employment ends or you transfer out of a Covered Class.

(2) All term life insurance of the Group Contract for your class ends by amendment or otherwise. But, on the date it ends, you must have been insured for five years for that insurance (or for that insurance and any Prudential rider or group contract replaced by that insurance).

Any such conversion is subject to the rest of this Section D.

Availability: You must apply for the individual contract and pay the first premium by the later of:

(1) the thirty-first day after you cease to be insured for the Employee Term Life Insurance; and

(2) the fifteenth day after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the ninety-second day after you cease to be insured for the Employee Term Life Insurance.

Individual Contract Rules: The individual contract must conform to the following:

Amount: Not more than your Employee Term Life Insurance under this Coverage when your insurance ends. But, if it ends because all term life insurance of the Group Contract for your class ends, the total amount of individual insurance which you may get in place of all your life insurance then ending under the Group Contract will not exceed the lesser of the following:

(1) The total amount of all your life insurance then ending under the Group Contract reduced by the amount of group life insurance from any carrier for which you are or become eligible within the next 31 days.

(2) $10,000.

Form: Any form of a life insurance contract that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

This does not include term insurance or a contract with disability or supplementary benefits.

Premium: Based on Prudential's rate as it applies to the form and amount, and to your class of risk and age at the time.

Effective Date: The end of the 31 day period after you cease to be insured for the Employee Term Life Insurance.

E. SUICIDE EXCLUSION.

If your death results from or is caused by suicide, while sane or insane:

(1) A death benefit is not payable if you die within one year of the date you became a Covered Person. But, Prudential will refund any premiums paid for your Employee Term Life Insurance under this Coverage.

(2) The amount of any increase in your death benefit is not payable if you die within one year of the date of the increase. But, Prudential will refund any premiums paid for that increase.

Any death benefit provided under a section of this Coverage is payable according to that section and the Beneficiary and Mode of Settlement Rules.

Option to Accelerate Payment of Death Benefits

The following is added to the Employee Term Life Coverage provision:

Definitions

- Terminally Ill Employee: An employee whose life expectancy is 12 months or less.
- Terminal Illness Proceeds: The amount of Employee Term Life Insurance that you may elect to place under this option. The Terminal Illness Proceeds are equal to 50% of the amount in force on your life on the date Prudential receives the proof that you are a Terminally Ill Employee, but not more than $100,000. However, the Terminal Illness Proceeds may be reduced if, within 12 months after the date Prudential receives such proof, a reduction on account of age would have applied to the amount of your Employee Term Life Insurance. In that case, the amount of the Terminal Illness Proceeds may not exceed the amount of such Insurance after applying the reduction.

Option: If you become a Terminally Ill Employee while insured under the Employee Term Life Insurance provision or while your death benefit protection is being extended under the Employee Term Life Coverage provision, you may elect to have the Terminal Illness Proceeds placed under this option. That election is subject to the conditions set forth below.

Payment of Terminal Illness Proceeds: If you elect this option, Prudential will pay the Terminal Illness Proceeds you place under this option in one sum when it receives proof that you are a Terminally Ill Employee.

If you do not want the Terminal Illness Proceeds in one sum, you may elect to have them paid in 12 equal monthly installments. The first monthly payment will be due when Prudential receives proof that you are a Terminally Ill Employee. The other payments are due on the same day of each later month.

To Whom Payable: The benefits under this provision are payable to you.

Amount Due But Unpaid at Your Death: If you elect monthly installments and you die before all payments have been made, Prudential will pay your Beneficiary or Beneficiaries determined under the Beneficiary Rules in one sum. That sum will be the total of the payments that remain.

Conditions: Your right to be paid under this option is subject to these terms:

(1) You must choose this option in writing in a form that satisfies Prudential.

(2) You must furnish proof that satisfies Prudential that your life expectancy is 12 months or less, including certification by a Doctor.

(3) Your Employee Term Life Insurance must not be assigned.

(4) Terminal Illness Proceeds will be made available to you on a voluntary basis only. Therefore:

  (a) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit.

(b) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this benefit.

Effect on Insurance: This benefit is in lieu of the benefits that would have been paid on your death with respect to the Terminal Illness Proceeds. When you elect this option, the total amount of Employee Term Life Insurance otherwise payable on your death, including any amount under an extended death benefit, will be reduced by the Terminal Illness Proceeds. Also, any amount you could otherwise have converted to an individual contract will be reduced by the Terminal Illness Proceeds.

Right to Elect Term Life Coverage under the Portability Plan

This right applies to the Optional Employee Term Life Coverage under the Group Contract.

It describes when and how you may become covered for similar coverage under the Portability Plan when your Optional Employee Term Life Coverage under the Group Contract ends. The terms and conditions of the Portability Plan will not be the same as those under this Group Contract. The amount of insurance available under the Portability Plan may not be the same as the amount under this Group Contract.

RIGHT TO APPLY FOR COVERAGE UNDER THE PORTABILITY PLAN

A right under this section is subject to the rest of these provisions.

You will have the right to apply for term life coverage under the Portability Plan if you meet all of these tests:

(1) Your Optional Employee Term Life Coverage ends for any reason other than:

  (a) your failure to pay, when due, any contribution required for it; or

  (b) the end of the Coverage for all Employees when such Coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.

(2) You meet the Active Work Requirement on the day your insurance ends.

(3) You are less than age 80.

(4) Your Amount of Insurance is at least $20,000 under the Optional Employee Term Life Coverage on the day your insurance ends.

PORTABILITY APPLICATION PERIOD

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. Evidence of insurability is not required to become insured under the Portability Plan. But, if you submit evidence and Prudential decides the evidence is satisfactory, you will pay lower premium rates.

The Portability Application Period is the 31 day period after your Optional Employee Term Life Coverage ends. But, if you have the right to convert your insurance under the Optional Employee Term Life Coverage to an individual contract, it is the longer of:

(1) the 31 day period after your Coverage ends; and

(2) the number of days during which you have the right to convert your insurance under the Coverage to an individual life insurance contract as shown in the Coverage.

EFFECT OF CONVERSION PRIVILEGE

The right to elect coverage under the Portability Plan is provided in lieu of the conversion privilege described in the Optional Employee Term Life Coverage, except as follows:

(1) You may convert your amount of insurance under the Optional Employee Term Life Coverage in excess of the maximum for term life coverage under the Portability Plan. This maximum is the lesser of 5 times your annual Earnings and $1,000,000.

(2) You may convert your insurance if you elected coverage under the Portability Plan, but Prudential decided that your evidence of insurability was not satisfactory.

If you elect to convert all of your insurance under the Optional Employee Term Life Coverage to an individual contract, you may not elect to apply for coverage under the Portability Plan.

If, during the Portability Application Period, you apply for coverage under the Portability Plan and then elect to convert all of your insurance under the Optional Employee Term Life Coverage to an individual contract, your coverage under the Portability Plan will not become effective.

The right to elect coverage under the Portability Plan does not affect your coverage under the Death Benefit During Conversion Period provision of the Optional Employee Term Life Coverage.

TERMS AND CONDITIONS OF THE PORTABILITY PLAN

The form, amount, first premium, and effective date will be as stated below.

Form and Amount: The form of term life coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as the Optional Employee Term Life Coverage under the Group Contract.

Amount: Not more than your amount of insurance under the Optional Employee Term Life Coverage when your insurance ends, but not less than $20,000.

The maximum amount of term life insurance under the Portability Plan is the lesser of 5 times your annual Earnings and $1,000,000.

First Premium: The first premium is due to Prudential within 31 days of the date the first bill is issued.

Effective Date: The day after the Portability Application Period ends.

Optional Dependents Term Life Coverage

FOR YOUR DEPENDENTS ONLY

A. DEATH BENEFIT WHILE A COVERED PERSON.

If a dependent dies while a Covered Person, the amount of insurance on that dependent under this Coverage is payable when Prudential receives written proof of death. But, all or part of the death benefit is not payable if it is excluded under Section E.

B. DEATH BENEFIT DURING A CONVERSION PERIOD.

A death benefit is payable under this Section B if a dependent dies:

(1) within 31 days after ceasing to be a Covered Person; and

(2) while entitled (under Section D) to a conversion of the insurance under this Coverage to an individual contract.

The amount of the benefit is equal to the amount of Dependents Term Life Coverage which could have been converted. It is payable even if conversion was not applied for. It is payable when Prudential receives written proof of death. But, all or part of the death benefit is not payable if it is excluded under Section E.

C. EXTENDED DEATH BENEFIT AND WAIVER OF PREMIUMS DURING EMPLOYEE'S TOTAL DISABILITY.

A death benefit is payable under this Section C if a dependent dies:

(1) while you have extension protection during Total Disability under the Employee Term Life Coverage of the Group Contract;

(2) after ceasing to be a Covered Person because of your Total Disability; and

(3) while the dependent, except for ceasing to be a Covered Person because of your Total Disability, would still be a Covered Person.

Amount of Extended Death Benefit: The benefit payable will be determined as if you continued to be insured for the Dependents Term Life Coverage of the Group Contract with respect to the dependent. No benefit is payable under this Section C if any benefit is payable under Section B.

