



## **AGREEMENT WITH DAVIS VISION, INC. FOR GROUP VISION INSURANCE**

This AGREEMENT (“Agreement”) is entered by and between **Davis Vision, Inc.** (“Contractor”), located at 881 Elkridge Landing Drive, Suite 300, Linthicum Heights MD 21090 and the **City of League City** (“City”), a home-rule municipality, located at 300 W. Walker St., League City, Texas 77573 on the date set forth below.

### **Terms:**

1. **Scope of Services:** Contractor will perform administrative services related to the provision of vision insurance by Metropolitan Life Insurance Company as set forth in **Exhibit A**, which is attached and incorporated herein, and which can be generally described as **Group Vision Insurance**. City acknowledges and agrees that Contractor performs the services for the insurer. If there is a conflict between the terms of this Agreement and Exhibit A, the terms of Exhibit A will prevail.
2. **Term and Termination:** This Agreement shall commence on **October 1, 2023** and shall expire on **September 30, 2027**. The period from commencement to expiration is the Contract Term. City reserves the right to terminate this Agreement for convenience upon thirty (30) days written notice to Contractor. Upon such termination, City shall pay Contractor, at the rate set out in **Exhibit A**, for services satisfactorily performed or products satisfactorily provided up through the date of termination. Notwithstanding any provision in this Agreement to the contrary, City will not be required to pay or reimburse Contractor for any services performed or for expenses incurred by Contractor after the date of the termination notice that could have been avoided or mitigated by Contractor.
3. **Compensation:** Contractor shall be paid for the services/products as set forth in **Exhibit A**. In no event shall the total compensation exceed **\$193,536** during the term of this Agreement. City shall tender payment (including progress/partial payments) for services/goods only after such services are completed or goods are delivered and are deemed to be acceptable under this Agreement, in the sole reasonable discretion of City. Contractor must submit to City invoices for all goods delivered and services provided, which invoices must include details and dates of service or delivery. Payment by City shall be made within thirty (30) days of receipt of an invoice, except for any portion of the invoiced amount that City disapproves as not compliant under this Agreement, in the sole reasonable discretion of City. If City disapproves any amount submitted for payment by Contractor, City shall give Contractor specific reasons for disapproval in writing.
4. **Insurance:** Contractor **is not** required during the Contract Term to maintain insurance as follows: (a) Comprehensive General Commercial Liability insurance covering bodily injury and property damage, with minimum coverage limits—exclusive of defense costs—of \$1,000,000 per occurrence and \$2,000,000 aggregate; (b) If Contractor will provide City “professional services,” as that term is used in Chapter 252 of the Texas Local Government Code, Professional Liability (errors and omissions/malpractice) insurance with minimum coverage limits—exclusive of defense costs—of \$2,000,000 per occurrence; and (c) If at any point during the Contract Term it is foreseeable that Contractor will enter upon City premises: (i) Worker’s Compensation coverage with statutory limits for the State of Texas, and (ii) Commercial Automobile Liability coverage with minimum coverage limits—exclusive of defense costs—of \$1,000,000 per occurrence and \$2,000,000 aggregate. All policies must contain a waiver of subrogation against City. Comprehensive General Liability and Commercial Automobile Liability policies must name the City as Additional Insured. Contractor shall pay all insurance deductibles and deductibles must not exceed \$10,000 unless approved in advance by City. Contractor shall provide City Certificates of Insurance evidencing these insurance requirements prior to the start of work.

5. **Liquidated Damages:** Contractor acknowledges that time is of the essence in performing this Agreement.
6. **Independent Contractor:** Contractor is an independent contractor and is not an employee, partner, joint venture, or agent of City. Contractor understands and agrees that he/she will not be entitled to any benefits generally available to City employees. Contractor shall be responsible for all expenses necessary to carry out the services under this Agreement and shall not be reimbursed by City for such expenses except as otherwise provided in this Agreement.
7. **Intellectual Property:** This Agreement shall be an Agreement for services and the parties intend and consider any work created specifically and solely for City as a result of this Agreement, including any and all documentation, images, products or results, to be a work (the "Work") for hire under federal copyright law. Ownership of the Work shall belong to and remain the exclusive property of City. The Work may be edited at any time within City's discretion. If the Work would not be considered a work-for-hire under applicable law, Contractor hereby assigns, transfers, and conveys any and all rights, title and interest to City, including without limitation all copyrights, patents, rights of reproduction, rights to ownership, and right to secure registrations, renewals, reissues and extensions thereof. As the sole copyright holder of the Work, City maintains and asserts the rights to use, reproduce, make derivative works from, and/or edit the Work in any form of medium, expression or technology now known or hereafter developed, at any time within City's discretion. Contractor shall not sell, disclose or obtain any other compensation for the services provided herein or the Work. If the Work is one to which the provisions of 17 U.S.C. § 106A apply, Contractor hereby waives and appoints City to assert on Contractor's behalf Contractor's moral rights or any equivalent rights regarding the form or extent of any alteration to the Work (including, without limitation, removal or destruction) or the making of any derivative works based on the Work, including, without limitation, photographs, drawings or other visual reproductions of the work, in any medium, for City's purposes.
8. **Confidentiality:** During the course of the services to be provided under this Agreement, Contractor may become privy to confidential information of City. Contractor agrees to treat as confidential the information or knowledge that becomes known to Contractor during performance of this Agreement and to not use, copy, or disclose such information to any third party unless authorized in writing by City. This provision does not restrict the disclosure of any information that is required to be disclosed under applicable law. Contractor shall promptly notify City of any misuse or unauthorized disclosure of City's confidential information and upon expiration of this Agreement shall return to City all confidential information in Contractor's possession or control. Contractor shall further comply with all information security policies of City that may apply and shall not make any press releases, public statements or advertisement referring to the services provided under this Agreement or the engagement of Contractor without the prior written approval of City.
9. **Warranties and Representations:** Contractor warrants and agrees that Contractor shall perform its services and conduct all operations in conformity with all applicable federal, state, and local laws, rules, regulations, and ordinances. For any service performed on premises owned or controlled by City, Contractor warrants and agrees that Contractor will perform said services in compliance with all City rules, including but not limited to, prohibitions related to tobacco use, alcohol, and other drugs.
10. **Licenses/Certifications:** Contractor represents and warrants that it will obtain and maintain in effect, and pay the cost of, all licenses, permits or certifications that may be necessary for Contractor's performance of this Agreement. If Contractor is a business entity, Contractor warrants, represents, covenants, and agrees that it is duly organized, validly existing and in good standing under the laws of the state of its formation; and is duly authorized and in good standing to conduct business in the State of Texas, that it has all necessary power and has received all necessary approvals to execute and deliver the Agreement and is authorized to execute this Agreement according to its terms on behalf of Contractor.
11. **Performance/Qualifications:** Contractor agrees and represents that Contractor has the personnel, experience, and knowledge necessary to qualify Contractor for the particular duties to be performed under

this Agreement. Contractor warrants that all services performed under this Agreement shall be performed consistent with generally prevailing professional or industry standards.

12. **Conflict of Interest:** Contractor warrants, represents, and agrees that Contractor presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with Contractor's performance of the services hereunder. Contractor further warrants and affirms that no relationship or affiliation exists between Contractor and City that could be construed as a conflict of interest with regard to this Agreement.
13. **INDEMNIFICATION: CONTRACTOR SHALL DEFEND, INDEMNIFY AND HOLD HARMLESS CITY, AND EACH OF ITS OFFICIALS, OFFICERS, AGENTS AND EMPLOYEES FROM AND AGAINST ALL CLAIMS, ACTIONS, SUITS, DEMANDS, PROCEEDINGS, COSTS, DAMAGES AND LIABILITIES, INCLUDING WITHOUT LIMITATION ATTORNEYS' FEES AND REASONABLE LITIGATION COSTS, BROUGHT BY A THIRD PARTY TO THE EXTENT ARISING OUT OF, CONNECTED WITH, OR RESULTING FROM ANY ACTS OR OMISSIONS OF CONTRACTOR OR ANY AGENT, EMPLOYEE, SUBCONTRACTOR, OR SUPPLIER OF CONTRACTOR IN THE EXECUTION OR PERFORMANCE OF THE SERVICES, TO THE EXTENT THE CLAIM ARISES FROM GROSS NEGLIGENCE, WILLFUL ACT, OR FINALLY ADJUDICATED VIOLATION OF LAW. THE PARTIES AGREE THAT CONTRACTOR IS NOT LIABLE UNDER ANY THEORY OF LAW OR EQUITY FOR THE ACTS OR OMISSIONS OF ANY EYE CARE OR MEDICAL PROVIDER, NOR FOR ANY LIABILITY ARISING OUT OF OR RELATED TO CITY'S ACTS OR OMISSIONS, INCLUDING BUT NOT LIMITED TO CITY'S FAILURE TO PROVIDE ACCURATE AND/OR COMPLETE INFORMATION TO CONTRACTOR.**
14. **Force Majeure:** Neither City nor Contractor shall be liable for any delay in the performance of this Agreement, nor for any other breach, nor for any loss or damage arising solely from uncontrollable forces such as fire, theft, storm, war, or any other force majeure that could not have been reasonably avoided by the exercise of due diligence.
15. **Notices:** Any notice given under this Agreement by either party to the other may be affected either by personal delivery in writing or by mail, registered or certified postage prepaid with return receipt requested. Mailed notices shall be addressed to the addresses of the Parties as they appear in the contract. Notices delivered personally shall be deemed communicated at the time of actual receipt. Mailed notices shall be deemed communicated three (3) days after mailing.
16. **Texas Family Code Child Support Certification:** Pursuant to Section 231.006 of the Texas Family Code, Contractor certifies that it is not ineligible to receive the award of or payments under the Agreement and acknowledges that the Agreement may be terminated, and payment may be withheld if this certification is inaccurate.
17. **State and/or City Auditor:** Contractor understands that acceptance of funds under the Agreement constitutes acceptance of the authority of the Texas State Auditor's Office, or any successor agency or the

City's internal auditor (collectively, the "Auditor"), to conduct an audit or investigation in connection with those funds. Contractor agrees to cooperate with the Auditor in the conduct of the audit or investigation, including without limitation providing all records requested. Contractor will include this provision in all contracts with permitted subcontractors.

