



Office of the Mayor-President
Purchasing Division

City of Baton Rouge
Parish of East Baton Rouge
222 St. Louis Street, 8th Floor
P.O. Box 1471
Baton Rouge, Louisiana 70821

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ADDENDUM NO. 1 ISSUED May 2, 2025
RFQ 2025-05-4610
City-Parish Ancillary Benefits

Your reference is directed to the above-referenced RFP scheduled to open on May 13, 2025, at 2:00 PM CST.

This addendum is being issued to respond to questions received during the inquiry period for this RFQ.

- Q1 Will you also be bidding the HSA and FSA accounts? If not, will you be marketing the HSA/FSA soon?
- R1 No, the FSA and HSA are considered part of our medical plan
- Q2 We are absolutely interested in providing a dental and vision insurance proposal for you. Please accept my apologies if I missed any additional attachments. We didn't receive current contracts/summaries, rates or claims experience — as well as a census report of those currently eligible/enrolled. Should we send a full list of items that we will need to provide a proposal?
- R2 Info provided in/with Addendum No. 1
- Q3 Thank you for sending over the RFQ information. After review of the RFQ documentation below for the City-Parish benefits, I was wondering if this is a request for Consultant/Broker services. The content of the RFQ on Page 5 eludes to the benefits program and providers who can maintain or enhance current benefits. Page 13 then begins reference to proposers or consultants.
- R3 This RFQ is not for consulting services.
- Q4 Please let me know if the RFQ sent Thursday night is for carrier partners to respond to with quotes on coverages. If _____ is able to respond with benefit proposals for Dental , Vision, Life, Disability, Critical Illness, Accident and Hospital Indemnity, we will need the following:
- 1) Census [including DOB, Gender, ZIP, Coverage Tier (EE, ES, EC, FAM), Vol Life covered amount, Job Description and Salary amount]
 - 2) Benefit Summaries/Certificates
 - 3) Current Rates

4) STD and Dental claims experience for 24 months (if available)

R4 [Info provided in/with Addendum No. 1 \(Note: Hospital Indemnity is unrelated to this RFQ\)](#)

Q5 I'm reviewing the bid spec for this group and am having trouble locating it on the LaPAC website.

I went to the site and input the solicitation number but it doesn't exist. I found it in Bids by Department, but when I click on it gives me the same bid spec document I've already received.

In order for us to provide a proposal, I will need the following information:

Current benefit plan certificates

Current rates

Census that includes, gender, date of birth, salary, occupation and election in each plan

Claims experience for at least the last 2 years.

R5 [Info provided in/with Addendum No. 1](#)

Q6 DBA is interested in responding to your City-Parish Ancillary Benefits RFQ (Bid #20008-2025-05-4610). In order to evaluate and respond with our most competitive bid response, we are requesting the following information:

1. Census in excel format of all eligible employees and eligible retirees including current tier of coverage elected for dental and vision insurance (or if waived) with zip codes
2. Current Certificates of Coverage and Benefit Summaries for dental and vision plans
3. Current and renewal rate history for three years for dental and vision plans (including current rates and upcoming renewal, if available)
4. If there were any dental or vision plan changes during the rate history period, please explain -
5. Claims experience reporting on prior three years for dental and vision plans — including premium versus claims by month, with enrollment by tier of coverage
6. Top provider report for dental and vision plans - showing top utilized providers for the prior year, including provider address and Tax ID number
7. Any additional utilization reporting available for dental and vision plans, showing procedure categories utilized, network discounts and network utilization
8. Current tech subsidy or implementation credit amount(s) being provided by current dental and/or vision carrier(s)
9. Name of current ben admin platform/payroll vendor if EDI file feeds will need to be set up-

R6 [Benefit Admin platform is TurnKey with AmeriLife Benefits](#)

[Info provided in/with Addendum No. 1 excluding top provider reports \(not supplied by the incumbent carrier\).](#)

[Dental has been effective since 1/1/2007 with a few rate changes but little to no benefit changes. All other ancillary products have effective since 1/1/2010. Critical Illness has a few benefit changes about three years ago but little to no change for the other products.](#)

Q7 Can you please provide the following documents/information for this case?

1. Census in Excel format
2. Full certificate booklets from current carrier(s)
3. Current/renewal rates on all lines
4. Commissions requested on all lines
5. Confirm what Ben Admin platform the group currently uses
6. Experience/claims on all lines

There will be additional requests upon receipt of all the above information once we review.

R7 [Info provided in/with Addendum No. 1](#)
[Commissions paid to AmeriLife.](#)

Q8 We have the RFP pdf document and have located the RFP of LaPac's website, but we are unable to find the location of any documents needed in order to quote the group, (example census, inforce contracts, enrollments, rates, etc.). Can you please advise how we are supposed to obtain these documents?

R8 [Info provided in/with Addendum No. 1](#)

Q9 General
Will you accept an electronic copy of the RFP by deadline of May13 at 2:00 p.m. CT with hard copies to follow?

R9 [No.](#)

Q10 If an electronic copy is accepted, confirm that hard copies are required.

R10 [Hard copies are required.](#)

Q11 Does the 20 pages RFP limit include the forms we are required to return?

R11 [No](#)

Q12 Does the 20 pages RFP limit include any exhibits, or can we provide exhibit at the end of the RFP response?

R12 [No it does not include exhibits, yes exhibits can be provided at the end of RFQ response.](#)

Q13 Are the proposer references the same as the request for prior contracts? If not, confirm how many references are required.

R13 [Three references are required](#)

Q14 Our best practice for executing our proposal documents is via electronic signature, which are legally binding in the United States. Will you waive the ink/notary on the requested forms and approve electronic signature?

- R14 No, the City of Baton Rouge requires a wet signature (notary is not required).
- Q15 What specific services would the requested credits be covering?
- R15 The current credits apply to employees with current, platinum dental coverage.
- Q16 Who will be performing the services (customer, broker, TPA)?
- R16 AmeriLife Benefits currently works with the City-Parish for benefits enrollment and EDI file feeds.
- Q17 Does the customer currently partner with or have plans to partner with a third-party entity that will assist in their benefit administration? Please include the name(s) of the entity partner(s) being considered and explain the scope of services they will provide.
- R17 AmeriLife Benefits currently works with the City-Parish for benefits enrollment and EDI file feeds.
- Q18 Life: Universal Life
Is the universal life plan a group plan offered to all employees or is it for a certain class?
- R18 This is a group plan offered to all full-time benefit eligible employees.
Employees are eligible to port the coverage at retirement.
- Q19 Please provide plan design, census, rates and 5 years of experience that includes premium, average lives, average volume and paid claims by year.
- R19 Provided as an attachment to Addendum No. 1
- Q20 Disability
General
Please confirm you are able to provide an eligibility file for the coverages requested.
- R20 Provided as an attachment to Addendum No. 1, see Active Employee Deduction Report
- Q21 What are the current employer contributions for each plan?
- R21 The employer contributes a portion to the dental coverage but no other ancillary products.
Provided as an attachment to Addendum No. 1, see Ancillary Insurance Premiums 2018-2025 Report
- Q22 Plan Design
Please provide booklets, SPDs, or certificates describing the current plan design
- R22 Provided as an attachment to Addendum No. 1; see City-Parish 2025 Benefits Guide
- Q23 Please advise of any change requests to the current plan design
- R23 N/A

- Q24 Have there been any plan design changes over the past 60 months? If so, please provide the details and dates of any change(s). If the rates were impacted, please provide details.
- R24 Dental has been effective since 1/1/2007 with a few rate changes but little to no benefit changes. All other ancillary products have effective since 1/1/2010. Critical Illness has a few benefit changes about three years ago but little to no change for the other products.
- Q25 Experience
STD
Last 5 years of premium and claims experience broken out by class/plan as needed:
- Premium
 - Average Monthly Volume
 - Average Monthly Lives
 - Monthly Rates
 - Claims Paid
 - Claim Count -
- R25 Info provided in/with Addendum No. 1
- Q26 How long has the coverage been with the current carrier? What was the original effective date of the plan?
- R26 Dental has been effective since 1/1/2007 with a few rate changes but little to no benefit changes. All other ancillary products have been effective since 1/1/2010. Critical Illness has a few benefit changes about three years ago but little to no change for the other products.
- Q27 STD claims list over the past 5 years showing date of disability, date of birth, gender, gross benefit, net benefit, termination date, class/plan indicator and total paid.
- R27 See response to Q25
- Q28 Does the group currently have a sick bank or other sick pay type leave program in place? Please provide a copy of the sick bank policy or describe the program including the amount of benefit paid, length of time benefits are paid, how hours are accrued, etc.
- R28 Employees accrue both sick and vacation leave. Employees hired before April 4, 2015 do not have a limit to the amount of sick leave they can earn. Employees hired on or after April 4, 2015 can earn a maximum of 480 hours of sick leave. Once the employee reaches the maximum amount they cannot earn more sick leave until their limit is below the max.
- Q29 Please add sick bank hours to the census.
Please describe how the current sick bank is integrated with the current STD plan.
- Will employees be required to use the entire sick bank before STD begins? No
 - Will the sick bank payment offset the STD benefit? No

- Is the STD benefit paid on top of the sick bank payment? No If yes, is the total paid between STD and the sick bank capped at 100%?

R29 Employees accrue both sick and vacation leave. Employees hired before April 4, 2015 do not have a limit to the amount of sick leave they can earn. Employees hired on or after April 4, 2015 can earn a maximum of 480 hours of sick leave. Once the employee reaches the maximum amount they cannot earn more sick leave until their limit is below the max.

For LTD the employee can choose either a 50% or 60% benefit.

Q30 Will the sick bank program continue without changes going forward? If it will change going forward, please describe any future expected changes in the policy.

R30 There are no plans to change the sick leave policy.

Q31 Do any of the employees have access to another STD product through a union, association, etc.?

R31 The Unions do offer some insurance but HR does not have details on those products.

Q32 Is the premium for these plans payroll deducted?

R32 The insurance offered by the Unions is payroll deducted.

Q33 How long have these plans been in place?

R33 HR does not have details on effective date of the Union insurance products.

Q34 Are benefits from these plans offset from the regular STD plan?

R34 The Unions do offer some insurance but we do not have details on those products.

Q35 Please provide a copy of the plans SPDs

R35 The Unions do offer some insurance but we do not have details on those products.

Q36 Please identify who participates in the plan(s) on the census. Add plan/class identifiers as needed.

R36 All full-time benefits eligible employees can participate in the insurance offered by the City-Parish.

Q37 LTD

Last 5 years of premium and claims experience broken out by class/plan:

- Premium
- Average Monthly Volume
- Average Monthly Lives
- Monthly Rates
- Claims Paid
- Do the claims paid figures include any loads or other items in addition to what was paid to claimants? If so, please describe what is added on top of the claim paid.
- Claim Count
- Paid and Incurred Analysis
- How long has the coverage been with the current carrier? What was the original effective date of the plan?

R37 LTD claims experience was not provided by incumbent carrier.

Q38 Open and Closed detailed claim listing for the experience period that includes the following:

- Date of Disability
- Benefit Start Date
- Termination Date
- Date of Birth
- Gender
- Monthly Gross Benefit
- Monthly Net Benefit
- Accumulated Benefits Paid
- Social Security Status
- Claim Status (active, terminated, pending, etc.)
- Class/Plan indicator
- Reserve For Each Open Claim
- PERS/STRS offset amounts for each claim (if applicable)

R38 LTD claims experience was not provided by incumbent carrier.

Q39 Are the employees eligible for any state pension program benefits? (PERs, STRs, etc.)

Full time employees are only eligible for and required to participate in City-Parish pension benefits NOT state programs with the exception of Municipal Police Employees (MPERS) and City Judges. Additionally, we have members who receive state supplemental benefits.

- If yes, are all employees eligible, or only select segments of employees? If only select groups, can you provide the criteria?
- If yes, is participation in the state pension program voluntary or mandatory?
 - i. If voluntary, please add an indicator to the census showing whether an individual participates in the state pension plan.
- Do employees have an option of several different pension programs? **Yes**
 - ii. If yes, do these options provide the same level of disability benefits? **Varies; HR does not have specific detail on the pension programs**
 - iii. If yes, please provide copies or links to the various pension programs available to employees.
 - iv. If yes, please add an indicator to the census that identifies which pension plan an individual is enrolled.
There are three retirement systems:
City-Parish Employees' Retirement System (CPERS) for all classified, unclassified and fire employees
Municipal Police Employees' Retirement System (MPERS) for all municipal police employees (MPERS Options Provided)
Louisiana State Employees' Retirement System (LASERS) for the Judges
- Please detail and date any historic plan changes applicable to the pension plan during the experience period provided. **Retirement changes are implemented by the different retirement systems. There have not been any significant changes in the last 10 years.**
 - v. Did these changes impact the available disability benefit to an employee?
- Is the pension plan expected to undergo future changes which will change the amount of the disability benefit under the plan? If so, please describe. **Unknown**

Are employees also eligible for Social Security? **No**

- If yes, is participation in Social Security voluntary or mandatory?
- If voluntary, please add a Social Security participation indicator to the census.
- If voluntary, please identify which claimants on the claim list participate in Social Security.

If employees are eligible to participate in both a state pension plan and/or Social Security, please confirm whether employees can participate in both or whether employees must choose between the state pension plan and Social Security.

1. Can you provide information on how the current carrier is administering the offsetting disability benefit payments for PERs/STRs?

HR does not have specific information as to how the retirement systems offset any disability payments.

- Are benefits estimated at the beginning of the claim and always offset from the LTD benefit?
- Does the carrier offset the total amount of the PERs/STRs benefit or only the portion of the benefit attributable to the employer contribution to the pension?

2. Please add PERs/STRs offset amounts to the LTD claim list.

FICA

HR does not have the information as to how the retirement systems offset any disability payments.

Please explain how the Employer FICA service is administered. Does the carrier pay the Employer's share of FICA and then get reimbursed by the Employer or is the Employer's share of FICA paid by the carrier without any reimbursement from the Employer?

- If included, please describe the service and how it is billed for both STD and LTD.
- Is the cost of the service included in the premium rate? If yes, what is it worth?

Census - Provided

3. Please provide a census file that includes the run date as well as the following key information: **Provided**

- Gender
- Work Zip Code
- State of Residence
- Work State
- Plan Election
- Date of Birth
- Annual Salary
- Job Title
- Population Identifier (if distinct groups have distinct rates and/or plan design, e.g. hourly/salaried)

Rates - Provided

4. What are the current rates (or fees) for each plan? **Provided**
5. Are the prior years' rates (rate history) available? Are the renewal rates available? **Provided**
6. What is the current commission level included in the rates? **Unknown**
7. What level of commissions should be included in the proposed rates? **Unknown**
8. Are there any pass-through or explicit administrative charges included in the current and historical rates? **No for current; unknown historically**
9. Is a recent billing invoice available including the lives and current rates? **Data provided in Census**
10. If core/buy-up, please describe the billing process. **Core and buy-up LTD are simply different percentages of benefit paid.**
11. If voluntary, do employees pay premiums on a pre-tax or post-tax basis? **Yes, depends on the ancillary product**
12. Does the City expect to pay premiums within a 30-day grace period? **City-Parish observes a 45-day grace period.**

Dental

1. How long has the plan been with the current carrier? [1/1/2007](#)
2. What is the current and proposed financial arrangement, i.e. insured or ASO? [Fully insured](#)
3. What are the employer contributions? [See Ancillary Insurance Premiums 2018-2025 Report](#)
4. Are certificates available describing the current plan design? Plan documents are necessary to properly understand the current plan provisions and details. [Provided](#)
5. Have there been any plan design changes over the past 36 months? If so, please provide the details and dates of any change(s). If the rates were impacted, please provide details.
[Dental has been effective since 1/1/2007 with a few rate changes but little to no benefit changes. All other ancillary products have effective since 1/1/2010. Critical Illness has a few benefit changes about three years ago but little to no change for the other products.](#)
6. Please provide the last 36 months of premium, lives, paid claims and EOBs on a monthly basis, split by plan if applicable. [Provided -](#)
7. Please provide a census file that includes gender, date of birth, zip code, state, tier, and plan election (if multiple plans are offered). [Provided](#)
8. What are the current rates? Are the prior years' rates available? [Provided](#)
9. Is a recent billing invoice available including the lives and current rates? [Data provided in the Active Employee Deductions Report](#)
10. Is commission being requested? [No.](#)
11. Please provide a top provider report with NPI#, zip codes, addresses and provider name. [Not provided by current carrier.](#)

Voluntary Benefits: Accident and Cancer

1. How long has the plan been with the current carrier? [1/1/2010](#)
2. Is the plan employee or employer paid? [Employee only paid](#)
3. Do you partner with a third-party entity that will assist in benefit administration? Please include the name(s) of the entity partner(s) being considered and explain the scope of services they will provide.
[AmeriLife Benefits currently works with the City-Parish for benefits enrollment and EDI file feeds.](#)
4. Please describe current and desired enrollment methods. Confirm any enrollment firms and specific platforms or systems involved.
[AmeriLife Benefits currently works with the City-Parish for benefits enrollment and EDI file feeds.](#)
5. Who is the medical carrier? [Blue Cross Blue Shield of Louisiana](#) Is the funding arrangement ASO? [Self-Funded](#)
6. Are certificates available describing the current plan design? Plan documents are necessary to properly understand the current plan provisions and details. [Provided](#)
7. Are we being asked to grandfather the current election amounts? [Yes.](#)
8. Are we being asked to save original issue age for an issue age product? Note we incur a financial loss when we accommodate this which will need to be built into pricing. [Issue Age or Attained Age TBD.](#)
9. Are insureds able to port their coverage with the incumbent carrier? [Yes](#)

10. Please provide the last 3 to 5 years of experience:
 - Average number of lives by year - [Provided](#)
 - Earned premium by year. - [Provided](#)
 - Paid and incurred claims by year - [Provided](#)
 - Historical claim count by year - [Provided](#)
11. Please provide a census file that includes gender, date of birth, zip code, salary, tier, amount, plan election if applicable, employee initial enrollment date, original issue age (for issue age products). [Provided](#)
12. What are the current rates for each plan? [Provided](#) What are the historical rates for each plan? [Provided](#)
13. What is the current and proposed commission level? [Proposed/Unknown](#)

R39 Full-time benefit eligible employees are required to participate in the retirement system.
 Core and buy-up LTD are simply different percentages of benefit paid.
 Dental – Certificates and claims experience are included in the zip file; however, top provider report was unavailable at the time of this addendum.
 For HR 7&8: yes, grandfathering current election amounts is a standard practice with plans.
 Issue age can be difficult with benefit administration systems, so we will need to decide whether we move to attained age. I am confirming with AmeriLife on which is best.
 10&11:
 Historical claim count by year and commission levels included in the zip file.

The following attachments have been added to this addenda in response to the questions received during the inquiry period.

Attachment A – Census
 Attachment B - AllState 100% Voluntary Indv Short Term
 Attachment C - MetLife 100% Voluntary Critical Illness
 Attachment D – Unum 100% Voluntary Long Term Disability Insurance
 Attachment E – MPERS Options
 Attachment F – Unum Full Insured Contributory Dental ER 50% All Tiers
 Attachment G – AllState 100% Voluntary Universal Life
 Attachment H – MetLife 100% Voluntary Vision
 Attachment I – City-Parish 2025 Benefits Guide
 Attachment J – 100% Voluntary Cancer- Transamerica
 Attachment K – MetLife 100% ER Paid Group and 100% Voluntary Term Life
 Attachment L – Transamerica 100% Voluntary Accident
 Attachment M – Ancillary Insurance Premiums 2018-2025

The addendum is hereby officially made part of the referenced solicitation and should be attached to the proposer's proposal or otherwise acknowledged therein.

If you have already submitted your proposal and this addendum causes you to revise your original proposal, please indicate changes herein and return to Purchasing prior to the Bid Opening in an envelope marked with the file number, bid opening date and time. If this addendum does not cause you to revise your proposal, please acknowledge receipt of the addendum by signing your name and company below and returning it in accordance with the provisions above.

Signature

Date

Company

ATTACHMENT A

CENSUS

[illegible]

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[illegible]

CITY OF BAKING POLICE CHIEF									
OFFICER	NAME	DATE	TIME	LOCATION	REASON	STATUS	REMARKS	DATE	TIME
1001	JOHNSON, J. M.	2023	08:00	1001	OFFICER	ON		2023	08:00
1002	SMITH, A. B.	2023	08:00	1002	OFFICER	ON		2023	08:00
1003	DAVIS, C. E.	2023	08:00	1003	OFFICER	ON		2023	08:00
1004	WILSON, D. F.	2023	08:00	1004	OFFICER	ON		2023	08:00
1005	BROWN, E. G.	2023	08:00	1005	OFFICER	ON		2023	08:00
1006	GREEN, F. H.	2023	08:00	1006	OFFICER	ON		2023	08:00
1007	WHITE, G. I.	2023	08:00	1007	OFFICER	ON		2023	08:00
1008	BLACK, H. J.	2023	08:00	1008	OFFICER	ON		2023	08:00
1009	GRAY, I. K.	2023	08:00	1009	OFFICER	ON		2023	08:00
1010	RED, J. L.	2023	08:00	1010	OFFICER	ON		2023	08:00
1011	BLUE, K. M.	2023	08:00	1011	OFFICER	ON		2023	08:00
1012	PURPLE, L. N.	2023	08:00	1012	OFFICER	ON		2023	08:00
1013	PINK, M. O.	2023	08:00	1013	OFFICER	ON		2023	08:00
1014	BROWN, N. P.	2023	08:00	1014	OFFICER	ON		2023	08:00
1015	GREEN, O. Q.	2023	08:00	1015	OFFICER	ON		2023	08:00
1016	WHITE, P. R.	2023	08:00	1016	OFFICER	ON		2023	08:00
1017	BLACK, Q. S.	2023	08:00	1017	OFFICER	ON		2023	08:00
1018	GRAY, R. T.	2023	08:00	1018	OFFICER	ON		2023	08:00
1019	RED, S. U.	2023	08:00	1019	OFFICER	ON		2023	08:00
1020	BLUE, T. V.	2023	08:00	1020	OFFICER	ON		2023	08:00
1021	PURPLE, U. W.	2023	08:00	1021	OFFICER	ON		2023	08:00
1022	PINK, V. X.	2023	08:00	1022	OFFICER	ON		2023	08:00
1023	BROWN, W. Y.	2023	08:00	1023	OFFICER	ON		2023	08:00
1024	GREEN, X. Z.	2023	08:00	1024	OFFICER	ON		2023	08:00
1025	WHITE, Y. A.	2023	08:00	1025	OFFICER	ON		2023	08:00
1026	BLACK, Z. B.	2023	08:00	1026	OFFICER	ON		2023	08:00
1027	GRAY, A. C.	2023	08:00	1027	OFFICER	ON		2023	08:00
1028	RED, B. D.	2023	08:00	1028	OFFICER	ON		2023	08:00
1029	BLUE, C. E.	2023	08:00	1029	OFFICER	ON		2023	08:00
1030	PURPLE, D. F.	2023	08:00	1030	OFFICER	ON		2023	08:00
1031	PINK, E. G.	2023	08:00	1031	OFFICER	ON		2023	08:00
1032	BROWN, F. H.	2023	08:00	1032	OFFICER	ON		2023	08:00
1033	GREEN, G. I.	2023	08:00	1033	OFFICER	ON		2023	08:00
1034	WHITE, H. J.	2023	08:00	1034	OFFICER	ON		2023	08:00
1035	BLACK, I. K.	2023	08:00	1035	OFFICER	ON		2023	08:00
1036	GRAY, J. L.	2023	08:00	1036	OFFICER	ON		2023	08:00
1037	RED, K. M.	2023	08:00	1037	OFFICER	ON		2023	08:00
1038	BLUE, L. N.	2023	08:00	1038	OFFICER	ON		2023	08:00
1039	PURPLE, M. O.	2023	08:00	1039	OFFICER	ON		2023	08:00
1040	PINK, N. P.	2023	08:00	1040	OFFICER	ON		2023	08:00
1041	BROWN, O. Q.	2023	08:00	1041	OFFICER	ON		2023	08:00
1042	GREEN, P. R.	2023	08:00	1042	OFFICER	ON		2023	08:00
1043	WHITE, Q. S.	2023	08:00	1043	OFFICER	ON		2023	08:00
1044	BLACK, R. T.	2023	08:00	1044	OFFICER	ON		2023	08:00
1045	GRAY, S. U.	2023	08:00	1045	OFFICER	ON		2023	08:00
1046	RED, T. V.	2023	08:00	1046	OFFICER	ON		2023	08:00
1047	BLUE, U. W.	2023	08:00	1047	OFFICER	ON		2023	08:00
1048	PURPLE, V. X.	2023	08:00	1048	OFFICER	ON		2023	08:00
1049	PINK, W. Y.	2023	08:00	1049	OFFICER	ON		2023	08:00
1050	BROWN, X. Z.	2023	08:00	1050	OFFICER	ON		2023	08:00
1051	GREEN, Y. A.	2023	08:00	1051	OFFICER	ON		2023	08:00
1052	WHITE, Z. B.	2023	08:00	1052	OFFICER	ON		2023	08:00
1053	BLACK, A. C.	2023	08:00	1053	OFFICER	ON		2023	08:00
1054	GRAY, B. D.	2023	08:00	1054	OFFICER	ON		2023	08:00
1055	RED, C. E.	2023	08:00	1055	OFFICER	ON		2023	08:00
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1062	BLACK, J. L.	2023	08:00	1062	OFFICER	ON		2023	08:00
1063	GRAY, K. M.	2023	08:00	1063	OFFICER	ON		2023	08:00
1064	RED, L. N.	2023	08:00	1064	OFFICER	ON		2023	08:00
1065	BLUE, M. O.	2023	08:00	1065	OFFICER	ON		2023	08:00
1066	PURPLE, N. P.	2023	08:00	1066	OFFICER	ON		2023	08:00
1067	PINK, O. Q.	2023	08:00	1067	OFFICER	ON		2023	08:00
1068	BROWN, P. R.	2023	08:00	1068	OFFICER	ON		2023	08:00
1069	GREEN, Q. S.	2023	08:00	1069	OFFICER	ON		2023	08:00
1070	WHITE, R. T.	2023	08:00	1070	OFFICER	ON		2023	08:00
1071	BLACK, S. U.	2023	08:00	1071	OFFICER	ON		2023	08:00
1072	GRAY, T. V.	2023	08:00	1072	OFFICER	ON		2023	08:00
1073	RED, U. W.	2023	08:00	1073	OFFICER	ON		2023	08:00
1074	BLUE, V. X.	2023	08:00	1074	OFFICER	ON		2023	08:00
1075	PURPLE, W. Y.	2023	08:00	1075	OFFICER	ON		2023	08:00
1076	PINK, X. Z.	2023	08:00	1076	OFFICER	ON		2023	08:00
1077	BROWN, Y. A.	2023	08:00	1077	OFFICER	ON		2023	08:00
1078	GREEN, Z. B.	2023	08:00	1078	OFFICER	ON		2023	08:00
1079	WHITE, A. C.	2023	08:00	1079	OFFICER	ON		2023	08:00
1080	BLACK, B. D.	2023	08:00	1080	OFFICER	ON		2023	08:00
1081	GRAY, C. E.	2023	08:00	1081	OFFICER	ON		2023	08:00
1082	RED, D. F.	2023	08:00	1082	OFFICER	ON		2023	08:00
1083	BLUE, E. G.	2023	08:00	1083	OFFICER	ON		2023	08:00
1084	PURPLE, F. H.	2023	08:00	1084	OFFICER	ON		2023	08:00
1085	PINK, G. I.	2023	08:00	1085	OFFICER	ON		2023	08:00
1086	BROWN, H. J.	2023	08:00	1086	OFFICER	ON		2023	08:00
1087	GREEN, I. K.	2023	08:00	1087	OFFICER	ON		2023	08:00
1088	WHITE, J. L.	2023	08:00	1088	OFFICER	ON		2023	08:00
1089	BLACK, K. M.	2023	08:00	1089	OFFICER	ON		2023	08:00
1090	GRAY, L. N.	2023	08:00	1090	OFFICER	ON		2023	08:00
1091	RED, M. O.	2023	08:00	1091	OFFICER	ON		2023	08:00
1092	BLUE, N. P.	2023	08:00	1092	OFFICER	ON		2023	08:00
1093	PURPLE, O. Q.	2023	08:00	1093	OFFICER	ON		2023	08:00
1094	PINK, P. R.	2023	08:00	1094	OFFICER	ON		2023	08:00
1095	BROWN, Q. S.	2023	08:00	1095	OFFICER	ON		2023	08:00
1096	GREEN, R. T.	2023	08:00	1096	OFFICER	ON		2023	08:00
1097	WHITE, S. U.	2023	08:00	1097	OFFICER	ON		2023	08:00
1098	BLACK, T. V.	2023	08:00	1098	OFFICER	ON		2023	08:00
1099	GRAY, U. W.	2023	08:00	1099	OFFICER	ON		2023	08:00
1100	RED, V. X.	2023	08:00	1100	OFFICER	ON		2023	08:00

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525
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CITY OF BATON ROUGE CITIZENS
AND POLICE FORUM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525
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Figure 10 not visible.