Waiver of Premiums: From the date Prudential receives proof of your Total Disability, as described in the Employee Term Life Coverage of the Group Contract, premiums for your Dependents Term Life Coverage will be waived while your death benefit protection is extended.

Effect of Conversion: An individual contract issued under Section D will be in place of all rights under this Section C. But, if all the requirements of this Section C have been met, these rights can be obtained in exchange for all benefits of the individual contract. Premiums paid under the individual contract will be refunded.

D. CONVERSION PRIVILEGE.

This privilege applies if you cease to be insured for the Dependents Term Life Coverage of the Group Contract with respect to a dependent. That dependent may have your insurance on the dependent under this Coverage, which then ends, converted to an individual life insurance contract. Evidence of insurability is not required. However, conversion is not available if the insurance ends for one of these reasons:

(1) You fail to make any required contribution for insurance under the Group Contract.

(2) All Dependents Term Life Coverage of the Group Contract for your class ends by amendment or otherwise. This (2) does not apply if, on the date it ends, you have been insured with respect to the dependent for five years for that insurance (or for that insurance and any Prudential rider or group contract replaced by that insurance).

Any such conversion is subject to the rest of this Section D.

Availability: The individual contract must be applied for and the first premium must be paid by the later of:

(1) the thirty-first day after you cease to be insured for Dependents Term Life Coverage with respect to the dependent; and

(2) the fifteenth day after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the ninety-second day after you cease to be insured for Dependents Term Life Coverage with respect to the dependent.

Individual Contract Rules: The individual contract must conform to the following:

Amount: Not more than the amount of Dependents Term Life Coverage on the dependent ending under this Coverage. But, if it ends because all the Dependents Term Life Coverage of the Group Contract for your class ends, the total amount of individual insurance which may be obtained in place of all the Dependents Term Life Coverage on the dependent then ending under the Group Contract will not exceed the lesser of the following:

(1) The total amount of all your Dependents Term Life Coverage on the dependent then ending under the Group Contract reduced by the amount of group life insurance from any carrier for which you are or become eligible with respect to the dependent within the next 31 days.

(2) $10,000.

Form: Any form of a life insurance contract that:

(1) conforms to Title Vll of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

This does not include term insurance or a contract with disability or supplementary benefits.

Premium: Based on Prudential's rate as it applies to the form and amount, and to the dependent's class of risk and age at the time.

Effective Date: The end of the 31 day period after you cease to be insured for Dependents Term Life Coverage with respect to the dependent.

E. SUICIDE EXCLUSION.

If a dependent's death results from or is caused by suicide, while sane or insane:

(1) A death benefit is not payable if the dependent dies within one year of the date the dependent became a Covered Person. But, Prudential will refund any premiums paid for the Dependents Term Life Coverage on that dependent.

(2) The amount of any increase in the death benefit with respect to the dependent is not payable if the dependent dies within one year of the date of the increase. But, Prudential will refund any premiums paid for that increase.

Any death benefit provided under a section of this Coverage is payable to you. If you are not living at the death of a dependent*, the death benefit is payable to the dependent's estate or, at Prudential's option, to any one or more of these surviving relatives of the dependent: wife; husband; Domestic Partner, mother; father; children; brothers; sisters.

*If you and a dependent die in the same event and it cannot be determined who died first, the insurance will be payable as if that dependent died before you.

Option to Accelerate Payment of Death Benefits

FOR YOUR DEPENDENT SPOUSE OR DOMESTIC PARTNER

The following is added to the Dependents Term Life Coverage provision.

Definitions

- Terminally Ill Dependent: A dependent Spouse or Domestic Partner whose life expectancy is 12 months or less.
- Terminal Illness Proceeds: The amount of Dependents Term Life Insurance that you may elect to place under this option. You may elect any amount up to 50% of the amount in force on your dependent's life on the date Prudential receives the proof that such dependent is a Terminally Ill Dependent, but not more than $100,000. However, the Terminal Illness Proceeds may be reduced if, within 12 months after the date Prudential receives such proof, a reduction on account of age would have applied to the amount of your Dependents Term Life Insurance for that dependent. In that case, the amount of the Terminal Illness Proceeds may not exceed the amount of such Insurance after applying the reduction.

Option: If your dependent becomes a Terminally Ill Dependent while you are insured for that dependent under the Dependents Term Life Insurance provision or while the dependent's death benefit protection is being extended under the Dependents Term Life Insurance provision, you may elect to have the Terminal Illness Proceeds placed under this option. That election is subject to the conditions set forth below.

Payment of Terminal Illness Proceeds: If you elect this option, Prudential will pay the Terminal Illness Proceeds you place under this option in one sum when it receives proof that your dependent is a Terminally Ill Dependent.

If you do not want the Terminal Illness Proceeds in one sum, you may elect to have them paid in 12 equal monthly installments. The first monthly payment will be due when Prudential receives proof that your dependent is a Terminally Ill Dependent. The other payments are due on the same day of each later month.

To Whom Payable: The benefits under this provision are payable to you.

Amount Due But Unpaid at Your Dependent's Death: If you elect monthly installments and your Terminally Ill Dependent dies before all payments have been made, Prudential will pay you in one sum. That sum will be the total of the payments that remain.

Amount Due But Unpaid at Your Death: If you elect monthly installments and you die before all payments have been made, Prudential will pay in one sum an amount equal to the total of the payments that remain. Payment will be made to your Spouse or Domestic Partner if living, otherwise to your estate.

Conditions: Your right to be paid under this option is subject to these terms:

(1) You must choose this option in writing in a form that satisfies Prudential.

(2) You must furnish proof that satisfies Prudential that your dependent's life expectancy is 12 months or less, including certification by a Doctor.

(3) Your Dependents Term Life Insurance must not be assigned.

(4) Terminal Illness Proceeds will be made available to you on a voluntary basis only. Therefore:

(a) If you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit.

(b) If you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement, you are not eligible for this benefit.

Effect on Insurance: This benefit is in lieu of the benefits that would have been paid on your dependent's death with respect to the Terminal Illness Proceeds. When you elect this option, the total amount of Dependents Term Life Insurance otherwise payable on your dependent's death, including any amount under an extended death benefit, will be reduced by the Terminal Illness Proceeds. Also, any amount your dependent could otherwise have converted to an individual contract will be reduced by the Terminal Illness Proceeds.

Right to Elect Dependents Term Life Coverage under the Portability Plan

This right applies to the Optional Dependents Term Life Coverage under the Group Contract.

It describes when and how your Qualified Dependents may become covered for similar coverage under the Portability Plan when your Optional Dependents Term Life Coverage under the Group Contract ends. The terms and conditions of the Portability Plan will not be the same as those under this Group Contract. The amount of insurance available under the Portability Plan may not be the same as the amount under this Group Contract.

RIGHT TO APPLY FOR COVERAGE UNDER THE PORTABILITY PLAN

A right under this section is subject to the rest of these provisions.

You will have the right to apply for dependents term life coverage under the Portability Plan for a Qualified Dependent if all of these tests are met:

(1) The Optional Dependents Term Life Coverage on the dependent ends because your Optional Employee Term Life Coverage ends for any reason other than:

  (a) your failure to pay, when due, any contribution required for it; or

  (b) the end of your employment on account of your retirement; or

  (c) the end of the Optional Employee Term Life Coverage for all Employees when such Coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.

(2) You apply and become covered for term life coverage under the Portability Plan.

(3) With respect to a dependent Spouse or Domestic Partner, that Spouse or Domestic Partner is less than age 80.

(4) With respect to a dependent child, that child is less than age 26.

(5) The dependent is covered for Optional Dependents Term Life Coverage on the day your Optional Employee Term Life Coverage ends.

(6) The dependent is not confined for medical care or treatment, at home or elsewhere on the day your Optional Employee Term Life Coverage ends.

If you die, your Spouse or Domestic Partner will have the right to apply for term life coverage under the Portability Plan if that Spouse or Domestic Partner meets all of the tests in (3), (5) and (6) above.

If you die, your Spouse or Domestic Partner will also have the right to apply for dependents term life coverage under the Portability Plan for a Qualified Dependent child if:

(1) that Spouse or Domestic Partner applies and becomes covered under the Portability Plan; and

(2) that child meets all of the tests in (4), (5) and (6) above.

If you divorce or your Domestic Partner ceases to be a Qualified Dependent, your Spouse or Domestic Partner will have the right to apply for term life coverage under the Portability Plan if:

(1) the Optional Dependents Term Life Coverage on your Spouse or Domestic Partner ends due to divorce or your Domestic Partner ceasing to be a Qualified Dependent; and

(2) that Spouse or Domestic Partner is less than age 80; and

(3) that Spouse or Domestic Partner is not confined for medical care or treatment, at home or elsewhere on the day the Optional Dependents Term Life Coverage on that Spouse or Domestic Partner ends.

PORTABILITY APPLICATION PERIOD

You have the right to apply for dependents term life coverage under the Portability Plan for your dependents during the Portability Application Period. In the case of your death or divorce or your Domestic Partner ceasing to be a Qualified Dependent, your Spouse or Domestic Partner has the right to apply for coverage under the Portability Plan during the Portability Application Period. Evidence of insurability is not required for a dependent to become insured under the Portability Plan. But, if evidence of insurability is submitted for your Spouse or Domestic Partner and Prudential decides the evidence is satisfactory, you or, in the case of your death or divorce or your Domestic Partner ceasing to be a Qualified Dependent, your Spouse or Domestic Partner will pay lower premium rates for your Spouse's or Domestic Partner's coverage.