18. **Jurisdiction:** Any disputes under this Agreement shall be brought in a court of competent jurisdiction in Galveston, Texas and governed by Texas law.
19. **Alternative Dispute Resolution:** To the extent that Chapter 2260, Texas Government Code, is applicable to this Contract and is not preempted by other applicable law, the dispute resolution process provided for in Chapter 2260 and the related rules adopted by the Texas Attorney General Pursuant to Chapter 2260, shall be used by City and Contractor to attempt to resolve any claim for breach of contract made by Contractor that cannot be resolved in the ordinary course of business. The Director of Finance of City shall examine Contractor's claim and any counterclaim and negotiate with Contractor in an effort to resolve such claims. This provision shall not be construed as a waiver by City of its right to seek redress in the courts.
20. **Entire Agreement:** This Agreement contains the entire understanding between the Parties and supersedes all prior agreements, arrangements, and understanding, oral or written between the Parties relating to this Agreement. This Agreement may not be modified except by mutual written agreement of the Parties executed subsequent to this Agreement.
21. **Eligibility to Receive Payment:** Contractor certifies that, as a matter of state law, it is not ineligible to receive the Agreement and payments pursuant to the Agreement and acknowledges that the Agreement may be terminated, and payment withheld if this representation is inaccurate.
22. **Payment of Debt/Delinquency to State:** Contractor certifies that it is not indebted to the City of League City and is current on all taxes owed to the City of League City. Contractor agrees that any payments owing to Contractor under the Agreement may be applied directly toward any debt or delinquency that Contractor owes the City of League City regardless of when it arises, until such debt or delinquency is paid in full.
17. **Products and Materials Produced in Texas:** If Contractor will provide services under the Agreement, Contractor covenants and agrees that in performing its duties and obligations under the Agreement, it will consider products and materials produced in Texas when such products and materials are available at a price and delivery time comparable to products and materials produced outside of Texas.
18. **Risk of Loss:** If and to the extent applicable, all work performed by Contractor pursuant to the Agreement will be at Contractor's exclusive risk until final and complete acceptance of the work by City. In the case of any loss or damage to the work prior to City's acceptance, bearing such loss or damage will be Contractor's responsibility.
23. **Publicity:** Contractor shall not use City's name, logo or likeness in any press release, marketing materials or other public announcement without receiving City's prior written approval.
24. **Legal Construction/Severability:** In the event that any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision, and this Agreement shall be construed as if such invalid, illegal or unenforceable provisions had never been contained in it. To this end, the provisions of this Agreement are declared to be severable. The Parties may mutually agree to renegotiate the Agreement to cure such illegality/invalidity or unconstitutionality if such may be reasonably accomplished.
25. **Limitations:** The Parties are aware that there are constitutional and statutory limitations on the authority of City to enter into certain terms and conditions of the Agreement, including, but not limited to, those terms and conditions relating to liens on City's property; disclaimers and limitations of warranties;

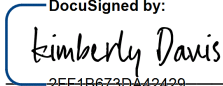

disclaimers and limitations of liability for damages; waivers, disclaimers and limitations of legal rights, remedies, requirements and processes; limitations of periods to bring legal action; granting control of litigation or settlement to another party; liability for acts or omissions of third parties; payment of attorneys' fees; dispute resolution; indemnities; and confidentiality (collectively, the "Limitations"). Any terms and conditions related to the Limitations will not be binding on City except to the extent authorized by the laws and Constitution of the State of Texas.

26. **Sovereign Immunity:** The Parties agree that neither the execution of the Agreement by City nor any other conduct, action or inaction of any City representative relating to the Agreement constitutes a waiver of sovereign immunity by City.
27. **Authority:** Contractor warrants and represents that Contractor has full power and authority to enter into and perform this Agreement and to make the grant of rights contained herein. The person signing on behalf of City represents that he/she has authority to sign this Agreement on behalf of City.
28. **Non-Waiver:** The Parties specifically agree that neither the occurrence of an event giving rise to a breach of contract claim nor the pendency of a claim constitute grounds for the suspension of performance by Contractor. No covenant or condition of this Agreement may be waived except by written consent of the waiving party. Forbearance or indulgence by one party in any regard whatsoever shall not constitute a waiver of the covenant or condition to be performed by the other party.
29. **Prohibitions Pursuant to Texas Government Code:** By executing this Agreement Contractor verifies that Contractor (1) does not boycott Israel and will not during the term of this Agreement per Section 2274.002; (2) is not engaged in business with Iran, Sudan, or any company on the list referenced in Section 2252.152; (3) does not boycott energy companies and will not during the term of this Agreement per 2274.002; and (4) does not have a practice, policy, guidance, or directive of this Agreement against a firearm entity or firearm trade association and will not during the term of this Agreement per 2274.002.

*(signature block on next page)*

Executed on \_\_\_\_\_ . *(date to be filled in by City Secretary)*

**DAVIS VISION, INC. - "Contractor"**

DocuSigned by:  
 Kimberly Davis Chief Financial Officer  *Form approved by Legal.*  
2FF1B673DA42429... **Click or tap here to enter text.** 8/30/2023 | 2:37 PM EDT 8/30/2023 | 2:31 PM EDT

**CITY OF LEAGUE CITY – "City"**

\_\_\_\_\_  
John Baumgartner, City Manager

**Attest:**

\_\_\_\_\_  
Diana Stapp, City Secretary

**Approved as to Form:**

\_\_\_\_\_  
Office of the City Attorney

# Exhibit A

## Scope of Services/Description of Products/Payment Schedule

(Exhibit A includes this page, Exhibit A-1 (Policy) and Exhibit A-2 (Certificate of Insurance))

### Group Vision Insurance - Benefits rates

City of League City's policy underwritten by Metropolitan Life Insurance Company (MLIC) will renew effective October 1, 2023.

The new rates are outlined below and will remain in effect for four year(s):

	<b>Employee Only</b>	<b>Employee + Spouse</b>	<b>Employee + Child(ren)</b>	<b>Employee + Family</b>
<b>Current Rates</b>	\$3.79	\$7.67	\$8.09	\$12.15
<b>New Rates under MLIC</b>	\$4.80	\$9.71	\$10.24	\$15.38

**Rate Period: October 1, 2023 – September 30, 2027**

1. **Administration Services Fee.** Client agrees to pay Company an administrative fee as noted in the chart above, each such amount above being per person per month.
2. **Client Payment.** Company will bill Client the amount specified in the schedules above without regard to the negotiated cost or the retail value of the services or materials selected by an eligible member.

# Exhibit A-1

## Policy





Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166

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

**Policyholder:** City of League City

**Group Policy No.:** VHX1U001-1-G

**EFFECTIVE DATE**

This policy will take effect on October 1, 2022.

**POLICY ANNIVERSARIES**

The first Policy Anniversary will be October 1, 2023. Subsequent Policy Anniversaries will be October 1, 2024 and each October 1 thereafter.

**PREMIUM PAYMENTS**

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

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

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

**POLICY SITUS**

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

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

Timothy J. Ring  
Secretary

Michel Khalaf  
President & CEO

**GROUP VISION INSURANCE POLICY**

**NON-DIVIDEND PAYING**

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

## NOTICE FOR RESIDENTS OF TEXAS

### Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

#### **Metropolitan Life Insurance Company**

To get information or file a complaint with your insurance company or HMO:

**Call: Corporate Consumer Relations Department at 1-800-438-6388**

**Toll-free: 1-800-438-6388**

Email: [Johnstown\\_Complaint\\_Referrals@metlife.com](mailto:Johnstown_Complaint_Referrals@metlife.com)

Mail: Metropolitan Life Insurance Company  
700 Quaker Lane  
2nd Floor  
Warwick, RI 02886

#### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

### ¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

#### **Metropolitan Life Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388**

**Teléfono gratuito: 1-800-438-6388**

Correo electrónico: [Johnstown\\_Complaint\\_Referrals@metlife.com](mailto:Johnstown_Complaint_Referrals@metlife.com)

Dirección postal: Metropolitan Life Insurance Company  
700 Quaker Lane  
2nd Floor  
Warwick, RI 02886

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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## DEFINITIONS

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

**Contribution** means any amount an Employee is required to pay toward the total Premium that MetLife charges for the insurance provided by this policy.

**Contributory Insurance** means any insurance for which an Employee is required to make a Contribution.

**Covered Person** means an Employee who is the subject of insurance under the certificates attached to the policy as Exhibits.

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

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

**Employer** means the Policyholder shown on the face page of this policy.

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

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

**Noncontributory Insurance** means any insurance for which the Employee is not required to make a Contribution.

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

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

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

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

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

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

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

## **SCHEDULE OF INSURANCE**

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

## **ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE**

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

## **PREMIUM RATE(S)**

### **Initial Rate(s)**

The initial Premium rate(s) are shown in the Exhibits to this policy.

### **Computation of Premium**

The Premium due on any Premium Due Date is determined by the total number of Covered Persons, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable.

### **Computation of Premiums for Changes in Insurance**

For insurance that takes effect on the first day of a Policy Month, Premium will be charged from the first day of that Policy Month. For insurance that takes effect after the first day of a Policy Month, Premium will be charged from the first day of the next Policy Month.