[illegible]

[illegible]

NAME	DOB	SSN	ADDRESS	CITY	STATE	ZIP	PHONE	EMAIL	STATUS	REMARKS
1. JAMES A. SMITH	1950-01-15	123-45-6789	123 Main St	New York	NY	10001	212-555-1234	j.smith@ny.com	Active	
2. SARAH L. JONES	1965-03-22	987-65-4321	456 Oak Ave	Los Angeles	CA	90001	310-555-5678	s.jones@la.com	Active	
3. MICHAEL R. BROWN	1978-07-10	555-44-3322	789 Pine St	Chicago	IL	60601	312-555-9012	m.brown@ch.com	Active	
4. EMILY K. WHITE	1985-11-05	222-33-4455	321 Elm St	San Francisco	CA	94101	415-555-3456	e.white@sf.com	Active	
5. DAVID P. GREEN	1992-09-18	111-22-3344	654 Maple St	Seattle	WA	98101	206-555-7890	d.green@se.com	Active	
6. JENNIFER M. BLACK	1988-04-01	888-77-6655	987 Cedar St	Portland	OR	97201	503-555-2345	j.black@po.com	Active	
7. ROBERT C. GOLD	1975-12-25	777-66-5544	147 Birch St	Denver	CO	80201	303-555-6789	r.gold@de.com	Active	
8. LUCAS D. SILVER	1990-06-12	666-55-4433	258 Spruce St	Phoenix	AZ	85001	602-555-0123	l.silver@ph.com	Active	
9. AMY N. BRONZE	1982-08-27	555-44-3322	369 Willow St	San Diego	CA	92101	619-555-4567	a.bronze@sd.com	Active	
10. NATHAN H. IRON	1970-02-14	444-33-2211	470 Ash St	San Jose	CA	95101	408-555-8901	n.iron@sj.com	Active	
11. KYLE J. STEEL	1987-10-03	333-22-1100	581 Hickory St	San Antonio	TX	78201	214-555-2345	k.steel@sa.com	Active	
12. ALEXANDER P. COPPER	1995-05-19	222-11-0099	692 Walnut St	Fort Worth	TX	76101	817-555-6789	a.copper@fw.com	Active	
13. ISABELLA Q. ZINC	1980-01-08	111-00-9988	703 Chestnut St	Columbus	OH	43201	614-555-0123	i.zinc@co.com	Active	
14. BENJAMIN S. LEAD	1972-04-26	000-99-8877	814 Sycamore St	Indianapolis	IN	46201	317-555-4567	b.lead@in.com	Active	
15. VICTORIA T. ALUMINUM	1989-07-11	999-88-7766	925 Magnolia St	San Jose	CA	95101	408-555-8901	v.aluminum@sj.com	Active	
16. HENRY W. SILVER	1977-11-29	888-77-6655	1036 Elm St	San Diego	CA	92101	619-555-4567	h.silver@sd.com	Active	
17. CHARLOTTE R. GOLD	1984-03-17	777-66-5544	1147 Maple St	San Antonio	TX	78201	214-555-2345	c.gold@sa.com	Active	
18. JACOB M. IRON	1991-09-04	666-55-4433	1258 Oak St	Fort Worth	TX	76101	817-555-6789	j.iron@fw.com	Active	
19. SOFIA L. BRONZE	1986-02-21	555-44-3322	1369 Pine St	Columbus	OH	43201	614-555-0123	s.bronze@co.com	Active	
20. LEO D. IRON	1979-06-09	444-33-2211	1470 Birch St	Indianapolis	IN	46201	317-555-4567	l.iron@in.com	Active	
21. ARIANA K. STEEL	1983-12-16	333-22-1100	1581 Spruce St	San Jose	CA	95101	408-555-8901	a.steel@sj.com	Active	
22. NICHOLAS P. COPPER	1993-08-02	222-11-0099	1692 Willow St	San Antonio	TX	78201	214-555-2345	n.copper@sa.com	Active	
23. ELENA Q. ZINC	1981-04-19	111-00-9988	1703 Ash St	San Jose	CA	95101	408-555-8901	e.zinc@sj.com	Active	
24. SEBASTIAN S. LEAD	1974-10-07	000-99-8877	1814 Hickory St	San Antonio	TX	78201	214-555-2345	s.lead@sa.com	Active	
25. ADAM T. ALUMINUM	1988-01-24	999-88-7766	1925 Walnut St	Fort Worth	TX	76101	817-555-6789	a.aluminum@fw.com	Active	
26. LUCAS W. SILVER	1976-05-12	888-77-6655	2036 Chestnut St	Columbus	OH	43201	614-555-0123	l.silver@co.com	Active	
27. ISABELLA R. GOLD	1985-09-30	777-66-5544	2147 Sycamore St	Indianapolis	IN	46201	317-555-4567	i.gold@in.com	Active	
28. JACOB M. IRON	1992-03-18	666-55-4433	2258 Magnolia St	San Jose	CA	95101	408-555-8901	j.iron@sj.com	Active	
29. SOFIA L. BRONZE	1987-07-06	555-44-3322	2369 Elm St	San Diego	CA	92101	619-555-4567	s.bronze@sd.com	Active	
30. LEO D. IRON	1980-11-24	444-33-2211	2470 Maple St	San Antonio	TX	78201	214-555-2345	l.iron@sa.com	Active	
31. ARIANA K. STEEL	1984-05-12	333-22-1100	2581 Oak St	Fort Worth	TX	76101	817-555-6789	a.steel@fw.com	Active	
32. NICHOLAS P. COPPER	1994-09-01	222-11-0099	2692 Pine St	Columbus	OH	43201	614-555-0123	n.copper@co.com	Active	
33. ELENA Q. ZINC	1982-03-19	111-00-9988	2703 Birch St	Indianapolis	IN	46201	317-555-4567	e.zinc@in.com	Active	
34. SEBASTIAN S. LEAD	1975-07-07	000-99-8877	2814 Spruce St	San Jose	CA	95101	408-555-8901	s.lead@sj.com	Active	
35. ADAM T. ALUMINUM	1989-11-25	999-88-7766	2925 Willow St	San Antonio	TX	78201	214-555-2345	a.aluminum@sa.com	Active	
36. LUCAS W. SILVER	1977-04-13	888-77-6655	3036 Ash St	San Jose	CA	95101	408-555-8901	l.silver@sj.com	Active	
37. ISABELLA R. GOLD	1986-08-31	777-66-5544	3147 Hickory St	San Antonio	TX	78201	214-555-2345	i.gold@sa.com	Active	
38. JACOB M. IRON	1993-02-19	666-55-4433	3258 Walnut St	Fort Worth	TX	76101	817-555-6789	j.iron@fw.com	Active	
39. SOFIA L. BRONZE	1988-06-07	555-44-3322	3369 Chestnut St	Columbus	OH	43201	614-555-0123	s.bronze@co.com	Active	
40. LEO D. IRON	1981-10-25	444-33-2211	3470 Sycamore St	Indianapolis	IN	46201	317-555-4567	l.iron@in.com	Active	
41. ARIANA K. STEEL	1985-04-13	333-22-1100	3581 Magnolia St	San Jose	CA	95101	408-555-8901	a.steel@sj.com	Active	
42. NICHOLAS P. COPPER	1995-08-02	222-11-0099	3692 Elm St	San Diego	CA	92101	619-555-4567	n.copper@sd.com	Active	
43. ELENA Q. ZINC	1983-02-20	111-00-9988	3703 Maple St	San Antonio	TX	78201	214-555-2345	e.zinc@sa.com	Active	
44. SEBASTIAN S. LEAD	1976-06-08	000-99-8877	3814 Oak St	Fort Worth	TX	76101	817-555-6789	s.lead@fw.com	Active	
45. ADAM T. ALUMINUM	1990-10-26	999-88-7766	3925 Pine St	Columbus	OH	43201	614-555-0123	a.aluminum@co.com	Active	
46. LUCAS W. SILVER	1978-04-14	888-77-6655	4036 Birch St	Indianapolis	IN	46201	317-555-4567	l.silver@in.com	Active	
47. ISABELLA R. GOLD	1987-08-32	777-66-5544	4147 Spruce St	San Jose	CA	95101	408-555-8901	i.gold@sj.com	Active	
48. JACOB M. IRON	1994-02-20	666-55-4433	4258 Willow St	San Antonio	TX	78201	214-555-2345	j.iron@sa.com	Active	
49. SOFIA L. BRONZE	1989-06-08	555-44-3322	4369 Ash St	San Jose	CA	95101	408-555-8901	s.bronze@sj.com	Active	
50. LEO D. IRON	1982-10-26	444-33-2211	4470 Hickory St	San Antonio	TX	78201	214-555-2345	l.iron@sa.com	Active	
51. ARIANA K. STEEL	1986-04-14	333-22-1100	4581 Walnut St	Fort Worth	TX	76101	817-555-6789	a.steel@fw.com	Active	
52. NICHOLAS P. COPPER	1996-08-03	222-11-0099	4692 Chestnut St	Columbus	OH	43201	614-555-0123	n.copper@co.com	Active	
53. ELENA Q. ZINC	1984-02-21	111-00-9988	4703 Sycamore St	Indianapolis	IN	46201	317-555-4567	e.zinc@in.com	Active	
54. SEBASTIAN S. LEAD	1977-06-09	000-99-8877	4814 Magnolia St	San Jose	CA	95101	408-555-8901	s.lead@sj.com	Active	
55. ADAM T. ALUMINUM	1991-10-27	999-88-7766	4925 Elm St	San Diego	CA	92101	619-555-4567	a.aluminum@sd.com	Active	
56. LUCAS W. SILVER	1979-04-15	888-77-6655	5036 Maple St	San Antonio	TX	78201	214-555-2345	l.silver@sa.com	Active	
57. ISABELLA R. GOLD	1988-08-33	777-66-5544	5147 Oak St	Fort Worth	TX	76101	817-555-6789	i.gold@fw.com	Active	
58. JACOB M. IRON	1995-02-21	666-55-4433	5258 Pine St	Columbus	OH	43201	614-555-0123	j.iron@co.com	Active	
59. SOFIA L. BRONZE	1990-06-09	555-44-3322	5369 Birch St	Indianapolis	IN	46201	317-555-4567	s.bronze@in.com	Active	
60. LEO D. IRON	1983-10-27	444-33-2211	5470 Spruce St	San Jose	CA	95101	408-555-8901	l.iron@sj.com	Active	
61. ARIANA K. STEEL	1987-04-15	333-22-1100	5581 Willow St	San Antonio	TX	78201	214-555-2345	a.steel@sa.com	Active	
62. NICHOLAS P. COPPER	1997-08-04	222-11-0099	5692 Ash St	San Jose	CA	95101	408-555-8901	n.copper@sj.com	Active	
63. ELENA Q. ZINC	1985-02-22	111-00-9988	5703 Hickory St	San Antonio	TX	78201	214-555-2345	e.zinc@sa.com	Active	
64. SEBASTIAN S. LEAD	1978-06-10	000-99-8877	5814 Walnut St	Fort Worth	TX	76101	817-555-6789	s.lead@fw.com	Active	
65. ADAM T. ALUMINUM	1992-10-28	999-88-7766	5925 Chestnut St	Columbus	OH	43201	614-555-0123	a.aluminum@co.com	Active	
66. LUCAS W. SILVER	1980-04-16	888-77-6655	6036 Sycamore St	Indianapolis	IN	46201	317-555-4567	l.silver@in.com	Active	
67. ISABELLA R. GOLD	1989-08-34	777-66-5544	6147 Magnolia St	San Jose	CA	95101	408-555-8901	i.gold@sj.com	Active	
68. JACOB M. IRON	1996-02-22	666-55-4433	6258 Elm St	San Diego	CA	92101	619-555-4567	j.iron@sd.com	Active	
69. SOFIA L. BRONZE	1991-06-10	555-44-3322	6369 Maple St	San Antonio	TX	78201	214-555-2345	s.bronze@sa.com	Active	
70. LEO D. IRON	1984-10-28	444-33-2211	6470 Oak St	Fort Worth	TX	76101	817-555-6789	l.iron@fw.com	Active	
71. ARIANA K. STEEL	1988-04-16	333-22-1100	6581 Pine St	Columbus	OH	43201	614-555-0123	a.steel@co.com	Active	
72. NICHOLAS P. COPPER	1998-08-05	222-11-0099	6692 Birch St	Indianapolis	IN	46201	317-555-4567	n.copper@in.com	Active	
73. ELENA Q. ZINC	1986-02-23	111-00-9988	6703 Spruce St	San Jose	CA	95101	408-555-8901	e.zinc@sj.com	Active	
74. SEBASTIAN S. LEAD	1979-06-11	000-99-8877	6814 Willow St	San Antonio	TX	78201	214-555-2345	s.lead@sa.com	Active	
75. ADAM T. ALUMINUM	1993-10-29	999-88-7766	6925 Ash St	San Jose	CA	95101	408-555-8901	a.aluminum@sj.com	Active	
76. LUCAS W. SILVER	1981-04-17	888-77-6655	7036 Hickory St	San Antonio	TX	78201	214-555-2345	l.silver@sa.com	Active	
77. ISABELLA R. GOLD	1990-08-35	777-66-5544	7147 Walnut St	Fort Worth	TX	76101	817-555-6789	i.gold@fw.com	Active	
78. JACOB M. IRON	1997-02-23	666-55-4433	7258 Chestnut St	Columbus	OH	43201	614-555-0123	j.iron@co.com	Active	
79. SOFIA L. BRONZE	1992-06-11	555-44-3322	7369 Sycamore St	Indianapolis	IN	46201	317-555-4567	s.bronze@in.com	Active	
80. LEO D. IRON	1985-10-29	444-33-2211	7470 Magnolia St	San Jose	CA	95101	408-555-8901	l.iron@sj.com	Active	
81. ARIANA K. STEEL	1989-04-17	333-22-1100	7581 Elm St	San Diego	CA	92101	619-555-4567	a.steel@sd.com	Active	
82. NICHOLAS P. COPPER	1999-08-06	222-11-0099	7692 Maple St	San Antonio	TX	78201	214-555-2345	n.copper@sa.com	Active	
83. ELENA Q. ZINC	1987-02-24	111-00-9988	7703 Oak St	Fort Worth	TX	76101	817-555-6789	e.zinc@fw.com	Active	
84. SEBASTIAN S. LEAD	1980-06-12	000-99-8877	7814 Pine St	Columbus	OH	43201	614-555-0123	s.lead@co.com	Active	
85. ADAM T. ALUMINUM	1994-10-30	999-88-7766	7925 Birch St	Indianapolis	IN	46201	317-555-4567	a.aluminum@in.com	Active	
86. LUCAS W. SILVER	1982-04-18	888-77-6655	8036 Spruce St	San Jose	CA	95101	408-555-8901	l.silver@sj.com	Active	
87. ISABELLA R. GOLD	1991-08-36	777-66-5544	8147 Willow St	San Antonio	TX	78201	214-555-2345	i.gold@sa.com	Active	
88. JACOB M. IRON	1998-02-24	666-55-4433	8258 Ash St	San Jose	CA	95101	408-555-8901	j.iron@sj.com	Active	
89. SOFIA L. BRONZE	1993-06-12	555-44-3322	8369 Hickory St	San Antonio	TX	78201	214-555-2345	s.bronze@sa.com	Active	
90. LEO D. IRON	1986-10-30	444-33-2211	8470 Walnut St	Fort Worth	TX	76101	817-555-6789	l.iron@fw.com	Active	
91. ARIANA K. STEEL	1990-04-18	333-22-1100	8581 Chestnut St	Columbus	OH	43201	614-555-0123	a.steel@co.com	Active	
92. NICHOLAS P. COPPER	2000-08-07	222-11-0099	8692 Sycamore St	Indianapolis	IN	46201	317-555-4567	n.copper@in.com	Active	
93. ELENA Q. ZINC	1988-02-25	111-00-9988	8703 Magnolia St	San Jose	CA	95101	408-555-8901	e.zinc@sj.com	Active	
94. SEBASTIAN S. LEAD	1981-06-13	000-99-8877	8814 Elm St	San Diego	CA	92101	619-555-4567	s.lead@sd.com	Active	
95. ADAM T. ALUMINUM	1995-10-31	999-88-7766	8925 Maple St	San Antonio	TX	78201	214-555-2345	a.aluminum@sa.com	Active	
96. LUCAS W. SILVER	1983-04-19	888-77-6655	9036 Oak St	Fort Worth	TX	76101	817-555-6789	l.silver@fw.com	Active	
97. ISABELLA R. GOLD	1992-08-37	777-66-5544	9147 Pine St	Columbus	OH	43201	614-555-0123	i.gold@co.com	Active	
98. JACOB M. IRON	1999-02-25	666-55-4433	9258 Birch St	Indianapolis	IN	46201	317-555-4567	j.iron@in.com	Active	
99. SOFIA L. BRONZE	1994-06-13	555-44-3322	9369 Spruce St	San Jose	CA	95101	408-555-8901	s.bronze@sj.com	Active	
100. LEO D. IRON	1987-10-31	444-33-2211	9470 Willow St	San Antonio	TX</					

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OFFICE OF THE ATTORNEY GENERAL									
OFFICE	NAME	ADDRESS	CITY	STATE	ZIP	PHONE	FAX	E-MAIL	WEBSITE
1	ALABAMA	1000	1000	1000	1000	1000	1000	1000	1000
2	ALASKA	1000	1000	1000	1000	1000	1000	1000	1000
3	ARIZONA	1000	1000	1000	1000	1000	1000	1000	1000
4	ARKANSAS	1000	1000	1000	1000	1000	1000	1000	1000
5	CALIFORNIA	1000	1000	1000	1000	1000	1000	1000	1000
6	COLORADO	1000	1000	1000	1000	1000	1000	1000	1000
7	CONNECTICUT	1000	1000	1000	1000	1000	1000	1000	1000
8	DELAWARE	1000	1000	1000	1000	1000	1000	1000	1000
9	FLORIDA	1000	1000	1000	1000	1000	1000	1000	1000
10	GEORGIA	1000	1000	1000	1000	1000	1000	1000	1000
11	HAWAII	1000	1000	1000	1000	1000	1000	1000	1000
12	IDaho	1000	1000	1000	1000	1000	1000	1000	1000
13	ILLINOIS	1000	1000	1000	1000	1000	1000	1000	1000
14	INDIANA	1000	1000	1000	1000	1000	1000	1000	1000
15	IOWA	1000	1000	1000	1000	1000	1000	1000	1000
16	KANSAS	1000	1000	1000	1000	1000	1000	1000	1000
17	KENTUCKY	1000	1000	1000	1000	1000	1000	1000	1000
18	LOUISIANA	1000	1000	1000	1000	1000	1000	1000	1000
19	MAINE	1000	1000	1000	1000	1000	1000	1000	1000
20	MARYLAND	1000	1000	1000	1000	1000	1000	1000	1000
21	MASSACHUSETTS	1000	1000	1000	1000	1000	1000	1000	1000
22	MICHIGAN	1000	1000	1000	1000	1000	1000	1000	1000
23	MINNESOTA	1000	1000	1000	1000	1000	1000	1000	1000
24	MISSISSIPPI	1000	1000	1000	1000	1000	1000	1000	1000
25	MISSOURI	1000	1000	1000	1000	1000	1000	1000	1000
26	MONTANA	1000	1000	1000	1000	1000	1000	1000	1000
27	NEBRASKA	1000	1000	1000	1000	1000	1000	1000	1000
28	NEVADA	1000	1000	1000	1000	1000	1000	1000	1000
29	NEW HAMPSHIRE	1000	1000	1000	1000	1000	1000	1000	1000
30	NEW JERSEY	1000	1000	1000	1000	1000	1000	1000	1000
31	NEW MEXICO	1000	1000	1000	1000	1000	1000	1000	1000
32	NEW YORK	1000	1000	1000	1000	1000	1000	1000	1000
33	NORTH CAROLINA	1000	1000	1000	1000	1000	1000	1000	1000
34	NORTH DAKOTA	1000	1000	1000	1000	1000	1000	1000	1000
35	OHIO	1000	1000	1000	1000	1000	1000	1000	1000
36	OKLAHOMA	1000	1000	1000	1000	1000	1000	1000	1000
37	OREGON	1000	1000	1000	1000	1000	1000	1000	1000
38	PENNSYLVANIA	1000	1000	1000	1000	1000	1000	1000	1000
39	RHODE ISLAND	1000	1000	1000	1000	1000	1000	1000	1000
40	SOUTH CAROLINA	1000	1000	1000	1000	1000	1000	1000	1000
41	SOUTH DAKOTA	1000	1000	1000	1000	1000	1000	1000	1000
42	TENNESSEE	1000	1000	1000	1000	1000	1000	1000	1000
43	TEXAS	1000	1000	1000	1000	1000	1000	1000	1000
44	UTAH	1000	1000	1000	1000	1000	1000	1000	1000
45	VERMONT	1000	1000	1000	1000	1000	1000	1000	1000
46	VIRGINIA	1000	1000	1000	1000	1000	1000	1000	1000
47	WASHINGTON	1000	1000	1000	1000	1000	1000	1000	1000
48	WEST VIRGINIA	1000	1000	1000	1000	1000	1000	1000	1000
49	WISCONSIN	1000	1000	1000	1000	1000	1000	1000	1000
50	WYOMING	1000	1000	1000	1000	1000	1000	1000	1000

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Case No.	Case Name	Case Type	Case Status	Case Date	Case Location	Case Description	Case Details	Case Outcome	Case Notes
1	Case 1	Case Type 1	Case Status 1	Case Date 1	Case Location 1	Case Description 1	Case Details 1	Case Outcome 1	Case Notes 1
2	Case 2	Case Type 2	Case Status 2	Case Date 2	Case Location 2	Case Description 2	Case Details 2	Case Outcome 2	Case Notes 2
3	Case 3	Case Type 3	Case Status 3	Case Date 3	Case Location 3	Case Description 3	Case Details 3	Case Outcome 3	Case Notes 3
4	Case 4	Case Type 4	Case Status 4	Case Date 4	Case Location 4	Case Description 4	Case Details 4	Case Outcome 4	Case Notes 4
5	Case 5	Case Type 5	Case Status 5	Case Date 5	Case Location 5	Case Description 5	Case Details 5	Case Outcome 5	Case Notes 5
6	Case 6	Case Type 6	Case Status 6	Case Date 6	Case Location 6	Case Description 6	Case Details 6	Case Outcome 6	Case Notes 6
7	Case 7	Case Type 7	Case Status 7	Case Date 7	Case Location 7	Case Description 7	Case Details 7	Case Outcome 7	Case Notes 7
8	Case 8	Case Type 8	Case Status 8	Case Date 8	Case Location 8	Case Description 8	Case Details 8	Case Outcome 8	Case Notes 8
9	Case 9	Case Type 9	Case Status 9	Case Date 9	Case Location 9	Case Description 9	Case Details 9	Case Outcome 9	Case Notes 9
10	Case 10	Case Type 10	Case Status 10	Case Date 10	Case Location 10	Case Description 10	Case Details 10	Case Outcome 10	Case Notes 10
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33	Case 33	Case Type 33	Case Status 33	Case Date 33	Case Location 33	Case Description 33	Case Details 33	Case Outcome 33	Case Notes 33
34	Case 34	Case Type 34	Case Status 34	Case Date 34	Case Location 34	Case Description 34	Case Details 34	Case Outcome 34	Case Notes 34
35	Case 35	Case Type 35	Case Status 35	Case Date 35	Case Location 35	Case Description 35	Case Details 35	Case Outcome 35	Case Notes 35
36	Case 36	Case Type 36	Case Status 36	Case Date 36	Case Location 36	Case Description 36	Case Details 36	Case Outcome 36	Case Notes 36
37	Case 37	Case Type 37	Case Status 37	Case Date 37	Case Location 37	Case Description 37	Case Details 37	Case Outcome 37	Case Notes 37
38	Case 38	Case Type 38	Case Status 38	Case Date 38	Case Location 38	Case Description 38	Case Details 38	Case Outcome 38	Case Notes 38
39	Case 39	Case Type 39	Case Status 39	Case Date 39	Case Location 39	Case Description 39	Case Details 39	Case Outcome 39	Case Notes 39
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41	Case 41	Case Type 41	Case Status 41	Case Date 41	Case Location 41	Case Description 41	Case Details 41	Case Outcome 41	Case Notes 41
42	Case 42	Case Type 42	Case Status 42	Case Date 42	Case Location 42	Case Description 42	Case Details 42	Case Outcome 42	Case Notes 42
43	Case 43	Case Type 43	Case Status 43	Case Date 43	Case Location 43	Case Description 43	Case Details 43	Case Outcome 43	Case Notes 43
44	Case 44	Case Type 44	Case Status 44	Case Date 44	Case Location 44	Case Description 44	Case Details 44	Case Outcome 44	Case Notes 44
45	Case 45	Case Type 45	Case Status 45	Case Date 45	Case Location 45	Case Description 45	Case Details 45	Case Outcome 45	Case Notes 45
46	Case 46	Case Type 46	Case Status 46	Case Date 46	Case Location 46	Case Description 46	Case Details 46	Case Outcome 46	Case Notes 46
47	Case 47	Case Type 47	Case Status 47	Case Date 47	Case Location 47	Case Description 47	Case Details 47	Case Outcome 47	Case Notes 47
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63	Case 63	Case Type 63	Case Status 63	Case Date 63	Case Location 63	Case Description 63	Case Details 63	Case Outcome 63	Case Notes 63
64	Case 64	Case Type 64	Case Status 64	Case Date 64	Case Location 64	Case Description 64	Case Details 64	Case Outcome 64	Case Notes 64
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75	Case 75	Case Type 75	Case Status 75	Case Date 75	Case Location 75	Case Description 75	Case Details 75	Case Outcome 75	Case Notes 75
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93	Case 93	Case Type 93	Case Status 93	Case Date 93	Case Location 93	Case Description 93	Case Details 93	Case Outcome 93	Case Notes 93
94	Case 94	Case Type 94	Case Status 94	Case Date 94	Case Location 94	Case Description 94	Case Details 94	Case Outcome 94	Case Notes 94
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99	Case 99	Case Type 99	Case Status 99	Case Date 99	Case Location 99	Case Description 99	Case Details 99	Case Outcome 99	Case Notes 99
100	Case 100	Case Type 100	Case Status 100	Case Date 100	Case Location 100	Case Description 100	Case Details 100	Case Outcome 100	Case Notes 100