The Portability Application Period is the longer of:

(1) the 31 day period after your Optional Dependents Term Life Coverage ends; and

(2) either:

  (a) the number of days during which you have the right to convert your insurance under the Optional Employee Term Life Coverage to an individual life insurance contract as shown in that Coverage; or

  (b) in the case of your death or divorce or your Domestic Partner ceasing to be a Qualified Dependent, the number of days during which your Spouse or Domestic Partner has the right to convert the insurance under the Optional Dependents Term Life Coverage to an individual life insurance contract as shown in that Coverage.

EFFECT OF CONVERSION PRIVILEGE

The right to elect coverage under the Portability Plan is provided in lieu of the conversion privilege described in the Optional Dependents Term Life Coverage, except as follows:

(1) If a dependent's amount of insurance under the Optional Dependents Term Life Coverage exceeds the lesser of 5 times your annual Earnings and $1,000,000, the dependent may convert the excess amount.

(2) A Spouse or Domestic Partner may convert the Dependents Insurance under the Coverage if coverage was elected under the Portability Plan, but Prudential decided that the evidence of insurability for that Spouse or Domestic Partner was not satisfactory.

If a dependent elects to convert all of the insurance under the Optional Dependents Term Life Coverage to an individual contract, you or, in the case of your death or divorce or your Domestic

Partner ceasing to be a Qualified Dependent, your Spouse or Domestic Partner may not elect to apply for coverage under the Portability Plan for that dependent.

If, during the Portability Application Period, you or, in the case of your death or divorce or your Domestic Partner ceasing to be a Qualified Dependent, your Spouse or Domestic Partner applies for coverage under the Portability Plan for a dependent and that dependent then elects to convert all of the insurance under the Optional Dependents Term Life Coverage to an individual contract, that dependent's coverage under the Portability Plan will not become effective.

The right to elect coverage under the Portability Plan does not affect a dependent's coverage under the Death Benefit During a Conversion Period provision of the Optional Dependents Term Life Coverage.

TERMS AND CONDITIONS OF THE PORTABILITY PLAN

The form, amount, first premium, and effective date will be as stated below.

Form and Amount: The form of dependents term life coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as those under the Group Contract.

Amount: Not more than the amount of insurance on the dependent under the Optional Dependents Term Life Coverage when that insurance ends.

For each dependent, the maximum amount of dependents term life insurance under the Portability Plan is the lesser of 5 times your annual Earnings and $1,000,000.

First Premium: The first premium is due to Prudential within 31 days of the date the first bill is issued.

Effective Date: The day after the Portability Application Period ends.

Basic Accidental Death and Dismemberment Coverage

FOR YOU ONLY

This Coverage pays benefits for accidental Loss which results from a Covered Accident.

Loss means your:

(1) loss of life.

(2) total and permanent loss of sight.

(3) total and permanent loss of speech.

(4) total and permanent loss of hearing.

(5) loss of hand or foot by severance at or above the wrist or ankle.

(6) loss of thumb and index finger of the same hand by severance at or above the point at which they are attached to the hand.

(7) loss due to Quadriplegia, Paraplegia, Hemiplegia or Uniplegia.

(8) loss due to Coma.

Covered Accident means an accident which happens to you while you are engaged in or the victim of a Hazard described in the Hazard provisions.

A. BENEFITS.

Benefits for accidental Loss are payable only if all of these conditions are met:

(1) You sustain an accidental bodily Injury while a Covered Person.

(2) The Loss results directly from that Injury and from no other cause.

(3) You suffer the Loss within 365 days after the Covered Accident. But, if the Loss is due to Coma, that Loss:

  (a) begins within 365 days after the Covered Accident;

  (b) continues for 31 consecutive days; and

  (c) is total, continuous and permanent at the end of that 31-day period.
  Any benefit for a Loss due to Coma will not begin until the end of the 31-day period in (b) above.

(4) The Loss is due to a Covered Accident.

For the purposes of the Coverage:

(1) Exposure to the elements will be considered an accidental bodily Injury.

(2) It will be presumed that you have suffered a Loss of life if your body has not been found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.

Not all such Losses are covered. See Losses Not Covered below.

Benefit Amount Payable: The amount payable depends on the type of Loss as shown below. All benefits are subject to the Limits below.

Loss of or by Reason of:	Percent of the Person's Amount of Insurance
Life	100
Sight of Both Eyes	100
Speech and Hearing in Both Ears	100
Both Hands	100
Both Feet	100
One Hand and One Foot	100
One Hand and Sight of One Eye	100
One Foot and Sight of One Eye	100
Quadriplegia	100
Paraplegia	75
Sight of One Eye	50
Speech	50
Hearing in Both Ears	50
One Hand	50
One Foot	50
Hemiplegia	50
Uniplegia	25
Thumb and Index Finger of the Same Hand	25
Coma	1% per month, up to 100 months

Limits Per Covered Accident:

(1) No more than your Amount of Insurance under this Coverage at the time of the Covered Accident will be paid for all Losses resulting from Injuries sustained in that accident.

(2) Benefits for accidental Loss which results from a Covered Accident will be paid only once, even if more than one Hazard provision applies.

B. LOSSES NOT COVERED.

A Loss is not covered if it results from any of these:

(1) Suicide or attempted suicide, while sane.

(2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

(3) Sickness, whether the Loss results directly or indirectly from the Sickness.

(4) Medical or surgical treatment of Sickness, whether the Loss results directly or indirectly from the treatment.

(5) Any bacterial or viral infection. But, this does not include:

(a) a pyogenic infection resulting from an accidental cut or wound; or

(b) a bacterial infection resulting from accidental ingestion of a contaminated substance.

(6) Taking part in any insurrection.

(7) War, or any act of war, except as provided by the War Risk Hazard provision. War means declared or undeclared war, and includes resistance to armed aggression.

(8) An accident that occurs while you are serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training.

(9) Commission of or attempt to commit an assault or a felony.

(10) Travel or flight in any vehicle used for aerial navigation, except as provided by any Hazard provision, if any of these apply:

(a) you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.

(b) you are performing as a pilot or a crew member of any aircraft.

(c) you are riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the Contract Holder or any of its subsidiaries or affiliates.

This includes getting in, out, on or off any such vehicle.

(11) Being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a Doctor.

The Claim Rules and the “To Whom Payable" part of the Schedule of Benefits apply to the payment of the benefits.

Hazard Provisions under Basic Accidental Death and Dismemberment Coverage

FOR YOU ONLY

These provisions describe the Hazards under the Coverage.

Hazard means any of the risks described below.

(1) **24 Hour All Risk Hazard:**

You are engaged in or the victim of a risk.

(2) **War Risk Hazard:**

During an Authorized Business Trip for your Employer, you are traveling in a Designated War Risk Area. This applies only if the Contract Holder gives Prudential the required information defined below at each of the following times:

(a) whenever conditions of war change in a Designated War Risk Area;

(b) whenever Prudential asks for it.

The following required information must be provided for each Employee who is covered for this risk:

(a) the Employee's name;

(b) the Employee's Amount of Insurance under the Coverage;

(c) the Designated War Risk Area to which the Employee plans to travel; and

(d) the duration of travel in a Designated War Risk Area.

Changes in War Risk Hazard: Prudential has the right to change: (1) the Designated War Risk Area(s) shown below if the conditions of war in those areas change; and (2) premium rates for this risk. Prudential will notify the Contract Holder in writing at least 10 days before a change in the premium rates is made.

Designated War Risk Area(s): All areas **except** those shown below:

United States of America	Afghanistan
Canada	Jammu & Kashmir
Algeria	Philippines
Angola	Nepal
Burundi	Sri Lanka (North & Eastern Provinces only)
Cote D'Ivoire	Iran
Dem. Republic of Congo	Iraq
Guinea	Israel
Ivory Coast	Kuwait
Liberia	Saudi Arabia
Zimbabwe	Syria
Somalia	Yemen
Sudan	Chechenia
Colombia	Uzbekistan
Haiti	

End of War Risk Hazard: The Contract Holder may write to Prudential, in advance, to ask that this Hazard be ended. Then this Hazard will end on the date requested. Prudential may end this Hazard at any time. But, written notice of its intent to do so must be given to the Contract Holder at least 10 days in advance. The end of this Hazard will not affect a claim incurred before the date the Hazard ends.

Additional Benefits under Basic Accidental Death and Dismemberment Coverage

FOR YOU ONLY

A. ADDITIONAL BENEFITS RELATED TO LOSSES.

If a benefit is payable under the Coverage for a Loss an additional benefit may be payable. Any such benefit is payable in addition to any other benefit payable under this Coverage. The additional amount payable for each additional benefit and any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

(1) **Additional Benefit for Loss of Life as a Result of an Accident in an Automobile While Using a Seat Belt:**

This additional benefit for your Loss of life only applies if you sustain an accidental bodily Injury resulting in the Loss while:

(a) you are a driver or passenger in an Automobile;

(b) you are wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer; and

(c) the actual use of a Seat Belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

Losses Not Covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

(2) **Additional Benefit for Loss of Life as a Result of an Accident in an Automobile While Using an Air Bag:**

This additional benefit for your Loss of life only applies if this test is met.