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

### **Right to Change Premium Rates**

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

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

1. when this policy is amended or endorsed;
2. when a class of eligible persons is added to or deleted from this policy for any reason including organizational restructuring, acquisition, spin-off or similar situations;
3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including organizational restructuring, acquisition, spin-off or similar situations;
4. when there is a significant change in the geographic distribution of either Certificateholders or Employees;

**PREMIUM RATES (Continued)**

5. when applicable law or regulatory requirements or the administration of such law or regulatory requirements:
  - a. requires a change in:
    - i. the insurance provided by this policy; and/or
    - ii. a class or classes of persons eligible for insurance under this policy;
  - b. results in a change in the amount of benefits paid under this policy; or
  - c. requires additional tax(es) to be paid.
6. when a Premium Due Date coincides with or next follows:
  - a. a change greater than 10% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed; or
  - b. a change greater than 10% in the amount of insurance provided by this policy since the later of the policy Effective Date and the last date Premium rates were changed.
7. on any other date agreed to by MetLife and the Policyholder.

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



## **GRACE PERIOD**

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

### **Policyholder's intent to end this policy during the grace period**

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

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

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

If more than one type of insurance coverage is provided under this policy then, to the extent there are different Premium Due Dates or different length grace periods for such coverages, this grace period provision will apply to each coverage independently of the others.

If more than one type of insurance coverage is provided under this policy, then to the extent such coverages have the same Premium Due Dates and the same length grace period, this grace period provision will apply to all such coverages simultaneously so that in the absence of written notice from the Policyholder of its intent to end a specific coverage, failure to pay the entire premium due by the end of the grace period will end all coverage under the policy.

### **Grace period extensions**

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

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

## **END OF INSURANCE PROVIDED BY THIS POLICY**

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

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

MetLife may end this policy as follows:

1. for non-payment of Premium, as set forth in the Grace Period provisions;
2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if fewer than:
  - a. 5% of persons eligible under this policy are insured for Contributory Insurance;
  - b. 10 Employees are insured by this Policy;
  - c. if fewer than 5% of all Employees with Dependents are insured for Contributory Dependent Insurance.
3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or
4. on any Policy Anniversary by giving the Policyholder 31 days advance Written notice.

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

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

## GENERAL PROVISIONS

**Entire Contract.** The entire contract is made up of the following:

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

### Policy Changes or Waivers

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

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

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

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

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

### Incontestability: Statements Made by the Policyholder

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

### Incontestability: Statements Made by Covered Persons

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

**GENERAL PROVISIONS (Continued)**

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

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

**Certificates**

MetLife will issue individual certificates to the Policyholder or the Policyholder's designee for delivery to each Certificateholder, as appropriate. Such certificates will describe:

1. the insurance protection to which the Certificateholder is entitled;
2. to whom the insurance benefits are payable; and,
3. with respect to life insurance, when the rights to convert the group life insurance to an individual policy of life insurance applies as well as what happens if the insured dies before the individual policy becomes effective.

The certificates are Exhibits to the policy. The term "certificate" includes certificate riders.

**Assignment**

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

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

**Information Needed and Policy Administration**

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

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

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

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

**Misstatement of Age**

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

**GENERAL PROVISIONS (Continued)**

**Non-Dividend Paying**

This policy does not pay dividends.

**Conformity with Law**

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

## SCHEDULE OF EXHIBITS

<b>Exhibit Number</b>	<b>Exhibit Type</b>	<b>Applies To</b>	<b>Effective Date</b>
1	Schedule of Initial Premium Rates	All Covered Persons	October 1, 2022
2	Certificate Forms and Attachments	Persons Specified In The Listed Forms And Attachments	October 1, 2022

**EXHIBIT 1**

**SCHEDULE OF INITIAL PREMIUM RATES**

The initial monthly Premium rates for the insurance provided by this policy as of October 1, 2022 are as follows:

Vision Insurance: - \$3.79 per Employee insured hereunder for Vision Insurance on the Employee's own account; \$7.67 per Employee insured hereunder for Vision Insurance on the Employee's own account and on account of a Spouse; \$8.09 per Employee insured hereunder for Vision Insurance on the Employee's own account and on account of Child(ren); and \$12.15 per Employee insured hereunder for Vision Insurance on the Employee's own account and on account of Spouse and Child(ren).

**EXHIBIT 2**

**CERTIFICATE FORMS**

Each of the forms listed here are Exhibits to the policy.

<b>Certificate Number</b>	<b>Form</b>	<b>Applies To</b>	<b>Effective Date</b>
1	GCERT2000	All Covered Persons	October 1, 2022



**THIS IS THE END OF THE GROUP INSURANCE POLICY.  
THE FOLLOWING IS ADDITIONAL INFORMATION REGARDING GUARANTEE ASSOCIATION  
NOTICES.  
DETACH AND SAVE THESE AS A SEPARATE DOCUMENT.**

## **ALASKA**

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

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

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

#### **COVERAGE**

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

#### **EXCLUSIONS FROM COVERAGE**

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

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

The association does not provide coverage for:

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;
- a credit given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation.
- that part of an unallocated annuity contract not issued to a specific employee; union, association of natural persons benefit plan, or a government lottery;

- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

## LIMITS ON AMOUNT OF COVERAGE

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

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

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

## COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

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

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

**ARKANSAS**

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

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

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

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

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

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

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

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

## COVERAGE

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

## EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under 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, other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims: or
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustee(s).

## LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

**COVERAGE**

- **Persons Covered**

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

- **Amounts of Coverage**

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

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

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

- **Life Insurance**  
80% of death benefits but not to exceed \$300,000  
80% of cash surrender or withdrawal values but not to exceed \$100,000
- **Annuities and Structured Settlement Annuities**  
80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

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

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of October 1, 2016, is \$554,556. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.



**COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE**

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

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

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

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**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](http://www.califega.org), or contact with of the following:

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

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

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

**COLORADO**

**NOTICE OF  
PROTECTION PROVIDED BY  
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION**

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

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

The basic protections provided by the Association are:

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

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

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website [www.colifega.org](http://www.colifega.org) or contact:

*Colorado Life and Health  
Insurance Protection Association  
201 Robert S. Kerr Ave. Suite 600  
Oklahoma City, OK 73102  
1-800-337-7796*

*Colorado Division of Insurance  
1560 Broadway, Suite 850  
Denver, CO 80202  
(303) 894-7499*

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

**DISTRICT OF COLUMBIA****SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION****General Purposes**

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

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

**Coverage**

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

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

**Coverage Limitations**

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

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

- \* With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - o \$300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - o \$300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - o \$300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - o \$300,000 for long-term care insurance benefits;
  - o \$300,000 for disability insurance benefits;
  - o \$500,000 for basic hospital, medical, and surgical insurance, or major medical insurance benefits;
  - o \$100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

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

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

### **Exclusions Examples**

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

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

The Guaranty Association also does not cover:

- \* Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- \* Any policy of reinsurance (unless an assumption certificate was issued);

- \* Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- \* Interest rate guarantees which exceed certain statutory limitations;
- \* Dividends, experience rating credits or fees for services in connection with a policy;
- \* Credits given in connection with the administration of a policy by a group contract holder; or
- \* Unallocated annuity contracts.

**Consumer Protection**

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

Policy or contract holders with additional questions may contact either:

**District of Columbia  
Department of Insurance, Securities  
and Banking  
1050 First St NE #801  
Washington, DC 20002  
Ph: (202) 727-8000  
Fax: (202) 354-1085**

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

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

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

**HAWAII**

**NOTICE CONCERNING COVERAGE  
LIMITATIONS AND EXCLUSIONS UNDER THE  
HAWAII LIFE AND DISABILITY INSURANCE  
GUARANTY ASSOCIATION ACT**

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

**DISCLAIMER**

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

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

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

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

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

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

## **COVERAGE**

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

## **EXCLUSIONS FROM COVERAGE**

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

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

The Guaranty Association also does not provide coverage for:

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

## **LIMITS ON AMOUNT OF COVERAGE**

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

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

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

**ILLINOIS**

**NOTICE OF  
PROTECTION PROVIDED BY  
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

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

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

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

- Life Insurance
  - \$300,000 for death benefits
  - \$100,000 for cash surrender or withdrawal values
- Health Insurance
  - \$500,000 for health benefit plans\*
  - \$300,000 for disability insurance benefits
  - \$300,000 for long-term care insurance benefits
  - \$100,000 for other types of health insurance benefits
- Annuities
  - \$250,000 for withdrawal and cash values

\*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

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

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.ilhiga.org](http://www.ilhiga.org) or contact:

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

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

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

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



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

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

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

**Basic Protections Currently Provided by ILHIGA**

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

**Life Insurance**

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

**Health Insurance**

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

**Annuities**

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

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

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

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

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

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

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at [www.inlifega.org](http://www.inlifega.org) or contact:

Indiana Life & Health Insurance  
Guaranty Association  
3502 Woodview Trace Suite 100  
Indianapolis, IN 46268  
(317) 636-8204

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

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

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

**IOWA****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 Act (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, 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, 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 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 net cash surrender and withdrawal values

Health Insurance

- \$500,000 for health benefit plans (see definition below)
- \$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, including net cash surrender and withdrawal values

Annuities

- \$250,000 in the present value of annuity benefits, including net 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 health benefit plans.

"Health benefit plan" is defined in the applicable Iowa law 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.

**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.

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 the long-term rider relates.

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](http://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  
1963 Bell Ave, Suite 100  
Des Moines, IA 50315  
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings.

The Association is subject to the supervision of 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 or HMO coverage. 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.**

**KANSAS**

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

**DISCLAIMER**

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

Kansas Life and Health Insurance  
Guaranty Association  
3745 SW Wanamaker Road, Suite C  
Topeka, KS 66610

Kansas Insurance Department  
1300 SW Arrowhead Road  
Topeka, KS 66604

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.

