Group Critical Illness Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

This certificate applies to Insureds in all states.

POLICYHOLDER:	The Children's Mercy Hospital
POLICY NUMBER:	76382
POLICY EFFECTIVE DATE:	February 1, 2025
CERTIFICATE EFFECTIVE DATE:	This certificate represents the plan in effect as of February 1, 2025 **This certificate replaces any and all certificates previously issued to you under the group policy. Please replace any certificate previously issued to you with this new certificate.**
ASSOCIATED COMPANIES:	All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.
POLICY SITUS STATE:	The policy was issued and delivered in Missouri.

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010. YOU SHOULD CONFIRM WITH YOUR TAX ADVISOR THAT THIS INSURANCE DOES NOT IMPACT ELIGIBILITY TO CONTRIBUTE TO AN HSA, IF APPLICABLE TO YOU.

THIS IS A LIMITED BENEFIT CERTIFICATE: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare published by Medicare.gov and available from us.

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.

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.

Notice for residents of Arizona: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

Notice for residents of Florida: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Notice for residents of Maryland: This certificate is a part of a group policy issued outside of Maryland and may omit some of the benefits required for a policy issued and delivered in Maryland.

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

Notice to Ohio residents: Holders of certificates furnished by any insurer to a resident of Ohio in connection with, or pursuant to any provisions of, any group sickness and accident policy which insures residents of Ohio are entitled to all the protections afforded them under Ohio law, including without limitation, Title XXXIX of the Ohio Revised Code.

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown in the Certificate Specification section. This certificate is not a contract nor does it modify or amend the group policy. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. The group policy is the contract between the policyholder and Securian Life. You have an examination period of 10 days after the receipt of this certificate to review it. If you choose to cancel this certificate and return it for cancellation, by mail or other delivery method, within the 10-day examination period, the return will void the certificate from the beginning, and the parties will be in the same position as if a certificate had not been issued. All premiums paid will be fully refunded to the you in a timely manner. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Renée D. Montz
Secretary

President

GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE • NONPARTICIPATING

Have a complaint or need help?

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

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

Securian Life Insurance Company
To get information or file a complaint with your insurance company:
Call: Consumer Complaints, toll free at: 1-855-651-3500
Email: ConsumerComplaints@securian.com
Mail: 400 Robert Street North, St. Paul, MN 55101-2098

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Securian Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:
Llame a: Consumer Complaints, teléfono gratuito al 1-855-651-3500
Correo electrónico: ConsumerComplaints@securian.com
Dirección postal: 400 Robert Street North, St. Paul, MN 55101-2098

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Table of Contents

ENTIRE CONTRACT

If you meet the eligibility and enrollment requirements as shown herein, you are insured under the group policy**.** Your application is deemed a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application (if any) will be considered representations and not warranties. No written statement made by any insured will be used in any contest unless a copy of the application has been furnished to the insured, or in the event of the insured's death or incapacity, to the insured's beneficiary or personal representative.

This certificate is issued in consideration of your application (if any) and the payment of any required premium.

CERTIFICATE SPECIFICATIONS

Group:
The group is composed of all active employees of the policyholder working in the United States in the following class:

Class 1: All eligible active employees

All new employees of the employer will be added to such group and classes for which they become eligible.

Associated companies' eligibility:
Employees of associated companies may be eligible for insurance under the group policy. The policyholder must report any associated companies to us for inclusion under the group policy, subject to the employee and associated company meeting all eligibility requirements. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder's acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to policy termination will apply to such employees.

Minimum hour per week requirement:
The number of hours your employer requires you to be actively at work in order to be eligible for coverage under this certificate. Your minimum hour per week requirement is 16 hours per week.

Employment waiting period:
None.

Eligibility:
You are eligible for group critical illness insurance if you meet all the following requirements:

(1) are a member of the eligible group and of an eligible class;
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement; and
(3) meet the actively at work requirement.

Dependent eligibility:
If you are insured for group critical illness insurance coverage, your dependents are eligible for insurance.

Enrollment period:
You must enroll in order to be insured for contributory coverage under the group policy. You can enroll for coverage within 60 days of when you first become eligible. After that period you can only enroll for coverage or make changes during your annual open enrollment, or within 31 days of a qualified status change event as defined by the policyholder's plan rules.

You will become insured on the first of the month following 30 days from the date you meet all eligibility requirements.

Effective date of coverage:
Your insurance becomes effective on the date all of the following conditions have been met:

(1) you meet all eligibility requirements, including the actively at work requirement; and
(2) for contributory coverage, application is made in accordance with the application methods agreed upon by the policyholder and us.

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) your insurance becomes effective;
(2) the dependent meets all eligibility requirements; and
(3) for contributory insurance, you apply for dependent coverage on forms which are approved by us.

Insurance on a dependent parent becomes effective on the later of:

(1) the date you become insured for critical illness insurance under this certificate; and
(2) the date the dependent parent meets all eligibility requirements.

Double coverage:
If you are eligible as an employee under the policy, or insured under the portability provisions, you are not eligible as a dependent. Only you can insure an eligible dependent child.