You sustain an accidental bodily Injury resulting in the Loss while:

(a) you are a driver or passenger in an Automobile;

(b) you are wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer;

(c) the actual use of a Seat Belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s);

(d) the Automobile is equipped with a factory-installed Air Bag; and

(e) a properly functioning Air Bag was deployed for the seat that you occupied.

Losses Not Covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or being engaged in an illegal occupation.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 5% of your Amount of Insurance; and

(2) $5,000.

(4) **Additional Benefit for Loss as a Result of Felonious Assault:**

This additional benefit only applies if you suffer a Loss that is the result of a Felonious Assault.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

(5) **Additional Benefit for Bereavement and Trauma Counseling:**

This additional benefit only applies if you require Bereavement and Trauma Counseling Sessions because you suffer a Loss. It is payable for Bereavement and Trauma Counseling Sessions that are held within one year after the date of the accident causing the Loss.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) the actual cost charged for counseling sessions; and

(2) $100.

This benefit is payable for up to 20 sessions.

(7) **Additional Benefit for Home Alteration and Vehicle Modification Expenses:**

This additional benefit for Home Alteration and Vehicle Modification Expenses only applies once during your lifetime. It applies if you suffer a Loss that requires home alteration or vehicle modification.

Additional Amount Payable under this Additional Benefit: An amount equal to the least of:

(1) the actual cost charged for the alteration or modification;

(2) 10% of your Amount of Insurance; and

(3) $10,000.

(8) **Additional Benefit for Monthly Medical Premium:**

This additional benefit for monthly medical premium only applies if all of these tests are met:

(a) You suffer an accidental bodily Injury that results in a Loss within 365 days of an accident.

(b) The accidental bodily Injury:

(i) results in your having to take a leave of absence from your job with your Employer; or

(ii) ends your employment with your Employer.

(c) You choose to continue membership in your Employer's medical plan beyond the time that it would otherwise end.

Additional Monthly Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 1% of your Amount of Insurance; and

(2) $250.

This benefit will be paid monthly until the first of these occurs:

(1) Your continued membership in your Employer's medical plan ends.

(2) You become covered under any other group medical plan.

(3) The benefit has been paid for 12 consecutive months.

Proof of enrollment in the Employer's medical plan and of continued medical premium contribution must be given to Prudential.

(9) **Additional Benefit for Monthly Rehabilitation Expense:**

This additional benefit for Rehabilitation Expense only applies if both of these tests are met:

(a) You suffer a Loss.

(b) A Doctor determines that rehabilitation is necessary to aid you in returning to the normal activities of a person of the same age and gender.

Additional Monthly Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 1% of your Amount of Insurance; and

(2) $250.

This benefit will be paid monthly until the first of these occurs:

(1) A Doctor determines that you no longer need rehabilitation.

(2) You fail to furnish any required proof of your continuing need for rehabilitation.

(3) You fail to submit to a medical exam by Doctors named by Prudential, at Prudential's expense, when and as often as Prudential requires.

(4) The benefit has been paid for 12 consecutive months.

B. OTHER ADDITIONAL BENEFITS.

(1) **Additional Benefit for Critical Burns:**

This additional benefit for your Critical Burns is payable only if all of these tests are met:

(a) You suffer Critical Burns while a Covered Person under the Coverage.

(b) The Critical Burns result in Permanent Disfigurement.

(c) The Critical Burns were sustained while you were Working for Your Employer.

(d) The Losses Not Covered provisions of the Coverage apply to this Additional Benefit as if there were a Loss.

This additional benefit is not payable for Loss of life.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 25% of your Amount of Insurance; and

(2) $25,000.

(2) **Additional Benefit for Occupational HIV or Hepatitis:**

This additional benefit for occupational HIV or Hepatitis is payable only if all of these tests are met:

(a) You are a Covered Person under the Coverage on the date of an Occupational Accident.

(b) You test positive for HIV or Hepatitis within 365 days of the date of an Occupational Accident.

(c) Within 72 hours following the Occupational Accident:

(i) You report the Occupational Accident to Prudential and to the Contract Holder in writing; and

(ii) You undergo a Food and Drug Administration (FDA) approved preliminary screening test for both HIV and Hepatitis which confirms that you do not have a positive test for HIV and Hepatitis at the time of the Occupational Accident.

(d) You provide to Prudential written notification of the test results directly from the laboratory that performed the test as soon as reasonably possible.

(e) Benefits under the Coverage would be payable if you suffered a Loss of life.

The monthly benefit begins on the first day of the month following the month you test positive for HIV or Hepatitis.

If you test positive for both Hepatitis and HIV as a result of the same Occupational Accident, only one monthly benefit will be paid.

This benefit does not pay any expenses incurred for testing for Hepatitis or HIV.

Additional Monthly Amount Payable under this Additional Benefit: A monthly amount equal to the lesser of:

(a) 3% of your Amount of Insurance; and

(b) $1,000.

This benefit will be paid monthly until the first of these occurs:

(a) You recover from Hepatitis if the benefit is being paid for that disease.

(b) The benefit has been paid for 24 consecutive months.

Optional Accidental Death and Dismemberment Coverage

FOR YOU ONLY

This Coverage pays benefits for accidental Loss which results from a Covered Accident.

Loss means your:

(1) loss of life.

(2) total and permanent loss of sight.

(3) total and permanent loss of speech.

(4) total and permanent loss of hearing.

(5) loss of hand or foot by severance at or above the wrist or ankle.

(6) loss of thumb and index finger of the same hand by severance at or above the point at which they are attached to the hand.

(7) loss due to Quadriplegia, Paraplegia or Hemiplegia.

(8) loss due to Coma.

Covered Accident means an accident which happens to you while you are engaged in or the victim of a Hazard described in the Hazard provisions.

A. BENEFITS.

Benefits for accidental Loss are payable only if all of these conditions are met:

(1) You sustain an accidental bodily Injury while a Covered Person.

(2) The Loss results directly from that Injury and from no other cause.

(3) You suffer the Loss within 365 days after the Covered Accident. But, if the Loss is due to Coma, that Loss:

  (a) begins within 365 days after the Covered Accident;

  (b) continues for 31 consecutive days; and

  (c) is total, continuous and permanent at the end of that 31-day period.
  Any benefit for a Loss due to Coma will not begin until the end of the 31-day period in (b) above.

(4) The Loss is due to a Covered Accident.

For the purposes of the Coverage:

(1) Exposure to the elements will be considered an accidental bodily Injury.

(2) It will be presumed that you have suffered a Loss of life if your body has not been found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.

Not all such Losses are covered. See Losses Not Covered below.

Benefit Amount Payable: The amount payable depends on the type of Loss as shown below. All benefits are subject to the Limits below.

Loss of or by Reason of:	Percent of Your Amount of Insurance
Life	100
Sight of Both Eyes	100
Speech and Hearing in Both Ears	100
Both Hands	100
Both Feet	100
One Hand and One Foot	100
One Hand and Sight of One Eye	100
One Foot and Sight of One Eye	100
Quadriplegia	100
Paraplegia	75
Sight of One Eye	50
Speech	50
Hearing in Both Ears	50
One Hand	50
One Foot	50
Hemiplegia	50
Thumb and Index Finger of the Same Hand	25
Coma	1% per month, up to 100 months

Limits Per Covered Accident:

(1) No more than your Amount of Insurance under this Coverage at the time of the Covered Accident will be paid for all Losses resulting from Injuries sustained in that accident.

(2) Benefits for accidental Loss which results from a Covered Accident will be paid only once, even if more than one Hazard provision applies.

B. LOSSES NOT COVERED.

A Loss is not covered if it results from any of these:

(1) Suicide or attempted suicide, while sane.

(2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

(3) Sickness, whether the Loss results directly or indirectly from the Sickness.

(4) Medical or surgical treatment of Sickness, whether the Loss results directly or indirectly from the treatment.

(5) Any bacterial or viral infection. But, this does not include:

(a) a pyogenic infection resulting from an accidental cut or wound; or

(b) a bacterial infection resulting from accidental ingestion of a contaminated substance.

(6) Taking part in any insurrection.

(7) War, or any act of war, except as provided by the War Risk Hazard provision. War means declared or undeclared war, and includes resistance to armed aggression.

(8) An accident that occurs while you are serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training.

(9) Commission of or attempt to commit an assault or a felony.

(10) Travel or flight in any vehicle used for aerial navigation, except as provided by any Hazard provision, if any of these apply:

(a) you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.

(b) you are performing as a pilot or a crew member of any aircraft.

(c) you are riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the Contract Holder or any of its subsidiaries or affiliates.

This includes getting in, out, on or off any such vehicle.

(11) Being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a Doctor.

The Claim Rules and the “To Whom Payable" part of the Schedule of Benefits apply to the payment of the benefits.

Hazard Provisions under Optional Accidental Death and Dismemberment Coverage

FOR YOU ONLY

These provisions describe the Hazards under the Coverage.

Hazard means any of the risks described below.

(1) **24 Hour All Risk Hazard:**

You are engaged in or the victim of a risk.