**LOUISIANA**

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

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

**Disclaimer**

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

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

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

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

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

**Department of Insurance**  
P.O. Box 94214  
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the Law), and is set forth at R.S. 22:2081 et seq. The following is a brief summary of this Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of LLHIGA.

**COVERAGE**

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

## **EXCLUSIONS FROM COVERAGE**

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

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

LLHIGA also does not provide coverage for:

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

## **LIMITS ON AMOUNTS OF COVERAGE**

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

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

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

**MARYLAND**

**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 and contract holders. 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 health maintenance organization or 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 and health maintenance organizations.

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 or Health Benefit Plans
  - \$500,000 for coverage provided by health benefit plans
  - \$300,000 for disability insurance
  - \$300,000 for long-term care insurance
  - \$100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - \$250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, \$250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

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

- \$300,000 in aggregate for all types of coverage listed above, with the exception of coverage provided by health benefit plans
- \$500,000 in aggregate for coverage provided by health benefit plans

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



To learn more about the above protections, please visit the Corporation's website at [www.mdlifega.org](http://www.mdlifega.org), or contact:

Maryland Life and Health Insurance Guaranty Corporation  
6210 Guardian Gateway  
Suite 195APG  
Aberdeen, Maryland 21005  
410-248-0407

**Insurance companies, health maintenance organizations and insurance producers 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 or a health benefit plan. When selecting an insurance company or health maintenance organization, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.**

**MINNESOTA**

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

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

If the insurer who issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer. In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association  
3300 Wells Fargo Center  
90 South 7th Street  
Minneapolis, MN 55402  
Phone: 612-322-8713  
Fax: 402-474-5393

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under Section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992; are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available.

The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment. **THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION. THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT.**

**THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.**

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

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

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

The basic protections provided by the Association are:

**Life Insurance**

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

**Health Insurance**

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

**Annuities**

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

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

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

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

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

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.ms lifega.org](http://www.ms lifega.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.

## MISSOURI

### NOTICE OF PROTECTION PROVIDED BY MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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

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

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

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- \* \$300,000 in aggregate for all types of coverage listed above, with the exception of health benefit plans
- \* \$500,000 in aggregate for health benefit plans
- \* \$5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

"Health benefit plan" is defined in section 376.718, RSMo.

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

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

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

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

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

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

**MONTANA**

**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.

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

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

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

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

**Note: Other restriction 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](http://www.mtlifega.org) or contact:

Montana Life and Health Insurance  
Guaranty Association  
PO Box 8247  
Missoula, MT 59807  
877-678-1048 or administrator@mtlifega.org

Office of the Montana State Auditor  
Commissioner of Securities and Insurance  
840 Helena Ave.  
Helena, MT 59601  
406-444-2040

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

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

**If there is any inconsistency between this notice and Montana law, then  
Montana law will control.**

**NEVADA****NOTICE OF PROTECTION PROVIDED BY  
NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION****Effective On or Before July 1, 2022**

This notice provides a **brief summary** regarding the protections provided to policyholders by the Nevada Life and Health Insurance Guaranty 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 and health maintenance organizations licensed in Nevada to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is limited and is *not* a substitute for consumers' care in selecting insurers. **Your policy or contract may not be covered, and if covered, there are substantial coverage limitations and exclusions. Further, coverage is dependent on continued residence in Nevada.** 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, and the law may change.

**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 Nevada 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 Nevada.

**Amounts of Coverage**

For any one life, per company, the coverage protections provided by the Association shall not exceed:

- **Life Insurance**
  - Death benefits: \$300,000
  - Cash surrender or withdrawal values: \$100,000
- **Annuities and Structured Settlement Annuities**
  - Present value of annuity benefits and structured settlement annuities, including cash surrenders or withdrawal values: \$250,000
  - Participants in a government retirement plan covered by an unallocated annuity as described by NRS 686.C.035: \$250,000
- **Health Insurance**
  - Disability Income and long-term care insurance, including net cash surrender values: \$300,000
  - Health Benefit Plan: \$500,000
  - Health insurance, other than disability income, long-term care insurance or Health Benefit Plan: \$100,000

*Please note that the maximum protection provided by the Association to an individual for all life insurance, annuities, and structured settlement annuities with one insurer is \$300,000; or for all life insurance, annuities, structured settlement annuities, and benefits for health benefit plans with one insurer, \$500,000, regardless of the number of policies or contracts covering the individual.*



## **COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE**

The following policies and persons are examples of those excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Nevada when it issued the policy or contract
- A policy or contract issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or an organization that is only licensed to issue charitable gift annuities
- Persons 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 except for annuities owned by a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code
- 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
- 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 exceed an average rate

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## **NOTICES**

Member insurers 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. The member insurer and its 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 or coverage offered by a health maintenance organization. You may file a complaint with the Nevada Insurance Commissioner if you believe any provision of the Nevada Life and Health Insurance Guarantee Association law has been violated. To learn more about coverage provided by the Association, please visit the Association's website at [www.nvlifega.org](http://www.nvlifega.org), or contact either of the following:

Nevada Life and Health Insurance  
Guaranty Association  
2377 Gold Meadow Way, Suite 100  
Gold River, CA 95670

Nevada Division Insurance  
Department of Business and Industry  
1818 E. College Pkwy., Suite 103  
Carson City, NV 89706

**When selecting an insurer, you should not rely on Association coverage. If there is any inconsistency between this notice and Nevada law, Nevada law will control.**

**NEW HAMPSHIRE****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 AND EXCLUSIONS****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.nhlfega.org](http://www.nhlfega.org)

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

February 2020

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

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

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

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

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

The North Carolina Life and Health Insurance Guaranty Association  
4441 Six Forks Rd Ste 106-153  
Raleigh, NC 27609-5729  
<https://www.nclifega.org/>

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

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

**COVERAGE**

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

**EXCLUSIONS FROM COVERAGE**

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

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

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

**LIMITS ON AMOUNT OF COVERAGE**

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

- (1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to a health benefit plan.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

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

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

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

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

1. Life Insurance
  - a. \$300,000 in death benefits
  - b. \$100,000 in cash surrender or withdrawal values
2. Health Insurance
  - a. \$500,000 for health benefit plans (see definition below)
  - b. \$300,000 in disability income insurance benefits
  - c. \$300,000 in long-term care insurance benefits
  - d. \$100,000 in other types of health insurance benefits
3. Annuities
  - a. \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

The maximum amount of protection for each individual, regardless of type of coverage is \$300,000; however, may be up to \$500,000 with regard to health benefit plans.

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

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

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

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

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

**COMPLAINTS AND COMPANY FINANCIAL INFORMATION**

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

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

**NEW JERSEY**

**NOTICE**

**NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

**DISCLAIMER**

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

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

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

The The New Jersey Life and Health Insurance  
Guaranty Association  
521 Newman Springs Road, Suite 22  
Lincroft, NJ 07738

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

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



## **COVERAGE**

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

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

## **EXCLUSIONS FROM COVERAGE**

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

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

The Association also does not provide coverage for:

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

## **LIMITS ON AMOUNT OF COVERAGE**

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

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than \$500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than \$100,000 in cash surrender values for annuity benefits, \$500,000 in life insurance death benefits or \$500,000 in present value of annuities--again no matter

how many policies and contracts that were with the same company, and no matter how many different types of coverages.

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

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

**NEW MEXICO**

**NOTICE OF  
PROTECTION PROVIDED BY  
NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION**

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

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

The basic protections provided by the Association are:

**Life Insurance**

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

**Health Insurance**

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

**Annuities**

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

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

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

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

To learn more about the above protections, please visit the Association’s website at [www.nmlifega.org](http://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
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**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.**

OHIO

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

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

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

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

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

Ohio Life and Health Insurance Guaranty Association  
5005 Horizons Drive , Suite 200  
Columbus, OH 43220

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

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

#### **COVERAGE**

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

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

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

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

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

## LIMITS ON AMOUNT OF COVERAGE

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

*Note to benefit plan trustees or other holders of unallocated annuities (GICs, DA Cs, etc.) covered by the act:* For unallocated annuities that fund governmental retirement plans under §§401, 403(b) or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

**For more information about the Ohio Life &Health Insurance Guaranty Association, visit our website at: [www.olhiga.org](http://www.olhiga.org).**

*As of 11/15/2018*

## OKLAHOMA

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

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

The basic protections provided by the Association are:

#### Life Insurance

- o \$300,000 in death benefits
- o \$100,000 in cash surrender or withdrawal values

#### Health Insurance

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

#### Annuities

- o \$300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

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

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

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

To learn more about the above protections, please visit the Association's website at [www.oklifega.org](http://www.oklifega.org), or contact:

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

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

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

**PENNSYLVANIA****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](http://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](http://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.