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Index	Project Name	Location	Start Date	End Date	Status	Progress (%)	Budget (M\$)	Actual Cost (M\$)	Variance (M\$)	ROI (%)	Risk Level	Notes
1	Alpha Project	New York	2023-01-01	2023-06-30	Completed	100	10.0	9.8	0.2	15.0	Low	On schedule, under budget.
2	Beta Project	London	2023-02-15	2023-07-31	In Progress	75	12.5	12.0	0.5	18.0	Medium	Minor delays, but within budget.
3	Gamma Project	Tokyo	2023-03-01	2023-08-31	On Hold	20	8.0	8.5	-0.5	10.0	High	Resource allocation issues.
4	Delta Project	Sydney	2023-04-10	2023-09-30	Planning	10	15.0	15.0	0.0	20.0	Medium	Initial phase, budget on track.
5	Epsilon Project	Mumbai	2023-05-01	2023-10-31	On Hold	5	6.0	6.0	0.0	12.0	Low	Waiting for client approval.
6	Zeta Project	Sao Paulo	2023-06-01	2023-11-30	Planning	15	9.0	9.0	0.0	14.0	Medium	Scope definition in progress.
7	Eta Project	Beijing	2023-07-01	2023-12-31	On Hold	0	11.0	11.0	0.0	16.0	High	Regulatory hurdles.
8	Theta Project	Stockholm	2023-08-01	2024-01-31	Planning	5	7.0	7.0	0.0	11.0	Medium	Market research ongoing.
9	Iota Project	Amsterdam	2023-09-01	2024-02-28	On Hold	0	5.0	5.0	0.0	9.0	Low	Vendor selection pending.
10	Kappa Project	Osaka	2023-10-01	2024-03-31	Planning	10	13.0	13.0	0.0	17.0	Medium	Initial meetings scheduled.
11	Lambda Project	Paris	2023-11-01	2024-04-30	On Hold	0	4.0	4.0	0.0	8.0	Low	Contract negotiations.
12	Mu Project	Seoul	2023-12-01	2024-05-31	Planning	5	10.0	10.0	0.0	13.0	Medium	Feasibility study complete.
13	Nu Project	Warsaw	2024-01-01	2024-06-30	On Hold	0	3.0	3.0	0.0	7.0	Low	Internal review pending.
14	Xi Project	Vienna	2024-02-01	2024-07-31	Planning	10	8.0	8.0	0.0	10.0	Medium	Stakeholder alignment.
15	Omicron Project	Zurich	2024-03-01	2024-08-31	On Hold	0	6.0	6.0	0.0	9.0	Low	Legal review in progress.
16	Pi Project	Geneva	2024-04-01	2024-09-30	Planning	5	7.0	7.0	0.0	10.0	Medium	Resource allocation.
17	Rho Project	Brussels	2024-05-01	2024-10-31	On Hold	0	5.0	5.0	0.0	8.0	Low	Client onboarding.
18	Sigma Project	Frankfurt	2024-06-01	2024-11-30	Planning	10	9.0	9.0	0.0	12.0	Medium	Initial scope definition.
19	Tau Project	Munich	2024-07-01	2024-12-31	On Hold	0	4.0	4.0	0.0	7.0	Low	Vendor selection.
20	Upsilon Project	Düsseldorf	2024-08-01	2025-01-31	Planning	5	6.0	6.0	0.0	9.0	Medium	Market analysis.
21	Phi Project	Dortmund	2024-09-01	2025-02-28	On Hold	0	3.0	3.0	0.0	6.0	Low	Contract review.
22	Chi Project	Essen	2024-10-01	2025-03-31	Planning	10	8.0	8.0	0.0	10.0	Medium	Stakeholder meeting.
23	Psi Project	Duisburg	2024-11-01	2025-04-30	On Hold	0	5.0	5.0	0.0	8.0	Low	Legal consultation.
24	Omega Project	Münster	2024-12-01	2025-05-31	Planning	5	7.0	7.0	0.0	9.0	Medium	Resource planning.
25	Alpha Project	Stuttgart	2025-01-01	2025-06-30	On Hold	0	4.0	4.0	0.0	7.0	Low	Client communication.
26	Beta Project	Heidelberg	2025-02-01	2025-07-31	Planning	10	9.0	9.0	0.0	11.0	Medium	Initial phase.
27	Gamma Project	Karlsruhe	2025-03-01	2025-08-31	On Hold	0	6.0	6.0	0.0	9.0	Low	Vendor selection.
28	Delta Project	Freiburg	2025-04-01	2025-09-30	Planning	5	8.0	8.0	0.0	10.0	Medium	Market research.
29	Epsilon Project	Regensburg	2025-05-01	2025-10-31	On Hold	0	5.0	5.0	0.0	8.0	Low	Contract review.
30	Zeta Project	Ingolstadt	2025-06-01	2025-11-30	Planning	10	7.0	7.0	0.0	9.0	Medium	Stakeholder alignment.
31	Eta Project	Landshut	2025-07-01	2025-12-31	On Hold	0	4.0	4.0	0.0	7.0	Low	Legal review.
32	Theta Project	Bayreuth	2025-08-01	2026-01-31	Planning	5	6.0	6.0	0.0	8.0	Medium	Resource allocation.
33	Iota Project	Erlangen	2025-09-01	2026-02-28	On Hold	0	3.0	3.0	0.0	6.0	Low	Client onboarding.
34	Kappa Project	Nuremberg	2025-10-01	2026-03-31	Planning	10	8.0	8.0	0.0	10.0	Medium	Initial scope.
35	Lambda Project	Leipzig	2025-11-01	2026-04-30	On Hold	0	5.0	5.0	0.0	8.0	Low	

Employee ID	Employee Name	Department	Position	Salary	Start Date	End Date	Status	Notes
1001	John Doe	Engineering	Software Engineer	\$75,000	2020-01-15	2025-12-31	Active	
1002	Jane Smith	Marketing	Marketing Specialist	\$65,000	2020-03-01	2025-12-31	Active	
1003	Mike Johnson	Sales	Sales Representative	\$55,000	2020-05-10	2025-12-31	Active	
1004	Sarah Lee	Finance	Financial Analyst	\$70,000	2020-07-01	2025-12-31	Active	
1005	David Kim	Operations	Operations Manager	\$85,000	2020-09-01	2025-12-31	Active	
1006	Emily White	Human Resources	HR Specialist	\$60,000	2020-11-01	2025-12-31	Active	
1007	Chris Brown	Engineering	Software Engineer	\$75,000	2021-01-15	2025-12-31	Active	
1008	Alice Green	Marketing	Marketing Specialist	\$65,000	2021-03-01	2025-12-31	Active	
1009	Bob Black	Sales	Sales Representative	\$55,000	2021-05-10	2025-12-31	Active	
1010	Grace Taylor	Finance	Financial Analyst	\$70,000	2021-07-01	2025-12-31	Active	
1011	Frank Miller	Operations	Operations Manager	\$85,000	2021-09-01	2025-12-31	Active	
1012	Heidi Wilson	Human Resources	HR Specialist	\$60,000	2021-11-01	2025-12-31	Active	
1013	Ivan Davis	Engineering	Software Engineer	\$75,000	2022-01-15	2025-12-31	Active	
1014	Julia Evans	Marketing	Marketing Specialist	\$65,000	2022-03-01	2025-12-31	Active	
1015	Kyle Foster	Sales	Sales Representative	\$55,000	2022-05-10	2025-12-31	Active	
1016	Laura Gibson	Finance	Financial Analyst	\$70,000	2022-07-01	2025-12-31	Active	
1017	Mark Hall	Operations	Operations Manager	\$85,000	2022-09-01	2025-12-31	Active	
1018	Nancy King	Human Resources	HR Specialist	\$60,000	2022-11-01	2025-12-31	Active	
1019	Oscar Lopez	Engineering	Software Engineer	\$75,000	2023-01-15	2025-12-31	Active	
1020	Peter Martinez	Marketing	Marketing Specialist	\$65,000	2023-03-01	2025-12-31	Active	
1021	Quinn Nelson	Sales	Sales Representative	\$55,000	2023-05-10	2025-12-31	Active	
1022	Rachel Olsen	Finance	Financial Analyst	\$70,000	2023-07-01	2025-12-31	Active	
1023	Sam Parker	Operations	Operations Manager	\$85,000	2023-09-01	2025-12-31	Active	
1024	Tina Quinn	Human Resources	HR Specialist	\$60,000	2023-11-01	2025-12-31	Active	
1025	Uma Reed	Engineering	Software Engineer	\$75,000	2024-01-15	2025-12-31	Active	
1026	Victor Scott	Marketing	Marketing Specialist	\$65,000	2024-03-01	2025-12-31	Active	
1027	Wendy Torres	Sales	Sales Representative	\$55,000	2024-05-10	2025-12-31	Active	
1028	Xavier Vance	Finance	Financial Analyst	\$70,000	2024-07-01	2025-12-31	Active	
1029	Yara Ward	Operations	Operations Manager	\$85,000	2024-09-01	2025-12-31	Active	
1030	Zoe York	Human Resources	HR Specialist	\$60,000	2024-11-01	2025-12-31	Active	

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NAME	DOB	SSN	ADDRESS	CITY	STATE	ZIP	PHONE	EMAIL	STATUS	REMARKS
JOHN DOE	1980-01-15	123-45-6789	123 Main St	New York	NY	10001	212-555-1234	john.doe@example.com	Active	
JANE SMITH	1985-03-22	987-65-4321	456 Elm St	Los Angeles	CA	90001	310-555-5678	jane.smith@example.com	Active	
ROBERT BROWN	1975-07-10	555-44-3322	789 Oak St	Chicago	IL	60601	312-555-9012	robert.brown@example.com	Active	
MICHAEL GARCIA	1990-11-05	222-33-4455	321 Pine St	San Antonio	TX	78201	210-555-3456	michael.garcia@example.com	Active	
SARAH JONES	1988-09-18	666-77-8899	654 Maple St	Portland	OR	97201	503-555-7890	sarah.jones@example.com	Active	
DAVID MILLER	1972-04-03	111-22-3344	987 Cedar St	Seattle	WA	98101	206-555-2345	david.miller@example.com	Active	
EMILY WILSON	1992-12-01	444-55-6677	147 Birch St	Denver	CO	80201	303-555-6789	emily.wilson@example.com	Active	
JAMES TAYLOR	1983-06-25	777-88-9900	258 Spruce St	Phoenix	AZ	85001	602-555-0123	james.taylor@example.com	Active	
AMANDA ROSS	1987-10-12	333-44-5566	369 Willow St	San Diego	CA	92101	619-555-4567	amanda.ross@example.com	Active	
CHRISTOPHER LEE	1978-02-28	888-99-0011	470 Ash St	San Jose	CA	95101	408-555-8901	christopher.lee@example.com	Active	
STEPHANIE HARRIS	1991-05-14	555-66-7788	581 Hickory St	San Francisco	CA	94101	415-555-2345	stephanie.harris@example.com	Active	
NATHAN KIM	1986-08-07	222-33-4455	692 Walnut St	Los Angeles	CA	90001	213-555-6789	nathan.kim@example.com	Active	
OLIVIA MARTIN	1989-11-20	999-00-1122	703 Chestnut St	San Francisco	CA	94101	415-555-0123	olivia.martin@example.com	Active	
LUKE ANDERSON	1982-03-09	666-77-8899	814 Elm St	San Jose	CA	95101	408-555-4567	luke.anderson@example.com	Active	
HANNAH THOMPSON	1993-07-26	333-44-5566	925 Oak St	San Francisco	CA	94101	415-555-8901	hannah.thompson@example.com	Active	
ISAC WHITE	1984-12-11	111-22-3344	106 Pine St	San Jose	CA	95101	408-555-2345	isac.white@example.com	Active	
GRACE GREEN	1995-04-04	444-55-6677	217 Cedar St	San Jose	CA	95101	408-555-6789	grace.green@example.com	Active	
COLEY BLACK	1981-09-17	777-88-9900	328 Birch St	San Jose	CA	95101	408-555-0123	coley.black@example.com	Active	
ADAM NELSON	1989-01-29	555-66-7788	439 Spruce St	San Jose	CA	95101	408-555-4567	adam.nelson@example.com	Active	
SKYLAR HARRIS	1994-06-16	222-33-4455	540 Willow St	San Jose	CA	95101	408-555-8901	skylar.harris@example.com	Active	
JOHN DOE	1980-01-15	123-45-6789	123 Main St	New York	NY	10001	212-555-1234	john.doe@example.com	Active	
JANE SMITH	1985-03-22	987-65-4321	456 Elm St	Los Angeles	CA	90001	310-555-5678	jane.smith@example.com	Active	
ROBERT BROWN	1975-07-10	555-44-3322	789 Oak St	Chicago	IL	60601	312-555-9012	robert.brown@example.com	Active	
MICHAEL GARCIA	1990-11-05	222-33-4455	321 Pine St	San Antonio	TX	78201	210-555-3456	michael.garcia@example.com	Active	
SARAH JONES	1988-09-18	666-77-8899	654 Maple St	Portland	OR	97201	503-555-7890	sarah.jones@example.com	Active	
DAVID MILLER	1972-04-03	111-22-3344	987 Cedar St	Seattle	WA	98101	206-555-2345	david.miller@example.com	Active	
EMILY WILSON	1992-12-01	444-55-6677	147 Birch St	Denver	CO	80201	303-555-6789	emily.wilson@example.com	Active	
JAMES TAYLOR	1983-06-25	777-88-9900	258 Spruce St	Phoenix	AZ	85001	602-555-0123	james.taylor@example.com	Active	
AMANDA ROSS	1987-10-12	333-44-5566	369 Willow St	San Diego	CA	92101	619-555-4567	amanda.ross@example.com	Active	
CHRISTOPHER LEE	1978-02-28	888-99-0011	470 Ash St	San Jose	CA	95101	408-555-8901	christopher.lee@example.com	Active	
STEPHANIE HARRIS	1991-05-14	555-66-7788	581 Hickory St	San Francisco	CA	94101	415-555-2345	stephanie.harris@example.com	Active	
NATHAN KIM	1986-08-07	222-33-4455	692 Walnut St	Los Angeles	CA	90001	213-555-6789	nathan.kim@example.com	Active	
OLIVIA MARTIN	1989-11-20	999-00-1122	703 Chestnut St	San Francisco	CA	94101	415-555-0123	olivia.martin@example.com	Active	
LUKE ANDERSON	1982-03-09	666-77-8899	814 Elm St	San Jose	CA	95101	408-555-4567	luke.anderson@example.com	Active	
HANNAH THOMPSON	1993-07-26	333-44-5566	925 Oak St	San Francisco	CA	94101	415-555-8901	hannah.thompson@example.com	Active	

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CITY OF ALBUQUERQUE, NEW MEXICO									
Job Title	Grade	Pay Range	Min	Max	Step	Step Amount	Step 1	Step 2	Step 3
Assistant City Manager	AS-1	\$114,000 - \$144,000	\$114,000	\$144,000	\$12,000	\$12,000	\$126,000	\$138,000	\$150,000
City Manager	AS-2	\$144,000 - \$180,000	\$144,000	\$180,000	\$12,000	\$12,000	\$156,000	\$168,000	\$180,000
Deputy City Manager	AS-3	\$180,000 - \$225,000	\$180,000	\$225,000	\$12,000	\$12,000	\$192,000	\$204,000	\$216,000
Assistant City Manager	AS-4	\$225,000 - \$270,000	\$225,000	\$270,000	\$12,000	\$12,000	\$237,000	\$249,000	\$261,000
City Manager	AS-5	\$270,000 - \$330,000	\$270,000	\$330,000	\$12,000	\$12,000	\$282,000	\$294,000	\$306,000
Deputy City Manager	AS-6	\$330,000 - \$405,000	\$330,000	\$405,000	\$12,000	\$12,000	\$342,000	\$354,000	\$366,000
Assistant City Manager	AS-7	\$405,000 - \$495,000	\$405,000	\$495,000	\$12,000	\$12,000	\$417,000	\$429,000	\$441,000
City Manager	AS-8	\$495,000 - \$600,000	\$495,000	\$600,000	\$12,000	\$12,000	\$507,000	\$519,000	\$531,000
Deputy City Manager	AS-9	\$600,000 - \$720,000	\$600,000	\$720,000	\$12,000	\$12,000	\$612,000	\$624,000	\$636,000
Assistant City Manager	AS-10	\$720,000 - \$864,000	\$720,000	\$864,000	\$12,000	\$12,000	\$732,000	\$744,000	\$756,000
City Manager	AS-11	\$864,000 - \$1,036,800	\$864,000	\$1,036,800	\$12,000	\$12,000	\$876,000	\$888,000	\$900,000
Deputy City Manager	AS-12	\$1,036,800 - \$1,244,160	\$1,036,800	\$1,244,160	\$12,000	\$12,000	\$1,048,800	\$1,060,800	\$1,072,800
Assistant City Manager	AS-13	\$1,244,160 - \$1,492,800	\$1,244,160	\$1,492,800	\$12,000	\$12,000	\$1,256,160	\$1,268,160	\$1,280,160
City Manager	AS-14	\$1,492,800 - \$1,791,360	\$1,492,800	\$1,791,360	\$12,000	\$12,000	\$1,504,800	\$1,516,800	\$1,528,800
Deputy City Manager	AS-15	\$1,791,360 - \$2,149,440	\$1,791,360	\$2,149,440	\$12,000	\$12,000	\$1,803,360	\$1,815,360	\$1,827,360
Assistant City Manager	AS-16	\$2,149,440 - \$2,579,520	\$2,149,440	\$2,579,520	\$12,000	\$12,000	\$2,161,520	\$2,173,520	\$2,185,520
City Manager	AS-17	\$2,579,520 - \$3,095,040	\$2,579,520	\$3,095,040	\$12,000	\$12,000	\$2,591,520	\$2,603,520	\$2,615,520
Deputy City Manager	AS-18	\$3,095,040 - \$3,714,080	\$3,095,040	\$3,714,080	\$12,000	\$12,000	\$3,107,040	\$3,119,040	\$3,131,040
Assistant City Manager	AS-19	\$3,714,080 - \$4,456,800	\$3,714,080	\$4,456,800	\$12,000	\$12,000	\$3,726,080	\$3,738,080	\$3,750,080
City Manager	AS-20	\$4,456,800 - \$5,348,160	\$4,456,800	\$5,348,160	\$12,000	\$12,000	\$4,468,800	\$4,480,800	\$4,492,800
Deputy City Manager	AS-21	\$5,348,160 - \$6,417,792	\$5,348,160	\$6,417,792	\$12,000	\$12,000	\$5,360,160	\$5,372,160	\$5,384,160
Assistant City Manager	AS-22	\$6,417,792 - \$7,701,360	\$6,417,792	\$7,701,360	\$12,000	\$12,000	\$6,429,360	\$6,441,360	\$6,453,360
City Manager	AS-23	\$7,701,360 - \$9,241,680	\$7,701,360	\$9,241,680	\$12,000	\$12,000	\$7,713,360	\$7,725,360	\$7,737,360
Deputy City Manager	AS-24	\$9,241,680 - \$11,090,016	\$9,241,680	\$11,090,016	\$12,000	\$12,000	\$9,253,680	\$9,265,680	\$9,277,680
Assistant City Manager	AS-25	\$11,090,016 - \$13,308,096	\$11,090,016	\$13,308,096	\$12,000	\$12,000	\$11,102,016	\$11,114,016	\$11,126,016
City Manager	AS-26	\$13,308,096 - \$15,969,792	\$13,308,096	\$15,969,792	\$12,000	\$12,000	\$13,320,096	\$13,332,096	\$13,344,096
Deputy City Manager	AS-27	\$15,969,792 - \$19,163,840	\$15,969,792	\$19,163,840	\$12,000	\$12,000	\$15,981,840	\$15,993,840	\$16,005,840
Assistant City Manager	AS-28	\$19,163,840 - \$22,999,680	\$19,163,840	\$22,999,680	\$12,000	\$12,000	\$19,175,840	\$19,187,840	\$19,199,840
City Manager	AS-29	\$22,999,680 - \$27,599,712	\$22,999,680	\$27,599,712	\$12,000	\$12,000	\$23,011,712	\$23,023,712	\$23,035,712
Deputy City Manager	AS-30	\$27,599,712 - \$33,519,648	\$27,599,712	\$33,519,648	\$12,000	\$12,000	\$27,611,648	\$27,623,648	\$27,635,648
Assistant City Manager	AS-31	\$33,519,648 - \$40,823,616	\$33,519,648	\$40,823,616	\$12,000	\$12,000	\$33,531,616	\$33,543,616	\$33,555,616
City Manager	AS-32	\$40,823,616 - \$49,788,224	\$40,823,616	\$49,788,224	\$12,000	\$12,000	\$40,835,616	\$40,847,616	\$40,859,616
Deputy City Manager	AS-33	\$49,788,224 - \$60,545,856	\$49,788,224	\$60,545,856	\$12,000	\$12,000	\$49,799,856	\$49,811,856	\$49,823,856
Assistant City Manager	AS-34	\$60,545,856 - \$73,855,008	\$60,545,856	\$73,855,008	\$12,000	\$12,000	\$60,559,808	\$60,571,808	\$60,583,808
City Manager	AS-35	\$73,855,008 - \$89,826,064	\$73,855,008	\$89,826,064	\$12,000	\$12,000	\$73,867,064	\$73,879,064	\$73,891,064
Deputy City Manager	AS-36	\$89,826,064 - \$109,791,616	\$89,826,064	\$109,791,616	\$12,000	\$12,000	\$89,838,616	\$89,850,616	\$89,862,616
Assistant City Manager	AS-37	\$109,791,616 - \$133,749,952	\$109,791,616	\$133,749,952	\$12,000	\$12,000	\$109,803,952	\$109,815,952	\$109,827,952
City Manager	AS-38	\$133,749,952 - \$162,299,904	\$133,749,952	\$162,299,904	\$12,000	\$12,000	\$133,761,904	\$133,773,904	\$133,785,904
Deputy City Manager	AS-39	\$162,299,904 - \$196,759,872	\$162,299,904	\$196,759,872	\$12,000	\$12,000	\$162,311,872	\$162,323,872	\$162,335,872
Assistant City Manager	AS-40	\$196,759,872 - \$238,719,840	\$196,759,872	\$238,719,840	\$12,000	\$12,000	\$196,769,840	\$196,781,840	\$196,793,840
City Manager	AS-41	\$238,719,840 - \$288,279,808	\$238,719,840	\$288,279,808	\$12,000	\$12,000	\$238,729,808	\$238,741,808	\$238,753,808
Deputy City Manager	AS-42	\$288,279,808 - \$347,839,776	\$288,279,808	\$347,839,776	\$12,000	\$12,000	\$288,289,776	\$288,301,776	\$288,313,776
Assistant City Manager	AS-43	\$347,839,776 - \$419,299,744	\$347,839,776	\$419,299,744	\$12,000	\$12,000	\$347,849,744	\$347,861,744	\$347,873,744
City Manager	AS-44	\$419,299,744 - \$503,759,712	\$419,299,744	\$503,759,712	\$12,000	\$12,000	\$419,309,712	\$419,321,712	\$419,333,712
Deputy City Manager	AS-45	\$503,759,712 - \$604,719,680	\$503,759,712	\$604,719,680	\$12,000	\$12,000	\$503,769,680	\$503,781,680	\$503,793,680
Assistant City Manager	AS-46	\$604,719,680 - \$733,679,648	\$604,719,680	\$733,679,648	\$12,000	\$12,000	\$604,729,648	\$604,741,648	\$604,753,648
City Manager	AS-47	\$733,679,648 - \$888,239,616	\$733,679,648	\$888,239,616	\$12,000	\$12,000	\$733,689,616	\$733,701,616	\$733,713,616
Deputy City Manager	AS-48	\$888,239,616 - \$1,077,799,584	\$888,239,616	\$1,077,799,584	\$12,000	\$12,000	\$888,249,584	\$888,261,584	\$888,273,584
Assistant City Manager	AS-49	\$1,077,799,584 - \$1,303,259,552	\$1,077,799,584	\$1,303,259,552	\$12,000	\$12,000	\$1,077,809,552	\$1,077,821,552	\$1,077,833,552
City Manager	AS-50	\$1,303,259,552 - \$1,577,719,520	\$1,303,259,552	\$1,577,719,520	\$12,000	\$12,000	\$1,303,269,520	\$1,303,281,520	\$1,303,293,520
Deputy City Manager	AS-51	\$1,577,719,520 - \$1,912,279,488	\$1,577,719,520	\$1,912,279,488	\$12,000	\$12,000	\$1,577,729,488	\$1,577,741,488	\$1,577,753,488
Assistant City Manager	AS-52	\$1,912,279,488 - \$2,316,839,456	\$1,912,279,488	\$2,316,839,456	\$12,000	\$12,000	\$1,912,289,456	\$1,912,301,456	\$1,912,313,456
City Manager	AS-53	\$2,316,839,456 - \$2,801,399,424	\$2,316,839,456	\$2,801,399,424	\$12,000	\$12,000	\$2,316,849,424	\$2,316,861,424	\$2,316,873,424
Deputy City Manager	AS-54	\$2,801,399,424 - \$3,375,959,392	\$2,801,399,424	\$3,375,959,392	\$12,000	\$12,000	\$2,801,409,392	\$2,801,421,392	\$2,801,433,392
Assistant City Manager	AS-55	\$3,375,959,392 - \$4,050,519,360	\$3,375,959,392	\$4,050,519,360	\$12,000	\$12,000	\$3,375,969,360	\$3,375,981,360	\$3,375,993,360
City Manager	AS-56	\$4,050,519,360 - \$4,825,079,328	\$4,050,519,360	\$4,825,079,328	\$12,000	\$12,000	\$4,050,529,328	\$4,050,541,328	\$4,050,553,328
Deputy City Manager	AS-57	\$4,825,079,328 - \$5,799,639,296	\$4,825,079,328	\$5,799,639,296	\$12,000	\$12,000	\$4,825,089,296	\$4,825,101,296	\$4,825,113,296
Assistant City Manager	AS-58	\$5,799,639,296 - \$6,924,199,264	\$5,799,639,296	\$6,924,199,264	\$12,000	\$12,000	\$5,799,649,264	\$5,799,661,264	\$5,799,673,264
City Manager	AS-59	\$6,924,199,264 - \$8,248,759,232	\$6,924,199,264	\$8,248,759,232	\$12,000	\$12,000	\$6,924,209,232	\$6,924,221,232	\$6,924,233,232
Deputy City Manager	AS-60	\$8,248,759,232 - \$9,873,319,200	\$8,248,759,232	\$9,873,319,200	\$12,000	\$12,000	\$8,248,769,200	\$8,248,781,200	\$8,248,793,200
Assistant City Manager	AS-61	\$9,873,319,200 - \$11,847,879,168	\$9,873,319,200	\$11,847,879,168	\$12,000	\$12,000	\$9,873,329,168	\$9,873,341,168	\$9,873,353,168
City Manager	AS-62	\$11,847,879,168 - \$14,222,439,136	\$11,847,879,168	\$14,222,439,136	\$12,000	\$12,000	\$11,847,889,136	\$11,847,901,136	\$11,847,913,136
Deputy City Manager	AS-63	\$14,222,439,136 - \$17,096,999,104	\$14,222,439,136	\$17,096,999,104	\$12,000	\$12,000	\$14,222,449,104	\$14,222,461,104	\$14,222,473,104
Assistant City Manager	AS-64	\$17,096,999,104 - \$20,571,559,072	\$17,096,999,104	\$20,571,559,072	\$12,000	\$12,000	\$17,096,999,072	\$17,097,011,072	\$17,097,023,072
City Manager	AS-65	\$20,571,559,072 - \$24,646,119,040	\$20,571,559,072	\$24,646,119,040	\$12,000	\$12,000	\$20,571,569,040	\$20,571,581,040	\$20,571,593,040
Deputy City Manager	AS-66	\$24,646,119,040 - \$29,420,679,008	\$24,646,119,040	\$29,420,679,008	\$12,000	\$12,000	\$24,646,129,008	\$24,646,141,008	\$24,646,153,008
Assistant City Manager	AS-67	\$29,420,679,008 - \$34,895,239,976	\$29,420,679,008	\$34,895,239,976	\$12,000	\$12,000	\$29,420,689,976	\$29,420,701,976	\$29,420,713,976
City Manager	AS-68	\$34,895,239,976 - \$41,069,799,944	\$34,895,239,976	\$41,069,799,944	\$12,000	\$12,000	\$34,895,249,944	\$34,895,261,944	\$34,895,273,944
Deputy City Manager	AS-69	\$41,069,799,944 - \$48,044,359,912	\$41,069,799,944	\$48,044,359,912	\$12,000	\$12,000	\$41,069,809,912	\$41,069,821,912	\$41,069,833,912
Assistant City Manager	AS-70	\$48,044,359,912 - \$56,018,919,880	\$48,044,359,912	\$56,018,919,880	\$12,000	\$12,000	\$48,044,369,880	\$48,044,381,880	\$48,044,393,880
City Manager	AS-71	\$56,018,919,880 - \$65,093,479,848	\$56,018,919,880	\$65,093,479,848	\$12,000	\$12,000	\$56,018,929,848	\$56,018,941,848	\$56,018,953,848
Deputy City Manager	AS-72	\$65,093,479,848 - \$75,368,039,816	\$65,093,479,848	\$75,368,039,816	\$12,000	\$12,000	\$65,093,489,816	\$65,093,501,816	\$65,093,513,816
Assistant City Manager	AS-73	\$75,368,039,816 - \$86,942,599,784	\$75,368,039,816	\$86,942,599,784	\$12,000	\$12,000	\$75,368,049,784	\$75,368,061,784	\$75,368,073,784
City Manager	AS-74	\$86,942,599,784 - \$99,917,159,752	\$86,942,599,784	\$99,917,159,752	\$12,000	\$12,000	\$86,942,609,752	\$86,942,621,752	\$86,942,633,752
Deputy City Manager	AS-75	\$99,917,159,752 - \$114,391,719,720	\$99,917,159,752	\$114,391,719,720	\$12,000	\$12,000	\$99,917,169,720	\$99,917,181,720	\$99,917,193,720
Assistant City Manager	AS-76	\$114,391,719,720 - \$130,466,279,688	\$114,391,719,720	\$130,466,279,688	\$12,000	\$12,000	\$114,391,729,688	\$114,391,741,688	\$114,391,753,688
City Manager	AS-77	\$130,466,279,688 - \$158,240,839,656	\$130,466,279,688	\$158,240,839,656	\$12,000	\$12,000	\$130,466,289,656	\$130,466,301,656	\$130,466,313,656
Deputy City Manager	AS-78	\$158,240,839,656 - \$188,815,399,624	\$158,240,839,656	\$188,815,399,624	\$12,000	\$12,000	\$158,240,849,624	\$158,240,861,624	\$158,240,873,624
Assistant City Manager	AS-79	\$188,815,399,624 - \$222,289,959,592	\$188,815,399,624	\$222,289,959,592	\$12,000	\$12,000	\$188,815,409,592	\$188,815,421,592	\$188,815