(2) **War Risk Hazard:**

During an Authorized Business Trip for your Employer, you are traveling in a Designated War Risk Area. This applies only if the Contract Holder gives Prudential the required information defined below at each of the following times:

(a) whenever conditions of war change in a Designated War Risk Area;

(b) whenever Prudential asks for it.

The following required information must be provided for each Employee who is covered for this risk:

(a) the Employee's name;

(b) the Employee's Amount of Insurance under the Coverage;

(c) the Designated War Risk Area to which the Employee plans to travel; and

(d) the duration of travel in a Designated War Risk Area.

Changes in War Risk Hazard: Prudential has the right to change: (1) the Designated War Risk Area(s) shown below if the conditions of war in those areas change; and (2) premium rates for this risk. Prudential will notify the Contract Holder in writing at least 10 days before a change in the premium rates is made.

Designated War Risk Area(s): All areas **except** those shown below:

United States of America	Afghanistan
Canada	Jammu & Kashmir
Algeria	Philippines
Angola	Nepal
Burundi	Sri Lanka (North & Eastern Provinces only)
Cote D'Ivoire	Iran
Dem. Republic of Congo	Iraq
Guinea	Israel
Ivory Coast	Kuwait
Liberia	Saudi Arabia
Zimbabwe	Syria
Somalia	Yemen
Sudan	Chechenia
Colombia	Uzbekistan
Haiti	

End of War Risk Hazard: The Contract Holder may write to Prudential, in advance, to ask that this Hazard be ended. Then this Hazard will end on the date requested. Prudential may end this Hazard at any time. But, written notice of its intent to do so must be given to the Contract Holder at least 10 days in advance. The end of this Hazard will not affect a claim incurred before the date the Hazard ends.

Additional Benefits under Optional Accidental Death and Dismemberment Coverage

FOR YOU ONLY

A. ADDITIONAL BENEFITS RELATED TO LOSSES.

If a benefit is payable under the Coverage for a Loss an additional benefit may be payable. Any such benefit is payable in addition to any other benefit payable under this Coverage. The additional amount payable for each additional benefit and any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

(1) **Additional Benefit for Loss of Life as a Result of an Accident in an Automobile While Using a Seat Belt:**

This additional benefit for your Loss of life only applies if you sustain an accidental bodily Injury resulting in the Loss while:

(a) you are a driver or passenger in an Automobile;

(b) you are wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer; and

(c) the actual use of a Seat Belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

Losses Not Covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 10% of your Amount of Insurance; and

(2) $10,000.

If it cannot be determined that you were wearing a Seat Belt at the time of the Accident, a benefit of $1,000 will be paid.

(2) **Additional Benefit for Loss of Life as a Result of an Accident in an Automobile While Using an Air Bag:**

This additional benefit for your Loss of life only applies if this test is met.

You sustain an accidental bodily Injury resulting in the Loss while:

(a) you are a driver or passenger in an Automobile;

(b) you are wearing a Seat Belt in the manner prescribed by the vehicle's manufacturer;

(c) the actual use of a Seat Belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s);

(d) the Automobile is equipped with a factory-installed Air Bag; and

(e) a properly functioning Air Bag was deployed for the seat that you occupied.

Losses Not Covered under this Additional Benefit: A Loss is not covered under this additional benefit if it results from driving or riding in any Automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or being engaged in an illegal occupation.

Additional Amount Payable under this Additional Benefit: An amount equal to the lesser of:

(1) 5% of your Amount of Insurance; and

(2) $5,000.

Definitions under Accidental Death and Dismemberment Coverage

FOR YOU ONLY

Some of the terms used in the Coverage:

Air Bag: An inflatable safety device that: (1) meets published federal safety standards; (2) is installed by the Automobile's manufacturer or replaced by an organization sanctioned by the Automobile's manufacturer; and (3) is not altered after that installation or replacement.

Authorized Business Trip: A trip that your Employer authorizes you to take for the purpose of furthering its business. An Authorized Business Trip: (1) starts when you leave your residence or Regular Place of Employment, whichever is later; and (2) ends when you return to your residence or Regular Place of Employment, whichever is earlier.

The term does not include Commuting to and from Work, vacations or leaves of absence.

Automobile: A validly registered:

(1) vehicle that may be legally driven with the standard issue class of motor vehicle driver's license and no additional class of license is necessary to operate this vehicle; or

(2) four wheel, two axle private passenger motor vehicle.

But Automobile does not include: (1) a motor vehicle intended for off-road use; or (2) a motor vehicle being used without the owner's permission.

Bereavement and Trauma Counseling Sessions: Sessions with a licensed psychiatrist, licensed psychologist or other medical professional acting within the scope of the license to assist in coping with the Loss and for which a charge is made.

Coma: A profound state of unconsciousness from which the person cannot be aroused, even by powerful stimulation, as determined by the person's Doctor.

Commuting to and from Work: Leaving your primary residence and going directly to your Regular Place of Employment; and returning from your Regular Place of Employment and going directly to your primary residence. Such commuting must take place during a regular workday.

Critical Burns: Burns that are classified by a Doctor as being second degree or higher over 25% of the person's body.

Felonious Assault: A Physical Attack by another person resulting in bodily harm to you. But, a Felonious Assault is not a moving violation as defined under the applicable state motor vehicle laws.

Hepatitis: Viral hepatitis, excluding Type A hepatitis.

Home Alteration and Vehicle Modification Expenses: One-time expenses that are charged for:

(1) alterations to your residence that are necessary to make the residence accessible and habitable to a person who has suffered a Loss; or

(2) modifications to a motor vehicle owned or leased by a person that are needed to make such vehicle accessible to or drivable by the person.

Such alteration or modification must be made: because of the Loss; completed by individuals experienced in such alteration or modification; meet appropriate marketing standards; and be in compliance with any applicable laws or regulations of appeal by any appropriate government authority.

The term does not include charges above the norm for similar alterations and modifications in the locality where the charges are incurred.

Occupational Accident: An exposure to the Human Immunodeficiency Virus (HIV) or Hepatitis which occurs while you are Working for Your Employer. The exposure must be: (1) cutaneous through abraded skin; (2) percutaneous; or (3) mucocutaneous.

Permanent Disfigurement: Scarring over 25% of the body that can be corrected only by cosmetic surgery.

Physical Attack: Any willful or unlawful use of force or violence upon you with the intent to cause bodily Injury to you. The Physical Attack must be considered a felony or misdemeanor in the jurisdiction in which it occurs.

Regular Place of Employment: The Employer's place of business at which you spend at least 50% of your working hours and which is located within 100 miles of your primary residence. Satellite offices located within 100 miles of your primary residence are also included.

Rehabilitation Expense: An expense that a Doctor has determined is needed to enable the injured person to return to the normal activities of a person of the same age and gender. Rehabilitation Expense includes: (1) the expense for treatment by a rehabilitation therapist who is licensed, registered and/or certified to provide such treatment; and (2) the expense of confinement in a health care facility for rehabilitation.

Return of Remains Expenses: Expenses for any of the following: (1) embalming; (2) cremation; (3) a coffin; and (4) transportation of the remains to return the person's body home.

Seat Belt: Any passive restraint device for an adult that meets published federal safety standards, is installed by the Automobile's manufacturer or replaced by an organization sanctioned by the Automobile's manufacturer; and is not altered or replaced after that installation.

Working for Your Employer: Performing the duties of your job with your Employer either on or off your Employer's premises. But the term does not include Commuting to and from Work, vacations or leaves of absence.

Right to Elect Accidental Death and Dismemberment Coverage under the Portability Plan

This right applies to the Optional Accidental Death and Dismemberment Coverage for Employees under the Group Contract.

It describes when and how you may become covered for similar coverage under the Portability Plan when your Optional Accidental Death and Dismemberment Coverage under the Group Contract ends. The terms and conditions of the Portability Plan will not be the same as those under this Group Contract. The amount of insurance available under the Portability Plan may not be the same as the amount under this Group Contract.

RIGHT TO APPLY FOR COVERAGE UNDER THE PORTABILITY PLAN

A right under this section is subject to the rest of these provisions.

You will have the right to apply for accidental death and dismemberment coverage under the Portability Plan if you meet all of these tests:

(1) Your Optional Accidental Death and Dismemberment Coverage ends for any reason other than:

   (a) your failure to pay, when due, any contribution required for it; or

   (b) the end of your employment on account of your retirement; or

   (c) the end of the Coverage for all Employees when such Coverage is replaced by group accidental death and dismemberment insurance from any carrier for which you are or become eligible within the next 31 days.

(2) You meet the Active Work Requirement on the day your insurance ends.

(3) You are less than age 80.

(4) Your Amount of Insurance is at least $20,000 under the Optional Accidental Death and Dismemberment Coverage on the day your insurance ends.

(5) You apply for term life coverage under the Portability Plan.

PORTABILITY APPLICATION PERIOD

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. Evidence of insurability is not required to become insured under the Portability Plan.

The Portability Application Period is the longer of:

(1) the 31 day period after your Optional Accidental Death and Dismemberment Coverage ends; and

(2) the number of days during which you have the right to apply for the term life coverage under the Portability Plan.

TERMS AND CONDITIONS OF THE PORTABILITY PLAN

The form, amount, first premium, and effective date will be as stated below.