RHODE ISLAND

Metropolitan Life Insurance Company

## SUMMARY

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

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

### LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

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

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

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

RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION  
235 Promenade Street, #426  
Providence, RI 02908  
TEL (401) 273-2921

RHODE ISLAND DIVISION OF INSURANCE  
1511 Pontiac Avenue  
Cranston, RI 02920  
(401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen Laws section 27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

## COVERAGE

Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

## EXCLUSIONS FROM COVERAGE

The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

## LIMITATIONS ON COVERAGE

The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

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

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

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

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

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

**SOUTH CAROLINA**

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

**LIMITS ON AMOUNTS OF COVERAGE**

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

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

**SOUTH DAKOTA**

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

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

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

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

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

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The 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](http://www.sdlifega.org)

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

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

(please see next page)

## COVERAGE

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

## EXCLUSIONS FROM COVERAGE

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

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

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

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

## LIMITS ON AMOUNT OF COVERAGE

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

**(please see next page)**

## **ADDITIONAL INFORMATION**

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

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

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



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

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

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage, exclusions and limits. **This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

**COVERAGE**

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

**EXCLUSIONS FROM COVERAGE**

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

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

The Guaranty Association also does not provide coverage for:

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

#### LIMITS ON AMOUNT OF COVERAGE

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

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

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

- life insurance death benefits - \$300,000
- life insurance cash surrender value - \$100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - \$100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000

- health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - \$100,000 for limited benefits and supplemental health coverages
  - \$300,000 for disability and long term care insurance
  - \$500,000 for basic hospital, medical and surgical insurance or major medical insurance

\*\*\*\*\*

**NOTE**

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

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

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

Tennessee Life and Health Insurance Guaranty Association  
 P.O. Box 190434  
 Nashville, TN 37201  
 Website: [www.tnlifega.org](http://www.tnlifega.org)

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

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**TEXAS****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:

**Texas Life and Health Insurance Guaranty Association**

515 Congress Avenue, Suite 1875  
Austin, TX 78701  
1-800-982-6362 or [www.txlifega.org](http://www.txlifega.org)

For questions about insurance, contact:

**Texas Department of Insurance**

P.O. Box 149104  
Austin, TX 78714-9104  
1-800-252-3439 or [www.tdi.texas.gov](http://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.

## UTAH

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

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

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

The basic protections provided by the Association are:

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

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

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

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

To learn more about the above protections, please visit the Association's website at [www.ulhiga.org](http://www.ulhiga.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
466 South 500 East, Suite 100  
Salt Lake City UT 84102  
(801) 320-9955

Utah Insurance Department  
4315 S. 2700 W., Suite 2300  
Taylorsville, UT 84129  
(801) 957-9200

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

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

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization) licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - \$300,000 in death benefits
  - \$100,000 in cash surrender and withdrawal values
  
- Health Insurance
  - \$500,000 for health benefit plans
  - \$300,000 in disability [income] insurance benefits
  - \$300,000 in long-term care insurance benefits
  - \$100,000 in other types of accident and sickness insurance benefits
  
- Annuities
  - \$250,000 in withdrawal and cash values

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

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

To learn more about the above protections, please visit the Association's website at [www.valifega.org](http://www.valifega.org) or contact:

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

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

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

**WEST VIRGINIA**

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

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

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

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

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

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

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

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

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



## COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life, health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

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

portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;

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

#### LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

**WYOMING**

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

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

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

The basic protections provided by the Association are:

\* Life Insurance

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

\* Health Insurance

- \$300,000 in health benefit plan benefits
- \$300,000 in disability insurance benefits
- \$300,000 in disability income insurance
- \$300,000 in long-term care insurance benefits
- \$100,000 in other types of health insurance benefits

\* Annuities

- \$250,000 in present value of benefits including net withdrawal and cash values

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

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

**EXCLUSIONS FROM COVERAGE**

Policy owners, contract owners, policy holders, certificate holders and enrollees are not protected by this Association if:

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

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;
- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy or contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- experience rating credits given in connection with the administration of a policy to a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing benefits under Medicare Part C, Medicare Part D, or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at [www.wylifega.org](http://www.wylifega.org) or contact:

Wyoming Life and Health  
Insurance Guaranty Association  
6700 N. Linder Rd, Suite 156, Box 139  
Meridian, ID 83646

Toll Free: (800) 362-0944  
Fax: (208) 968-0206  
Website: [www.wylifega.org](http://www.wylifega.org)  
Email: [administrator@wylifega.org](mailto: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](http://doi.wyo.gov)  
Email: [wyinsdep@wyo.gov](mailto: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.**

# **Exhibit A-2**

## **Certificate of Insurance**



Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166

## CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a legal contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

**Policyholder:** City of League City

**Group Policy Number:** VHX1U001-1-G

**Type of Insurance:** Vision Insurance

**MetLife Toll Free Number(s):**  
**For Claim Information** FOR VISION CLAIMS: 1-833-EYE-LIFE (1-833-393-5433)

### **THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.**

**FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.**

**THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.**

**For Idaho Residents: TEN DAY RIGHT TO EXAMINE CERTIFICATE:** You may return the certificate to Us within 10 days from the date You receive it. If You return it within the 10 day period, the certificate will be considered never to have been issued. We will refund any premium paid after We receive Your notice of cancellation.

**THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.**

**For Residents of North Dakota:** If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

**For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.**

**For New Mexico Residents:** If You are not satisfied with Your certificate for any reason, You may return it to Us within 30 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund any premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

**For New Hampshire Residents: 30 Day Right to Examine Certificate.**

Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

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

## **NOTICE FOR RESIDENTS OF TEXAS**

### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

### **Metropolitan Life Insurance Company**

To get information or file a complaint with your insurance company or HMO:

**Call: Corporate Consumer Relations Department at 1-800-438-6388**

**Toll-free: 1-800-438-6388**

Email: [RTQA@versanthealth.com](mailto:RTQA@versanthealth.com)

Mail: Davis Vision  
Attention: Complaints and Appeals  
P.O. Box 791  
Latham, NY 12110

### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### **Metropolitan Life Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388**



**Teléfono gratuito: 1-800-438-6388**

Correo electrónico: [RTQA@versanthealth.com](mailto:RTQA@versanthealth.com)

Dirección postal: Davis Vision  
Attention: Complaints and Appeals  
P.O. Box 791  
Latham, NY 12110

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

## **NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON**

### **The Definition Of Child Is Modified For The Coverages Listed Below:**

#### **For Alaska Residents (Vision Insurance):**

The term also includes newborns.

#### **For Connecticut Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

A Child's insurance will not end due to age until the end of the Year in which that Child attains age 26.

#### **For Louisiana Residents (Vision Insurance):**

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

#### **For Minnesota Residents (Vision Insurance):**

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

#### **For Montana Residents (Vision Insurance):**

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

#### **For New Hampshire Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

#### **For New Mexico Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied vision insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

**NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON (continued)**

**For Utah Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Vision plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

**For Washington Residents (Vision Insurance):**

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

## **NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR VISION INSURANCE**

### **Notice Regarding Your Rights and Responsibilities**

#### **Rights:**

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to vision treatment are the responsibility of You and the Vision Provider. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Vision Insurance sections of this certificate for more details.
- You may request a written response from MetLife to any written concern or complaint.

#### **Responsibilities:**

- You are responsible for the prompt payment of any charges for services performed by the Vision Provider not fully covered by your Vision Insurance.
- You should consult with the Vision Provider about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Vision Provider the most current, complete and accurate information about Your medical and vision history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Vision Provider.

## **NOTICE FOR RESIDENTS OF ARKANSAS**

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

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

## **NOTICE FOR RESIDENTS OF CALIFORNIA**

### **IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:**

**DAVIS VISION  
ATTENTION: COMPLAINTS AND APPEALS  
P.O. BOX 791  
LATHAM, NY 12110**

**1-800-438-6388**

**IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:**

**DEPARTMENT OF INSURANCE  
CONSUMER SERVICES  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013**

**WEBSITE: <http://www.insurance.ca.gov/>**

**1-800-927-4357 (within California)  
1-213-897-8921 (outside California)**

## NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for vision insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

**"Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term **"Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.



## **NOTICE FOR RESIDENTS OF IDAHO**

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance  
Consumer Affairs  
700 West State Street, 3<sup>rd</sup> Floor  
PO Box 83720  
Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

## **NOTICE FOR RESIDENTS OF ILLINOIS**

### **IMPORTANT NOTICE**

To make a complaint to MetLife, You may write to:

Davis Vision  
Attention: Complaints and Appeals  
P.O. Box 791  
Latham, NY 12110

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR RESIDENTS OF INDIANA**

**Questions regarding your policy or coverage should be directed to:**

**Metropolitan Life Insurance Company**

**1-833-EYE-LIFE (1-833-393-5433)**

If you (a) need the assistance of the government 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 email:

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

Complaint can be filed electronically at [www.in.gov/idoi](http://www.in.gov/idoi)

## **NOTICE FOR RESIDENTS OF MAINE**

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

## **NOTICE FOR MASSACHUSETTS RESIDENTS**

### **CONTINUATION OF VISION INSURANCE**

1. If Your Vision Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Vision Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Vision Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

**Plant Closing** and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

### **CONTINUATION OF VISION INSURANCE FOR YOUR FORMER SPOUSE**

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Vision Insurance for Your former Spouse that would otherwise end may be continued.

To continue Vision insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Vision Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Vision Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Vision Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

## **NOTICE FOR RESIDENTS OF MISSISSIPPI**

### **CLAIMS FOR VISION INSURANCE**

#### **Routine Questions on Vision Insurance Claims**

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

#### **Initial Determination**

If Your claim for Vision Insurance benefits is a Clean Claim and it is approved, benefits will be paid within 25 days after We receive Proof in an electronic form of a covered loss, or within 35 days after receipt of Proof in paper form of a covered loss. Proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

**"Clean Claim"** means a claim that:

- does not require further information, adjustment or alteration by You or the provider of the services in order to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on Your behalf, a claim submitted more than 30 days after the date the provider bills You. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

If We do not deny payment of such benefits to You by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for Clean Claims submitted in paper form, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 3 percent per month until such benefits are finally settled. If We do not pay benefits to You when due and payable, You may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. We will pay benefits when We receive satisfactory Proof of Your claim.

If We are unable to pay a claim for Vision Insurance benefits because additional information or documentation is required, or there is a particular circumstance requiring special treatment, within 25 days after the date We receive the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, We will send You notice of what supporting documentation or information is needed. Any claim or portion of a claim for Vision Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to You within 20 days after it is received.