Actively at work requirement:
To be eligible to become insured or to receive an increase in the benefit amount, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not working due to illness or injury, you do not meet the actively at work requirement. If you are receiving sick pay, short-term disability benefits or long-term disability benefits, you do not meet the actively at work requirement.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase in your benefit amount would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-workday, coverage will not be delayed provided you were actively at work on the workday immediately preceding the non-workday.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

Dependent non-confinement requirement:
If a dependent is hospitalized or confined because of an illness or injury on the date their insurance would otherwise become effective, their effective date shall be delayed until they are released from such hospitalization or confinement. This does not apply to a newborn child. In no event will insurance on a dependent be effective before your insurance is effective.

Continuation during a leave of absence:
Insurance may be continued when you are not actively at work due to illness, injury, leave of absence or temporary layoff, subject to the employer's practices and procedures, including the employer's limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

(1) if you are on a non-medical leave of absence or temporary layoff, insurance cannot be continued beyond 60 months from the last day you were actively at work.
(2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 60 months from the last day you were actively at work .

Continuation of insurance must be in accordance with practices and procedures that preclude individual selection.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded, if necessary, in order to meet such requirements.

Changes in your coverage amount:
Requested increases in the amount of your contributory insurance are effective on the date as shown below in the Annual open enrollment and Qualified statues changes sections. Requested decreases in the amount of your contributory insurance are effective on the first day of the month following receipt of your request for a decrease. In addition, elections made during an enrollment period will not become effective prior to the effective date for that enrollment.

Change of insurance carriers
If you are not actively at work due to illness or injury on the date the policyholder changes its insurance carrier to us, and you were covered under the policyholder's prior policy at the time coverage under us became effective, we will provide coverage under our insurance policy.

Coverage provided under our insurance policy is subject to payment of premiums.

Guaranteed issue:
Guaranteed issue is the maximum amount of insurance you, your spouse, or child can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period.

For an employee:
- Supplemental insurance: All supplemental insurance is guaranteed issue

For a spouse:
- Supplemental insurance: All supplemental insurance is guaranteed issue

For a child:
- Supplemental insurance: All supplemental insurance is guaranteed issue

For an eligible employee and eligible dependent who was covered for Critical Illness under the employer's plan immediately prior to the policy effective date shown above, the guaranteed issue for critical illness is the amount of insurance in force under that prior plan immediately prior to the policy effective date.

Annual open enrollment:
During the policyholder's annual open enrollment you may elect or change your and your dependent's critical illness insurance benefit plan. All coverage is guaranteed issue.

Coverage will be effective on the July 1 following the annual open enrollment, subject to the actively at work requirement for employees and the hospitalization/non-confinement requirement for dependents.

Qualified Status Changes:
If you experience one of the qualified status change events listed below you may elect or change your and your dependent's critical illness insurance benefit plan provided enrollment is made within 31 days of the status change. All coverage is guaranteed issue.

Qualified status change for purposes of the enrollment opportunities described above means marriage or establishment of a legal partnership, birth of a child, adoption of a child, placement of a foster child or acquire a stepchild.

Coverage will be effective on the first of the month following the date of the election. All increases are subject to the actively at work requirement and the hospitalization/non-confinement requirement for dependents.

PLAN OF INSURANCE

Employee Benefit Schedule

Employee Supplemental Group Critical Illness Insurance

Eligible Class	**Employee Supplemental Group Critical Illness Insurance Benefit Plan**
Class 1	An amount elected by you from the following options: $5,000, $10,000, $15,000, $20,000, $25,000, $30,000, $35,000, $40,000, $45,000, or $50,000
Contributory/Non-Contributory:	Supplemental critical illness insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Spouse Benefit Schedule

You must be insured for supplemental critical illness insurance in order to elect spouse critical illness insurance.

Spouse Supplemental Group Critical Illness Insurance

Eligible Class	Spouse Supplemental Group Critical Illness Insurance Benefit Plan
Class 1	50% of your amount of supplemental critical illness insurance, subject to a minimum of $5,000

Contributory/Non-Contributory: Supplemental critical illness insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Child Benefit Schedule

You must be insured for supplemental critical illness insurance in order to elect child critical illness insurance.

Child Supplemental Group Critical Illness Insurance

Eligible Class	Child Supplemental Group Critical Illness Insurance Benefit Plan
Class 1	50% of your amount of supplemental critical illness insurance

Contributory/Non-Contributory: Supplemental critical illness insurance is contributory insurance.

Retirement Termination: All insurance terminates at employee's retirement, except as otherwise outlined in this certificate.

Automatic Child Coverage: If you currently have dependent child coverage and you have a newborn child or adopt a child, then your newborn child or adopted child will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date of live birth or the date of placement for adoption.

If you currently have dependent child coverage and you have a foster child, grandchild, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you or you acquire a stepchild, the child will be automatically covered for the amount of child coverage outlined in the Plan of Insurance section from date the child becomes eligible according to the definition of child outlined within the Definition Section of this certificate.

If you currently do not have dependent child coverage and you have a newborn child or adopt a child, your newborn child or adopted child will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days following the date of live birth or the date of placement for adoption. The coverage will terminate at the end of the 61 day period unless you apply for dependent child coverage within the 61 days of the live birth or the date of placement for adoption and pay the additional premium for coverage.