Form and Amount: The form of accidental death and dismemberment coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as the Optional Accidental Death and Dismemberment Coverage under the Group Contract.

Amount: Not more than your amount of insurance under the Optional Accidental Death and Dismemberment Coverage when your insurance ends, but not less than $20,000.

The maximum amount of accidental death and dismemberment insurance under the Portability Plan is the lesser of 5 times your annual Earnings and $1,000,000.

In no event can your amount of accidental death and dismemberment insurance under the Portability Plan exceed your amount of term life insurance under the Portability Plan.

First Premium: The first premium is due to Prudential within 31 days of the date the first bill is issued.

Effective Date: The day after the Portability Application Period ends.

General Information

BENEFICIARY RULES

The rules in this section apply to insurance payable on account of your death, when the Coverage states that they do. But these rules are modified by any burial expenses rule in the Schedule of Benefits and, if there is an assignment, by the following sections: Limits on Assignments; and Effect of Gift Assignment of Rights of Group Life Insurance Under Another Group Contract.

“Beneficiary" means a person chosen, on a form approved by Prudential, to receive the insurance benefits.

You have the right to choose a Beneficiary for each Coverage under this Prudential Group Contract.

If there is a Beneficiary for the insurance under a Coverage, it is payable to that Beneficiary. Any amount of insurance under a Coverage for which there is no Beneficiary at your death will be payable to the first of the following: your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. This order will apply unless otherwise provided in the Limits on Assignments.

You may change the Beneficiary at any time without the consent of the present Beneficiary. The Beneficiary change form must be filed through the Contract Holder. The change will take effect on the date the form is signed. But it will not apply to any amount paid by Prudential before it receives the form.

If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise.

If you and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before you.

MODE OF SETTLEMENT RULES

The rules in this section apply to Life and Accident Insurance payable on account of a Covered Person’s death. But these rules are subject to the Limits on Assignments section.

Insurance payable on account of a Covered Person’s death is normally paid to the Beneficiary in one sum. Subject to applicable law, where the amount of the benefit meets Prudential's current minimum requirement, payment in one sum will be made by establishing a retained asset account in the Beneficiary’s name, unless the Beneficiary elects another settlement or payment option available at the time of claim, and the benefit distribution will be deemed complete when the account is established. The retained asset account is an interest-bearing draft account backed by the financial strength of Prudential. Funds are held in Prudential’s general account or elsewhere as Prudential may direct and an account in the Beneficiary’s name is credited interest at a rate set by Prudential’s discretion, subject to a minimum rate that will change no more than once every 90 days on advance notice to the Beneficiary. The Beneficiary is provided a draftbook and has immediate access to the entire amount by writing drafts for any amount up to the account balance. The retained asset account is not a bank account and is not insured by the Federal Deposit Insurance Corporation; it is a contractual undertaking between Prudential and the Beneficiary. Further information about the account is provided at the time of claim. Prudential may at its discretion provide other forms of

payment in one sum. But another mode of settlement may be arranged with Prudential for all or part of the insurance, as stated below.

Arrangements for Mode of Settlement: You may arrange a mode of settlement by proper written request to Prudential.

If, at a Covered Person's death, no mode of settlement has been arranged for an amount of the person's Life or Accident Insurance, the Beneficiary and Prudential may then mutually agree on a mode of settlement for that amount.

Conditions for Mode of Settlement: The Beneficiary must be a natural person taking in the Beneficiary's own right. A mode of settlement will apply to secondary Beneficiaries only if Prudential agrees in writing. Each installment to a person must not be less than $20.00. A change of Beneficiary will void any mode of settlement arranged before the change.

Choice by Beneficiary: A Beneficiary being paid under a mode of settlement may, if Prudential agrees, choose (or change the Beneficiary's choice of) a payee or payees to receive, in one sum, any amount which would otherwise be payable to the Beneficiary's estate.

Prudential has prepared information about the modes of settlement available. Ask the Contract Holder for this.

INCONTESTABILITY OF LIFE INSURANCE

This limits Prudential's use of a person's statements in contesting an amount of Life Insurance for which the person is insured. These are statements made to persuade Prudential to accept the person for insurance. They will be considered to be made to the best of the person's knowledge and belief. These rules apply to each statement:

(1) It will not be used in the contest unless:

   (a) It is in a written instrument signed by the person and

   (b) A copy of that instrument is or has been furnished to the person or to the person's Beneficiary.

(2) If it relates to the person's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during the person's lifetime.

LIMITS ON ASSIGNMENTS

You may assign your insurance under a Coverage. Unless the Schedule of Benefits states otherwise, insurance under any Coverage providing death benefits or periodic benefits on account of disability may be assigned only as a gift assignment. Any rights, benefits or privileges that you have as an Employee may be assigned. This includes any right you have to choose a Beneficiary or to convert to another contract of insurance. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Contract Holder.

This paragraph applies only to insurance for which you have the right to choose a Beneficiary, when that right has been assigned. If an assigned amount of insurance becomes payable on account of your death and, on the date of that death, there is no Beneficiary chosen by the assignee, it will be payable to:

(1) the assignee, if living; or

(2) the estate of the assignee, if the assignee is not living.

It will not be payable as stated in the Beneficiary Rules.

EFFECT OF GIFT ASSIGNMENT OF RIGHTS OF GROUP LIFE INSURANCE UNDER ANOTHER GROUP CONTRACT

This Section applies to all Coverages providing Employee death benefits.

If you are eligible for insurance under the Group Contract on the Group Contract's effective date you will have no rights, benefits or privileges under any such Coverage if, on the day before that date, all the following were true:

(1) You were insured for group life insurance under another group contract. That contract was issued by Prudential or another insurance carrier to cover Employees of the Employer.

(2) Your group life insurance under the other group contract ended.

(3) An irrevocable and absolute gift assignment made by you was in effect. It was made before the other contract ended. That assignment was of all your rights, benefits and privileges of the group life insurance under the other group contract. Those rights were owned by the assignee or the assignee's successor.

The owner of those rights of the group life insurance under the other group contract on the day before this Group Contract's effective date will be the owner of the rights, benefits, and privileges you would have had under a Coverage if this section did not apply. This includes, but is not limited to, any right of assignment you would have had under the Limits on Assignments section above. The term "assignee" as used in that section includes such an owner.

The term "group life insurance", as used above, means only group life insurance provided under a group contract in effect on the day before the date the Employer became included under the Group Contract.

DEFINITIONS

Active Work Requirement: A requirement that you be actively at work on a full time or part time basis at the Employer's place of business or at any other place that the Employer's business requires you to go. You are considered actively at work during a normal vacation if you were actively at work on your last regularly scheduled workday.

Calendar Year: A year starting January 1.

Contributory Insurance, Non-contributory Insurance: Contributory Insurance is insurance for which the Contract Holder has the right to and may require your direct contribution to the cost of coverage. Non-contributory Insurance premiums are paid by the Contract Holder, usually without direct contribution from you. The rate for Non-contributory insurance may be determined, or in some cases, reduced, in part, based on your contributions for contributory insurance or other benefits offered to you under the Contract Holder benefit plan.

Coverage: A part of the Booklet consisting of:

(1) A benefit page labeled as a Coverage in its title.

(2) Any page or pages that continue the same kind of benefits.

(3) A Schedule of Benefits entry and other benefit pages or forms that by their terms apply to that kind of benefits.

Covered Person under a Coverage: An Employee who is insured for Employee Insurance under that Coverage; a Qualified Dependent for whom an Employee is insured for Dependents Insurance, if any, under that Coverage.

Dependents Insurance: Insurance on the person of a dependent.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license.

Earnings: This is the gross amount of money paid to you by the Employer in cash for performing the duties required of your job. Bonuses, overtime pay, Earnings for more than 40 hours per week, and all other benefits are not included.

Employee: A person employed by the Employer; a proprietor or partner of the Employer. The term also applies to that person for any rights after insurance ends.

Employee Insurance: Insurance on the person of an Employee.

The Employer: Collectively, all employers included under the Group Contract.

Injury: Injury to the body of a Covered Person.

Prudential: The Prudential Insurance Company of America.

Sickness: Any disorder of the body or mind of a Covered Person, but not an Injury; pregnancy of a Covered Person, including abortion, miscarriage or childbirth.

You: An Employee.

CLAIM RULES

These rules apply to payment of benefits under all accident Coverages.

Proof of Loss: Prudential must be given written proof of the loss for which claim is made under the Coverage. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any Coverage provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end.

A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

When Benefits are Paid: Benefits are paid when Prudential receives written proof of the loss. But, if a Coverage provides that benefits are payable at equal intervals of a month or less, Prudential will not have to pay those benefits more often.

Physical Exam and Autopsy: Prudential, at its own expense, has the right to examine the person whose loss is the basis of claim. Prudential may do this when and as often as is reasonable while the claim is pending. Prudential also has the right to arrange for an autopsy in case of accidental death, if it is not forbidden by law.