**NOTICE FOR RESIDENTS OF MISSISSIPPI****Claim Denial Appeals**

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You (or the provider, if You assigned the benefits to the provider) shall be entitled to recover any interest which may accrue plus damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS**

### **CONTINUATION OF YOUR VISION INSURANCE**

If You are a resident of New Hampshire, Your Vision Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all employees;
- this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Vision Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Vision Insurance;
- the amount of premium payment that is required to continue Your Vision Insurance;
- the manner in which You must request to continue Your Vision Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Vision Insurance may include:

- any amount that You contributed for Your Vision Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Vision Insurance, You must:

- send a written request to continue Your Vision Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Vision Insurance; or
- the date You become eligible for coverage under any other group Vision coverage.



## **NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)**

### **CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE**

If You are a resident of New Hampshire, Your Vision Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all Dependents;
- this Vision Insurance is changed, for the class of employees to which You belong, to end Vision Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Vision Insurance for Your Dependents ends because You fail to pay a required premium.

If Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Vision Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Vision Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Vision Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Vision Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Vision Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Vision Insurance for Your Dependents may include:

- any amount that You contributed for Your Vision Insurance before it ended; and
- any amount the Employer paid.

To continue Vision Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Vision Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Vision Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Vision Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Vision Insurance for Your Dependents will end.

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)**

### **CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE (Continued)**

The maximum continuation period will be the longest of the following that applies:

- 36 months if Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Vision Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if Vision Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Vision Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months with respect to a Dependent Child if Vision Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Vision Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Vision Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Vision Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group vision coverage.

## NOTICE FOR RESIDENTS OF NEW MEXICO

### Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/ConsumerAssistance/index.aspx>.

## NOTICE FOR RESIDENTS OF PENNSYLVANIA

Vision Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

## **NOTICE FOR RESIDENTS OF ALL STATES**

**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.**

## **NOTICE FOR RESIDENTS OF TEXAS**

If You are a resident of Texas and live in a county where there is no In-Network Vision Provider and travel distance to an In-Network Vision Provider is more than 90 minutes travel time and 75 miles away, We will pay benefits for Covered Services provided by an Out-of-Network Vision Provider as if the service was provided by an In-Network Vision Provider. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Vision Provider. Please call Us at 1-833-EYE-LIFE (1-833-393-5433) for assistance.

If You or a Dependent receive emergency or urgent vision care from an Out-of-Network Vision Provider, We will pay benefits for those Covered Services provided by an Out-of-Network Vision Provider as if the services were provided by an In-Network Vision Provider.

## NOTICE FOR RESIDENTS OF UTAH

### 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. (For the purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

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

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

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

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

To learn more about the above protections, please visit the Association's website at [www.ulhiga.org](http://www.ulhiga.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
466 South 500 East, Suite 100  
Salt Lake City UT 84102  
(801) 320-9955

Utah Insurance Department  
4315 S. 2700 W., Suite 2300  
Taylorsville, UT 84129  
(801) 957-9200

## NOTICE TO RESIDENTS OF VIRGINIA

### IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

Davis Vision  
Attention: Complaints and Appeals  
P.O. Box 791  
Latham, NY 12110

To phone in a claim related question, You may call Claims Customer Service at:  
1-833-EYE-LIFE (1-833-393-5433)

If You have any questions regarding an appeal or grievance concerning the vision services that You have been provided that have not been satisfactorily addressed by this Vision Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218-1157  
1-804-371-9691 - phone  
1-877-310-6560 - toll-free  
1-804-371-9944 - fax  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov) - email

Or:

Office of Licensure and Certification  
Division of Acute Care Services  
Virginia Department of Health  
9960 Mayland Drive  
Suite 401  
Henrico, Virginia 23233-1463  
Phone number: 1-800-955-1819/ local: 804-367-2106  
Fax: (804) 527-4503  
[MCHIP@vdh.virginia.gov](mailto:MCHIP@vdh.virginia.gov)

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.



**NOTICE TO RESIDENTS OF VIRGINIA (continued)****VISION INSURANCE: PROCEDURES FOR VISION CLAIMS****Routine Questions on Vision Insurance Claims**

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

**Claim Denial Appeals**

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

## NOTICE FOR RESIDENTS OF WISCONSIN

### 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.

Davis Vision  
Attention: Complaints and Appeals  
P.O. Box 791  
Latham, NY 12110  
1-833-EYE-LIFE (1-833-393-5433)

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 contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

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

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**SCHEDULE OF BENEFITS**

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents are only covered for insurance:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

**BENEFIT****BENEFIT AMOUNTS AND HIGHLIGHTS****Provider Network:****Davis Vision Network****Vision Insurance For You and Your Dependents**

	<b>Exam</b>	<b>Lenses</b>	<b>Frame</b>	<b>Contacts</b>
<b>Service Interval</b>	Once per Plan Year	Once Per Plan Year	Once Per Plan Year	Once Per Plan Year

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Exam Co-Payment</b> <i>Co-Payment shall not apply to Retinal Imaging</i>	\$10	\$0
<b>Materials Co-Payment</b> <i>Co-Payment shall not apply to Contact Lenses</i>	\$25	\$0

	<b>In-Network Coverage (Using an In-Network Vision Provider)</b>	<b>Out-of-Network Coverage (Using an Out-of-Network Vision Provider)</b>
<b>EYE EXAMINATION (one per frequency)</b>	Covered in full after any applicable Co-Payment  Comprehensive examination of visual functions and prescription of corrective eyewear.	\$40 allowance after any applicable Co-Payment  Comprehensive examination of visual functions and prescription of corrective eyewear.
<b>LOW VISION</b>  Low Vision Services means the evaluation, diagnosis and prescription of Low Vision devices by an eyecare professional who specializes in low vision rehabilitation. Low Vision evaluation does not include orthoptics or vision training. It includes the initial Low Vision evaluation and follow-up visits	<b>Comprehensive Evaluation</b> \$300 Allowance once every 60 months  <b>Follow-up Evaluation</b> \$100 Allowance for each follow-up visit up to four times every 60 months  <b>Low Vision Aids</b> \$600 Allowance per aid, \$1,200 lifetime maximum	<b>Comprehensive Evaluation</b> \$300 Allowance once every 60 months  <b>Follow-up Evaluation</b> \$100 Allowance for each follow-up visit up to four times every 60 months  <b>Low Vision Aids</b> \$600 Allowance per aid, \$1,200 lifetime maximum

**SCHEDULE OF BENEFITS (continued)**

	<b>In-Network Coverage (Using an In-Network Vision Provider)</b>	<b>Out-of-Network Coverage (Using an Out-of-Network Vision Provider)</b>	
<b>RETINAL IMAGING</b>	<p>Covered in full with a Co-Payment not to exceed \$39.</p> <p>Coverage for retinal imaging is an enhancement to eye examination.</p> <p>Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.</p>	Applied to the allowance for the eye examination	
<b>STANDARD CORRECTIVE LENSES</b>	<p>Covered in full after any applicable Co-Payment</p> <p>Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)</p>	Single Vision	\$40 allowance
		Lined Bifocal	\$60 allowance
		Lined Trifocal	\$80 allowance
		Lenticular	\$80 allowance

**SCHEDULE OF BENEFITS (continued)**

	<b>In-Network Coverage (Using an In-Network Vision Provider)</b>		<b>Out-of-Network Coverage (Using an Out-of-Network Vision Provider)</b>
<b>STANDARD LENS OPTIONS</b>	Standard Polycarbonate (child up to age 18)	Covered in full	Applied to the allowance for the applicable corrective lens
These lens options are available with a "not to exceed" pricing/maximum member out of pocket amount. <sup>1</sup>	Tints/Dyes – Solid	Covered in full	Applied to the allowance for the applicable corrective lens
	Tints/Dyes – Gradient	Covered in full	
	Progressive – Standard	\$50	Applied to the allowance for the applicable corrective lens
	Progressive – Premium	\$90	
	Progressive – Ultra	\$140	
	Progressive – Ultimate	\$175	
	Ultra Violet Coating	\$12	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (adult)	Covered in full	
	Scratch Resistant Coating	Standard - Covered in full  Premium - \$30	
	In-network providers offer a scratch protection plan that will replace lenses which have become scratched under normal usage within one year of dispensing, when scratch resistant coating was applied. This plan has a co-payment of:  Single Vision –\$20  Multifocal –\$40		
	Anti-Reflective Coating – Standard	\$35	
	Anti-Reflective Coating – Premium	\$48	
	Anti-Reflective Coating – Ultra	\$60	
	Anti-Reflective Coating – Ultimate	\$85	
Photochromic	\$65		

**SCHEDULE OF BENEFITS (continued)**

	Blue Light Filtering	\$15
	Digital Single Vision	\$30
	Polarized	\$75
	High Index (1.67/1.74)	\$55/\$120
<b>FRAMES</b>		
<b>DAVIS VISION NETWORK COLLECTION</b>		Not Covered
	<b>Fashion:</b> Covered in full	
	<b>Designer:</b> Covered in full	
	<b>Premier:</b> Covered in full	
<b>NON-COLLECTION</b>	Covered up to a \$200 allowance after any applicable Co-Payment  \$200 allowance at Visionworks	\$45 allowance after any applicable Co-Payment
<b>CONTACT LENSES</b>	The allowance will be applied to one contact lenses purchase. If part of the allowance remains after the first occurrence in a service interval, the remainder will be applied in later contact lens purchases in the same service interval	
<b>FITTING AND EVALUATION COLLECTION</b>	<b>Standard and Specialty Fit:</b>  Covered in full after any applicable Co-Payment	Not Applicable
<b>ELECTIVE COLLECTION</b>	Covered in full	Not Covered
	<b>Planned Replacement:</b> 4 boxes	
	<b>Disposable:</b> 8 boxes	
	Contact lenses are provided in place of lens and frame benefits available herein.	
<b>FITTING AND EVALUATION NON-COLLECTION</b>	<b>Standard Fit:</b>  Covered in full after \$25 Co-Payment  <b>Specialty Fit:</b>  \$60 allowance, after \$25 Co-Payment	Not Applicable
<b>ELECTIVE NON-COLLECTION</b>	\$150 allowance  Contact lenses are provided in place of lens and frame benefits available herein.	\$150 allowance  Contact lenses are provided in place of lens and frame benefits available herein.
<b>NECESSARY</b>	Covered in full  Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision	\$210 allowance  Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Out-of-Network

**SCHEDULE OF BENEFITS (continued)**

	Provider. Contact lenses are provided in place of lens and frame benefits available herein.	Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.
<b>Benefit for all Providers</b>		
<b>REFRACTIVE SURGERY PROGRAM</b>	\$200 Lifetime Allowance	

<sup>1</sup> Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

<b>Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)</b>	
<b>ADDITIONAL PAIR DISCOUNTS</b>	Members may receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the providers usual and customary rate may be available. Contact lenses may be available at a 10% discount.
<b>ADDITIONAL SAVINGS ON LENS ENHANCEMENTS</b>	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program. <sup>2</sup>
<b>ADDITIONAL SAVINGS ON FRAMES</b>	20% off any amount over your frames allowance. <sup>2</sup>
<b>ADDITIONAL SAVINGS ON CONTACTS</b>	15% off any amount over your contact lens allowance. <sup>2</sup> 15% discount on additional contacts. <sup>2</sup>

<sup>2</sup> These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.