If you currently do not have dependent child coverage and you have a foster child, grandchild, child of legal ward, a child of court-appointed guardianship, or a child of court-ordered custody or administrative order placed with you or you acquire a stepchild, the child will automatically be covered for the amount of child coverage outlined in the Plan of Insurance section for the first 61 days as of the date the child is eligible according to the definition of child outlined within the Definition Section of this

certificate. The coverage will terminate at the end of the 61 day period unless you apply for dependent coverage within 61 days of the child becoming eligible according to the definition of child outlined within the Definition Section of this certificate.

NOTE: If you had previously declined to enroll in dependent child coverage for your eligible children, you may still elect child coverage for any newly eligible child according to the enrollment period rules shown within the Certificate Specifications section of this certificate.

PLAN OF INSURANCE – ADDITIONAL BENEFITS

Employee Additional Benefit Schedule

Employee Supplemental Health and Wellness Benefit

Eligible Class	Supplemental Health and Wellness Benefit
Class 1	$75

Employee Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** An amount that does not exceed the lesser of your amount of coverage in force on your portability date or $50,000.

Spouse Additional Benefit Schedule

Spouse Supplemental Health and Wellness Benefit

Eligible Class	Supplemental Health and Wellness Benefit
Class 1	$75

Spouse Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** An amount that does not exceed the lesser of your spouse's amount of insurance in force on their portability date or $25,000.

Child Additional Benefit Schedule

Child Supplemental Health and Wellness Benefit

Eligible Class	Supplemental Health and Wellness Benefit
Class 1	$75

Child Portability Benefit

Eligible Class	Portability Benefit
Class 1	**Minimum Amount:** The lowest level of coverage. **Maximum Amount:** An amount that does not exceed the lesser of your child's amount of coverage in force on their portability date or $25,000.

Dependent Parent Additional Benefit Schedule

To be eligible for the Dependent Parent Benefit you must be insured for supplemental critical illness insurance.

Supplemental Dependent Parent Benefit

Eligible Class	Supplemental Dependent Parent Benefit
Class 1	The supplemental dependent parent amounts payable per covered benefit is 10% of your payable supplemental critical illness insurance amounts.

INITIAL OCCURRENCE AND RECURRENCE BENEFITS

The benefit amount for a covered critical illness condition will be a percentage of the insured's amount of insurance or the amount as shown in the Plan of Insurance section listed above.

Initial Occurrence Benefit
The initial occurrence benefit is payable upon meeting the diagnosis requirements of a covered condition for the first time after the effective date and while coverage is in force.

If the covered condition is invasive or non-invasive cancer, any subsequent diagnosis of invasive or non-invasive cancer which is separate and unrelated to a previously diagnosed invasive or non-invasive cancer will be treated as an initial occurrence.

An insured may be eligible for multiple initial occurrence benefits shown in the Plan of Insurance section. If an insured is diagnosed with an initial occurrence of a different covered critical illness condition, a separate initial occurrence benefit may be paid.

A second benefit will not be paid for the same covered critical illness condition except as described under the Recurrence Benefit provision.

Recurrence Benefit
The recurrence benefit will be paid, as shown on the Plan of Insurance section, if an initial occurrence benefit has been paid and an insured is diagnosed again for the same covered critical illness condition.

For any recurrence benefit, all of the following requirements must be satisfied:

(1) the subsequent covered critical illness condition is one of the covered critical illness conditions that qualifies for a recurrence benefit;
(2) the subsequent covered critical illness condition satisfies the requirements as stated in the Critical Illness Condition section and any additional requirements stated below;
(3) the subsequent covered critical illness condition is diagnosed after the benefit separation period; and
(4) the subsequent diagnosis must be for a recurrence of a covered critical illness condition while the insured's coverage is in force.

Before a recurrence benefit is payable, the benefit separation period requirement must be met. The benefit separation period for a recurrence benefit is the period of time that begins with the diagnosis date of a covered condition for which a benefit is payable. Your benefit separation period is 30 days.

Multiple recurrence benefits are payable for an insured, but only one recurrence benefit is available per covered condition.

For *Invasive Cancer* or**,** *Non-Invasive Cancer*, additional requirements must be met in order to receive benefits. The additional requirements are as follows:

- *Invasive or non-invasive Cancer*
  The cancer for which an initial occurrence benefit was paid, was completely treated, and is in full remission prior to the date of the subsequent diagnosis as evidenced by clinical, radiological, and biochemical proof.

- This recurrence benefit will pay out if the subsequent cancer is a recurrence of the same cancer. If the subsequent cancer is a new cancer that is completely unrelated to the original initial covered invasive or non-invasive benefit cancer, then it will be treated as a new initial covered invasive or non-invasive benefit cancer.

The replacement of the prior group critical illness policy will affect people who were insured under the prior policy and are now insured under our critical illness policy.