[illegible]

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Index	Symbol	Company Name	Country	Market Cap (USD)	Revenue (USD)	Profit (USD)	EPS	P/E Ratio	Dividend Yield (%)	52-Week High	52-Week Low	Volume	Market Cap (USD)	Revenue (USD)	Profit (USD)	EPS	P/E Ratio	Dividend Yield (%)	52-Week High	52-Week Low	Volume
1	GOOGL	Alphabet Inc.	USA	2,800,000,000,000	281,500,000,000	73,800,000,000	11.10	24.3	0.00	2,800.00	2,800.00	100,000,000	2,800,000,000,000	281,500,000,000	73,800,000,000	11.10	24.3	0.00	2,800.00	2,800.00	100,000,000
2	AMZN	Amazon.com Inc.	USA	1,500,000,000,000	376,000,000,000	30,800,000,000	3.10	48.4	0.00	1,500.00	1,500.00	50,000,000	1,500,000,000,000	376,000,000,000	30,800,000,000	3.10	48.4	0.00	1,500.00	1,500.00	50,000,000
3	MSFT	Microsoft Corporation	USA	1,200,000,000,000	72,700,000,000	20,900,000,000	5.60	21.4	0.00	1,200.00	1,200.00	30,000,000	1,200,000,000,000	72,700,000,000	20,900,000,000	5.60	21.4	0.00	1,200.00	1,200.00	30,000,000
4	FB	Meta Platforms Inc.	USA	800,000,000,000	113,000,000,000	29,000,000,000	11.00	7.3	0.00	800.00	800.00	20,000,000	800,000,000,000	113,000,000,000	29,000,000,000	11.00	7.3	0.00	800.00	800.00	20,000,000
5	BRK.A	Berkshire Hathaway Inc.	USA	600,000,000,000	364,000,000,000	63,900,000,000	236.00	1.1	0.00	600.00	600.00	10,000,000	600,000,000,000	364,000,000,000	63,900,000,000	236.00	1.1	0.00	600.00	600.00	10,000,000
6	APPL	Apple Inc.	USA	2,900,000,000,000	292,900,000,000	99,800,000,000	156.00	18.6	0.00	2,900.00	2,900.00	40,000,000	2,900,000,000,000	292,900,000,000	99,800,000,000	156.00	18.6	0.00	2,900.00	2,900.00	40,000,000
7	INTC	Intel Corporation	USA	40,000,000,000	18,200,000,000	3,100,000,000	3.10	12.9	0.00	40.00	40.00	1,000,000	40,000,000,000	18,200,000,000	3,100,000,000	3.10	12.9	0.00	40.00	40.00	1,000,000
8	IBM	International Business Machines Corporation	USA	20,000,000,000	58,400,000,000	6,300,000,000	15.00	13.3	0.00	20.00	20.00	500,000	20,000,000,000	58,400,000,000	6,300,000,000	15.00	13.3	0.00	20.00	20.00	500,000
9	ORCL	Oracle Corporation	USA	100,000,000,000	31,200,000,000	5,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000	100,000,000,000	31,200,000,000	5,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000
10	CRM	Salesforce.com Inc.	USA	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000
11	ADBE	Adobe Inc.	USA	200,000,000,000	17,800,000,000	3,100,000,000	15.00	13.3	0.00	200.00	200.00	1,000,000	200,000,000,000	17,800,000,000	3,100,000,000	15.00	13.3	0.00	200.00	200.00	1,000,000
12	QCOM	Qualcomm Inc.	USA	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000
13	TXN	TXU Energy Inc.	USA	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000
14	CVX	Chevron Corporation	USA	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000	100,000,000,000	20,800,000,000	3,100,000,000	15.00	6.7	0.00	100.00	100.00	1,000,000
15	WMT	Walmart Inc.	USA	100,000,0																	

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CITY OF ALBUQUERQUE GENERAL									
LINE	ITEM	DESCRIPTION	QUANTITY	UNIT	PRICE	TOTAL	TAXES	FEES	REMARKS
1	1000	1000	1	EA	1000	1000			
2	1000	1000	1	EA	1000	1000			
3	1000	1000	1	EA	1000	1000			
4	1000	1000	1	EA	1000	1000			
5	1000	1000	1	EA	1000	1000			
6	1000	1000	1	EA	1000	1000			
7	1000	1000	1	EA	1000	1000			
8	1000	1000	1	EA	1000	1000			
9	1000	1000	1	EA	1000	1000			
10	1000	1000	1	EA	1000	1000			
11	1000	1000	1	EA	1000	1000			
12	1000	1000	1	EA	1000	1000			
13	1000	1000	1	EA	1000	1000			
14	1000	1000	1	EA	1000	1000			
15	1000	1000	1	EA	1000	1000			
16	1000	1000	1	EA	1000	1000			
17	1000	1000	1	EA	1000	1000			
18	1000	1000	1	EA	1000	1000			
19	1000	1000	1	EA	1000	1000			
20	1000	1000	1	EA	1000	1000			
21	1000	1000	1	EA	1000	1000			
22	1000	1000	1	EA	1000	1000			
23	1000	1000	1	EA	1000	1000			
24	1000	1000	1	EA	1000	1000			
25	1000	1000	1	EA	1000	1000			
26	1000	1000	1	EA	1000	1000			
27	1000	1000	1	EA	1000	1000			
28	1000	1000	1	EA	1000	1000			
29	1000	1000	1	EA	1000	1000			
30	1000	1000	1	EA	1000	1000			
31	1000	1000	1	EA	1000	1000			
32	1000	1000	1	EA	1000	1000			
33	1000	1000	1	EA	1000	1000			
34	1000	1000	1	EA	1000	1000			
35	1000	1000	1	EA	1000	1000			
36	1000	1000	1	EA	1000	1000			
37	1000	1000	1	EA	1000	1000			
38	1000	1000	1	EA	1000	1000			
39	1000	1000	1	EA	1000	1000			
40	1000	1000	1	EA	1000	1000			
41	1000	1000	1	EA	1000	1000			
42	1000	1000	1	EA	1000	1000			
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44	1000	1000	1	EA	1000	1000			
45	1000	1000	1	EA	1000	1000			
46	1000	1000	1	EA	1000	1000			
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49	1000	1000	1	EA	1000	1000			
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55	1000	1000	1	EA	1000	1000			
56	1000	1000	1	EA	1000	1000			
57	1000	1000	1	EA	1000	1000			
58	1000	1000	1	EA	1000	1000			
59	1000	1000	1	EA	1000	1000			
60	1000	1000	1	EA	1000	1000			
61	1000	1000	1	EA	1000	1000			
62	1000	1000	1	EA	1000	1000			
63	1000	1000	1	EA	1000	1000			
64	1000	1000	1	EA	1000	1000			
65	1000	1000	1	EA	1000	1000			
66	1000	1000	1	EA	1000	1000			
67	1000	1000	1	EA	1000	1000			
68	1000	1000	1	EA	1000	1000			
69	1000	1000	1	EA	1000	1000			
70	1000	1000	1	EA	1000	1000			
71	1000	1000	1	EA	1000	1000			
72	1000	1000	1	EA	1000	1000			
73	1000	1000	1	EA	1000	1000			
74	1000	1000	1	EA	1000	1000			
75	1000	1000	1	EA	1000	1000			
76	1000	1000	1	EA	1000	1000			
77	1000	1000	1	EA	1000	1000			
78	1000	1000	1	EA	1000	1000			
79	1000	1000	1	EA	1000	1000			
80	1000	1000	1	EA	1000	1000			
81	1000	1000	1	EA	1000	1000			
82	1000	1000	1	EA	1000	1000			
83	1000	1000	1	EA	1000	1000			
84	1000	1000	1	EA	1000	1000			
85	1000	1000	1	EA	1000	1000			
86	1000	1000	1	EA	1000	1000			
87	1000	1000	1	EA	1000	1000			
88	1000	1000	1	EA	1000	1000			
89	1000	1000	1	EA	1000	1000			
90	1000	1000	1	EA	1000	1000			
91	1000	1000	1	EA	1000	1000			
92	1000	1000	1	EA	1000	1000			
93	1000	1000	1	EA	1000	1000			
94	1000	1000	1	EA	1000	1000			
95	1000	1000	1	EA	1000	1000			
96	1000	1000	1	EA	1000	1000			
97	1000	1000	1	EA	1000	1000			
98	1000	1000	1	EA	1000	1000			
99	1000	1000	1	EA	1000	1000			
100	1000	1000	1	EA	1000	1000			

ATTACHMENT B
ALLSTATE 100%
VOLUNTARY INDV
SHORT TERM

Additional Individual Short Term DI Details

Policy Inception Date: January 1, 2014

Rate History: Rate have remained the same since inception.

Tech Subsidy/Implementation Credit: Ongoing 4.5% subsidy

Commissions: Flat 10% paid to Amerilife

Plan Changes: None since inception

PartnerProfile

Block Experience

Prepared for

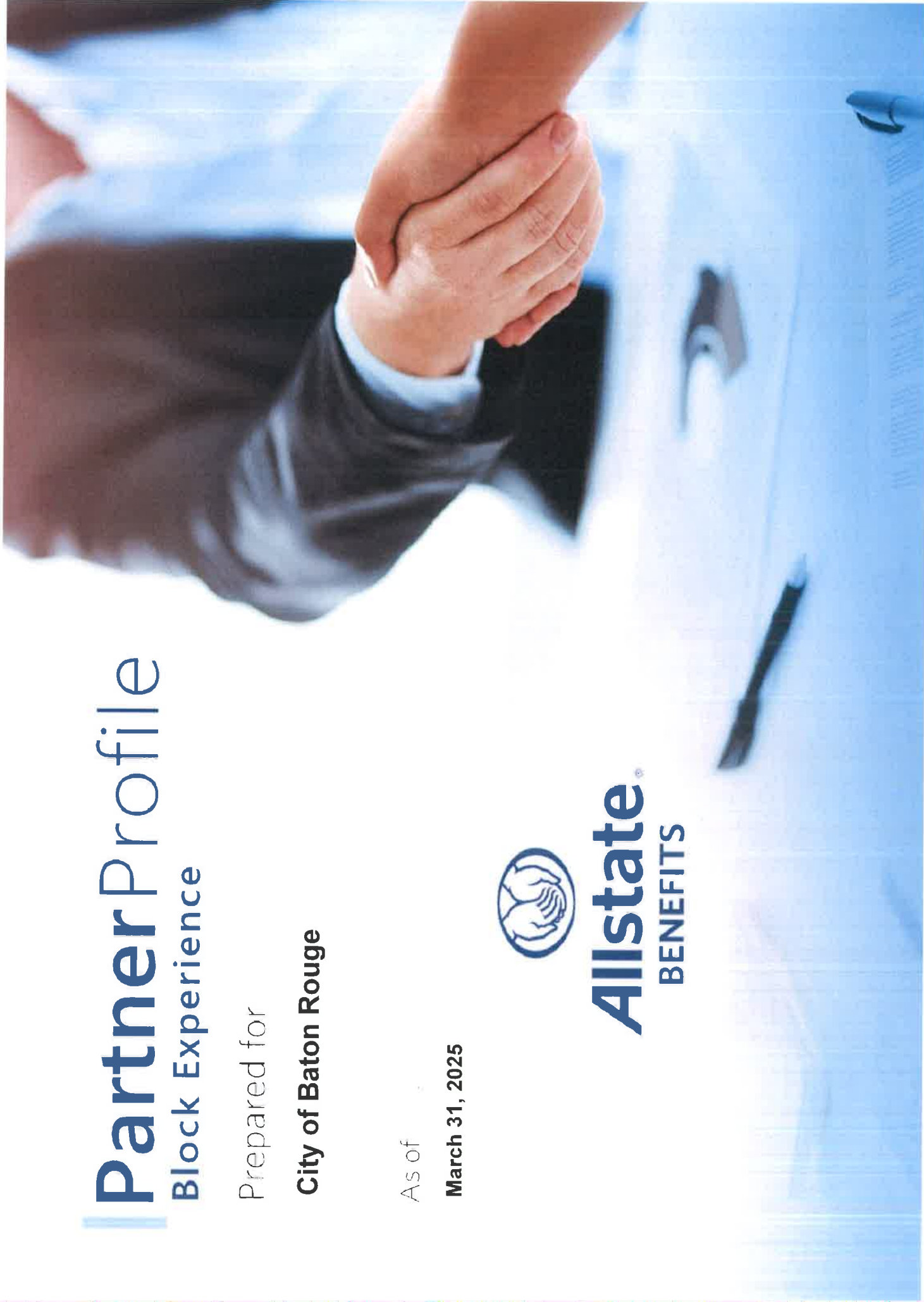
City of Baton Rouge

As of

March 31, 2025



Allstate®
BENEFITS



City of Baton Rouge

Report Assumptions and Definitions

- The utilization and participation data is current as of: March 31, 2025
- Persistency data as of: December 31, 2024

Persistency and Participation :

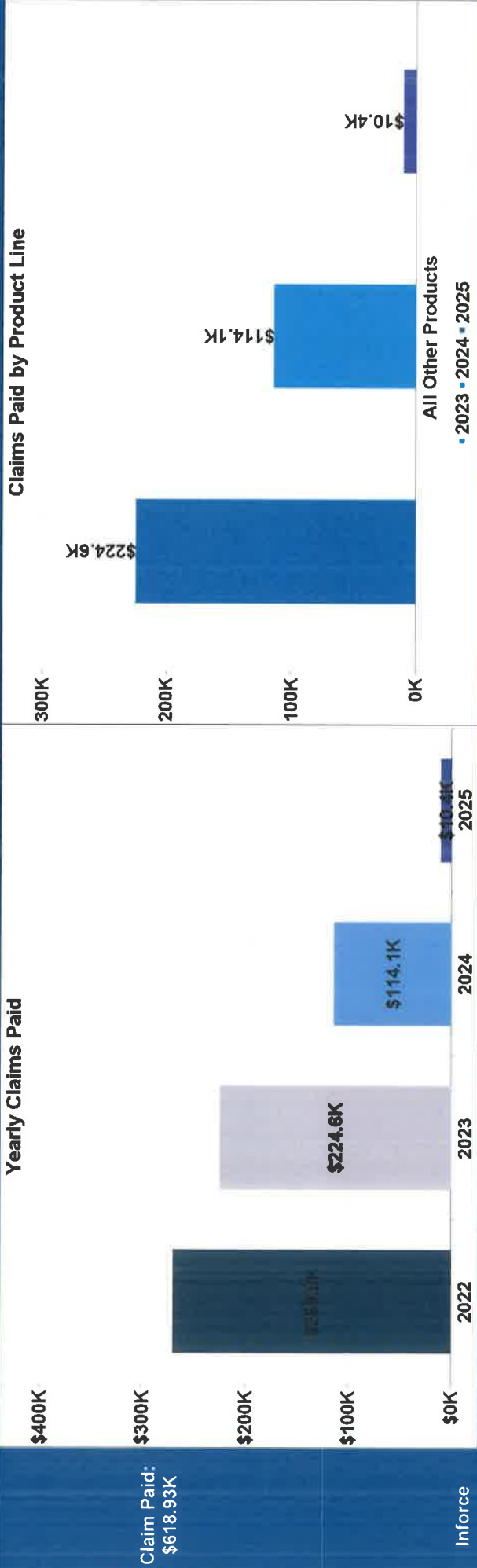
- Persistency is the proportion of the premium that remained in force for at least one (1) and/or two (2) year(s) past issue. Persistency is a continuous measure that may include account(s) and/or product(s) no longer active.
- Allstate Benefits products are supported on two different policy administration systems – Life70 and Genelco. Insured policy counts are tracked independently by administration system.
 - o The Life70 administration system supports the Accident, Critical Illness, Short Term Disability, and Permanent Life products. The Genelco administration system supports the Hospital Indemnity plan, employer-paid Critical Illness, and true group Short Term Disability.
 - o The Number of Insured Employees is tracked independently by administration system
 - Life70: The admin system is able to determine that employee Tom Smith has purchased both Accident and Universal Life, which is recorded as 2 policies but just 1 insured employee
 - Genelco: The admin system records employee Tom Smith has purchased both Hospital Indemnity and true group Short Term Disability as 2 policies and 1 insured employee
 - Allstate is unable to reconcile insured employees between the Life70 and Genelco systems, so Tom Smith would be reported as 2 insured employees versus 1 insured employee. Tom Smith would be recorded as 4 policies.

Claims Utilization :

- Claims utilization is presented from January 1, 2022 - March 31, 2025.
- The utilization data in this Claims Utilization Report represents claims paid in the period, rather than incurred.
- A claimant may be counted multiple times if he or she had claims paid on multiple benefits for the same product.
- The benefit claim count is calculated by counting the number of distinct policies in a year that submit a claim that is paid on the benefit.
- The utilization data in the report will include ported policies.
- Year-over-year change is presented as the change between the last two (2) full calendar years.

Overview

Block Paid Claims Utilization - Paid Amount



Claim Paid:
\$618.93K

Inforce
Policies:
2K

Paid Claims Utilization by Top Benefit Type - Paid Amount

January 1, 2022 - March 31, 2025

Accident

Benefit Type	% of Total	Year over Year Change
--------------	------------	-----------------------

Critical Illness

Benefit Type	% of Total	Year over Year Change
--------------	------------	-----------------------

Hospital Indemnity

Benefit Type	% of Total	Year over Year Change
--------------	------------	-----------------------

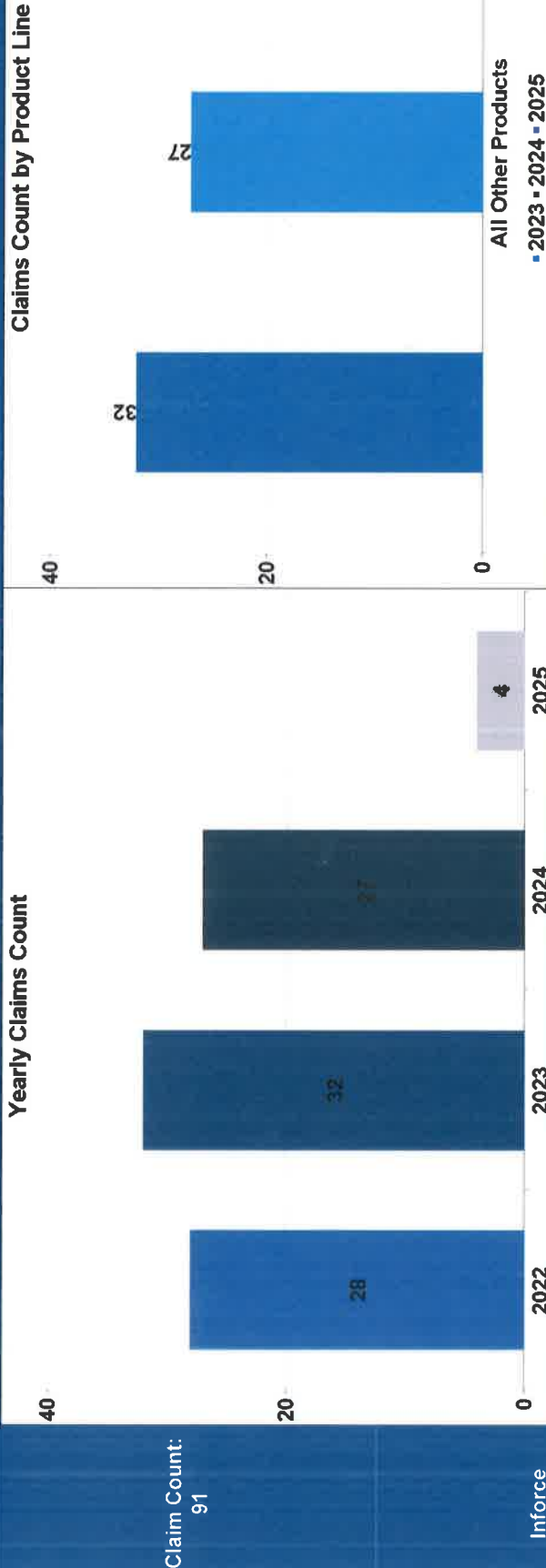
All Other Products

Benefit Type	% of Total	Year over Year Change
DEATH	69.39%	-63.19%
DISABILITY	30.61%	-8.82%

Overall
Saturation
Rate:
53%

City of Baton Rouge

Block Paid Claims Utilization - Claim Count



Claim Count:
91

Inforce Policies:
2K

Overall Saturation Rate:
53%

Paid Claims Utilization by Top Benefit Type - Claim Count

January 1, 2022 - March 31, 2025

Accident

Benefit Type	% of Total	Year over Year Change
--------------	------------	-----------------------

Critical Illness

Benefit Type	% of Total	Year over Year Change
--------------	------------	-----------------------

Hospital Indemnity

Benefit Type	% of Total	Year over Year Change
--------------	------------	-----------------------

All Other Products

Benefit Type	% of Total	Year over Year Change
DISABILITY	81.32%	-14.81%
DEATH	18.68%	-20.00%

All Other Products

Benefit	2022		2023		2024		2025	
	Paid Amount	Claim Count	Paid Amount	Claim Count	Paid Amount	Claim Count	Paid Amount	Claim Count
DEATH	\$198,606	8	\$168,774	5	\$62,122	4	\$0	0
DISABILITY	\$71,163	20	\$55,832	27	\$52,022	23	\$10,407	4
Total	\$269,770	28	\$224,606	32	\$114,144	27	\$10,407	4



City of Baton Rouge

As Of 3/31/2025

Group Detail

Inforce Group Numbers: 3		Total Annualized Inforce Premium: \$909,489		Total Annualized New Sales Premium: \$81,730			Total Eligible Employees: 3,000		
Group Number	Group Name	Product	Eligible	Inforce Policies	Inforce Policies	Inforce Policies	New Sales Policies	New Sales Policies	New Sales Policies
				As of 03/31/23	As of 03/31/24	As of 03/31/25	04/22 - 03/23	04/23 - 03/24	04/24 - 03/25
V5708	CITY OF BATON ROUGE/CORONER'S	Disability	2,700	1	N/A	N/A	N/A	N/A	N/A
V5708	CITY OF BATON ROUGE/CORONER'S	Universal Life	2,700	2	N/A	N/A	N/A	N/A	N/A
V5708	Sub Total			3	N/A	N/A	N/A	N/A	N/A
V5704	CITY OF BATON ROUGE/DISTRICT	Disability	3,000	11	8	11	N/A	N/A	4
V5704	CITY OF BATON ROUGE/DISTRICT	Universal Life	3,000	30	28	26	N/A	1	N/A
V5704	Sub Total			41	36	37	N/A	1	4
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	499	533	499	88	110	42
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	1,276	1,433	1,447	154	263	97
V4629	Sub Total			1,775	1,966	1,946	242	373	139
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	2	2	2	N/A	N/A	N/A
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	3	2	2	N/A	N/A	N/A
V5311	Sub Total			5	4	4	N/A	N/A	N/A
GRAND TOTALS				1,824	2,006	1,987	242	374	143