## DEFINITIONS

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

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Anisometropia** means a condition of unequal refractive state of the two eyes, one eye requiring a different lens correction than the other.

**Child** means the following: (for residents of Alaska, Connecticut, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Utah and Washington, the Child Definition is modified as explained in the notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried. The term also includes Your grandchild who is under age 26, unmarried and who was able to be claimed by You as a Dependent for Federal Income Tax purposes at the time You applied for Vision Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

If You provide Us notice, a Child also includes a child for whom You must provide Vision Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term includes an Employee's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit.

**The term does not include** any person who is insured under the Group Policy as an employee.

**Contributory Insurance** means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Vision Insurance for You and Vision Insurance for Your Dependents.

**Co-Payment or Co-Pay** means a fixed dollar amount for which We are not responsible, as shown in the Schedule of Benefits. You must pay Your Co-Payment at the time services are rendered or materials ordered.

**Covered Person(s)** means an employee and/or a Dependent covered under this Certificate.

**Covered Services and Materials** mean a vision service or materials used to treat Your or Your Dependent's vision condition which is:

- prescribed or performed by a Vision Provider while such person is insured for Vision Insurance;
- Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS sections of this certificate.

**Dependent(s)** means Your Spouse and/or Child.

**DEFINITIONS (continued)**

**Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other;
  4. sharing a primary residence with the other; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

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

**Full-Time** means Active Work of at least 30 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

**In-Network Vision Provider** means an optometrist, therapeutic optometrist, ophthalmologist, or optician licensed and otherwise qualified to practice vision care and/or provide vision care materials who is contracted to provide Plan Benefits to Covered Persons of MetLife and accepts reimbursement at the negotiated rate.

**Keratoconus** means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

**Maximum Benefit Allowance** means the maximum amount We will allow for Covered Services and Materials provided by a Vision Provider.

**Necessary** means Covered Services and Materials that are necessary and meet with professionally recognized standards of practice. The fact that a Vision Provider may prescribe, order, recommend or approve a service or material does not, in itself, make it medically necessary, or make it a Covered Service and Material even though it is listed in the Group Policy or the Benefit Schedule as Covered Service and Material.

**Out-of-Network Vision Provider/Non-Network Vision Provider** means any optometrist, therapeutic optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted to provide vision care services and/or vision care materials to Covered Persons of MetLife.

**Plan or Plan Benefits** means the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Certificate.

**Progressive Lens** means a multifocal lens that makes the transition from distance to near vision by a gradual, progressive addition of power. The result is a lens with a seamless appearance.

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

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

Proof must be provided at the claimant's expense.

## **DEFINITIONS (continued)**

**Service Interval or Frequency** means a period of consecutive months, as shown in the SCHEDULE OF BENEFITS, in which You or Your Dependent may receive Covered Services and Materials. This period starts on Your or Your Dependent's effective date of coverage. A subsequent service interval starts after vision services or materials are received. Once Covered Services and Materials are received during any service interval, additional services are not covered during the same service interval and are subject to an additional charge.

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

**Spouse** means Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority. However, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

**Vision Provider** means an eye care professional who is an optometrist, therapeutic optometrist, ophthalmologist, or registered dispensing optician, who:

- Is licensed as such by the proper authorities in the jurisdiction where such services are performed;
- Is acting within the scope of such license.

**We, Us and Our** mean MetLife.

**Written or Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**Year or Yearly**, for Vision Insurance, means the 12 month period that begins January 1.

**You and Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

**All Full-Time employees and retired employees of the Policyholder.**

With respect to retirees, You are eligible for insurance if You were Actively at Work and covered for insurance on the day immediately preceding the date of Your retirement and have retired in accord with the Policyholder's retirement plan. Please be aware that:

- references to Active Work and Actively at Work will not apply; and
- end of employment will mean the end of the person's status as a retiree, as stated in the Policyholder's retirement plan.

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on October 1, 2022, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after October 1, 2022, You will be eligible for insurance on the first day of the month following the date You enter that class.

### **ENROLLMENT PROCESS FOR VISION INSURANCE**

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Vision Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

### **DATE YOUR INSURANCE TAKES EFFECT**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

#### **If You Do Not Enroll When First Eligible**

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

**ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)****Enrollment During An Annual Enrollment Period**

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible. The changes to Your insurance made during an enrollment period will take effect on the first day of the month following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

**Enrollment Due to a Qualifying Event**

You may enroll for insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event, will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- You previously did not enroll for Vision Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted; or
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines).

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the last day of the calendar month in which You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You; or
5. the last day of the calendar month in which Your employment ends for any reason other than retirement, Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; and

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS**

### **ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE**

**All Full-Time employees and retired employees of the Policyholder.**

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on October 1, 2022, You will be eligible for Dependent insurance on the later of:

1. October 1, 2022; and
2. the date You obtain a Dependent.

If You enter an eligible class after October 1, 2022, You will be eligible for Dependent insurance on the later of:

1. the first day of the month following the date You enter a class eligible for insurance; and
2. the date You obtain a Dependent.

No person may be insured as a Dependent of more than one employee.

### **ENROLLMENT PROCESS FOR DEPENDENT VISION INSURANCE**

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

In order to enroll for Vision Insurance for Your Dependents, You must either (a) already be enrolled for Vision Insurance for You or (b) enroll at the same time for Vision Insurance for You.

The Vision Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Vision Insurance only when You are first eligible, during an enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

### **DATE VISION INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for Dependent Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

#### **If You Do Not Enroll When First Eligible**

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next enrollment period for Vision Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

**ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)****Enrollment During An Annual Enrollment Period**

During any enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the month following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.

**Enrollment Due to a Qualifying Event**

You may enroll for Dependent Insurance for which You are eligible between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- Your taking leave under the United States Family and Medical Leave Act; or
- Your dependent's ceasing to qualify as a dependent under this or under other group coverage; or
- You previously did not enroll for Vision for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted; or
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines).

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.



## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

### **DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS**

A Dependent's insurance will end on the earliest of:

1. the date You die;
2. the date Vision Insurance for You ends;
3. the date the Group Policy ends;
4. the last day of the calendar month in which You cease to be in an eligible class;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the last day of the calendar month in which Your employment ends for any reason other than retirement; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the end of the period for which the last premium has been paid; or
9. the last day of the calendar month the person ceases to be a Dependent.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

**CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT****FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date, but not more frequently than once a year after the two-year period following the child's attainment of the limiting age.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

**FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

**COBRA CONTINUATION FOR VISION INSURANCE**

If Vision Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Policyholder for information regarding continuation of insurance under COBRA.

**AT YOUR OPTION: CONTINUATION OF YOUR INSURANCE DURING A LABOR DISPUTE**

You may elect to continue Vision Insurance if You cease to be Actively at Work as the result of a labor dispute. Such insurance will continue for up to 6 months if the following conditions are met:

- at least 75% of the Employees eligible to continue insurance elect to continue this insurance for such time period; and
- You pay the required premium for such insurance, which includes any contributions You were making, and any portion being paid by Your Employer, before You stopped Active Work. We may increase the required premium by up to 20% while You are continuing Your insurance under this provision.

If continued, Vision Insurance will end upon the earliest of the following:

- premium payment is required and You fail to pay premiums for such insurance; or
- the number of Employees who elect to continue such insurance falls below 75% of all employees eligible to continue this insurance for such time period; or
- You begin full-time employment with another employer; or
- You cease to be eligible to continue Vision Insurance under this section and You do not immediately resume Active Work in a class that is eligible for such insurance.

**AT THE POLICYHOLDER'S OPTION**

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)**

1. for the period You cease Active Work in an eligible class due to layoff, up to 3 months;
2. for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, up to 3 months;
3. for the period You cease Active Work in an eligible class due to injury or sickness, up to 18 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

## **VISION INSURANCE**

Benefits are available for Covered Services and Materials provided by either In-Network Vision Providers or Out-of-Network Vision Providers. However, You may be able to reduce Your out-of-pocket costs by using In-Network Vision Providers because Out-of-Network Vision Providers have not entered into an agreement to limit their charges. You are always free to receive services from any Vision Provider. You do not need any authorization from Us before seeing a Vision Provider.

In-Network Vision Providers have agreed to provide Covered Services and Materials as listed in the SCHEDULE OF BENEFITS.

If You or a Dependent incur a charge for Covered Services and Materials from an Out-of-Network Vision Provider, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

The benefits available under this Vision Insurance are set forth on the SCHEDULE OF BENEFITS. In addition to the Co-Payment, if applicable, You may be responsible for:

- the cost of any services or materials that are not Covered Services and Materials; and
- the cost of any service or material that is in excess of the Maximum Benefit Allowance listed on the SCHEDULE OF BENEFITS.