Legal Action: No action at law or in equity shall be brought to recover on the Group Contract until 60 days after the written proof described above is furnished. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

INCONTESTABILITY OF INSURANCE TO WHICH THE CLAIM RULES APPLY

This limits Prudential's use of a person’s statements in contesting an amount of that insurance for which the person is insured. These are statements made to persuade Prudential to effect an amount of that insurance. They will be considered to be made to the best of the person’s knowledge and belief. These rules apply to each statement:

(1) It will not be used in a contest to avoid or reduce that amount of insurance unless:

   (a) It is in a written application signed by the person; and

   (b) A copy of that application is or has been furnished to the person.

(2) It will not be used in the contest after that amount of insurance has been in force, before the contest, for at least two years during the person’s lifetime.

ADJUSTMENTS IN BENEFITS BECAUSE OF AGE MISSTATEMENTS

This section applies to any Coverage to which the Claim Rules apply. If the benefits of the insurance under any such Coverage depend on age, and the age of a Covered Person is found to have been misstated, the benefits of such insurance for that person will then be changed to those that apply to the person’s correct age.

When Your Insurance Ends

EMPLOYEE AND DEPENDENTS INSURANCE

Your Employee Insurance under a Coverage or your Dependents Insurance under a Coverage will end when the first of these occurs:

- Your membership in the Covered Classes for the insurance ends because your employment ends (see below) or for any other reason.
- The part of the Group Contract providing the insurance ends.
- You make a written request to the Contract Holder to end your Employee or Dependents Insurance under a Coverage.
- You fail to pay, when due, any contribution required for an insurance of the Group Contract. But, failure to contribute will not cause Non-Contributory Insurance to end, and failure to contribute for Dependents Insurance will not cause your Employee Insurance to end.
- The Insurance is Dependents Insurance under the Dependents Term Life Coverage and your Employee Insurance under the Employee Term Life Coverage ends.

Your Dependents Insurance for a Qualified Dependent under a Coverage will end when that person ceases to be a Qualified Dependent for that Coverage. (See Continued Coverage for an Incapacitated Child below.)

End of Employment: For insurance purposes, your employment will end when you are no longer a full-time or part-time Employee actively at work for the Employer. But, under the terms of the Group Contract, the Contract Holder may consider you as still employed in the Covered Classes during certain types of absences from full-time or part-time work. This is subject to any time limits or other conditions stated in the Group Contract.

If you stop active full-time or part-time work for any reason, you should contact the Employer at once to determine what arrangements, if any, have been made to continue any of your insurance.

Continued Coverage for an Incapacitated Child: This applies to the Dependents Insurance you have for a child. The insurance for the child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true:

(1) The child is then mentally or physically incapable of earning a living. Prudential must receive proof of this within the next 31 days.

(2) The child otherwise meets the definition of Qualified Dependent.

If these conditions are met, the age limit will not cause the child to stop being a Qualified Dependent under that Coverage. This will apply as long as the child remains so incapacitated.

ADDITIONAL PROVISIONS FOR MINNESOTA RESIDENTS

For Minnesota residents, there are additional provisions about your right to continue or convert coverage after your insurance ends.

A. CONVERSION PRIVILEGE

The following provision replaces the conversion provisions in the Employee and Dependents Term Life Coverage sections of your booklet. But the provisions of this section A do not apply if section B applies.

If you cease to be insured for the Employee and Dependents Term Life Insurance of the Group Contract for one of the reasons stated below, you may convert all or part of your insurance under this Coverage, which then ends, to an individual life insurance contract. Evidence of insurability is not required. The reasons are:

(1) Your employment or membership ends or you transfer out of a Covered Class.

(2) All term life insurance of the Group Contract for your class ends by amendment or otherwise.

Any such conversion is subject to the rest of this Section.

Availability: You must apply for the individual contract and pay the first premium within 31 days after you cease to be insured for the Employee and Dependents Term Life Insurance.

Individual Contract Rules: The individual contract must conform to the following:

Amount: Not more than your Employee and Dependents Term Life Insurance under this Coverage when your insurance ends.

Form: Any form of a life insurance contract that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

This does not include term insurance or a contract with disability or supplementary benefits.

Premium: Based on Prudential's rate as it applies to the form and amount, and to your class of risk and age at the time.

Effective Date: The end of the 31 day period during which you may apply for it.

B. CONTINUED LIFE INSURANCE COVERAGE AT YOUR OPTION

The following provision is added to the When Your Insurance Ends section of your booklet. When this section B applies, section A above does not.

You have the right to continue your Employee and Dependents Insurance under the life Coverages of the Group Contract if your insurance ends: (1) because you are voluntarily or involuntarily terminated or laid off from your employment (other than for gross misconduct) or (2) because your work hours are reduced.

The Contract Holder will give a written notice of the right to elect to continue the insurance. Such notice will state the amount of the payments, if any, required for the continued insurance and the manner in which any payments must be made. The amount of the contributions required to keep the insurance in force may be different from the amount you have been contributing. But, in no event will the amount exceed 102% of the cost for other Employees in like circumstance whose employment is not ending or whose work hours have not been reduced.

If you want to continue the insurance, the election notice must be completed and returned to the Contract Holder, along with any required first payment, within 60 days of the later of: (1) the date the insurance would otherwise have ended; or (2) the date you receive the notice informing you of the right to continue. If this is done, the insurance will be continued from the date it would have ended until the first of these occurs:

(1) The day 18 months from the date employment ended or work hours were reduced.

(2) If you fail to make any payment required by the Contract Holder for the continued insurance, the end of the period for which you have made required payments.

(3) The day you become covered under any other group life plan.

(4) The part of the Group Contract providing the insurance ends.

While Employee and Dependents Insurance is continued under this part, all other terms of the Group Contract will apply, except that the For Employee Insurance part of the Delay of Effective Date section will not apply.

When continued insurance under this provision ends, you may elect to convert your coverage. See the Conversion section below.

CONVERSION AFTER CONTINUATION

At the expiration of the Continuation coverage in this section B, you may convert all or part of your insurance under this Coverage, which then ends, to an individual life insurance contract. Evidence of insurability is not required. Any such conversion is subject to the rest of this Section.

Availability: You must apply for the individual contract and pay the first premium within 31 days after the expiration of your continued coverage.

Individual Contract Rules: The individual contract must conform to the following:

Amount: Not more than your Employee and Dependents Term Life Insurance under this Coverage when your continued coverage ends.

Form: Any form of a life insurance contract that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for; and

(3) provides the same or substantially similar benefits.

Premium: Based on Prudential's rate as it applies to the form and amount, and to your class of risk and age at the time.

Effective Date: The end of the 31 day period during which you may apply for it.

The Claims and Appeals section
is not part of the
Group Insurance Certificate.

CLAIMS AND APPEALS

Plan Benefits Provided by

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits. For all purposes of this Group Contract, the Employer/Policyholder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such written execution.

Claim Procedures

1. Determination of Benefits

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

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information

relevant to your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

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

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i)

the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and

(g) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on

timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

RIDER TO BE ATTACHED TO YOUR BOOKLET

NOTICE OF CHANGE

Covered Classes: The "Covered Classes" are these Employees of the Contract Holder (and its Associated Companies): As shown in the Covered Classes section of your Booklet's Schedule of Benefits.

Effective Date of Change: The first day on or after January 1, 2021 on which you are insured (see the section of your Booklet entitled "When You Become Insured"). The section of your Booklet entitled "Delay of Effective Date" does not apply to this change.

Group Contract No.: G-49038-CO

Your Booklet is changed as follows:

- The **The Amount Limit Due to Age** provision of the **Basic Employee Term Life Coverage** section of the **Schedule of Benefits** is enlarged to include the following:

  If your amount of insurance is reduced by this Limit, you may convert the amount of the reduction to an individual life insurance contract. The same rules and conversion period death benefit apply for that amount as would apply if you had then ceased to be insured under the Group Contract because of your transfer out of a Covered Class.

- The **The Amount Limit Due to Age** provision of the **Optional Employee Term Life Coverage** section of the **Schedule of Benefits** is enlarged to include the following:

  If your amount of insurance is reduced by this Limit, you may convert the amount of the reduction to an individual life insurance contract. The same rules and conversion period death benefit apply for that amount as would apply if you had then ceased to be insured under the Group Contract because of your transfer out of a Covered Class.

All other provisions in your Booklet remain unchanged.

_____

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

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, Alaska 99522-0207
(907) 243-2311
Division of Insurance
550 West Seventh Avenue, Suite 1560
Anchorage, Alaska 99501-3567
(907) 269-7900

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

Residents of this state who purchase life insurance, annuities or health 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") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the state of Arkansas. Other conditions may also preclude coverage..

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

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

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

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

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act") which is codified at Ark. Code Ann. §§ 23-96-101, *et seq.* Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

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

LIMITS ON AMOUNTS OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided 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 1607.02(b)(2)(C).