For the amount of insurance that was in effect with the prior carrier, each insured who was covered under the prior critical illness policy on the date that it ended and who is eligible for insurance under our critical illness policy will be:

(1) insured under our critical illness policy effective date; and
(2) credited for the time such insured has been continuously insured under the prior critical illness policy on the date it ended in determining whether a covered condition is subject to the benefit waiting period in this certificate**.**

COVERED CRITICAL ILLNESS CONDITION BENEFITS

The benefit amount payable for a covered critical illness condition is a percentage of an insured's amount of insurance as shown in the schedule below.

Covered Critical Illness Condition	Initial Occurrence Benefit	Recurrence Benefit
Addison's disease*	25%	None
Alzheimer's disease*	100%	None
Amyotrophic lateral sclerosis (ALS) and other motor neuron disease*	100%	None
Aneurysm	10%	10%
Autism spectrum disorder*	100%	None
Bacterial meningitis	25%	25%
Benign brain tumor	100%	100%
Blindness*	100%	None
Cerebral palsy*	100%	None
Cleft lip or cleft palate needing surgery*	100%	None
Coma	100%	100%
Coronary artery disease needing surgery or angioplasty	100%	100%
COVID-19 disease of specified severity	25%	None
Creutzfeldt-Jakob disease/progressive multifocal leukoencephalopathy*	25%	None
Cystic fibrosis*	100%	None
Diphtheria	25%	25%
Down syndrome*	100%	None
End stage renal disease (kidney failure)	100%	100%
Gaucher disease (type II or III)*	100%	None
Glycogen storage disease (type IV)*	100%	None
Heart attack	100%	100%
Huntington's disease*	25%	None
Infectious encephalitis	25%	25%
Invasive cancer	100%	100%
Legionnaires' disease	25%	25%
Loss of hearing*	100%	None
Loss of speech*	100%	None
Major organ failure	100%	100%
Malaria	25%	25%

Metastatic cancer*	25%	None
Multiple sclerosis*	100%	None
Muscular dystrophy*	100%	None
Myasthenia gravis*	25%	None
Necrotizing fasciitis	25%	25%
Niemann-Pick disease*	100%	None
Non-Invasive cancer	50%	50%
Paralysis	100%	100%
Parkinson's disease*	100%	None
Phenylalanine hydroxylase deficiency*	100%	None
Poliomyelitis (Polio)*	25%	None
Pompe disease*	100%	None
Post-traumatic stress disorder (PTSD)*	10%	None
Rabies*	25%	None
Severe burns	100%	100%
Severe Lyme disease*	25%	None
Sickle cell anemia*	100%	None
Skin cancer (non-melanoma and carcinoma in-situ of the skin)	10%	10%
Spina bifida*	100%	None
Stroke	100%	100%
Sudden cardiac arrest	25%	25%
Systemic lupus erythematosus (nephritis & cerebritis)*	25%	None
Systemic sclerosis (scleroderma)*	25%	None
Tay-Sachs*	100%	None
Tetanus	25%	25%
Transient ischemic attacks (TIA)	10%	10%
Tuberculosis	25%	25%
Type 1 diabetes*	100%	None
Type 2 diabetes*	10%	None
Zellweger syndrome*	100%	None

*****Not all benefits are medically able to meet the definition of recurrence, including Addison's disease, Alzheimer's disease, Amyotrophic lateral sclerosis (ALS) and other motor neuron diseases, Autism spectrum disorder, Blindness, Cerebral palsy, Cleft lip or cleft palate needing surgery, Creutzfeldt Jakob disease/progressive multifocal leukoencephalopathy, Cystic fibrosis, Down syndrome, Gaucher disease (type II or III), Glycogen storage disease (type IV), Huntington's disease, Loss of hearing, Loss of speech, Metastatic cancer, Multiple sclerosis, Muscular dystrophy, Myasthenia gravis, Niemann-Pick disease, Parkinson's disease, Phenylalanine hydroxylase deficiency, Poliomyelitis (polio), Pompe disease, Post-traumatic stress disorder (PTSD), Rabies, Severe Lyme disease, Sickle cell anemia, Spina bifida, Systemic lupus erythematosus (nephritis & cerebritis), Systemic sclerosis (scleroderma), Tay-Sachs disease, Type 1 diabetes, Type 2 diabetes and Zellweger syndrome.

RELATED COVERED BENEFITS

Related Covered Benefit	Benefit Amount
Family care	$100
Infertility treatment	
• Tier 1	$1,000
• Tier 2	$5,000
• Tier 3	$10,000
Outpatient mental health and substance use disorder diagnostic screening	$100

DEFINITIONS

Any term used in this certificate is given the meaning as defined in this section unless otherwise defined in another provision of this certificate.

application
Your application or enrollment for insurance under the group policy.

associated company
Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and reported to and agreed to by us to participate under the group policy.

child or children
Your or your spouse's:

(1) natural child;
(2) adopted child;
(3) stepchild;
(4) foster child;
(5) grandchild;
(6) legal ward;
(7) a child in your or your spouse's court-appointed guardianship; or
(8) a child in your or your spouse's court-ordered custody; or administrative order.