City of Baton Rouge

As Of 3/31/2025

Group Number	Group Name	Product	Eligible	Inforce Premium As of 03/31/23	Inforce Premium As of 03/31/24	Inforce Premium As of 03/31/25	New Sales Premium 04/22 - 03/23	New Sales Premium 04/23 - 03/24	New Sales Premium 04/24 - 03/25
V5708	CITY OF BATON ROUGE/CORONER'S	Disability	2,700	\$351	N/A	N/A	N/A	N/A	N/A
V5708	CITY OF BATON ROUGE/CORONER'S	Universal Life	2,700	\$710	N/A	N/A	N/A	N/A	N/A
V5708	Sub Total			\$1,061	N/A	N/A	N/A	N/A	N/A
V5704	CITY OF BATON ROUGE/DISTRICT	Disability	3,000	\$7,108	\$5,231	\$5,973	N/A	N/A	\$2,231
V5704	CITY OF BATON ROUGE/DISTRICT	Universal Life	3,000	\$10,726	\$9,308	\$8,755	N/A	\$633	N/A
V5704	Sub Total			\$17,834	\$14,539	\$14,728	N/A	\$633	\$2,231
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	\$235,694	\$253,491	\$245,372	\$39,464	\$57,111	\$25,153
V4629	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	\$543,648	\$635,596	\$648,306	\$76,317	\$133,467	\$54,346
V4629	Sub Total			\$779,342	\$889,087	\$893,677	\$115,780	\$190,577	\$79,499
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Disability	3,000	\$749	\$749	\$749	N/A	N/A	N/A
V5311	CITY OF BATON ROUGE/PARISH OF EAST	Universal Life	3,000	\$607	\$335	\$335	N/A	N/A	N/A
V5311	Sub Total			\$1,355	\$1,083	\$1,083	N/A	N/A	N/A
	GRAND TOTALS			\$799,593	\$904,709	\$909,489	\$115,780	\$191,210	\$81,730



Group Voluntary Disability Income (Louisiana)

Product Illustration

Benefit Period: 6 Months

Portability: Yes

Mental and Nervous

Disorders Covered: No

Accident Elimination Period:

Sickness Elimination Period:

Premium Mode:

Rate Class:

14 days

14 days

Monthly

Preferred Plus

Additional Riders:

None

Monthly Benefit	Issue Ages				
	18-49	50-59	60-64	65-69	70 +
\$400.00	\$13.01	\$17.37	\$23.33	\$25.09	\$27.61
\$500.00	\$16.26	\$21.72	\$29.16	\$31.36	\$34.51
\$600.00	\$19.51	\$26.06	\$34.99	\$37.63	\$41.41
\$700.00	\$22.77	\$30.40	\$40.82	\$43.91	\$48.31
\$800.00	\$26.02	\$34.75	\$46.65	\$50.18	\$55.21
\$900.00	\$29.27	\$39.09	\$52.48	\$56.45	\$62.11
\$1,000.00	\$32.52	\$43.43	\$58.32	\$62.72	\$69.02
\$1,100.00	\$35.78	\$47.78	\$64.15	\$69.00	\$75.92
\$1,200.00	\$39.03	\$52.12	\$69.98	\$75.27	\$82.82
\$1,300.00	\$42.28	\$56.46	\$75.81	\$81.54	\$89.72
\$1,400.00	\$45.53	\$60.81	\$81.64	\$87.81	\$96.62
\$1,500.00	\$48.79	\$65.15	\$87.47	\$94.09	\$103.52
\$1,600.00	\$52.04	\$69.49	\$93.31	\$100.36	\$110.43
\$1,700.00	\$55.29	\$73.84	\$99.14	\$106.63	\$117.33
\$1,800.00	\$58.54	\$78.18	\$104.97	\$112.90	\$124.23
\$1,900.00	\$61.80	\$82.52	\$110.80	\$119.18	\$131.13
\$2,000.00	\$65.05	\$86.87	\$116.63	\$125.45	\$138.03
\$2,100.00	\$68.30	\$91.21	\$122.46	\$131.72	\$144.93
\$2,200.00	\$71.55	\$95.55	\$128.30	\$137.99	\$151.84
\$2,300.00	\$74.81	\$99.90	\$134.13	\$144.27	\$158.74
\$2,400.00	\$78.06	\$104.24	\$139.96	\$150.54	\$165.64
\$2,500.00	\$81.31	\$108.58	\$145.79	\$156.81	\$172.54
\$2,600.00	\$84.56	\$112.93	\$151.62	\$163.08	\$179.44
\$2,700.00	\$87.82	\$117.27	\$157.45	\$169.36	\$186.34
\$2,800.00	\$91.07	\$121.61	\$163.29	\$175.63	\$193.25
\$2,900.00	\$94.32	\$125.96	\$169.12	\$181.90	\$200.15
\$3,000.00	\$97.57	\$130.30	\$174.95	\$188.17	\$207.05
\$3,100.00	\$100.83	\$134.64	\$180.78	\$194.45	\$213.95
\$3,200.00	\$104.08	\$138.99	\$186.61	\$200.72	\$220.85
\$3,300.00	\$107.33	\$143.33	\$192.44	\$206.99	\$227.75
\$3,400.00	\$110.58	\$147.67	\$198.28	\$213.26	\$234.66
\$3,500.00	\$113.84	\$152.02	\$204.11	\$219.54	\$241.56
\$3,600.00	\$117.09	\$156.36	\$209.94	\$225.81	\$248.46
\$3,700.00	\$120.34	\$160.70	\$215.77	\$232.08	\$255.36
\$3,800.00	\$123.59	\$165.05	\$221.60	\$238.35	\$262.26
\$3,900.00	\$126.85	\$169.39	\$227.43	\$244.63	\$269.16
\$4,000.00	\$130.10	\$173.73	\$233.27	\$250.90	\$276.07
\$4,100.00	\$133.35	\$178.08	\$239.10	\$257.17	\$282.97
\$4,200.00	\$136.60	\$182.42	\$244.93	\$263.44	\$289.87
\$4,300.00	\$139.86	\$186.76	\$250.76	\$269.72	\$296.77
\$4,400.00	\$143.11	\$191.11	\$256.59	\$275.99	\$303.67
\$4,500.00	\$146.36	\$195.45	\$262.42	\$282.26	\$310.57
\$4,600.00	\$149.61	\$199.79	\$268.26	\$288.53	\$317.48
\$4,700.00	\$152.87	\$204.14	\$274.09	\$294.81	\$324.38
\$4,800.00	\$156.12	\$208.48	\$279.92	\$301.08	\$331.28
\$4,900.00	\$159.37	\$212.82	\$285.75	\$307.35	\$338.18
\$5,000.00	\$162.62	\$217.17	\$291.58	\$313.62	\$345.08

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Group Voluntary Disability Income (Louisiana)

Product Illustration

Benefit Period: 12 Months

Portability: Yes

Mental and Nervous

Disorders Covered: No

Accident Elimination Period:

Sickness Elimination Period:

Premium Mode:

Rate Class:

14 days

14 days

Monthly

Preferred Plus

Additional Riders:

None

Monthly Benefit	Issue Ages				
	18-49	50-59	60-64	65-69	70 +
\$400.00	\$16.63	\$21.96	\$32.55	\$34.49	\$40.22
\$500.00	\$20.78	\$27.45	\$40.68	\$43.11	\$50.27
\$600.00	\$24.94	\$32.94	\$48.82	\$51.73	\$60.33
\$700.00	\$29.10	\$38.44	\$56.96	\$60.35	\$70.38
\$800.00	\$33.25	\$43.93	\$65.09	\$68.97	\$80.44
\$900.00	\$37.41	\$49.42	\$73.23	\$77.59	\$90.49
\$1,000.00	\$41.57	\$54.91	\$81.37	\$86.22	\$100.55
\$1,100.00	\$45.72	\$60.40	\$89.50	\$94.84	\$110.60
\$1,200.00	\$49.88	\$65.89	\$97.64	\$103.46	\$120.66
\$1,300.00	\$54.04	\$71.38	\$105.78	\$112.08	\$130.71
\$1,400.00	\$58.19	\$76.87	\$113.91	\$120.70	\$140.77
\$1,500.00	\$62.35	\$82.36	\$122.05	\$129.32	\$150.82
\$1,600.00	\$66.51	\$87.85	\$130.19	\$137.95	\$160.88
\$1,700.00	\$70.66	\$93.34	\$138.32	\$146.57	\$170.93
\$1,800.00	\$74.82	\$98.83	\$146.46	\$155.19	\$180.99
\$1,900.00	\$78.98	\$104.33	\$154.60	\$163.81	\$191.04
\$2,000.00	\$83.13	\$109.82	\$162.73	\$172.43	\$201.10
\$2,100.00	\$87.29	\$115.31	\$170.87	\$181.05	\$211.15
\$2,200.00	\$91.45	\$120.80	\$179.01	\$189.68	\$221.21
\$2,300.00	\$95.60	\$126.29	\$187.14	\$198.30	\$231.26
\$2,400.00	\$99.76	\$131.78	\$195.28	\$206.92	\$241.32
\$2,500.00	\$103.92	\$137.27	\$203.42	\$215.54	\$251.37
\$2,600.00	\$108.07	\$142.76	\$211.55	\$224.16	\$261.43
\$2,700.00	\$112.23	\$148.25	\$219.69	\$232.78	\$271.48
\$2,800.00	\$116.39	\$153.74	\$227.83	\$241.41	\$281.54
\$2,900.00	\$120.54	\$159.23	\$235.96	\$250.03	\$291.59
\$3,000.00	\$124.70	\$164.72	\$244.10	\$258.65	\$301.65
\$3,100.00	\$128.86	\$170.22	\$252.24	\$267.27	\$311.70
\$3,200.00	\$133.01	\$175.71	\$260.37	\$275.89	\$321.76
\$3,300.00	\$137.17	\$181.20	\$268.51	\$284.51	\$331.81
\$3,400.00	\$141.33	\$186.69	\$276.65	\$293.14	\$341.87
\$3,500.00	\$145.48	\$192.18	\$284.78	\$301.76	\$351.92
\$3,600.00	\$149.64	\$197.67	\$292.92	\$310.38	\$361.98
\$3,700.00	\$153.80	\$203.16	\$301.06	\$319.00	\$372.03
\$3,800.00	\$157.95	\$208.65	\$309.19	\$327.62	\$382.09
\$3,900.00	\$162.11	\$214.14	\$317.33	\$336.24	\$392.14
\$4,000.00	\$166.27	\$219.63	\$325.47	\$344.87	\$402.20
\$4,100.00	\$170.42	\$225.12	\$333.60	\$353.49	\$412.25
\$4,200.00	\$174.58	\$230.61	\$341.74	\$362.11	\$422.31
\$4,300.00	\$178.74	\$236.11	\$349.88	\$370.73	\$432.36
\$4,400.00	\$182.89	\$241.60	\$358.01	\$379.35	\$442.42
\$4,500.00	\$187.05	\$247.09	\$366.15	\$387.97	\$452.47
\$4,600.00	\$191.21	\$252.58	\$374.29	\$396.60	\$462.53
\$4,700.00	\$195.36	\$258.07	\$382.42	\$405.22	\$472.58
\$4,800.00	\$199.52	\$263.56	\$390.56	\$413.84	\$482.64
\$4,900.00	\$203.68	\$269.05	\$398.70	\$422.46	\$492.69
\$5,000.00	\$207.83	\$274.54	\$406.83	\$431.08	\$502.75

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Group Voluntary Disability Income (Louisiana)

Product Illustration

Benefit Period: 6 Months

Portability: Yes

Mental and Nervous

Disorders Covered: No

Accident Elimination Period:

30 days

Sickness Elimination Period:

30 days

Premium Mode:

Monthly

Rate Class:

Preferred Plus

Additional Riders:

None

Monthly Benefit	Issue Ages				
	18-49	50-59	60-64	65-69	70 +
\$400.00	\$8.20	\$12.04	\$13.98	\$14.82	\$17.37
\$500.00	\$10.25	\$15.05	\$17.47	\$18.52	\$21.72
\$600.00	\$12.30	\$18.06	\$20.97	\$22.23	\$26.06
\$700.00	\$14.36	\$21.07	\$24.46	\$25.93	\$30.40
\$800.00	\$16.41	\$24.08	\$27.96	\$29.64	\$34.75
\$900.00	\$18.46	\$27.09	\$31.45	\$33.34	\$39.09
\$1,000.00	\$20.51	\$30.10	\$34.95	\$37.05	\$43.43
\$1,100.00	\$22.56	\$33.11	\$38.44	\$40.75	\$47.78
\$1,200.00	\$24.61	\$36.12	\$41.94	\$44.46	\$52.12
\$1,300.00	\$26.66	\$39.13	\$45.43	\$48.16	\$56.46
\$1,400.00	\$28.71	\$42.14	\$48.93	\$51.87	\$60.81
\$1,500.00	\$30.76	\$45.15	\$52.42	\$55.57	\$65.15
\$1,600.00	\$32.81	\$48.16	\$55.92	\$59.28	\$69.49
\$1,700.00	\$34.86	\$51.17	\$59.41	\$62.98	\$73.84
\$1,800.00	\$36.91	\$54.18	\$62.91	\$66.69	\$78.18
\$1,900.00	\$38.97	\$57.19	\$66.40	\$70.39	\$82.52
\$2,000.00	\$41.02	\$60.20	\$69.90	\$74.10	\$86.87
\$2,100.00	\$43.07	\$63.21	\$73.39	\$77.80	\$91.21
\$2,200.00	\$45.12	\$66.22	\$76.89	\$81.51	\$95.55
\$2,300.00	\$47.17	\$69.23	\$80.38	\$85.21	\$99.90
\$2,400.00	\$49.22	\$72.24	\$83.88	\$88.92	\$104.24
\$2,500.00	\$51.27	\$75.25	\$87.37	\$92.62	\$108.58
\$2,600.00	\$53.32	\$78.26	\$90.87	\$96.33	\$112.93
\$2,700.00	\$55.37	\$81.27	\$94.36	\$100.03	\$117.27
\$2,800.00	\$57.42	\$84.28	\$97.86	\$103.74	\$121.61
\$2,900.00	\$59.47	\$87.29	\$101.35	\$107.44	\$125.96
\$3,000.00	\$61.52	\$90.30	\$104.85	\$111.15	\$130.30
\$3,100.00	\$63.58	\$93.31	\$108.34	\$114.85	\$134.64
\$3,200.00	\$65.63	\$96.32	\$111.84	\$118.56	\$138.99
\$3,300.00	\$67.68	\$99.33	\$115.33	\$122.26	\$143.33
\$3,400.00	\$69.73	\$102.34	\$118.83	\$125.97	\$147.67
\$3,500.00	\$71.78	\$105.35	\$122.32	\$129.67	\$152.02
\$3,600.00	\$73.83	\$108.36	\$125.82	\$133.38	\$156.36
\$3,700.00	\$75.88	\$111.37	\$129.31	\$137.08	\$160.70
\$3,800.00	\$77.93	\$114.38	\$132.81	\$140.79	\$165.05
\$3,900.00	\$79.98	\$117.39	\$136.30	\$144.49	\$169.39
\$4,000.00	\$82.03	\$120.40	\$139.80	\$148.20	\$173.73
\$4,100.00	\$84.08	\$123.41	\$143.29	\$151.90	\$178.08
\$4,200.00	\$86.13	\$126.42	\$146.79	\$155.61	\$182.42
\$4,300.00	\$88.19	\$129.43	\$150.28	\$159.31	\$186.76
\$4,400.00	\$90.24	\$132.44	\$153.78	\$163.02	\$191.11
\$4,500.00	\$92.29	\$135.45	\$157.27	\$166.72	\$195.45
\$4,600.00	\$94.34	\$138.46	\$160.77	\$170.43	\$199.79
\$4,700.00	\$96.39	\$141.47	\$164.26	\$174.13	\$204.14
\$4,800.00	\$98.44	\$144.48	\$167.76	\$177.84	\$208.48
\$4,900.00	\$100.49	\$147.49	\$171.25	\$181.54	\$212.82
\$5,000.00	\$102.54	\$150.50	\$174.75	\$185.25	\$217.17

This rate insert is part of the approved brochure for City of Baton Rouge Parish of East and is not to be used on its own.

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Group Voluntary Disability Income (Louisiana)

Product Illustration

Benefit Period: 12 Months

Portability: Yes

Mental and Nervous

Disorders Covered: No

Accident Elimination Period:

30 days

Sickness Elimination Period:

30 days

Premium Mode:

Monthly

Rate Class:

Preferred Plus

Additional Riders:

None

Monthly Benefit	Issue Ages				
	18-49	50-59	60-64	65-69	70 +
\$400.00	\$10.72	\$14.91	\$19.32	\$20.46	\$24.48
\$500.00	\$13.40	\$18.63	\$24.15	\$25.57	\$30.60
\$600.00	\$16.07	\$22.36	\$28.97	\$30.69	\$36.71
\$700.00	\$18.75	\$26.09	\$33.80	\$35.80	\$42.83
\$800.00	\$21.43	\$29.81	\$38.63	\$40.92	\$48.95
\$900.00	\$24.11	\$33.54	\$43.46	\$46.03	\$55.07
\$1,000.00	\$26.79	\$37.27	\$48.29	\$51.15	\$61.19
\$1,100.00	\$29.47	\$40.99	\$53.12	\$56.26	\$67.31
\$1,200.00	\$32.15	\$44.72	\$57.95	\$61.38	\$73.43
\$1,300.00	\$34.83	\$48.45	\$62.78	\$66.49	\$79.55
\$1,400.00	\$37.51	\$52.17	\$67.61	\$71.61	\$85.67
\$1,500.00	\$40.19	\$55.90	\$72.44	\$76.72	\$91.79
\$1,600.00	\$42.87	\$59.63	\$77.27	\$81.84	\$97.91
\$1,700.00	\$45.55	\$63.35	\$82.10	\$86.95	\$104.03
\$1,800.00	\$48.22	\$67.08	\$86.92	\$92.07	\$110.14
\$1,900.00	\$50.90	\$70.81	\$91.75	\$97.18	\$116.26
\$2,000.00	\$53.58	\$74.53	\$96.58	\$102.30	\$122.38
\$2,100.00	\$56.26	\$78.26	\$101.41	\$107.41	\$128.50
\$2,200.00	\$58.94	\$81.99	\$106.24	\$112.53	\$134.62
\$2,300.00	\$61.62	\$85.71	\$111.07	\$117.64	\$140.74
\$2,400.00	\$64.30	\$89.44	\$115.90	\$122.76	\$146.86
\$2,500.00	\$66.98	\$93.17	\$120.73	\$127.87	\$152.98
\$2,600.00	\$69.66	\$96.89	\$125.56	\$132.99	\$159.10
\$2,700.00	\$72.34	\$100.62	\$130.39	\$138.10	\$165.22
\$2,800.00	\$75.02	\$104.35	\$135.22	\$143.22	\$171.34
\$2,900.00	\$77.70	\$108.07	\$140.05	\$148.33	\$177.46
\$3,000.00	\$80.37	\$111.80	\$144.87	\$153.45	\$183.57
\$3,100.00	\$83.05	\$115.53	\$149.70	\$158.56	\$189.69
\$3,200.00	\$85.73	\$119.25	\$154.53	\$163.68	\$195.81
\$3,300.00	\$88.41	\$122.98	\$159.36	\$168.79	\$201.93
\$3,400.00	\$91.09	\$126.71	\$164.19	\$173.91	\$208.05
\$3,500.00	\$93.77	\$130.43	\$169.02	\$179.02	\$214.17
\$3,600.00	\$96.45	\$134.16	\$173.85	\$184.14	\$220.29
\$3,700.00	\$99.13	\$137.89	\$178.68	\$189.25	\$226.41
\$3,800.00	\$101.81	\$141.61	\$183.51	\$194.37	\$232.53
\$3,900.00	\$104.49	\$145.34	\$188.34	\$199.48	\$238.65
\$4,000.00	\$107.17	\$149.07	\$193.17	\$204.60	\$244.77
\$4,100.00	\$109.85	\$152.79	\$198.00	\$209.71	\$250.89
\$4,200.00	\$112.52	\$156.52	\$202.82	\$214.83	\$257.00
\$4,300.00	\$115.20	\$160.25	\$207.65	\$219.94	\$263.12
\$4,400.00	\$117.88	\$163.97	\$212.48	\$225.06	\$269.24
\$4,500.00	\$120.56	\$167.70	\$217.31	\$230.17	\$275.36
\$4,600.00	\$123.24	\$171.43	\$222.14	\$235.29	\$281.48
\$4,700.00	\$125.92	\$175.15	\$226.97	\$240.40	\$287.60
\$4,800.00	\$128.60	\$178.88	\$231.80	\$245.52	\$293.72
\$4,900.00	\$131.28	\$182.61	\$236.63	\$250.63	\$299.84
\$5,000.00	\$133.96	\$186.33	\$241.46	\$255.75	\$305.96

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

GROUP DISABILITY INSURANCE POLICY

NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the employer's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

A handwritten signature in cursive script, appearing to read "Gary S. Stewart".

Secretary

A handwritten signature in cursive script, appearing to read "Gregory J. Seidner".

President

**THIS IS A GROUP DISABILITY ONLY POLICY WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS POLICY**

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POLICY SPECIFICATIONS

POLICYHOLDER: CITY OF BATON ROUGE/PARISH OF EAST BATON ROUGE
POLICY NUMBER: V4629, V5311, V5704-V5711
POLICY EFFECTIVE DATE: January 1, 2014
POLICY ANNIVERSARY DATE: January 1, 2015 and the first day of January each calendar year thereafter.
GOVERNING JURISDICTION: The state of Louisiana and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All full-time active employees who work 30 or more hours a week for the employer.

ELIGIBILITY WAITING PERIOD: 30 days

MONTHLY BENEFIT: The amount* elected by each insured employee or member, not to exceed 60% of monthly earnings, subject to a minimum of \$400 and a maximum of \$5,000.

OPTIONAL RIDERS: None

GUARANTEED ISSUE LIMIT: We may ask for evidence of insurability if a person proposed for insurance applies for a monthly benefit amount over \$5,000.

PLAN I

ELIMINATION PERIOD: 14 days for disability due to an injury
14 days for disability due to a sickness
Benefits begin the day after the elimination period is completed.

MAXIMUM PERIOD OF PAYMENT: 6 months

PLAN II

ELIMINATION PERIOD: 14 days for disability due to an injury
14 days for disability due to a sickness
Benefits begin the day after the elimination period is completed.

MAXIMUM PERIOD OF PAYMENT: 12 months

PLAN III

ELIMINATION PERIOD: 30 days for disability due to an injury
30 days for disability due to a sickness
Benefits begin the day after the elimination period is completed.

MAXIMUM PERIOD OF PAYMENT: 6 months

PLAN IV

ELIMINATION PERIOD: 30 days for disability due to an injury
30 days for disability due to a sickness
Benefits begin the day after the elimination period is completed.

MAXIMUM PERIOD OF PAYMENT: 12 months

POLICY SPECIFICATIONS (Continued)

WAIVER OF PREMIUM: Premium payments are required while the insured employee or member is receiving payments under this policy during the first 30 days of disability.

INITIAL RATE: Monthly rate is determined on the certificate effective date based on the insured employee or member's issue age on such dates, as follows:

Issue Age	PLAN I	PLAN II
	Monthly rate per \$100 of monthly benefit	Monthly rate per \$100 of monthly benefit
18 to 49	\$3.25	\$4.16
50 to 59	\$4.34	\$5.49
60 to 64	\$5.83	\$8.14
65 to 69	\$6.27	\$8.62
70 and over	\$6.90	\$10.05

Issue Age	PLAN III	PLAN IV
	Monthly rate per \$100 of monthly benefit	Monthly rate per \$100 of monthly benefit
18 to 49	\$2.05	\$2.68
50 to 59	\$3.01	\$3.73
60 to 64	\$3.49	\$4.83
65 to 69	\$3.70	\$5.11
70 and over	\$4.34	\$6.12

RATE GUARANTEE DATE: 01/01/2016

PREMIUM DUE: The initial date agreed to between American Heritage Life Insurance Company and the policyholder and each specified date thereafter.

All premiums must be sent on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE: The insured employee pays the cost of coverage.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

Location (City and State)

None

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date. However, we may change premiums at any time for reasons which affect the risk assumed, including the reasons shown below:

1. a change occurs in this policy design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members increases or decreases by 15% or more; or
4. a new law or a change in any existing law is enacted which applies to this policy; or
5. less than 10 of those eligible for coverage are participating.

We will notify the policyholder and each employer participating in the Trust in writing at least 45 days before a premium rate is changed. Rates shall not increase in the first 12 months of coverage and shall not increase more than once in a 6 month period thereafter.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the RATE GUARANTEE provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

WAIVER OF PREMIUM

We do not require premium payment for an insured employee or member after being disabled the longer of 30 days or completion of the elimination period for the duration of that disability. The waiver of the premium will not exceed the maximum benefit period.

We do not require premium payment for an insured employee or member while he or she is receiving disability payments.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder or employer must provide us with the following on a regular basis:

1. information about employees or members:
 - a. who are eligible to become insured; and
 - b. whose amounts of coverage change; and
 - c. whose coverage ends; and
2. occupational information and any other information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder or employer records that have a bearing, in our opinion, on this policy must be made available for review by us at any reasonable time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if participation is not met as described in the RATE GUARANTEE provision.

Evidence of insurability is also required if the employee or member:

1. voluntarily canceled coverage and is reapplying; or
2. is applying for an amount of coverage over the Guaranteed Issue Limit; or
3. is applying for the coverage at any time after the initial enrollment period; or
4. is applying for an increase in the amount of coverage, during the re-enrollment period.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder or any employer, made in any applications or employer agreements to participate under the Trust, can be used to void the policy.

POLICYHOLDER PROVISIONS (Continued)

CLERICAL ERROR

Clerical error on the part of the policyholder, by any employer or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder or any employer documenting any clerical errors.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 60 days written notice to the policyholder, if:

1. less than 10 of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 10 people are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

If the premium is not paid during the grace period, the policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must send us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both we and the policyholder agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

Coverage with respect to an employer participating in the Trust will terminate according to the terms of the Participation Agreement signed by the employer.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member; and
5. the Participation Agreements signed by the employers participating under the Trust.

Any statements made by the policyholder or by an insured employee or member or any employer participating under the Trust, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or insured employee or member or any employer will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the employer or the insured employee or member or his or her personal representative, if any, if such written statement will be used in defense of a claim.

If any of the statements are not complete and/or not true at the time they are made, we can:

1. reduce or deny any claim; or
2. cancel coverage from the original effective date.

POLICYHOLDER PROVISIONS (Continued)

CERTIFICATES OF INSURANCE

We will furnish to the policyholder or each employer participating under the Trust a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

This policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members.

(This space intentionally left blank.)



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

**1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776**

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**THIS IS A GROUP DISABILITY ONLY POLICY WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS POLICY**



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A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"The policy" means the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

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

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

**THIS IS GROUP DISABILITY ONLY COVERAGE WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS CERTIFICATE**

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive, Jacksonville, Florida 32224

CERTIFICATE SPECIFICATIONS

FORM NO. DESCRIPTION OF BENEFITS					ANNUAL PREMIUM AMOUNT
		ELIMINATION PERIOD	MAXIMUM BENEFIT PERIOD	MAXIMUM MONTHLY BENEFIT AMOUNT	
GVDICLA	SHORT TERM DISABILITY	14 days for injury 14 days for sickness	12 months	\$5,000.00	\$XX.XX
					TOTAL \$XXXX.XX

The effective date of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method: PAYROLL - MONTHLY

Premium Class: INDUSTRY A

INSURED:	JOHN DOE	ISSUE AGE:	35
EFFECTIVE DATE:	JANUARY 1, 2014	CERTIFICATE NUMBER:	123456
POLICY NUMBER:	V4629, V5311		
BENEFICIARY:	AS NAMED AT ENROLLMENT OR LATER CHANGED		

GROUP DISABILITY COVERAGE

GVDICLA

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective at 12:01 a.m. on the effective date shown on the Certificate Specifications page provided you are an active employee on that date.