NOTICES

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

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

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

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

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

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

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

The basic protections provided by the Association are:

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

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

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website http://colorado.lhiga.com, email jkelldorf@gmail.com or contact:

Colorado Life and Health Insurance Protection Association *P. O. Box 36009* *Denver, CO 80236* *(303) 292-5022*	*Colorado Division of Insurance* *1650 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, CURRENT LIMITATIONS AND CONSUMER PROTECTION

General Purposes

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

The purpose of the Guaranty Association is to provide statutorily-determined benefits associated with covered policies and contracts in the unlikely event that a member insurer is unable to meet its financial obligations and is found by a court of law to be insolvent. When a member insurer is found by a court to be insolvent, the Guaranty Association will assess the other member insurers to satisfy the benefits associated with any outstanding covered claims of persons residing in the District of Columbia. However, the protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

Coverage

The 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 benefits;
- $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

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

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner of regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;

- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contacts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to the District of Columbia Department of Insurance, Securities and Banking (DISB) and they will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
1050 First Street, N.E., Suite 801
Washington, DC 20002
(202) 727-8000

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

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and the amounts of coverage provided under the Act. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on the insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any rights established in any policy or contract or under the Act.

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. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The basic protections provided by the Association are:

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

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

Annuities
- $250,000 in withdrawal and cash values

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

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

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

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

The basic protections provided by the Association are:

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

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

Annuities
- $250,000 in annuity benefits, cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000. Special rules may apply with regard to hospital, medical-surgical and major medical insurance benefits.

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

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

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

Iowa Insurance Division
330 Maple Street
Des Moines, IA 50319
(515) 281-5705

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. That information may be accessed from the "Helpful Links & Information" page located on the website of the Iowa Insurance Division at www.iid.state.ia.us.

The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

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

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 insured persons who reside in Idaho, and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is not unlimited, however, and is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

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

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

This information is provided by:

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

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

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

COVERAGE:

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

EXCLUSIONS FROM COVERAGE:

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

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

The Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE:

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

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

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

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

The Association was established to provide protection in the unlikely event that your member life, Annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by its Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage and pay claims, 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 60523-4324
(773) 714-8050

Illinois Department of Insurance
4th Floor
320 West Washington Street
Springfield, Illinois 62727
(217) 782-4515

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, 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 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 to 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 and long term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

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

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

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

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

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

guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

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, Suite100
Indianapolis, IN 46268
317-636-8204

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

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (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 ACT 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 members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

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

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

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

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

LLHIGA
P.O. Drawer 442126
Baton Rouge, Louisiana 70804

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

The Association also does not provide coverage for:

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

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

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

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

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

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

LIMITS ON AMOUNTS OF COVERAGE

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the Association will not pay more than $500,000 in health insurance benefits; $250,000 in present value of annuities (including cash surrender and cash withdrawal values); or $300,000 in life insurance death benefits (but not more than $100,000 in cash surrender and cash withdrawal values) – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. Other conditions, requirements or exclusions may apply.

Effective Date: August 1, 2014

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

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

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

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

The basic protections provided by the Corporation are:

- Life Insurance

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

- Health Insurance

[$300,000 in health insurance benefits, including net cash surrenders and net cash withdrawal values]

- $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
- $300,000 for disability insurance
- $300,000 for long-term care insurance
- $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
- $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, [are the amounts listed above] is.

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

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

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

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

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

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

The Prudential Insurance Company of America

751 Broad Street, Newark NJ, 07102-3777

1-800-346-3778

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

If the insurer or health maintenance organization that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, or health maintenance organization coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

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

Minnesota Life and Health Insurance
Guaranty Association

90 South Seventh Street 3300 Wells
Fargo Center
Minneapolis, MN 55402
Main Phone: (612) 322-8713

The maximum amount the guaranty association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization 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, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $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 and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

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

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, CONTRACT, 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, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

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

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

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

The basic protections provided by the Association are as follows:

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

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

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

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

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

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

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

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

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

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

Mississippi Life and Health Insurance Guaranty Association 330 North Mart Plaza Jackson, MS. 39206-5327 601-981-0755	Mississippi Insurance Department Woolfolk Building 501 N. West Street, Suite 1001 Jackson, MS 39201 601-359-3569

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, effective January 1, 2020.

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

In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate subject to the terms and conditions found in the Montana Life and Health Insurance Guaranty Association law, and subject to the following maximum limits:

- Life Insurance - $300,000 in death benefits, but limited to $100,000 in cash surrender and net cash withdrawal values

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

- Annuities
  - $250,000 present value, including net cash surrender and net cash withdrawal values

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

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

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

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

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

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

When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control. *Amd.2019 Montana Administrative Rules p.1741, Eff. 1/1/20.*

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 insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box below*, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

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

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

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

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

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

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

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer 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
    - 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 $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 NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT of 2019 (RSA 408-F) (the Act)
AND
NOTICE CONCERNING COVERAGE AND LIMITATIONS

SUMMARY:

This notice provides a brief summary of the purpose of the New Hampshire Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under New Hampshire law, which determines who and what is covered and the amounts of coverage. This summary does not cover all provisions of the law and it does not in any way change one's rights or obligations under the Act or the rights or obligations of the Association.

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

DISCLAIMER:

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

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

COVERAGE:

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

Coverage provided under the current, amended Act may be different from coverage provided prior to 2020, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

BASIC LIMITS ON AMOUNT OF COVERAGE:

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

The basic protections provided by the Association are limited to:

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

With respect to any one life, the Association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages, except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.

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

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

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

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

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

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

NOTICE
NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

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

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

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

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

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

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

COVERAGE

Following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

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

EXCLUSIONS FROM COVERAGE

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

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

The Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

NOTICE OF
PROTECTION PROVIDED BY
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

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

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

The basic protections provided by the Association are:

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

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

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

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

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

New Mexico Life Insurance
Guaranty Association
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

GUARANTY ASSOCIATION ACT SUMMARY DOCUMENT
Effective January 1, 2020

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

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

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

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

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

The Nevada Life and Health Insurance Guaranty Association
4600 Kietzke Lane, Suite O-269
Reno, Nevada 89502
(Business and Mailing Address)
Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
1818 E. College Parkway, Suite 103

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

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

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

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

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

EXCLUSIONS FROM COVERAGE

Not covered by the Nevada Guaranty Association:

- If they are eligible for protection under the law by another State Guaranty Association;
- The insurer is not authorized to do business in the state of Nevada; or
- If the policy was insured by a fraternal benefit society, a mandatory state pooling plan, or a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

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

- Any policy or portion of a policy which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Where interest rate yields exceed an average rate;
- Any 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 (not insured by an insurance company or administered by an insurance company);
- Unallocated annuity contracts (which give rights to group contract holders and not to individuals) other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code and the Nevada Revised Statute 686C.130; or
- Medicare or Medicare Advantage contracts.

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

www.nvlifega.org

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

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

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

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

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

Ohio Life and Health Insurance Guaranty Association
5005 Horizons Drive,
Suite 200
Columbus, OH 43220

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

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

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under sections 401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

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

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

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

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

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

COVERAGE

Persons Covered

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

Amounts of Coverage

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

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

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

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

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
● any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

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

The following policies and persons are among those that are excluded from Association coverage:
● A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
● If the person is provided coverage by the guaranty association of another state
● A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

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

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

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

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

The Prudential Insurance Company of America

SUMMARY

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

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

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

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

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

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

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

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

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act") can be found beginning at R.I. Gen. Laws section 27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE

Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE

The Association does **NOT** protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the “Blues”), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer’s plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

LIMITATIONS ON COVERAGE

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also for any one insured life, no matter

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

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

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

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

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

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

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

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

Disclaimer

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

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

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

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

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

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

SCLAHIGA also does not provide coverage for:

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

LIMITS ON AMOUNTS OF COVERAGE

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

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

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

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that 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, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

(please turn to back of page)

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

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

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's 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, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

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

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

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

The Guaranty Association also does not provide coverage for:

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

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

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to the group contractholder, 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

NOTE

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

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

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

Tennessee Life and Health Guaranty Association
P.O. Box 190434
Nashville, TN 37219
Website: www.tnlifega.org

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

TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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

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

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

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

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

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

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

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

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

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

- Health Insurance
    - o $500,000 for health benefit 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:

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

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA
23218-1157
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 40256
Olympia, WA 98504-0259
360-725-7214

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

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

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

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

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

3. WHO IS PROTECTED UNDER THE ACT?

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

- You are a Washington resident; or

- You are not a Washington resident, but only if: the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or

- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

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

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

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

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

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

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

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

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

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

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

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

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

   The Act provides the following maximum amounts of protection:

   Life Insurance Death Benefits $500,000

   Disability Benefits $500,000

   Present Value of Individual Annuities $500,000

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

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

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

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

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

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

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

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

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

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contractholder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
    i. multiple employer welfare arrangement;
    ii. minimum premium group insurance plan;
    iii. stop loss group insurance plan; or
    iv. administrative services only contract.

- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;

- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;

- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;

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

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under §§ 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits including net

cash surrender and net cash withdrawal values, per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

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

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

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

The basic protections provided by the Association are:

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

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

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

EXCLUSIONS FROM COVERAGE

Policy owners, contract owners, policy holders, certificate holders and enrollees are *not* protected by this Association if:

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

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;
- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy of contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- experience rating credits given in connection with the administration of a policy to a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing benefits under Medicare Part C, Medicare Part D or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

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

Wyoming Life and Health
Insurance Guaranty Association
6700 N. Linder Rd, Ste 156, Box 139
Meridian, ID 83646

Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: *www.wylifega.org*
Email: *administrator@wylifega.org*

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002

Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: *doi.wyo.gov*
Email: *wyinsdep@wyo.gov*

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

When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming law, then Wyoming law will control.