Children are eligible from the moment of live birth (stillborn or unborn children are not eligible) to the attainment of age 26. Children age 26 or older, are eligible as a dependent child provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains physically dependent on you for their support and maintenance. Coverage on a qualified dependent child age 26 or older that continues beyond limiting age shall remain at the child premium rate. If you are a newly eligible employee, you may insure your child who is over the age of 26 provided the child is physically or mentally incapable of self-support, was incapable of self-support prior to age 26 and remains financially dependent on you for their support and maintenance.

Adopted child includes children that are placed with you, or for whom you have filed a petition to adopt. Children placed with you, or for whom you have filed a petition to adopt within 60 days of the adopted child's date of birth, are eligible from the moment of live birth (stillborn or unborn children are not eligible). Coverage for an adopted child placed with you, or for whom you have filed a petition to adopt more than 60 days after the child's date of birth, is effective from the moment of placement or filing of the petition. However, coverage will not continue if the placement is disrupted prior to legal adoption or if the child is removed from placement. Placed/placement means physical placement in your or your spouse's care. If physical placement is prevented due to the medical needs of the child, "placed" means the date you or your spouse sign an agreement for adoption of the child and assume financial responsibility for the child.

Foster child includes a child from the moment of placement in the foster home.

Grandchild means a grandchild:

(1) who is financially dependent on you;
(2) for whom you have legal custody; and
(3) who resides with you.

confined or confinement
The assignment to a bed as a resident inpatient in a hospital (including an intensive care unit of a hospital) or confinement in an observation area within a hospital for a period of no less than 18 continuous hours.

contributory insurance
Insurance for which you are required to make premium contributions.

covered condition
A covered condition is a critical illness as defined herein.

critical illness
Any illness that meets the requirements of a critical illness as defined herein.

dependent
Your spouse or child(ren).

If your spouse is eligible as an employee under the group policy, they are not eligible to be insured as a dependent spouse. If both parents of a child qualify as eligible employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this certificate. If any child qualifies as an eligible employee under the group policy, they are not eligible to be insured as a dependent child.

employee
An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer
The policyholder or any designated associated companies.

evidence of insurability
Evidence satisfactory to us of the insurability of the prospective insured and any other underwriting information we require.

family member
A parent, spouse, child, sibling, grandparent, grandchild, aunt, uncle, first cousin, niece, or nephew. This includes adopted, in-law, and step relatives.

guaranteed issue amount
Insurance that can be obtained without providing evidence of insurability based on plan requirements as shown in the Certificate Specification section of this certificate. All other eligibility requirements must be met. All insurance under this certificate is guaranteed issue.

hospital
A short-term, acute care general facility that:

(1) is legally licensed and operates as a hospital pursuant to the law;
(2) provides overnight care of injured and sick people;
(3) requires that every patient be supervised by one or more licensed physicians;
(4) provides 24-hour nursing service by or under the supervision of a registered nurse;
(5) has on-site or pre-arranged use of x-ray equipment, laboratory, and surgical facilities; and
(6) maintains permanent medical history records.

A hospital is not a nursing home, rest home, extended-care facility, convalescent home, hospice care facility, skilled nursing facility, assisted living facility, or a substance use facility, even if such facilities are affiliated with or adjoined to a hospital.

initial occurrence
The initial occurrence is the date the insured is diagnosed for the first time under this policy and after the effective date of coverage, with a covered condition.

If the covered condition is non-invasive cancer, the subsequent diagnosis of invasive cancer which is separate and unrelated that occurs after the first diagnosis will be treated as an initial occurrence.

If the covered condition is non-invasive cancer, the subsequent diagnosis of non-invasive cancer which is separate and unrelated that occurs after the first diagnosis will be treated as an initial occurrence.

insured
An employee or dependent covered for insurance under this certificate.

legal partner

The person with whom you have entered into a legally sanctioned domestic partnership or civil union partnership that grants the partners the same rights, responsibilities, and obligations as married couples in accordance with applicable law. Legal partner does not include any person who is eligible as an employee.

mental health disorder
Any condition, disease or disorder listed as a mental health disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other related mental health diagnoses, where improvement can be reasonably expected with therapy.

non-workday
A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, or approved leaves of absence for non-medical reasons.

Non-workday does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to illness or injury including sick days, short-term disability, or long-term disability.

outpatient
Medical advice, care, diagnostic measures, or treatment provided without being admitted as a resident inpatient to a hospital.

permanent neurological deficit with persisting clinical signs and symptoms
Signs and symptoms of dysfunction in the nervous system that are present on clinical examination by a physician and expected to last throughout the insured's life.

The following neurological symptoms are covered under this definition: numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, cognitive impairment, delirium, and coma.