If you are not an active employee on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.

Any decrease in coverage will take effect on the first day of the calendar month that next follows the date you apply for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to the policyholder. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
 - a. the initial enrollment period; or
 - b. a re-enrollment period or at any time, subject to evidence of insurability.
2. You may increase coverage at any time, subject to evidence of insurability.
3. You may decrease coverage at any time.
4. You may discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if you:

1. voluntarily canceled coverage and are reapplying; or
2. are applying for an amount of coverage over the Guaranteed Issue Limit; or
3. are applying for coverage, or for an increase in the amount of coverage, during the re-enrollment period; or
4. are applying for the coverage at any time after the initial enrollment period.

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payment was made; or
3. the last day you are an active employee with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder or the employer participating under the Trust, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

If we accept a premium for coverage extending beyond the date, age or event specified for termination, such premium will be refunded, coverage will terminate and claims will not be paid. We will provide coverage for a payable claim which occurs while you are covered under the policy.

Coverage may be eligible for continuation as outlined in the PORTABILITY PRIVILEGE provision.

GENERAL PROVISIONS (Continued)

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease active employment with your current employer due to a temporary layoff or leave of absence, and if premiums are paid, coverage will be continued for 3 months following the date active employment ceased.

We will continue your coverage in accordance with your employer's written human resource policy on temporary layoff, leave of absence or family and medical leave of absence, if premium payments continue and the employer approved your leave in writing, for the following periods:

1. If you are on temporary layoff or leave of absence, coverage will be continued for 3 months following the date you ceased active employment.
2. If you are on a Family and Medical Leave of Absence as defined by the Federal Family and Medical Leave Act of 1993, and any amendments, coverage will continue as though you are in active employment. Coverage will continue up to the greater of the leave period required under the:
 - a. Federal Family and Medical Leave Act of 1993, and any amendments; or
 - b. applicable state law.

If your employer's human resource written policy does not provide for continuation of coverage during a family and medical leave of absence, coverage will be reinstated when you return to active employment.

We will not:

1. apply a new eligibility waiting period; or
2. apply a new pre-existing condition exclusion; or
3. require evidence of insurability.

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

INCONTESTABILITY

After 2 years from the effective date of your coverage, no misstatement, made in writing, can be used to void coverage or deny a claim for a disability incurred.

CLERICAL ERROR

Clerical error on the part of the policyholder, by any employer or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder or any employer documenting any clerical errors.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

CONFORMITY WITH STATE STATUTES

Any provision of the policy which, on the policy effective date, is in conflict with the laws of the state in which it was delivered or issued for delivery, is amended to conform to the minimum requirements of such laws.

PRE-EXISTING CONDITION LIMITATION

We will not pay for disabilities during the first 12 months of coverage due to a pre-existing condition.

You have a pre-existing condition if:

1. your disability begins in the first 12 months after your effective date of coverage; and
2. you received medical treatment, consultation, care or services, including diagnostic measures, took or were prescribed drugs or medicines, took over the counter medications or followed treatment recommendations in the 12 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be effective; or
3. you had symptoms in the 12 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be effective.

WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim made by you not to exceed the amount you were insured under a prior group policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior group policy when it terminated; and
3. the prior group policy:
 - a. had the same policyholder as this policy; and
 - b. provided coverage substantially similar to this policy; and
 - c. was issued before the policy date of this policy; and
 - d. terminated within 60 days of the policy date of this policy.

WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim made by you not to exceed the amount you were insured under a prior individual policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior individual policy when it terminated; and
3. the prior individual policy:
 - a. provided coverage substantially similar to this policy; and
 - b. was issued before the policy date of this policy; and
 - c. terminated within 60 days of the policy date of this policy.

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EXCLUSIONS

We will not pay benefits for any disabilities that are caused by, contributed to by or result from:

1. Bipolar affective disorder (manic depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression or mental illness. We will pay, however, for covered disabilities resulting from Alzheimer's disease or similar forms of senility or senile dementia first manifested while coverage is in force.
2. War, declared or undeclared, participation in a riot, insurrection or rebellion.
3. Illegal activities or participation in an illegal occupation.
4. Intentionally self-inflicted injury or action.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.
6. Participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports.
7. Voluntary inhalation of fumes or gases.
8. Cosmetic surgery (except complications from such surgery will be covered).
9. Pre-existing conditions during the first 12 months of coverage.
10. Occupational sickness or injury, unless covered by an on-the-job disability rider.

We will not pay a benefit for any period of disability during which you are incarcerated.

As used in this provision, mental illness means a psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, post traumatic stress disorder, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

As used in this provision, substance abuse means the consuming of alcohol or taking of other drugs at dosages that place your psychological and physical welfare in danger or which habitual influence of such substance (except as prescribed and directed by a doctor) endangers public health, safety or welfare.

As used in this provision, occupational sickness or injury means a sickness or injury that was caused by, contributed to by or aggravated by any employment for pay or profit.

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BENEFIT INFORMATION

GENERAL

The following are shown on the Certificate Specifications page:

1. the elimination period(s); and
2. the monthly benefit amount.

You must be an active employee on the date your disability occurs for disability benefits to be payable.

We may require an exam by a doctor, other medical practitioner, or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require an interview by our authorized representative.

The loss of a professional or occupational license or certification does not, in itself, constitute a disability.

A. Elimination Period

You must be totally disabled continuously throughout the elimination period.

If your covered disability is the result of an injury or sickness that occurs while covered under the policy, the elimination period is the time period stated on the Certificate Specifications page.

B. Monthly Benefit Amount

We pay the monthly benefit amount (or part of the monthly benefit amount, if less than a full month) for a covered disability at the end of the month for which it is due. You will receive benefits as long as you remain totally disabled, except:

1. we pay only up to the maximum benefit period for any one total disability; and
2. any monthly benefit we pay is subject to the DEDUCTIBLE SOURCES OF INCOME provision.

If a monthly benefit is payable for any period less than a full month, we pay 1/30th of the applicable monthly benefit for each day.

When a benefit is due for a payable claim, we will send you a payment each month up to the maximum benefit period. The maximum benefit period during a continuous period of disability is shown on the Certificate Specifications page.

We will stop sending payments and your claim will end on the earliest of the following:

1. when you are able to return to work in your own occupation on a part-time or full-time basis but choose not to do so; or
2. the end of the maximum benefit period; or
3. the date you are no longer disabled under the terms of the policy; or
4. the date proof of your continuing disability is not submitted; or
5. the date of your death.

C. Amount of Payment

When you are totally disabled and not working we will follow the process described below to determine your amount of payment:

1. Multiply your monthly earnings by 60%.
2. Subtract any deductible sources of income from item 1.
3. Determine the lesser of the amount listed on the Certificate Specifications page and the result of item 2.
4. Compare item 3 with the \$100 minimum monthly payment and we will pay the greater of the two.

The amount calculated in item 4 is your monthly payment.

After the elimination period, if you continue to be disabled for less than 1 month, we will send 1/30th of your payment for each day of disability.

We may apply this amount toward an outstanding overpayment.

D. Deductible Sources of Income

Deductible sources of income include:

The amount that you receive, or are eligible to receive, as disability income payments under any:

1. individual disability income policies; or
2. other group insurance coverage.

BENEFIT INFORMATION (Continued)

DISABILITY BENEFITS

A. Total Disability Benefit

We pay the monthly benefit amount after the elimination period if we receive sufficient proof that you are totally disabled.

Benefits will not continue beyond the maximum benefit period for total disability.

You are totally disabled when we determine that due to a sickness or injury you are:

1. unable to perform the material and substantial duties of your own occupation; and
2. under the regular care of a doctor; and
3. not working in any job for wage or profit.

B. Partial Disability Benefit

We pay 50% of the monthly benefit if we receive sufficient proof that you are partially disabled, subject to the following:

1. the total disability benefit must have been payable for at least one full month immediately prior to being partially disabled; and
2. the maximum benefit period for a partial disability is 3 months; and
3. for a given period of disability, you may receive either a partial disability benefit, or a total disability benefit, but not both.

Benefits paid under this benefit count towards your maximum benefit period.

You are partially disabled when we determine that due to a sickness or injury you are:

1. unable to perform the material and substantial duties of your own occupation on a full-time basis, but you are able to work on a part-time basis; and
2. under the regular care of a doctor.

C. Concurrent Disability

During any period in which you are disabled due to more than one cause, benefits will be paid as if you are disabled due to only one cause. In no event will being disabled due to more than one cause extend the time for which benefits will be paid under the maximum benefit period.

D. Recurrent Disability

If you have a recurrent disability, we will treat the disability as part of the prior claim and another elimination period will not have to be completed if you were continuously insured under the policy for the period between the prior claim and the recurrent disability and:

1. your recurrent disability occurs within 6 months of the end of your prior claim; or
2. you fully performed any occupation for your employer on a full-time basis for less than 30 full days and your current disability is unrelated to your prior disability for which we made a payment.

Your recurrent disability will be subject to the same terms as your prior claim.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. Your new claim will be subject to all of the policy provisions.

If you become entitled to payments under any other group disability policy, you will not be eligible for payments under our policy.

As used in this provision, recurrent disability means a disability which is:

1. caused by a worsening in condition; or
2. due to the same cause(s) or related cause(s) as the prior disability for which we made a payment.

As used in the provision, any occupation means any gainful occupation for which you are suited by education, training or experience.

BENEFIT INFORMATION (Continued)

DISABILITY BENEFITS (Continued)

E. Organ Donor Benefit

If your disability is the result of your serving as an organ donor in an organ transplant procedure performed while covered under the policy, we will pay the monthly benefit you would receive if you are totally or partially disabled. Sufficient proof that you are totally or partially disabled must be received by us.

As used in this provision, organ transplant means the surgical transplantation of a:

1. kidney; or
2. lung; or
3. portion of the liver, pancreas, or intestines; or
4. bone marrow.

A procedure to have bone marrow removed and stored for your own future use is not considered organ donation.

F. Waiver of Premium

After you have been totally or partially disabled as the result of a covered sickness or injury for 30 or more consecutive days while covered under the policy, or after the elimination period shown on the Certificate Specifications page, whichever is greater, we will waive the premium for this coverage and any attached rider(s) for as long as you remain disabled. The waiver of the premium will not exceed the maximum benefit period shown on the Certificate Specifications page. You must pay all premiums to keep your coverage and any attached rider(s) in force until you have qualified for waiver of premium as described in this provision.

You must send us written notice as soon as you are no longer disabled. We will assume that you are no longer disabled if you:

1. do not send us satisfactory proof of loss when we request it; or
2. notify us that you are no longer disabled.

You must pay all premiums to keep your coverage and any attached rider(s) in force beginning with the first premium due after you are no longer disabled.

Waiver of premium does not apply to any period that you are totally or partially disabled as a result of sickness or injury which is excluded by name or specific description under the policy.

There is no limit to the number of times that you can receive a waiver of premium.

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PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions.

Such coverage will be available if:

1. coverage under the policy terminates under the **TERMINATION OF COVERAGE** provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose; and
4. any required information is sent to us.

No portability coverage will be provided if your insurance under the policy terminated due to the discovery of fraud or material misrepresentation or due to your failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Changes made to the policy after portability coverage begins will not apply to you unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured employees or members and may change on any premium due date. If you are on portability coverage, we will give you written notice at least 60 days before a change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such insured employee or member is the policyholder.

TERMINATION OF INSURANCE

Portability coverage will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or the date you request to discontinue coverage in writing.

TERMINATION OF THE POLICY

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

CLAIM INFORMATION

NOTICE OF A CLAIM

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, written proof of your claim must be sent to us no later than 90 days after the elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity. Notice given to us by, or on behalf of, you or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the claim form is not received within 15 days of the request, written proof of your claim may be sent to us without waiting for the form.

We must be notified immediately when you return to work in any capacity.

FILING A CLAIM

You and the policyholder must complete your own sections of the claim form and then give it to the attending doctor. The doctor should complete the attending physician statement on the form and send it directly to us. The form will include an additional section for completion by your employer, if different from the policyholder. In this event, the claim form should be forwarded to your employer before it is given to the doctor for completion.

PROOF OF CLAIM

Proof of claim, provided at your expense, must show:

1. proof that you are under the regular care of a doctor whose specialty or expertise is the most appropriate for treating the disabling condition(s) according to generally accepted medical practice;
2. the date your disability began;
3. the cause of your disability;
4. the extent of your disability, including restrictions and limitations preventing you from performing your own occupation;
5. the prognosis of your disability;
6. the name and address of any hospital or institution where treatment was received, including all attending doctors;
7. objective medical findings which support your disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations accepted as standard in the practice of medicine, for the disabling condition(s); and
8. the appropriate documentation of monthly earnings; and
9. proof of active employment on the date your disability began.

We may request that proof of continuing disability be sent to us indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by us.

In some cases, you will be required to give us authorization to obtain additional medical information, and to provide non-medical information as part of the proof of claim, or proof of continuing disability. We will deny a claim, or stop sending payments, if any appropriate information is not submitted.

As used in this provision, generally accepted medical practice means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payments to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

CLAIM INFORMATION (Continued)

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim; or
3. your receipt of deductible sources of income.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

UNPAID PREMIUM

Any unpaid premium that is due from you may be deducted from the payment of your claim.

CLAIM REVIEW

If your claim is denied, we will provide written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of your claim; and
4. the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

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GLOSSARY

Active Employment means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your own occupation. For the purposes of this coverage:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not your employer's scheduled work days only if you were an active employee on the preceding scheduled work day.

Your work site must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which your job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Deductible Sources of Income means income from deductible sources listed in this certificate which you receive while disabled. This income will be subtracted from the gross monthly disability payment.

Doctor means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize you, your spouse, children, parents or siblings as a doctor for a claim that is sent to us.

Eligibility Waiting Period means the continuous period of time that you must be in active employment in an eligible class before eligible for coverage under the policy.

Elimination Period means a period of continuous total disability which must be satisfied before you are eligible to receive benefits from us.

Employee means a person who is a citizen or resident of the United States or Canada in active employment with his or her employer.

Employer means the individual, company or corporation under which you are in active employment, and includes any division, subsidiary, or affiliated company of such employer or an organization participating in the Trust that we have issued coverage under the policy to and are providing coverage to its eligible employees or members according to the terms of the Participation Agreement.

Evidence of Insurability means a statement of your medical history which we will use to determine if you are approved for coverage. Evidence of insurability will be provided at your expense.

Full-Time Basis means a job at which you have worked 25 or more hours a week for pay or profit.

Gainful Occupation means an occupation that is or can be expected to provide you with an income of the lesser of the gross monthly disability payment or \$6,000 per month within 12 months of your return to work.

Grace Period means the 31 day period of time following the premium due date during which premium payment may be made.

Gross Monthly Disability Payment means the monthly benefit amount before we subtract deductible sources of income.

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Initial Enrollment Period means one of the following periods during which you may first apply in writing for coverage under the policy:

1. if eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if you become eligible for coverage after the policy effective date, the period ending 31 days after the date first eligible to apply for coverage.

GLOSSARY (Continued)

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are insured under the policy will be treated as a sickness. Disability must begin while you are insured under the policy.

Insured Employee or Member means the employee or member covered under the policy.

Material and Substantial Duties means duties that:

1. are normally required for the performance of your own occupation; and
2. cannot be reasonably omitted or modified, except if required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if working or having the capacity to work 40 hours per week.

Maximum Benefit Period means the longest period of time we will make payments to you for any one period of disability.

Member means a member in good standing in the labor union or association named as the policyholder and who is : (a) a citizen or resident of the United States; and (b) is (i) engaged in, or (ii) able to engage in and currently seeking, active employment.

Monthly Benefit Amount means the total benefit amount listed on the Certificate Specifications page for which you are insured under the policy subject to the maximum benefit period.

Monthly Earnings means your gross monthly income from your employer in effect just prior to the date of disability. Gross monthly income is the total income before taxes and any pre-tax deductions made under a qualified deferred compensation plan recognized by the Internal Revenue Service. It will always be considered to be 1/12th of the basic annual wage payable by your employer at the start of the term of continuous disability. Regardless of your timing of payment from your employer, it will be considered to be received over a 12 month period. It does not include income received from commissions, bonuses, overtime pay, or other extra compensation. It does not include income received from sources other than your employer.

If you become disabled while on a covered layoff or leave of absence, we will use your gross monthly income from your employer in effect just prior to the date the absence began.

Monthly Payment means your payment after any deductible sources of income have been subtracted from the gross monthly disability payment.

Own Occupation means the occupation you are performing when a period of disability begins. It refers to the occupation as performed in the national economy, rather than for a specific employer in a specific location.

Part-Time Basis means the ability to work and earn between 20% and 80% of your monthly earnings.

Payable Claim means a claim for which we are liable under the terms of the policy.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity or Trust to whom the policy is issued.

Re-enrollment Period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if currently enrolled.

Regular Care means that you:

1. personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat a disabling condition(s); and
2. are receiving appropriate treatment and care of a disabling condition(s), which conforms with standard medical practice, by a doctor whose specialty or experience is the most appropriate for the disabling condition(s), according to standard medical practice.

Sickness means an illness or disease. Disability must begin while you are insured under the policy.

GLOSSARY (Continued)

Temporary Layoff or **Leave of Absence** or **Family and Medical Leave of Absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

We, Us, and Our means American Heritage Life Insurance Company.

You and **Your** mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

**1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776**

A Stock Company

**THIS IS GROUP DISABILITY ONLY COVERAGE WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS CERTIFICATE**



Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?

Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?

We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?

You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user ...

Our website, www.allstateatwork.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstateatwork.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstateatwork.com Privacy Statement provides information relating to your use of the website. This includes, for example:

- 1) our use of online collecting devices known as "cookies";
- 2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
- 3) who should use our website;
- 4) the security of information over the Internet;
- 5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don't hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company	Holiday Life Insurance Company
Bluegrass Life Insurance Company	Kentucky Home Mutual
Acme United Insurance Company	Keystone State Life
SMA Life Assurance Company	National Guardian Life

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

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

DISCLAIMER

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

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

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

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

**Louisiana Life and Health
Insurance Guaranty Association
P.O. Drawer 44126
Baton Rouge, Louisiana 70804**

**Louisiana 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 Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change 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 Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

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

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy was issued by a non-profit organization which exclusively furnishes hospital service, or medical or surgical benefits, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contract holder;
- (6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (7) unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

ATTACHMENT C
METLIFE 100%
VOLUNTARY CRITICAL
ILLNESS

Additional Critical Illness Details

Policy Inception Date: January 1, 2023

Rate History: Rates haven't changed since inception.

Tech Subsidy/Implementation Credit: 3% platform fee

Commissions: Flat 15% paid to Amerilife

Plan Changes: No since inception

CRITICAL ILLNESS PLAN 1



**METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK**

CERTIFICATE OF CRITICAL ILLNESS 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. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Person Specifications page and Eligibility Provisions: Dependent Insurance section for details.

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.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	City of Baton Rouge/Parish of East Baton Rouge
Group Policy Number:	0143258
MetLife Toll Free Number:	1-800-GETMET8

Important Notice: Subject to the provisions of this Certificate, including limitations, exclusions and Proof requirements, this Certificate provides limited benefits in the event You are Diagnosed with certain critical illnesses.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify the Group Policyholder that You are cancelling Your Certificate within 30 days from the date of delivery by calling the Group Policyholder. If You notify the Group Policyholder that You are cancelling within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

This is a supplement to health insurance and is not a substitute for Medical Coverage. Lack of Medical Coverage (or other minimum essential coverage) may result in an additional payment with Your taxes. You should have Medical Coverage when You enroll for this insurance.

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

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

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

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 non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to 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.

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COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	The later of January 1, 2023 or the date that applies to the insured's Certificate as shown in the insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder: Group Policy Number:	City of Baton Rouge/Parish of East Baton Rouge 0143258
MetLife Contact Information:	1-800-GETMET8
Your Name:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Your Certificate Number:	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife
Coverage for Your Dependents	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

Notification Requirement

The following notification requirement(s) apply to Dependent coverage:

- If You elect coverage for Your Dependent Children, You must provide notification to Your employer, when all of Your Dependent Children: exceed the Dependent Child Age Limit; or, no longer otherwise meet the definition of a Dependent Child.
- If You elect coverage for Your Spouse, You must provide notification to Your employer, if Your Spouse no longer meets the definition of a Spouse.

You should instead provide the notification to Us if Your coverage is being continued under the At Your Option: Portability Through Continuation of Insurance With Premium Payment provision by calling the toll free number shown on this Certificate.

Please refer to the Schedule of Insurance for information regarding Your Benefit Amounts.

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

SCHEDULE OF INSURANCE

IMPORTANT NOTE: Payment of the benefits listed in this Schedule of Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.

The benefits listed only apply to Dependents if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

BENEFIT AMOUNT

	For You	For Your Spouse	For Your Dependent Children
Benefit Amount	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife	See Insured's Certificate or the Group Policyholder's participant file which has been provided to MetLife

BENEFIT SEPARATION PERIOD

For an Initial Benefit for a Covered Person	30 days
For a Recurrence Benefit for a Covered Person	90 days

Please refer to the Benefit Separation Period provision in the Limitations section for additional information.

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: BENIGN TUMOR		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Benign Brain Tumor	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

COVERED CONDITION CATEGORY: CANCER		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Invasive Cancer	100% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Invasive Cancer	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Non-Invasive Cancer	25% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Skin Cancer	5% of the Benefit Amount, but not less than \$250; payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Cardiovascular Disease treated with: Coronary Artery Bypass Graft	50% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CHILDHOOD DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
cerebral palsy	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
cleft lip or cleft palate	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
cystic fibrosis	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
diabetes (type 1)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Down syndrome	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
sickle cell anemia	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
spina bifida	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Coma	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Loss of: Ability to Speak; Hearing; or Sight	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Paralysis of 2 or more limbs	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: HEART ATTACK		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Heart Attack	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Sudden Cardiac Arrest	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: INFECTIOUS DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
bacterial cerebrospinal meningitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
diphtheria	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
encephalitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
Legionnaire's disease	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
malaria	25% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

necrotizing fasciitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
osteomyelitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
rabies	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
tetanus	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
tuberculosis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
COVID-19	25% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: KIDNEY FAILURE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Kidney Failure	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Major Organ Transplant	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
ALS	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Alzheimer's Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Multiple Sclerosis	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
muscular dystrophy	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Parkinson's Disease (Advanced)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

systemic lupus erythematosus (SLE)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
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COVERED CONDITION CATEGORY: SEVERE BURN		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Severe Burn	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

COVERED CONDITION CATEGORY: STROKE		
COVERED CONDITION	INITIAL BENEFIT	RECURRENCE BENEFIT
Stroke	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

SUPPLEMENTAL BENEFITS		
BENEFIT	BENEFIT AMOUNT	BENEFIT MAXIMUM
Health Screening Benefit	For You: \$50 per day For Your Spouse: \$50 per day For Your Dependent Child: \$50 per day	We will pay the Health Screening Benefit: 1 time per Covered Person, per Calendar Year

LIMITATIONS

BENEFIT SEPARATION PERIOD

Benefit Separation Period

The Benefit Separation Period is the number of days that must elapse between Occurrences of Covered Conditions for a Covered Person as described below in order for a benefit to be payable.

Initial Benefit Separation Period

The Initial Benefit Separation Period is the number of days that must elapse between an Occurrence of a Covered Condition for which a benefit is payable and an Occurrence of a different Covered Condition in order for an Initial Benefit to be payable for the later Covered Condition.

Once a Covered Condition has Occurred for which a benefit is payable, in order for an Initial Benefit to be payable for an Occurrence of any other Covered Condition that would otherwise qualify for an Initial Benefit payment, the Initial Benefit Separation Period must be satisfied. The Initial Benefit Separation Period is set forth on the Schedule.

In the event another Covered Condition Occurs within the Initial Benefit Separation Period, the following rules will apply:

- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition(s) is less than the Initial Benefit amount We would pay for the new Covered Condition, We will pay an additional amount equal to:
 - the amount We would have paid for the new Covered Condition had the Initial Benefit Separation Period been satisfied; minus
 - the amount We paid for the prior Covered Condition(s).
- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition is equal to or exceeds the Initial Benefit amount We would pay for the new Covered Condition, an additional amount is not payable.

Examples:

The following examples are provided for illustration purposes to explain how the Initial Benefit Separation Period will be applied and an additional amount is calculated as described above. These examples do not necessarily reflect the benefits of Your specific coverage.

Benefit Amount	\$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1 st	Based on the Schedule, the plan pays 50% of the Benefit Amount = \$5,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1 st , prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 100% of the Benefit Amount = \$10,000
Adjustment Calculation for Occurrence of Covered Condition B	<p>\$10,000 minus \$5,000 (Difference between amount paid for Covered Condition A and amount that would be paid for Covered Condition B).</p> <p>Result: An additional \$5,000 would be payable for the Occurrence of Covered Condition B</p>

LIMITATIONS (Continued)

Benefit Amount	\$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1 st	Based on the Schedule, the plan pays 100% of the Benefit Amount = \$10,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1 st prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 25% of the Benefit Amount = \$2,500
Adjustment Calculation for Occurrence of Covered Condition B	<p>The amount payable for Covered Condition A (\$10,000) exceeded the amount that would be payable for Covered Condition B (\$2,500).</p> <p>Result: An additional benefit would not be payable for the Occurrence of Covered Condition B</p>

Recurrence Benefit Separation Period

The Benefit Separation Period that applies to a Recurrence Benefit for a Covered Person for a subsequent Occurrence of the same Covered Condition is subject to all of the following:

- a benefit must have been payable for the prior Occurrence of the Covered Condition; and
- the Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

The Recurrence Benefit Separation Period is set forth on the Schedule. The Recurrence Benefit Separation Period is measured from the date of the most recent Occurrence of the same Covered Condition for which a benefit was payable.

Example:

The following example is provided for illustration purposes to explain how the Recurrence Separation Period will be applied and a Recurrence Benefit is calculated as described above. This example does not necessarily reflect the benefits of Your specific coverage.

Recurrence Benefit Separation Period	180 days
Covered Condition A Occurs on January 1 st	Initial Benefit paid for Covered Condition A
Covered Condition A Occurs again on March 1 st	<p>The Recurrence Benefit Separation Period is measured from January 1, the date Condition A Occurred.</p> <p>Result: The Recurrence Benefit for Covered Condition A is not paid because the 180 day Recurrence Benefit Separation Period had not been satisfied when Condition A Occurred again.</p>

GENERAL EXCLUSIONS

The exclusions that appear below apply to all Covered Conditions and benefits set forth in this Certificate. Please note that certain Covered Conditions have additional exclusions that are set forth in the benefit provisions of this Certificate.