We do not provide vision services. Whether or not benefits are available for a particular service does not mean You should or should not receive the service. You and Your Vision Provider have the right and are responsible at all times for choosing the course of treatment and services to be performed.

When requesting Covered Services and Materials from an In-Network Vision Provider, We recommend that You confirm that the Vision Provider is currently an In-Network Vision Provider at the time that the Covered Services and Materials are provided.

You can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-833-EYE-LIFE (1-833-393-5433) or by visiting Our website at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

## **PLAN BENEFITS**

We will pay benefits for charges incurred by You or a Dependent for Covered Services and Materials as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

If You receive Covered Services and Materials from an In-Network Vision Provider, We will pay the provider directly for all covered benefits.

If You or Your Dependent receive Covered Services and Materials from an Out-of-Network Vision Provider, and You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

### **In-Network**

If Covered Services and Materials are provided by an In-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS.

If an In-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying:

- the Co-Payment, if applicable; and
- the cost of any service or material that is in excess of the Plan Benefits listed on the SCHEDULE OF BENEFITS.

## **VISION INSURANCE (continued)**

### **Out-of-Network**

If Covered Services and Materials are provided by an Out-of-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS, subject to the Maximum Benefit Allowance.

Out-of-Network Vision Providers may charge You more than the Maximum Benefit Allowance. If an Out-of-Network Vision Provider provides Covered Services and Materials, You will be responsible for paying any amount in excess of the Maximum Benefit Allowance charged by the Out-of-Network Vision Provider.

### **Necessary Contact Lenses**

Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's In-Network Vision Provider. Generally, coverage will be authorized for the following reasons:

- Aphakia—379.31 or 743.35.
- Nystagmus—379.50 through 379.56, 386.11, 386.12 or 386.2.
- Keratoconus—371.60, 371.61, 371.62, 743.41, or 743.42.
- Corneal transplant—V42.5.
- Corneal dystrophies—371.50 through 371.58.
- Anisometropia greater than or equal to 2.00 diopters difference in any meridian based on the spectacle prescription.
- High ametropia greater than or equal to  $\pm 10.00$  diopters in either eye in any meridian based on the spectacle prescription.
- Irregular astigmatism—367.22.

The codes listed above are from the International Classification of Diseases, Ninth Revision, Clinical Modification and are used to describe diseases, injuries, symptoms and conditions. If You have questions about the diagnoses listed above or the codes included with the diagnoses, please contact Your Vision Provider.

**VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS**

Subject to the Service Intervals and Plan Benefits indicated in the SCHEDULE OF BENEFITS, the following will be Covered Services and Materials:

1. One complete visual examination, if indicated as a Covered Service on the SCHEDULE OF BENEFITS. Dilation is included as a Covered Service when provided by an In-Network Vision Provider.
2. Standard corrective lenses. We will cover a pair of standard single vision, lined bifocal, lined trifocal or lenticular lenses that are necessary to correct vision. Standard corrective lenses are as follows:
  - eyesizes up to and including 60mm;
  - multi-focal lenses in all segment widths;
  - prism and slab off;
  - base curves (regardless of curve);
  - lenses with the combined power in any meridian is +/- .50 diopters or greater in at least one eye; and
  - plastic or glass lenses.
3. The following lens options described in the SCHEDULE OF BENEFITS: tint (solid and gradient), standard plastic scratch coating, standard polycarbonate (if you are less than 18 years of age), standard anti-reflective coating, plastic photochromic, blue light filtering, digital single vision, polarized, high index (1.67/1.74).
4. Contact lenses.
  - A standard fitting and 1 follow-up visit by a Vision Provider.
  - The following contact lenses options, as described in the SCHEDULE OF BENEFITS: conventional, disposable, and Necessary.
5. Necessary low vision aids and evaluations.
6. We do not cover costs above the Maximum Benefit Allowance shown in the SCHEDULE OF BENEFITS for frames. If frames are selected that are more expensive than that amount, You will be charged the difference between the Maximum Benefit Allowance and the Vision Provider's charge for the more expensive frame.
7. Necessary contact lenses in lieu of all benefits for vision materials.

**VISION INSURANCE: EXCLUSIONS**

We will not pay Vision Insurance benefits for charges incurred for:

1. Services and/or materials not specifically included in the SCHEDULE OF BENEFITS as covered Plan Benefits.
2. Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the SCHEDULE OF BENEFITS.
3. Plano lenses (lenses with refractive correction of less than  $\pm .50$  diopter).
4. Two pairs of glasses instead of bifocals.
5. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
6. Orthoptics or vision training and any associated supplemental testing.
7. Medical or non-refractive surgical treatment of the eye.
8. Prescription or non-prescription medications.
9. Contact lens insurance policies and service agreements.
10. Refitting of contact lenses after the initial (90-day) fitting period.
11. Contact lens modification, polishing and cleaning.
12. Any eye examination or any corrective eyewear required as a condition of employment.
13. Services or supplies received by You or Your Dependent before the Vision Insurance starts for that person.
14. Missed appointments.
15. Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
16. Local, state and/or federal taxes, except where MetLife is required by law to pay.
17. Services:
  - for which the employer of the person receiving such services is required to pay by law; or
  - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
18. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
19. Services and materials obtained while outside the United States, except for emergency vision care.
20. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

## **VISION INSURANCE: FILING A CLAIM**

### **CLAIMS FOR VISION INSURANCE**

If you select an In Network Vision Provider, You do not need to file a claim.

If you select an Out-of-Network Vision Provider, You may provide full payment to the Out-of-Network Vision Provider at the time of service and submit the invoice including an itemized statement of charges with Your claim form, or You may be able to assign the claim to the Out-of-Network Vision Provider. If the Out-of-Network Vision Provider accepts the assignment, the provider will submit the claim on your behalf. You will be responsible for any charges not covered by the Plan.

Out of network claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-833-EYE-LIFE (1-833-393-5433). Vision claim forms can also be downloaded from [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits). The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, Your claim will be paid subject to the terms and provisions of this certificate and the Group Policy.

### **CLAIMS FOR VISION INSURANCE BENEFITS**

**When a claimant files a claim for Vision Insurance benefits described in this certificate**, both the notice of claim and the required Proof should be sent to Us within 180 days from the date of service.

Claim and Proof may be given to Us by following the steps set forth below:

**Step 1**

A claimant can request a claim form by downloading it from [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

**Step 2**

Complete the claim form as instructed and return it with the invoice.

**Step 3**

The claimant must give Us Proof not later than 180 days from the date of service.



## VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

### Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

### Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

**Initial Appeal.** All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person in Writing within thirty (30) calendar days after receipt of the request for the appeal.

**Second Level Appeal.** If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

**Other Remedies.** When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

**Time of Action.** No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

**Insurance Fraud:** Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, may be guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

## **GENERAL PROVISIONS**

### **Assignment**

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, You may assign Vision Insurance benefits to the Vision Provider providing such service.

### **Vision Insurance: Who We Will Pay**

If You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

### **Entire Contract**

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by You, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

### **Conformity with Law**

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

**THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.  
THE FOLLOWING IS ADDITIONAL INFORMATION.**



Delaware American Life Insurance Company  
 MetLife Health Plans, Inc.  
 MetLife Legal Plans, Inc.  
 MetLife Legal Plans of Florida, Inc.  
 Metropolitan General Insurance Company

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

## Our Privacy Notice

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

### SECTION 1: Plan Sponsors and Group Insurance Contract Holders

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

### SECTION 2: Protecting Your Information

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

### SECTION 3: Collecting Your Information

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

### SECTION 4: How We Get Your Information

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

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

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

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

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

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

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at [www.mib.com](http://www.mib.com).

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## **SECTION 5: Using Your Information**

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

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

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## **SECTION 6: Sharing Your Information With Others**

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

Other reasons we may share your information include:

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

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## **SECTION 7: HIPAA**

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

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

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## **SECTION 8: Accessing and Correcting Your Information**

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

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

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**SECTION 9: Questions**

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

**Send privacy questions to:**

MetLife Privacy Office  
P. O. Box 489  
Warwick, RI 02887-9954  
[privacy@metlife.com](mailto:privacy@metlife.com)

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

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## HIPAA Notice of Privacy Practices for Protected Health Information

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

**PLEASE REVIEW IT CAREFULLY.**

Dear MetLife Customer:

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

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

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

### **NOTICE SUMMARY**

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

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

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

**In addition, we may use or disclose PHI:**

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

**You have the right to:**

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

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

**We are required by law to:**

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

**NOTICE DETAILS**

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

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

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

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

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.

- **For Health Care Operations:** We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.

- **To Affiliates and Business Associates:** We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health information organizations e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.

- **To Plan Sponsors:** We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.

- **To Individuals Involved in Your Care:** We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.

- **Where Required by Law or for Public Health Activities:** We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.

- **To Avert a Serious Threat to Health or Safety:** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services:** We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of



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

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

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

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

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

### **Your Rights Regarding Protected Health Information That We Maintain About You**

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

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy

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

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

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

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

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

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

• **Right to Request Confidential**

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

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

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

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

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

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

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

**ADDITIONAL INFORMATION**

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

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

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

## **Uniformed Services Employment And Reemployment Rights Act**

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

### **Continuation of Group Vision Insurance:**

If you take a leave from employment for “service in the uniformed services,” as that term is defined in USERRA, and as a consequence your vision insurance coverage under your employer’s group vision insurance policy ends, you may elect to continue vision insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for vision insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total vision insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents’ insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) while you have vision insurance coverage under your employer’s group vision insurance policy pursuant to USERRA. Contact your employer for more information.