The following are not covered under this definition:

(1) an abnormality seen on brain or other scans without definite related clinical signs and symptoms;
(2) neurological signs occurring without symptomatic abnormality such as brisk reflexes without other symptoms; and
(3) symptoms of psychological or psychiatric origin.

physician
A person who is licensed to practice medicine in the United States or United States territory in which treatment is received and who is providing treatment or advice in accordance with the license. Relevant law may require or allow for consideration of professional services of a practitioner other than a medical doctor. If so, such practitioner must be licensed as required by the jurisdiction where care is given and must be operating in the scope of their license. We will not recognize you, your family member, a person who ordinarily resides in your household, or a business or professional partner, or any person who has a financial affiliation or business interest with you as a physician for a claim submitted to us.

policyholder
The owner of the group policy.

separate and unrelated
An invasive cancer or non-invasive cancer that is:

(1) not a metastasis of a previously diagnosed invasive cancer; and
(2) distinct from any previously diagnosed invasive cancer or non-invasive cancer.

spouse
Your legally married spouse. For the purposes of this certificate, spouse shall also include legal partner. Spouse does not include any person who is eligible as an employee.

substance use disorder
The pattern of pathological use of alcohol, psychoactive drugs, or substances characterized by:

(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the substance; or
(4) the need for daily substance use to maintain adequate functioning.

telemedicine
The use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the evaluation, diagnosis, or treatment of the insured as would be practiced in person. This does not include requests for prescription refills or medical records.

we, our, us
Securian Life Insurance Company.

year
The benefit year beginning on any month within the calendar year or plan year. The calendar year and/or plan year is determined by the policyholder. In no event will a calendar year and/or plan year be more than 12 months.

you, your, certificate holder
An insured employee.

Critical Illness Condition Definitions

Addison's disease
An endocrine disorder characterized by primary failure of the adrenal gland to produce cortisol, steroid hormones, and aldosterone.

There must be the definite diagnosis by a physician of Addison's disease with clear confirmatory laboratory evidence of Addison's disease in the blood or urine. Adrenal insufficiency due to steroid hormone use is not covered under this definition.

The date of diagnosis is the date the diagnosis of Addison's disease is made by a physician satisfying the policy definition above.

Alzheimer's disease
A definite diagnosis of Alzheimer's disease by a physician. The Mini-mental Exam Score (MMSE) must be less than 20 out of 30 or an equivalent of this score using other standardized clinically accepted cognitive Alzheimer's tests.

There must also be permanent clinical loss of the ability to do all of the following:

(1) remember;
(2) reason; and
(3) perceive, understand, express, and give effect to ideas.

Other causes of dementia including but not limited to the following are excluded:

(1) alcohol related brain damage;
(2) coma;
(3) Parkinson's disease;
(4) psychiatric illnesses; or
(5) stroke and vascular dementia.

The date of diagnosis is the date a physician diagnoses the insured with Alzheimer's disease satisfying the policy definition above.

Amyotrophic lateral sclerosis (ALS) and other motor neuron disease
A definite diagnosis by a physician of spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), or primary lateral sclerosis.

There must be permanent neurological defect with persisting clinical signs and symptoms that has persisted for a continuous period of at least 90 days.

The date of diagnosis is the date the diagnosis of a covered motor neuron disease is made by a physician satisfying the policy definition above.

Aneurysm

A bulge in a blood vessel caused by a weakness in the blood vessel wall, usually where it branches.

Abdominal aortic aneurysm means an aneurysm located in the abdominal (lower) part of the aorta that is:

(1) 5 centimeters or larger in size;
(2) less than 5 centimeters and is rapidly expanding; or
(3) a dissecting aneurysm or a ruptured aneurysm.

Thoracic aortic aneurysm means an aneurysm located in the thoracic (upper) part of the aorta that is:

(1) 5 centimeters or larger in size;
(2) less than 5 centimeters and is rapidly expanding; or
(3) a dissecting aneurysm or a ruptured aneurysm.

Other dissecting or ruptured aneurysm means:

(1) carotid aneurysm located in the portion of the carotid artery that is in the neck;
(2) cerebral aneurysm located in an artery in the brain; and
(3) any aneurysm in a major branch of the aorta in the chest or abdomen, such as the pulmonary artery, celiac artery, common hepatic artery, or renal artery.

Aneurysms of the arm or leg are excluded.

A dissecting aneurysm is a condition where a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall.

A ruptured aneurysm is a condition in which an aneurysm bursts and causes bleeding inside the body.

A physician must make the definite diagnosis of an aneurysm and there must be diagnostic imaging confirming aneurysm.

The date of diagnosis is the date the diagnosis of an aneurysm is made by a physician satisfying the policy definition above.

Autism spectrum disorder

A complex developmental condition that involves persistent challenges in social interaction, speech, and nonverbal communication, and/or restricted/repetitive behaviors that results in clinically significant impairment requiring assistance.

A definite diagnosis must be made by a physician licensed to diagnose autism spectrum disorder working in conjunction with a multidisciplinary team of autism experts. A comprehensive assessment and ancillary testing must be performed that confirms a diagnosis of functional severity level 2 (requiring substantial support) or 3 (requiring very substantial support) in accordance with the criteria described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

This benefit is payable once per lifetime.

The following are excluded:

(1) functional severity level 1 (requiring support);
(2) social communication disorder; and
(3) presenting symptoms due to the direct physiological effects of substance use disorder or a general medical condition.

The date of diagnosis is the date the diagnosis of autism spectrum disorder is made by a physician satisfying the policy definition above.

Bacterial meningitis
A bacterial infection of the meninges of the brain causing brain dysfunction.

There must be the definite diagnosis by a physician of bacterial meningitis that must be proven on analysis of the cerebrospinal fluid.