We will not pay benefits for any Covered Condition for a Covered Person caused by, or that takes place during:

- the Covered Person's active participation in an insurrection, rebellion, riot or terrorist act;
- the Covered Person's engagement in any illegal occupation or activity that constitutes a felony under the laws of the jurisdiction in which the activity took place;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- war, whether declared or undeclared; or act of war;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. Motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all terrain vehicle; or a snow mobile. For purposes of this exclusion intoxicated means that the Covered Person's:
 - blood alcohol level met or exceeded .08%; or
 - blood delta-9-tetrahydrocannabinol (THC) level met or exceeded the limit established by the laws of the jurisdiction for drug-impaired driving where the incident took place;
- the Covered Person voluntarily taking or using any drug, medication or sedative unless it is:
 - taken or used as prescribed by a Physician; or
 - an "over the counter" drug, medication or sedative taken according to package directions; or
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for:

- any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico unless the Diagnosis is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the Diagnosis is made outside the United States, Canada or Mexico.

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. 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 Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

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

Benefit Amount means the amount We use to determine the benefit payable for a Covered Condition.

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

Certificate means this Certificate including any riders attached to it.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results.

Contribution means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

Covered Condition means those conditions or treatments listed in the Schedule for which a benefit is payable as described in this Certificate. A Covered Condition does not include Supplemental Benefits.

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

Dependent means Your Spouse and/or Dependent Child.

Dependent Child means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, while such child is younger than the Dependent Child Age Limit; or
- Your grandchild, while such child is younger than the Dependent Child Age Limit.
- Your grandchild, who is in Your legal custody and residing with You, while such child is younger than the Dependent Child Age Limit.

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

DEFINITIONS (Continued)

Dependent Child Age Limit means:

- the end of the calendar month in which the Dependent Child reaches age 26.

Dependent Insurance means insurance under this Certificate for Your Dependents.

Diagnosis or Diagnosed means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings, and using generally accepted medical standards.

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

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

Group Policyholder means City of Baton Rouge/Parish of East Baton Rouge.

DEFINITIONS (Continued)

Hospital means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through a contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Initial Benefit means the benefit, as specified in the Schedule, that is payable for a Covered Condition the first time that such condition Occurs for a Covered Person while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate.

Medical Coverage means coverage under Medicare or an insurance policy, health maintenance organization contract, or employer's plan of self-insurance providing benefits for hospital, surgical and medical expenses or treatment. Medical Coverage does not include Medicaid.

Medical Restriction means a person is:

- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

Occurs or Occurrence means, for a Covered Person, an Occurrence of a particular Covered Condition as defined in the benefit provision for that Covered Condition while coverage is in effect under this Certificate for such Covered Person.

Physician means:

- a person:
 - who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.); or
 - any other person whose services, according to applicable law, must be treated as Physician's services; and
- such person is acting within the scope of a valid license issued in the United States, Canada or Mexico to make a Diagnosis of a Covered Condition or to perform the services required for a Covered Condition for which a claim is made.

The term Physician does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone who is a member of Your household;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

DEFINITIONS (Continued)

Proof means Written evidence satisfactory to Us that a claimant 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.

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

Recur or Recurrence means another Occurrence of the same Covered Condition for which We have already paid a benefit.

Recurrence Benefit means a benefit, as specified in the Schedule, that is payable for another Occurrence of the same Covered Condition for the same Covered Person for whom We have already paid a benefit while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate. The Schedule shows the Covered Conditions for which a Recurrence Benefit is payable.

Schedule means the Schedule of Insurance that appears in this Certificate, and the Covered Person Specifications page.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

Spouse means Your lawful spouse.

Supplemental Benefit(s) are the following:

- Health Screening Benefit.

Surgery means a procedure performed by a Physician involving the cutting of the Covered Person's skin or tissue that in and of itself is intended to be curative or palliative. Surgery does not include endoscopic or non-invasive procedures.

Transplant List means the list maintained by the Organ Procurement and Transportation Network (OPTN).

DEFINITIONS (Continued)

Treatment Free means that a Covered Person is symptom free and not receiving medical treatment or care from a Physician for the Covered Condition for which We paid an Initial Benefit or Recurrence Benefit. For purposes of this term, medical treatment does not include:

- the Covered Person receiving maintenance drug therapy while in remission; or
- routine medical assessments to verify that a Covered Condition is no longer present or remains in remission.

United States means the United States of America, its territories and its possessions.

We, Us and Our mean Metropolitan Life Insurance Company.

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

CLASS 1

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the Critical Illness Insurance available for Your eligible class.

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

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

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

DATE YOUR INSURANCE TAKES EFFECT

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

BENEFIT CHANGES

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

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Class 1 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

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

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

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

ENROLLMENT PROCESS

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

DATE DEPENDENT INSURANCE TAKES EFFECT

Newborn Children

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 31 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 31 days, You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child if You are required to make such Contributions.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)

Adopted Children

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

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

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 31 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child if You are required to make such Contributions. You must do this within 31 days of the date the child is adopted by You or Placed for Adoption with You. Coverage will continue unless the child's placement is disrupted prior to legal adoption.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

Placed for Adoption or Placement for Adoption means:

- the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child; or
- a child placed in Your home following execution of an act of voluntary surrender in favor of You or Your legal representatives.

Other Dependents

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

BENEFIT CHANGES

Benefit changes with respect to a Dependent are subject to the Benefit Changes provision in the Eligibility Provisions: Insurance for You section of this Certificate.

If a Dependent for whom insurance is in effect under this Certificate is under a Medical Restriction on the date that an increase in benefits would otherwise take effect, the increase will not take effect for the Dependent until such Dependent is no longer under a Medical Restriction.

SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER

The Group Policy is replacing another policy of group insurance that provided similar benefits, that was issued to the Group Policyholder. This section explains how the replacement of that other group insurance policy will affect people who were covered under that policy.

In this section, the terms listed below will have the meanings listed below.

New Policy means the Group Policy under which this Certificate is issued.

Old Policy means the policy of group insurance that was replaced by the New Policy.

Replacement Date means the effective date of the New Policy.

Transferring Dependents means each of Your Dependents who:

- was insured under the Old Policy on the date it ended; and
- meets the requirements to be eligible for insurance under the New Policy, or is a Disabled Child.

If You were insured under the Old Policy on the date it ended and, You meet the requirements to be eligible for insurance under the New Policy (without regard to any requirement that You be Actively at Work), You, and each of Your Transferring Dependents will be insured under the New Policy on the Replacement Date subject to and in accordance with the provisions of this section.

You and each of Your Transferring Dependents will be automatically enrolled and insured under the New Policy on the Replacement Date.

Disabled Child means a child who:

- has attained the Dependent Age Limit but otherwise meets the definition of Dependent Child;
- is incapable of self-sustaining employment by reason of developmental disability, mental impairment or disorder, or physical disability; and
- is chiefly dependent on You for support and maintenance.

Crediting of Time

You and each Transferring Dependent will be credited for the time each such person had been continuously insured under the Old Policy on the date it ended in determining whether a Covered Condition is eligible for a Recurrence Benefit under this Certificate.

COVERED CONDITION CATEGORY: BENIGN TUMOR

ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE BENIGN TUMOR COVERED CONDITION CATEGORY

Benign Tumor Covered Condition means the following:

- Benign Brain Tumor.

A Benign Tumor Covered Condition does not include any such tumor resulting from:

- neurofibromatosis I or II;
- Von Hippel Lindau disease;
- tuberous sclerosis; or
- Cowden disease.

Benign Brain Tumor means the presence of a non-cancerous tumor located in the brain, or a non-cancerous Meningioma.

Benign Brain Tumor does not include:

- acoustic neuromas;
- tumors of the skull;
- tumors of the spinal cord; or
- pituitary adenomas.

Meningioma means a tumor located on the membranes that cover the brain.

Occurs or Occurrence, with respect to a Benign Tumor Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Benign Tumor Covered Condition will be deemed to Occur on the date that the Diagnosis of a Benign Tumor Covered Condition is made.

Permanent Neurological Deficit means the presence of one, or more, of the following deficits:

- impaired cognition;
- impaired or loss of vision;
- impaired or loss of hearing;
- impaired or loss of the ability to speak and communicate;
- balance disruption; or
- impaired or loss of ability to ambulate independently.

INITIAL BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

We will pay the applicable Initial Benefit for a Benign Tumor Covered Condition shown on the Schedule, the first time that the Benign Tumor Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

COVERED CONDITION CATEGORY: BENIGN TUMOR (Continued)

RECURRENCE BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

For any Benign Tumor Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Benign Tumor Covered Condition if:

- the subsequent Occurrence of the Benign Tumor happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Benign Tumor Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A BENIGN TUMOR COVERED CONDITION

Proof of a Benign Tumor Covered Condition requires the following additional documentation:

- a pathological or Clinical Diagnosis as described below; and
- submission of medical records evidencing that the Benign Tumor Covered Condition:
 - requires treatment by a Physician that is a Surgery or radiation therapy; or
 - resulted in a Permanent Neurological Deficit that is attributable to the Benign Tumor Covered Condition;

A pathological Diagnosis of a Benign Tumor Covered Condition must include the following:

- microscopic (histologic) examination of fixed tissues, including those taken by a biopsy; and
- magnetic resonance imaging (MRI), computerized tomography (CT scan), or other reliable imaging techniques that have been completed as part of the evaluation to Diagnose a Benign Tumor Covered Condition.

We will accept a Clinical Diagnosis of a Benign Tumor Covered Condition only if the following conditions are met:

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician is treating the Covered Person for the Benign Tumor Covered Condition.

Such Proof requirements must be documented in a Written report by a Physician.

In the event a Covered Person has been paid a benefit for a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and satisfies the Proof requirements for Invasive or Non-Invasive Cancer, We will pay the applicable benefit for a Cancer Covered Condition reduced by the Benefit Amount that We paid for the Benign Brain Tumor. In the event the Benefit Amount We had already paid for Benign Brain Tumor equals or exceeds the amount that would have been payable for a Cancer Covered Condition, We will not pay an additional benefit.

COVERED CONDITION CATEGORY: CANCER

ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE CANCER COVERED CONDITION CATEGORY

Cancer Covered Condition means the following:

- Invasive Cancer;
- Non-Invasive Cancer; or
- Skin Cancer.

Carcinoma in Situ means a group of abnormal cells that remain in the location where the cells first formed.

Chemotherapy means the administration of drugs or biologics that are prescribed by a Physician to either eliminate the cancerous cells, or prevent or slow the growth of the cancerous cells.

Invasive Cancer means the presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Invasive Cancer includes the following:

- a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness;
- a cancer that is a leukemia or lymphoma; or
- where a Covered Person has terminal cancer and has a life expectancy of 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

Occurs or Occurrence, with respect to a Cancer Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Cancer Covered Condition will be deemed to Occur on the date that the Diagnosis of the Cancer Covered Condition is made.

Non-Invasive Cancer (including Carcinoma in Situ) means the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Non-Invasive Cancer includes the following:

- a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness;
- a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or
- a Carcinoma in Situ classified as TisN0M0.

Non-Invasive Cancer does not include Skin Cancer.

Separate and Unrelated with respect to a Cancer Covered Condition means a Cancer Covered Condition that is:

- not a Recurrence of any previously Diagnosed Cancer Covered Condition;
- not a metastasis of a previously Diagnosed Cancer Covered Condition; and
- distinct in the cause and etiology from any previously Diagnosed Cancer Covered Condition.

Skin Cancer means any malignant growth that arises on the surface of the skin that is any of the following:

- basal cell carcinoma;
- squamous cell carcinoma; or
- malignant melanoma that remains confined to the epidermis.

TNM Classification of Malignant Tumors ("TNM Staging") means the classification standards for cancer developed by the American Joint Committee on Cancer.

COVERED CONDITION CATEGORY: CANCER (Continued)

INITIAL BENEFIT FOR A CANCER COVERED CONDITION

We will pay the applicable Initial Benefit for a Cancer Covered Condition shown on the Schedule for a Covered Person:

- the first time a Cancer Covered Condition Occurs for such Covered Person; or
- for a Cancer Covered Condition that is Separate and Unrelated from any prior Cancer Covered Condition for which We paid a benefit.

The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

Related Occurrence for a Cancer Covered Condition

In the event a Covered Person has an initial Occurrence of a Cancer Covered Condition that is not an Invasive Cancer, and the Cancer Covered Condition for which We paid a benefit is subsequently Diagnosed as a Cancer Covered Condition for which We would pay a higher benefit as shown on the Schedule, We will pay the difference between what We paid and the applicable higher Initial Benefit amount. The Initial Benefit Separation Period does not apply to payment of the Initial Benefit for a Related Occurrence for a Cancer Covered Condition as described in this provision.

RECURRENCE BENEFIT FOR A CANCER COVERED CONDITION

For any Cancer Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cancer Covered Condition for which We have already paid a benefit if:

- the subsequent Occurrence of the Cancer Covered Condition happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Cancer Covered Condition.

We will not pay a Recurrence Benefit for a Cancer Covered Condition that is a Skin Cancer.

ADDITIONAL PROOF REQUIREMENTS FOR A CANCER COVERED CONDITION

Proof of an Occurrence of a Cancer Covered Condition requires the following additional documentation:

- A pathological Diagnosis that is based upon microscopic (histologic) examination of fixed tissues, including those taken by a biopsy, or preparations of blood or bone marrow.
- If a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards, We will accept a Clinical Diagnosis based on the following:
 - medical diagnostic testing that supports the Diagnosis; and
 - the Covered Person is being treated for the Cancer Covered Condition by a Physician.

In the event a Covered Person was paid a benefit for an Occurrence of a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and meets the Proof requirements for a Cancer Covered Condition, We will pay the appropriate benefit for a Cancer Covered Condition reduced by the benefit amount that We already paid for the Benign Brain Tumor. Please refer to the Covered Condition Category: Benign Tumor section of this Certificate for details.

Such Proof requirements must be documented in a Written report by a Physician.

COVERED CONDITION CATEGORY: CANCER (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A CANCER COVERED CONDITION

We will not pay benefits for a Diagnosis of a Cancer Covered Condition for:

- myelodysplastic syndrome;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as a maximum severity of Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging;
- any papillary, follicular or medullary tumor of the thyroid that is classified as a T1N0M0 or less under TNM Staging and is one centimeter or less in diameter, unless there is metastasis; or
- any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV.

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CARDIOVASCULAR DISEASE COVERED CONDITION CATEGORY

Cardiovascular Disease Covered Condition means the following:

- coronary artery disease where:
 - the arteries of the heart are damaged or diseased, valves of the heart are damaged or diseased, or there is impaired cardiac function due to the presence of plaques, or fatty deposit, buildup on the artery walls that has caused narrowing of the coronary arteries resulting in partial or complete blockage of the arteries; and
 - a treatment listed below is required to treat the coronary artery disease:
 - Coronary Artery Bypass Graft.

Coronary Angioplasty (Percutaneous Coronary Intervention or PCI) means a cardiac catheterization procedure to treat Cardiovascular Disease by utilizing a catheter with a balloon, laser, laser-assisted device, rotational device, stent placement or other mechanical means to unblock an occluded coronary artery.

Coronary Artery Bypass Graft means a heart Surgery procedure to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. Surgical access to the heart may be done by a procedure that is:

- a Surgery in which a Median Sternotomy is performed; or
- a minimally invasive endoscopic cardiac Surgery procedure is performed.

Coronary Artery Bypass Graft does not include:

- Coronary Angioplasty;
- coronary angiography; or
- any other intra-catheter technique.

Median Sternotomy means a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom.

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE (Continued)

Occurs or Occurrence, with respect to a Cardiovascular Disease Covered Condition, means a Covered Person receives the applicable treatment specified in the definition of the term Cardiovascular Disease Covered Condition, and such treatment was performed by a Physician while the coverage is in effect under this Certificate for such Covered Person. A Cardiovascular Disease Covered Condition will be deemed to Occur on the date such treatment was performed.

INITIAL BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Cardiovascular Disease Covered Condition treatment shown on the Schedule, the first time that a Cardiovascular Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

For any Cardiovascular Disease Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cardiovascular Disease Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

RULE FOR MORE THAN ONE OCCURRENCE OF A CARDIOVASCULAR DISEASE COVERED CONDITION

If the Covered Person has more than one Occurrence of a Cardiovascular Disease Covered Condition at the same time, or on the same day, for which a benefit is payable, We will pay the applicable benefit shown on the Schedule for one Cardiovascular Disease Covered Condition, which will be for the Covered Condition that pays the highest Benefit Amount.

ADDITIONAL PROOF REQUIREMENTS FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

Proof of a Cardiovascular Disease Covered Condition requires a Clinical Diagnosis and the following additional documentation:

- submission of medical records that include test results for at least one of the following:
 - cardiac perfusion scan;
 - cardiac catheterization;
 - doppler ultrasound;
 - echocardiogram;
 - electrocardiogram (EKG);
 - angiogram; or
 - positron emission tomography (PET scan); and
- that treatment for the Cardiovascular Disease Covered Condition was performed by a Physician.

Such Proof requirements must be documented in a Written report by a Physician.

SPECIAL EXCLUSIONS APPLICABLE TO A CARDIOVASCULAR DISEASE COVERED CONDITION

We will not pay benefits for a Cardiovascular Disease Covered Condition:

- for a Heart Attack;
- for which the treatment required for payment of a benefit is received outside the United States, Canada or Mexico unless confirmation of the Cardiovascular Disease Covered Condition and treatment received is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the treatment was performed outside the United States, Canada or Mexico; or
- for a cardiac catheterization performed for diagnostic purposes only.

COVERED CONDITION CATEGORY: CHILDHOOD DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CHILDHOOD DISEASE COVERED CONDITION CATEGORY

Childhood Disease Covered Condition means any of the following:

- cerebral palsy;
- cleft lip or cleft palate;
- cystic fibrosis;
- diabetes type 1 (diabetes type 2 is not a Covered Condition);
- Down syndrome;
- sickle cell anemia (sickle cell trait is not a Covered Condition); or
- spina bifida (spina bifida occulta is not a Covered Condition).

Occurs or Occurrence, with respect to a Childhood Disease Covered Condition, means a Dependent Child is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Dependent Child. A Childhood Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Childhood Disease Covered Condition is made.

INITIAL BENEFIT FOR A CHILDHOOD DISEASE COVERED CONDITION

We will pay the Initial Benefit shown on the Schedule for a Childhood Disease Covered Condition, the first time that a Childhood Disease Covered Condition Occurs for a Dependent Child who is a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

If more than one Childhood Disease Covered Condition Occurs for a Dependent Child at the same time, We will only pay an Initial Benefit for one Covered Condition which will be for the Childhood Disease Covered Condition that pays the highest Benefit Amount.

ADDITIONAL PROOF REQUIREMENTS FOR A CHILDHOOD DISEASE COVERED CONDITION

A Clinical Diagnosis of a Childhood Disease Covered Condition must be made in Writing by a Physician and substantiated in the medical records.

SPECIAL EXCLUSIONS APPLICABLE TO A CHILDHOOD DISEASE COVERED CONDITION

We will not pay benefits for:

- a suspected or probable Diagnosis of a Childhood Covered Condition; or
- a Childhood Covered Condition that is Diagnosed for a stillborn child.

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS

ADDITIONAL DEFINITIONS THAT APPLY TO THE FUNCTIONAL LOSS COVERED CONDITION CATEGORY

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, as confirmed by a Physician and characterized by the absence of purposeful response to commands, including:

- eye opening;
- verbal response; and
- motor response.

Coma does not include a medically induced Coma.

Functional Loss Covered Condition means the following:

- Coma;
- Loss of: Ability to Speak; Hearing or Sight; or
- Paralysis.

Loss of: Ability to Speak; Hearing or Sight means the following each of which must last for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician:

- for Loss of Ability to Speak - total loss of audible communication (aphonia), if such loss cannot be corrected to any functional degree by any procedure, air or device;
- for Loss of Hearing - deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device; or
- for Loss of Sight - loss of sight in both eyes. With correction, visual acuity must be 20/200 or worse in both eyes, or the field of vision must be less than 20 degrees in both eyes. Loss of sight does not include blindness or loss of sight in one eye due to a previous existing blindness in the other eye.

Occurs or Occurrence, with respect to a Functional Loss Covered Condition means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Functional Loss Covered Condition will be deemed to Occur on the date that a Diagnosis of a Functional Loss Covered Condition is made.

Paralysis means the total and irrevocable loss of extremity movement affecting 2 or more limbs and:

- has lasted for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician; or
- is a result of a transected spinal cord with supporting clinical and radiological evidence and no expectation of a return to function.

INITIAL BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for a Functional Loss Covered Condition, the first time that a Functional Loss Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

For any Functional Loss Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Functional Loss Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A FUNCTIONAL LOSS COVERED CONDITION

A Clinical Diagnosis of a Functional Loss Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

SPECIAL EXCLUSIONS APPLICABLE TO A FUNCTIONAL LOSS COVERED CONDITION

We will not pay benefits for a Functional Loss Covered Condition for any of the following:

- a Functional Loss Covered Condition that is associated with the total and irreversible loss of all brain function (brain death);
- a Functional Loss Covered Condition that is a dismemberment of an extremity; or
- any Functional Loss Covered Condition for which, in general medical opinion or practice, Surgery, an adaptive device or other corrective measure could restore function.

COVERED CONDITION CATEGORY: HEART ATTACK

ADDITIONAL DEFINITIONS THAT APPLY TO THE HEART ATTACK COVERED CONDITION CATEGORY

Heart Attack Covered Condition means the following:

- Myocardial Infarction; or
- Sudden Cardiac Arrest.

Myocardial Infarction means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

Myocardial Infarction does not include Sudden Cardiac Arrest.

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly, and unexpectedly, stops beating because of an internal electrical disturbance of the heart, which results in a Covered Person being pronounced deceased by a Physician.

Occurs or Occurrence, with respect to a Heart Attack Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Heart Attack Covered Condition will be deemed to Occur on the date that a Diagnosis of a Heart Attack Covered Condition is made.

INITIAL BENEFIT FOR A HEART ATTACK COVERED CONDITION

We will pay the applicable Initial Benefit for a Heart Attack Covered Condition shown on the Schedule, the first time a Heart Attack Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

If a Covered Person sustains a Myocardial Infarction and Sudden Cardiac Arrest which Occur at the same time, or on the same day, and for which a Heart Attack Covered Condition benefit is payable, We will pay an Initial Benefit for a single Heart Attack Covered Condition which will be for the Heart Attack Covered Condition that pays the highest Benefit Amount.

RECURRENCE BENEFIT FOR A HEART ATTACK COVERED CONDITION

For any Heart Attack Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Heart Attack Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

COVERED CONDITION CATEGORY: HEART ATTACK (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A HEART ATTACK COVERED CONDITION

Proof of a Heart Attack Covered Condition requires a pathological Diagnosis or Clinical Diagnosis as described below.

For a pathological Diagnosis of a Heart Attack Covered Condition, the following additional documentation must be provided:

- for Myocardial Infarction, documentation that shows:
 - an elevation of enzymes, troponins or other biochemical cardiac markers, and
 - two of the three following criteria associated with the Myocardial Infarction:
 - confinement in a Hospital as an inpatient;
 - documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Myocardial Infarction must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or
 - documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Myocardial Infarction must show changes from the Covered Person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.
- for Sudden Cardiac Arrest, additional documentation that shows that the Sudden Cardiac Arrest was caused or contributed to by any of the following, or that the Covered Person had a documented medical history of any of the following:
 - coronary artery disease;
 - Myocardial Infarction;
 - myocarditis;
 - cardiomyopathy;
 - valvular heart disease;
 - congenital heart disease; or
 - cardiac electrical conduction abnormalities.

We will accept a Clinical Diagnosis of a Heart Attack Covered Condition only if a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards. We will accept a Clinical Diagnosis of Sudden Cardiac Arrest if the sole cause of death shown on a death certificate and medical records indicates cardiovascular collapse, Sudden Cardiac Arrest, or sudden cardiac death.

Such Proof requirements must be documented in a Written report by a Physician.

COVERED CONDITION CATEGORY: INFECTIOUS DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE INFECTIOUS DISEASE COVERED CONDITION CATEGORY

Infectious Disease Covered Condition means each of the following diseases for which a Covered Person was confined in a Hospital as an inpatient for the number of consecutive days as specified below:

- bacterial cerebrospinal meningitis;
- diphtheria;
- encephalitis;
- Legionnaire's disease;
- malaria;
- necrotizing fasciitis;
- osteomyelitis;
- rabies;
- tetanus;
- tuberculosis; or
- COVID-19.

Occurs or Occurrence, with respect to an Infectious Disease Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. An Infectious Disease Covered Condition will be deemed to Occur on the date a Diagnosis of an Infectious Disease Covered Condition is made.

INITIAL BENEFIT FOR AN INFECTIOUS DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for an Infectious Disease Covered Condition, the first time that an Infectious Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR AN INFECTIOUS DISEASE COVERED CONDITION

Proof of an Infectious Disease Covered Condition requires the following additional documentation:

- a Covered Person was confined in a Hospital as an inpatient for 5 consecutive days for treatment of the Infectious Disease Covered Condition; and
- a Clinical Diagnosis:
 - made in Writing by a Physician; and
 - substantiated in the medical records.

COVERED CONDITION CATEGORY: KIDNEY FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE KIDNEY FAILURE COVERED CONDITION CATEGORY

Kidney Failure Covered Condition means the total, end stage, irreversible failure of all functioning kidneys, provided that a Physician has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

Occurs or Occurrence, with respect to a Kidney Failure Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Kidney Failure Covered Condition will be deemed to Occur on the earlier of:

- the date a Covered Person receives the first kidney dialysis treatment; or
- the date a Covered Person is placed on the Transplant List.

INITIAL BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Initial Benefit for a Kidney Failure Covered Condition shown on the Schedule, the first time that a Kidney Failure Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Recurrence Benefit shown on the Schedule for another Occurrence of a Kidney Failure Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A KIDNEY FAILURE COVERED CONDITION

A Clinical Diagnosis of a Kidney Failure Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT

ADDITIONAL DEFINITIONS THAT APPLY TO THE MAJOR ORGAN TRANSPLANT COVERED CONDITION CATEGORY

Bone Marrow means the soft, sponge-like tissue within the bone that produces white blood cells, red blood cells and platelets.

Major Organ Transplant Covered Condition means the following:

- Major Organ Transplant.

Major Organ Transplant means:

- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver, or liver tissue from a human donor, is medically necessary;
- the irreversible failure of a Covered Person's heart, lung, pancreas, or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary;
- the irreversible failure of a Covered Person's Bone Marrow for which a Physician has determined that replacement of the Bone Marrow (stem cells) from a human donor is medically necessary; and
- for all of the above listed transplants, one of the following additional requirements are met:
 - the Covered Person has been placed on the Transplant List; or
 - such Major Organ Transplant Procedure has been performed.

Major Organ Transplant Procedure means a Covered Person undergoes a procedure for any of the transplant types to which the term Major Organ Transplant Covered Condition applies.

Occurs or Occurrence means, while the coverage is in effect under this Certificate for a Covered Person:

- with respect to Major Organ Transplant, the earlier of:
 - the date a Covered Person is placed on the Transplant List; or
 - the date a Covered Person undergoes a Major Organ Transplant Procedure.

If a Covered Person is placed on the Transplant List and then subsequently undergoes a Major Organ Transplant Procedure of the same organ for which the Covered Person was on the Transplant List, We will treat this as a single Occurrence of a Major Organ Transplant Covered Condition.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT (Continued)

INITIAL BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will pay the applicable Initial Benefit for a Major Organ Transplant Covered Condition shown on the Schedule, the first time that a Major Organ Transplant Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

For a Major Organ Transplant Covered Condition for which the Schedule shows a Recurrence Benefit, once We have paid an Initial Benefit for a Covered Person for a Major Organ Transplant Covered Condition, any subsequent Occurrence of Major Organ Transplant Covered Condition for the same or another organ within the definition of Major Organ Transplant Covered Condition will be considered a Recurrence of the Major Organ Transplant Covered Condition and We will pay the applicable Recurrence Benefit. The Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

SPECIAL LIMITATIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

Payment of benefits for a Major Organ Transplant Covered Condition is subject to the following:

- Two or more organs transplanted on the same day, or during the same Surgery, shall be deemed one Occurrence of a Major Organ Transplant.

ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

A Clinical Diagnosis of a Major Organ Transplant Covered Condition must be made in Writing by a Physician. In addition, documentation of the following must be provided:

- for Major Organ Transplant:
 - that the Covered Person has been placed on the Transplant List and the date of such placement; or
 - that the Major Organ Transplant has been performed.

SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will not pay benefits for a Major Organ Transplant Covered Condition for a Covered Person:

- if prior to the Covered Person's coverage becoming effective under this Certificate, the Covered Person had been placed on a Transplant List for the same organ for which the Major Organ Transplant Procedure is performed;
- for a transplant involving organs received from non-human donors;
- for a transplant involving implantation of mechanical devices or mechanical organs; or
- for a transplant involving islet cell transplants.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE PROGRESSIVE DISEASE COVERED CONDITION CATEGORY

Activities of Daily Living means the following:

- Bathing: washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs.
- Transferring: moving into or out of a bed, chair or wheelchair.
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene.
- Continence: ability to maintain control of bowel and bladder function; or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag).
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Alzheimer's Disease means the development of multiple, progressive Cognitive Disturbances that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information). Alzheimer's Disease must be confirmed by neuropsychological testing. Results of one or more of the following tests may be provided as confirmation in addition to the neuropsychological testing:

- computed tomography (CT);
- magnetic resonance imaging (MRI); or
- positron emission tomography (PET) documents the presence of abnormal deposits of proteins which have formed amyloid plaques and tau tangles.

Alzheimer's Disease does not include:

- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's Disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause Cognitive Disturbances (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, or neurosyphilis);
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition such as schizophrenia or psychoses;
- a form of dementia that is Other Dementia; or
- any form of dementia that is not Clinically Diagnosed as Alzheimer's Disease.

Cognitive Disturbances means the following intellectual impairments:

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- anosia (failure to recognize or identify objects despite intact sensory function); or
- disturbance in executive functioning (i.e. planning, organizing, sequencing, or abstracting).

Multiple Sclerosis means a progressive neurological condition with evidence of all of the following:

- well-defined neurological abnormalities lasting more than a continuous period of 6 months confirmed by neurological exam;
- presence of demyelination in at least two separate areas of the central nervous system;
- evidence that such demyelination damage took place at different points in time; and
- diagnostic testing results that document the following:
 - magnetic resonance imaging (MRI) that show T2 – weighted lesions;
 - an abnormal response on evoked potential testing; or
 - oligoclonal antibodies or a high immunoglobulin (IgG) index present in cerebrospinal fluid.

Multiple Sclerosis does not include clinically isolated syndrome (CIS).

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

Occurs or Occurrence, with respect to a Progressive Disease Covered Condition, means a Covered Person is Diagnosed with a such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Progressive Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Progressive Disease Covered Condition is made.

Other Dementia means the development of multiple progressive cognitive defects:

- manifested by memory impairment and other Cognitive Disturbances; and
- for which one or more of the following tests document changes to the specific areas of the brain that result in Cognitive Disturbances: electroencephalogram (EEG); or imaging studies, including computed tomography (CT), magnetic resonance imaging (MRI), fluorodeoxyglucose positron emission tomography (FDG Pet Scan) or amyloid positron-emission tomography scan.

Other Dementia includes the following types of neurological conditions:

- dementia with Lewy bodies;
- progressive supranuclear palsy;
- corticobasal degeneration;
- Parkinson's disease dementia;
- frontotemporal dementia;
- primary progressive aphasia;
- normal-pressure hydrocephalus; or
- rapidly progressive dementia as in Creutzfeldt-Jakob disease.

Other Dementia does not include:

- Alzheimer's Disease;
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition, such as schizophrenia or psychoses;
- any form of Parkinson's disease other than Parkinson's disease dementia; or
- reversible dementias such as those cause by thyroid or other hormonal abnormalities, or vitamin deficiencies.

Parkinson's Disease (Advanced) means a chronic, slowly progressive neurological condition affecting the brain's ability to produce dopamine and that is marked by tremor of the muscles, rigidity, slowness of movement, impaired balance, and a shuffling gait which has resulted in a Covered Person's inability to perform at least 2 Activities of Daily Living for a continuous period of 90 days.

Progressive Disease Covered Condition means any of the following:

- Alzheimer's disease;
- amyotrophic lateral sclerosis (referred to as ALS or Lou Gehrig's Disease);
- Multiple Sclerosis;
- muscular dystrophy;
- Parkinson's Disease (Advanced); or
- systemic lupus erythematosus (SLE).

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

INITIAL BENEFIT FOR A PROGRESSIVE DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Progressive Disease Covered Disease shown on the Schedule, the first time that a Progressive Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR A PROGRESSIVE DISEASE COVERED CONDITION

A Clinical Diagnosis of a Progressive Disease Covered Condition must be made in Writing by a Physician and must be substantiated by the current clinical diagnostic criteria for the condition in the medical records.

COVERED CONDITION CATEGORY: SEVERE BURN

ADDITIONAL DEFINITIONS THAT APPLY TO THE SEVERE BURN COVERED CONDITION CATEGORY

Occurs or Occurrence, with respect to a Severe Burn Covered Condition, means that a Covered Person sustains a Severe Burn Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Severe Burn Covered Condition will be deemed to Occur on the date a Covered Person sustains a Severe Burn Covered Condition.

Severe Burn Covered Condition means a Covered Person has sustained a burn that is, at least, a Third-Degree Burn.

Third-Degree Burn means a full-thickness burn caused by acute thermal, chemical, electrical, or radiation exposure that has caused destruction of the skin dermis, epidermis and hypodermis layers.

INITIAL BENEFIT FOR A SEVERE BURN COVERED CONDITION

We will pay the Initial Benefit for a Severe Burn Covered Condition shown on the Schedule the first time that a Severe Burn Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A SEVERE BURN COVERED CONDITION

We will pay the Recurrence Benefit for a Severe Burn Covered Condition shown on the Schedule for another Occurrence of a Severe Burn Covered Condition if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A SEVERE BURN COVERED CONDITION

Proof of a Severe Burn Covered Condition requires additional documentation of the following:

- the Severe Burn Covered Condition was treated by a Physician;
- the Severe Burn covers at least 18% of the Covered Person's total body surface area; and
- a Clinical Diagnosis of Severe Burn that:
 - sets forth the date the Severe Burn Occurred;
 - is made in Writing by a Physician using the current clinical diagnostic criteria and burn classification standards; and
 - is substantiated in the medical records.

COVERED CONDITION CATEGORY: STROKE

ADDITIONAL DEFINITIONS THAT APPLY TO THE STROKE COVERED CONDITION CATEGORY

Stroke Covered Condition means the following:

- Stroke.

Stroke means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:

- hemorrhage;
- thrombus; or
- embolus from an extra-cranial source.

The term Stroke does not include Transient Ischemic Attacks, or prolonged reversible ischemic attacks).

Occurs or Occurrence, with respect to a Stroke Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Stroke Covered Condition will be deemed to Occur on the date the Diagnosis of the Stroke Covered Condition is made.

Transient Ischemic Attack (TIA) means a temporary ischemic event (including prolonged reversible ischemic attacks) in which:

- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Clinical Diagnosis.

INITIAL BENEFIT FOR A STROKE COVERED CONDITION

We will pay the applicable Initial Benefit for a Stroke Covered Condition shown on the Schedule, the first time that a Stroke Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A STROKE COVERED CONDITION

For any Stroke Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Stroke Covered Condition for which We have already paid a benefit if such subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A STROKE COVERED CONDITION

Proof of a Stroke Covered Condition requires the following additional documentation:

- medical records indicating objective evidence of a significant neurological, motor or sensory impairment that is functional and measurable; and
- for a Stroke – a pathological Diagnosis:
 - demonstrated on magnetic resonance imaging (MRI), computerized tomography (CT) or other reliable imaging techniques; and
 - confirmed in Writing by a Physician no earlier than 30 days after the Stroke with such impairments being present and considered permanent on the date that such Written confirmation is made.

Such Proof requirements must be documented in a Written report by a Physician.

COVERED CONDITION CATEGORY: STROKE (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A STROKE COVERED CONDITION

We will not pay benefits for a Diagnosis of a Stroke Covered Condition for:

- a Transient Ischemic Attack;
- cerebral symptoms due to migraine;
- cerebral injury resulting from trauma or hypoxia; or
- vascular disease affecting the eye or optic nerve or vestibular functions.

SUPPLEMENTAL BENEFITS

HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while insured under this Certificate, upon submission of Proof, We will pay the Health Screening Benefit shown on the Schedule for the day the measure was taken, subject to all of the following:

- We will pay the Health Screening Benefit amount based on the Schedule that was in effect on the day the Covered Person received the screening measure; and
- We will pay the Health Screening Benefit no more than the number of times shown on the Schedule.

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- routine health check-up exam
- biopsies for cancer
- blood chemistry panel
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast ultrasound
- breast sonogram
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- colonoscopy
- complete blood count (CBC)
- coronavirus testing
- dental exam
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- electroencephalogram (EEG)
- endoscopy
- eye exams
- fasting blood glucose test
- fasting plasma glucose test
- flexible sigmoidoscopy
- hearing test
- hemocult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- immunization
- lipid panel
- mammogram
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy

SUPPLEMENTAL BENEFITS (Continued)

- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasounds for cancer detection
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy

WHEN INSURANCE ENDS

Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance With Premium Payment section of this Certificate. Please see that section for details.

DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

For Residents of Massachusetts:

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.
- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Critical Illness Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

AT YOUR OPTION: PORTABILITY THROUGH CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
 - non-payment of premium or Contribution; or
 - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for critical illness insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
 - the date Continued Insurance for You ends for any reason;
 - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
 - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (Continued)

FOR INTELLECTUALLY OR PHYSICALLY DISABLED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law. Proof of such disability must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two-year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical disability; and
- continues to qualify as a Dependent Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

CLAIMS

NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll-free number shown on the face page of this Certificate within 30 days or as soon as reasonably possible from the date of the loss.

CLAIM FORM

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

PROOF OF LOSS

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

PAYMENT OF BENEFITS

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

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

- If You are not alive to receive benefits that are payable to You, We will pay benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive benefits, We may pay up to \$10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

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

YOUR BENEFICIARY

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

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

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

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

CLAIMS (Continued)

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

APPEALING A CLAIM DECISION

If We deny Your claim, You may appeal the decision by Writing to Us at the address indicated on the claim form within 180 days of receiving Our decision. Appeals must be in Writing and must include at least the following information:

- name of the Covered Person;
- name of the Group Policyholder;
- claim number;
- Group Policy number; and
- an explanation why You are appealing the decision.

As part of Your appeal, You may submit any Written comments, documents, records, or other information relating to Your claim. After We receive Your Written request appealing the decision, We will conduct a review of Your claim. We will notify You in Writing within 45 days after Our receipt of Your request for an appeal of: (i) Our decision; or (ii) if additional time will be required to complete the review. If additional time is needed, We will notify You of the reason additional time is required.

AUTHORIZATIONS

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

EXAMINATIONS

With respect to a pending claim, at Our expense and as often as is reasonably necessary, in order to substantiate Our Proof requirements:

- We may require a Covered Person to have an independent examination by a Physician of Our choice; and/or
- We may require a Covered Person to have an interview by phone or in person with Our representative.

Failure of a Covered Person to have an independent exam or to be interviewed at Our request as specified in this provision may result in the denial of the claim to which the exam or interview pertains.

AUTOPSY

With respect to a pending claim, at Our expense, in order to substantiate Our Proof requirements, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

TIME LIMIT ON LEGAL ACTIONS

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

REFUND TO US FOR OVERPAYMENT OF BENEFITS

If, at any time, We determine that benefits paid under this Certificate were more than the benefits due:

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

GENERAL PROVISIONS

CHANGES IN STANDARDS

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

ENTIRE CONTRACT

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- 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. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

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

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase in benefits after the increase has been in force for 2 years, unless such statement is fraudulent.

MISSTATEMENTS

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

ASSIGNMENT

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

CONFORMITY WITH LAW

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

STANDARD OF TIME

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

ACCESS TO DISCOUNTS FOR SERVICES

You will receive access to discounts for certain services, where available.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10116-0188

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. The Schedule of Exhibits lists each Exhibit to this policy, to whom it applies and its effective date.

Policyholder: City of Baton Rouge/Parish of East Baton Rouge

Group Policy No.: 0143258

EFFECTIVE DATE

This policy will take effect on January 1, 2023.

POLICY ANNIVERSARIES

Policy anniversaries will be January 1, 2024 and each subsequent January 1.

PREMIUM PAYMENTS

This policy 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 by this policy's effective date. Any later Premiums are due monthly on the 1st day of the Policy Month. These dates are the Premium Due Dates.

POLICY SITUS

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

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

Signed by _____
(A licensed MetLife agent or resident agent if required by law.)

**GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-DIVIDEND PAYING**

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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 will share the same meaning.

Covered Person means an Employee and/or a Dependent as set forth in the Exhibits attached to this policy which applies to the Employee.

Dependent means an individual who is eligible for insurance as provided in the Exhibits attached to this policy.

Employee means an individual who is eligible for insurance as an Employee as set forth in the Exhibits attached to this policy which applies to that individual.

Employer means the Policyholder shown on page 1 and any subsidiaries, affiliates, divisions, branches or other similar entities of such Policyholder as specified in Exhibit 3.

Policy Anniversary is defined on page 1.

Policy Month. The first Policy Month will begin on the effective date shown on page 1. Subsequent Policy Months will begin on the same day of each subsequent calendar month.

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

Premium Due Date is defined on page 1.

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 or electronic media, and which is consistent with applicable law.

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

SCHEDULE OF INSURANCE

The Schedules of Insurance which apply under this policy are set forth in the Exhibits attached to this policy.

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

The Eligibility and Effective Dates of Insurance provisions that apply under this policy are set forth in the Exhibits that are attached to this policy.

CONTRIBUTIONS

The maximum amount that an Employee may be required to contribute to the cost of insurance will not exceed the Premium charged for the amounts of such insurance.

PREMIUM RATE(S)

Initial Rate(s)

The initial Premium rate(s) are shown in Exhibit 1.

Frequency of Premium Payment

Premiums for this policy will be paid as shown on page 1. MetLife and the Policyholder may agree that payment be made in advance every 3, 6 or 12 months.

Computation of Premium

The Premium due on any Premium Due Date is determined by the total amount of insurance provided by this policy on such Premium Due Date, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable.

MetLife may use any reasonable method to compute Premiums due under this policy.

Premiums for Changes in Insurance

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. However, if a policy amendment or evidence of good health is required for such insurance, Premium will be charged as of the date such insurance takes effect. If insurance ends, Premium will be charged to the date insurance ends.

PREMIUM RATES (Continued)

Right to Change Premium Rates

MetLife may change Premium rates for changes which materially affect the risk 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 corporate 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 corporate restructuring, acquisition, spin-off or similar situations;
4. when there is a significant change in the geographic distribution of insured Employees;
5. when applicable law requires a change in:
 - a. the insurance provided by this policy; and/or
 - b. the class of persons eligible for insurance under this policy; or
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.

MetLife will notify the Policyholder, in Writing, at least 45 days before a Premium rate change of twenty percent or more.

In addition, MetLife may change Premium rates:

1. except as may be stated in Exhibit 1, on any date on or after the first Policy Anniversary; this will be done no more frequently than every 12 months and only if MetLife notifies the Policyholder, in Writing, at least 45 days before such change; and
2. on any other date agreed to by MetLife and the Policyholder.

The new Premium rates will apply only to Premiums due on or after the date the rate change takes effect.

GRACE PERIOD

Each Premium due after the effective date of this policy may be paid up to 90 days after its Premium Due Date. This period is the grace period. The insurance provided by this policy will stay in effect during this period. MetLife will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, this policy will end at the end of the last day of the grace period. If MetLife fails to give Written notice to the Policyholder, this policy will continue in effect until the date such 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 the grace period of its intent to end this policy before the end of the grace period. In this case, this policy will end on the later of:

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

If the Policyholder replaces this policy with another group insurance policy but does not give MetLife notice of intent to end this policy, the grace period provisions will apply.

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

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

END OF INSURANCE PROVIDED BY THIS POLICY

The Policyholder can end this policy by giving 31 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 can end this policy as follows:

1. on the date Premium is not paid when due, subject to the Grace Period provisions;
2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if less than:
 - a. 5% of persons eligible under this policy are insured for Contributory Insurance;
 - b. 100% of persons eligible under this policy are insured for Noncontributory Insurance; or
 - c. 10 Employees are insured by this policy;
3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or
4. on any Policy Anniversary, except during a Rate Guarantee Period as may be provided in Exhibit 1, by giving the Policyholder 60 days advance Written notice by certified mail.

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.

END OF INSURANCE PROVIDED BY THIS POLICY (Continued)

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

GENERAL PROVISIONS

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

1. this policy, including its Exhibits, which include the certificates attached as Exhibits to this policy;
2. the enrollment forms, if any, of those Employees who are Covered Persons;
3. the Policyholder's application; and
4. the amendments and endorsements to this policy, if any.

Policy Changes or Waivers. The terms and provisions of this policy may be changed, at any time, without the consent of the Covered Persons or anyone else with a beneficial interest in it. MetLife will issue amendments or endorsements to effect such changes. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement will not affect the insurance provided under certificates issued before the effective date of the change, unless retroactivity is consistent with applicable law.

An officer of MetLife must approve in Writing any change or 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 such changes or waivers. A change or waiver will be evidenced by an amendment Signed by an officer of MetLife and the Policyholder or an endorsement Signed by an officer of MetLife. 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 statement to avoid insurance, reduce benefits or defend a claim unless it is contained in a Written application. MetLife will not use such statement to contest insurance after it has been in force for 2 years from its effective date, or date of last reinstatement, unless the statement is fraudulent.

Incontestability: Statements Made by Covered Persons. Any statement made by a Covered Person will be considered a representation and not a warranty. 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 has Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to the Covered Person or his beneficiary.

MetLife will not use a Covered Person's statements which relate to insurability to contest insurance after it has been in force for 2 years, unless the statement is fraudulent. 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, unless such statement is fraudulent.

Certificates. MetLife will issue certificates to the Policyholder, for delivery to each Employee covered under the policy, a certificate that has been prepared for each such Employee so as to describe the Employee's benefits and rights under this policy.

Assignment. The rights and benefits under this policy are not assignable, except as required by law or as permitted by MetLife.

GENERAL PROVISIONS (Continued)

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:

- Will 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 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 of the Policyholder's plan 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.

Non-Dividend Paying. This policy does not pay dividends.

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

SCHEDULE OF EXHIBITS

Exhibit Number	Exhibit Type	Applies To	Effective Date
1	Schedule of Premium Rates	All Covered Persons	January 1, 2023
2	Certificate Forms	All Employees	January 1, 2023
3	List of Policyholder's Subsidiaries, Affiliates, Divisions, Branches and Other Similar Entities	All Covered Persons	January 1, 2023

EXHIBIT 1

SCHEDULE OF PREMIUM RATES

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

Rates are determined separately for each Employee and covered Spouse and are based on the person's age as of the 31st day of December of the preceding calendar year.

For Dependent Children, an additional premium amount is charged for each Employee who elects dependent child coverage, regardless of the actual number of dependent children covered for that Employee.

Premium rates below are shown based on \$1,000 of coverage.

CLASS 1: All Active Full-Time Employees

Age	Employee	Spouse
< 25	\$0.13	\$0.13
25- 29	\$0.15	\$0.15
30- 34	\$0.25	\$0.25
35- 39	\$0.44	\$0.44
40- 44	\$0.78	\$0.78
45- 49	\$1.39	\$1.37
50- 54	\$2.25	\$2.19
55- 59	\$3.56	\$3.38
60- 64	\$5.46	\$5.08
65- 69	\$8.35	\$7.66
70- 74	\$12.06	\$11.14
75- 79	\$16.94	\$15.91
80- 84	\$21.14	\$20.09
85+	\$22.65	\$21.64

Dependent Child(ren) \$0.05

EXHIBIT 1 - SCHEDULE OF PREMIUM RATES (Continued)

Rate Guarantee Period

Subject to the Right to Change Premium Rates provision on page 5, these Premium rates will be in effect from January 1, 2023 to December 31, 2027.

Employees who become insured for Group Critical Illness Insurance under the Group Policy will have access to certain non-insured Healthcare Navigation Services. These services will be available for Employees, their enrolled Dependents and any of the following family members of the Employee, without regard to Dependent status: spouses or domestic/civil union partners; children; parents; and parents-in-law at no additional premium. MetLife has arranged for these services to be provided by a third-party service provider. The services include access to education and support from personal consultants with healthcare expertise, including the following: decision support related to health care services and benefits; assistance with understanding health benefits; concierge services to coordinate care, assess costs of care, find doctors and facilitate appointments; medical claim/bill review and correction. The services also include access to self-service decision support tools via a web portal that can be used to assess costs of care and find doctors. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third-party service provider. While Employees, their enrolled Dependents and family members may receive health care provider suggestions and cost estimates, care coordination and education regarding diagnosis and treatments as part of the Healthcare Navigation Services, their physicians or other health care providers remain responsible for the actual medical care and the associated outcomes and costs.

EXHIBIT 2

CERTIFICATE FORMS

The coverage plans available under this policy are as follows:

Class 1

Critical Illness Plan 1

Certificates for each coverage plan available under this policy are issued to the Policyholder for delivery to certificateholders as follows:

- certificates to be delivered to certificateholders who, on their certificate effective date, reside in the following jurisdictions:
 - Alaska
 - Arkansas
 - Colorado
 - Connecticut
 - Florida
 - Idaho
 - Minnesota
 - Mississippi
 - Missouri
 - Montana
 - Nebraska
 - New Hampshire
 - New Mexico
 - North Carolina
 - North Dakota
 - Ohio
 - Oklahoma
 - South Carolina
 - South Dakota
 - Texas
 - Utah
 - Vermont
 - Washington
 - West Virginia
 - Wisconsin
 - Wyoming
- a Louisiana certificate for delivery to certificateholders who, on their certificate effective date, reside in all other jurisdictions.

EXHIBIT 3

LIST OF POLICYHOLDER SUBSIDIARIES, AFFILIATES, DIVISIONS, BRANCHES AND OTHER SIMILAR ENTITIES

The subsidiaries, affiliates, divisions, branches and other similar entities listed below are included for insurance under this policy as of the effective dates shown below. The Policyholder acts for all listed subsidiaries, affiliates, divisions, branches and other similar entities in all matters of this policy. Such actions bind all listed subsidiaries, affiliates, divisions, branches and other similar entities.

MetLife and the Policyholder must agree to any change to this list. If change is needed, a policy amendment will be issued and attached to this policy to reflect the change to this Exhibit.

**Name/Address of Subsidiary, Affiliate, Division,
Branch and Other Similar Entity**

Effective Date

NONE

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The association does not provide coverage for:

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

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

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

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

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

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

DISCLAIMER

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

COVERAGE

- **Persons Covered**

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

- **Amounts of Coverage**

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

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

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

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

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

- **Health Insurance**

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

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

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

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

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

Coverage

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

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

Coverage Limitations

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

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

- * With respect to any one life, regardless of the number of policies, contracts, or certificates:
 - 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. 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.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Basic Protections Currently Provided by ILHIGA

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

Life Insurance

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

Health Insurance

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

Annuities

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

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

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

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

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

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

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

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

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

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

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

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

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

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

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association 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, 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.

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

DISCLAIMER

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

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

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

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

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

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

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

Disclaimer

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

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

LLHIGA also does not provide coverage for:

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

LIMITS ON AMOUNTS OF COVERAGE

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

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

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

<p style="text-align: center;">NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION</p>
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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.mdlife.ga.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.

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

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

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

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

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

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

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

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

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

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

The basic protections provided by the Association are:

Life Insurance

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

Health Insurance

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

Annuities

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

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

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

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

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

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

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

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

EN-GUAR-12-20 MS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This notice provides a **brief summary** of the Montana Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders.

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

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

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

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

Note: Other restrictions to coverage apply. Certain policies and contracts may not be covered or fully covered.

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

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

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

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

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

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

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

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

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, 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.

<p style="text-align: center;">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</p>
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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

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

February 2020

NOTICE

NEW JERSEY LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

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

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

DISCLAIMER

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

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

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

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

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

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

COVERAGE

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

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

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

EXCLUSIONS FROM COVERAGE

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

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

The Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

NEW MEXICO

NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

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

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

The basic protections provided by the Association are:

Life Insurance

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

Health Insurance

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

Annuities

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

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

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

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

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

**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.

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 or contact:

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

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

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

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

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

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

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

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

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

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

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

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

As of 11/15/2018

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

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

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

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

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

COVERAGE

Persons Covered

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

Amounts of Coverage

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

Life insurance:

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

Accident, accident and health, or health insurance (including HMOs):

- o Up to \$500,000 for health benefit plans, with some exceptions.
- o Up to \$300,000 for disability income benefits.
- o Up to \$300,000 for long-term care insurance benefits.
- o Up to \$100,000 for all other types of health insurance.

Individual annuities

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

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

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

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

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

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

NOTICES

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

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

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

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

**Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company**

SUMMARY

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

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

**LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION DISCLAIMER**

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Association does not provide coverage for:

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

LIMITATIONS ON COVERAGE

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

- \$300,000 in life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- \$100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, major medical insurance, or long-term care insurance including any net cash surrender and net cash withdrawal values;
- \$300,000 for disability insurance;
- \$300,000 for long-term care insurance;
- \$500,000 for basic hospital, medical, and surgical insurance;
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- \$250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- \$250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased;
- \$5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

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

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

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

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

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

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

Disclaimer

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

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

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

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

South Carolina Life and Accident and Health Insurance Guaranty Association

Attention: Executive Director
P.O. Box 8625
Columbia, SC 29202

South Carolina Department of Insurance

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are 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 Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

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

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

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

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

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

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

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

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

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

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

(please see next page)

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

(please see next page)

ADDITIONAL INFORMATION

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

- present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
 - \$100,000 for limited benefits and supplemental health coverages
 - \$300,000 for disability and long term care insurance
 - \$500,000 for basic hospital, medical and surgical insurance or major medical insurance

NOTE

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

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

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

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

**Nashville, TN 37219
Website: www.tnlifeqa.org**

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

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

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

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

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

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

The basic protections provided by the Association are:

- Life Insurance
 - 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(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

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

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

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

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

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does not provide coverage for:

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

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

LIMITS ON AMOUNT OF COVERAGE

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

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

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

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

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

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

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

The basic protections provided by the Association are:

* Life Insurance

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

* Health Insurance

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

* Annuities

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

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

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

EXCLUSIONS FROM COVERAGE

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

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

company or similar plan in which the policy-holder is subject to future assessments, by an insurance exchange, or by an entity similar to those listed here.

The Association also does not provide coverage for:

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

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

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

Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002

Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

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



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.

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, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

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.

Collecting Your Information

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

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.

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

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. 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

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long-term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. 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 anything we learned as part of 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.

Questions

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

Send privacy questions to:

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

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.