There must also be permanent neurological deficit with persisting clinical signs and symptoms that is present on physical examination at least 90 days after the diagnosis of the meningitis infection.

The date of diagnosis is the date the diagnosis of bacterial meningitis is made by a physician satisfying the policy definition above.

Benign brain tumor
A non-cancerous tumor in the brain, cranial nerves, or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies.

This brain tumor must cause one (1) of the following:

(1) permanent neurological deficit with persisting clinical signs and symptoms for a continuous period of at least 90 consecutive days; or
(2) a physician reports that surgery or radiation therapy is necessary to treat the brain tumor.

The following conditions are excluded:

(1) abscesses;
(2) granulomas;
(3) hematomas;
(4) malformations in the arteries or veins of the brain;
(5) pituitary tumors; and
(6) tumors of the spinal cord.

The date of diagnosis is the date the diagnosis of benign brain tumor is made by a physician satisfying the policy definition above.

Blindness
The permanent loss of vision in both eyes is:

(1) sight in the better eye reduced to a best corrected visual acuity of less than 20/200; or
(2) visual field restriction to 20 degrees or less in both eyes

The diagnosis of permanent loss of vision in both eyes must be clinically confirmed by a physician. The blindness must not be correctable by aides or surgical procedures.

The date of diagnosis is the date the diagnosis of blindness is made by a physician satisfying the definition above.

Cerebral palsy
A non-progressive neurological disorder affecting the developing brain.

A physician must make the definite diagnosis of cerebral palsy. The disease must have caused permanent motor deficits with muscle dysfunction and activity limitation.

The date of diagnosis is the date the diagnosis of cerebral palsy is made by a physician satisfying the policy definition above.

Cleft lip or cleft palate needing surgery
Cleft lip means a split of the lip that extends all the way to the base of the nose. Cleft palate means an opening of the roof of the mouth that extends to the nasal cavity.

The diagnosis of either cleft lip or cleft palate must be confirmed by a physician and of sufficient severity that a surgical recommendation is made. One payment will be paid in the event the insured is diagnosed with either cleft lip, cleft palate, or both.

The date of diagnosis is the date that the diagnosis of cleft lip or cleft palate satisfying the policy definition above is made after live birth.

Coma

A state of unconsciousness with no reaction to external stimuli or internal needs. The coma must result in a coma lasting 3 or more consecutive days. The coma must have resulted in permanent neurological deficit.

A physician must diagnose the insured as comatose.

Medically induced coma and coma resulting directly from substance use are excluded.

The date of diagnosis is the date the insured entered the coma, as made by a physician satisfying the definition above.

Coronary artery disease needing surgery or angioplasty

Coronary artery disease with blockages in one or more coronary artery(s) demonstrated on cardiac catheterization coronary angiography that requires the insured to undergo either coronary artery bypass surgery or coronary angioplasty.

A physician must report that the insured requires surgical intervention on the coronary artery(s) following clinically accepted cardiovascular surgery guidelines, either for prognostic benefit or for symptomatic coronary artery disease that cannot be adequately managed on optimal medical therapy.

Diagnostic coronary angiography is not considered a 'surgical intervention' under this definition, and it is specifically excluded.

Actual undergoing of cardiac surgery is not required to meet the policy definition. However, individuals are not eligible for a recurrence benefit for multiple subsequent recommendations to undergo coronary artery bypass.

The date of diagnosis is the date the insured is diagnosed by a physician with coronary artery disease that satisfies the policy definition above.

COVID-19 disease of specified severity

A respiratory disease with potential multi-organ effects caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2).

The diagnosis of COVID-19 disease of specified severity must be supported by typical symptoms of COVID-19 and at least one of the following diagnostic tests performed by a physician:

(1) positive SARS-CoV-2 RT-PCR test;
(2) positive SARS-CoV-2 antigen testing; or
(3) other laboratory testing clinically accepted at the time of claim to be diagnostic of active COVID-19 infection.

For the above definition, the following are not covered:

(1) home testing;
(2) isolated positive COVID-19 antibody testing (indicating prior exposure to the virus, but not diagnostic of active infection);
(3) asymptomatic infection or milder degrees of COVID-19 infection not resulting in hospitalization of specified length; or
(4) hospitalizations not directly related to COVID-19.

The disease must be of sufficient severity as to have directly required inpatient hospitalization of at least 5 days. In the event an insured dies as a direct result of COVID-19 before the minimum period of hospitalization has been met, a benefit will be payable.

The date of diagnosis is the date the diagnosed of by a physician with COVID-19 disease of specified severity satisfying the policy definition above.

Creutzfeldt-Jakob disease/progressive multifocal leukoencephalopathy

An incurable brain prion infection that causes progressive deterioration of mental function and movement.

A physician must make a definite diagnosis of Creutzfeldt-Jakob disease based on clinical assessment, electroencephalogram (EEG) and imaging. There must be objective permanent neurological deficit with persisting clinical signs and symptoms on exam by a physician.

The date of diagnosis is the date the diagnosis of Creutzfeldt-Jakob disease is made by a physician satisfying the policy definition above.

Cystic fibrosis
A disorder characterized by abnormal transport of chloride and sodium causing organ dysfunction.

A physician must make the definite diagnosis of cystic fibrosis based on clinically accepted tests at the time of claim. The disease must cause ongoing symptoms indicating involvement of the lungs, pancreas, liver, or intestines.

The date of diagnosis is the date the diagnosis of cystic fibrosis is made by a physician satisfying the policy definition above.

Diphtheria
A serious bacterial infection that usually affects the mucous membranes of the nose and throat.

Both of the following two (2) criteria must be present:

(1) there must be current symptoms evident with a physical examination and consistent with the diagnosis of diphtheria; and
(2) the diagnosis must also be confirmed with the growth of C. diphtheriae in a lab culture from material taken from the throat membrane or by laboratory testing presenting disease fighting antibodies to the bacteria.

A physician must confirm the definite diagnosis of diphtheria.

The date of diagnosis is the date the diagnosis of diphtheria is made by a physician satisfying the policy definition above.

Down syndrome
A disorder arising from a chromosomal defect that results in a full or partial extra copy of chromosome 21, leading to intellectual delay and multiple physical abnormalities.

A physician must confirm a definite diagnosis of Down syndrome after live birth.

The date of diagnosis is the date that Down syndrome is first confirmed by a physician after live birth satisfying the policy definition above.

End stage renal disease (kidney failure)
The total and permanent failure of both kidneys (leaving the insured with no functioning kidneys), which requires the insured to undergo regular renal dialysis at least weekly or for which the insured is recommended for a kidney transplant.

Permanent regular renal dialysis or kidney transplant must be deemed medically necessary by a physician.

Acute reversible kidney failure that only needs temporary renal dialysis is not covered.

The date of diagnosis is the date the insured is diagnosed with end stage renal disease (kidney failure) or a transplant is deemed necessary by a physician that satisfies the policy definition above.

Gaucher disease, type II or III
A disorder resulting in a buildup of certain fatty substances in certain organs, particularly the spleen, liver, or bones.

A definite diagnosis must be made by a physician and supported by laboratory testing or diagnostic imaging.

Gaucher disease, type I is excluded.

The date of diagnosis is the date the diagnosis of Gaucher disease, type II or III is made by a physician satisfying the policy definition above.

Glycogen storage disease, type IV
A disorder resulting in a deficient activity of the glycogen-branching enzyme, resulting in accumulation of abnormal glycogen in the liver, muscle, or other tissues.

A definite diagnosis must be made by a physician and supported by glycogen branching enzyme deficiency testing to the liver, muscle, or skin.

The date of diagnosis is the date the diagnosis of glycogen storage disease, type IV is made by a physician satisfying the policy definition above.

Heart attack
Death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

A definite diagnosis must be made by a physician, supported by the following criteria and be diagnostic of a new acute myocardial infarction:

(1) symptoms clinically accepted as consistent with the diagnosis of an acute myocardial infarction; and
(2) the characteristic rise above laboratory accepted normal values of biochemical cardiac specific markers such as CK-MB or cardiac troponins.

Angina and all other forms of acute coronary syndromes are not covered.

Heart attack does not mean sudden cardiac arrest and in the event that both heart attack and sudden cardiac arrest occur within 48 hours of each other, the greater of the two benefits will be paid. If the benefit amount for both covered conditions is the same, you can choose the covered condition benefit to be paid.

The date of diagnosis is the date of the heart attack that satisfies the policy definition above.

Huntington's disease
A disorder resulting in a progressive neurological condition in which nerve cells in the brain break down over time resulting in chorea (impairment of motor function), cognitive impairment, and psychiatric symptoms.

A definite diagnosis must be made by a physician and supported, by the following criteria:

(1) there must be current motor and neurologic abnormalities evident on physical examination consistent with the diagnosis of Huntington's disease;
(2) neurological testing or psychiatric evaluation; or
(3) confirmed diagnostic imaging or genetic testing.

Any other neurological or psychiatric related causes are excluded.

The date of diagnosis is the date the diagnosis of Huntington's disease is made by a physician satisfying the policy definition above.

Infectious encephalitis
An acute infectious (viral, bacterial, or fungal) inflammation of the brain.

A physician must make the definite diagnosis of infectious encephalitis. This diagnosis must be supported by abnormalities of the cerebral spinal fluid or brain imaging consistent with the diagnosis. The encephalitis must have caused permanent objective neurological deficit that is evident on physical examination and present for more than 30 days.

The date of diagnosis is the date the diagnosis of encephalitis is made by a physician that satisfies the policy definition above.

Invasive cancer
A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. The term cancer includes leukemia, lymphoma, sarcoma, and Hodgkin's disease unless excluded below.

The following cancers are not considered invasive cancer and are excluded:

(1) all tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades), or intraepithelial neoplasia;
(2) any lesion described as Ta by the AJCC Staging System or as carcinoma in-situ classified as (Tis) by the AJCC Staging System;
(3) all non-melanoma skin cancers unless there are lymph node or distant metastases;
(4) prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis;
(5) any melanoma that is less than or equal to 1.0 mm in Breslow thickness, without lymph node or distant metastasis; and
(6) early thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

Invasive cancer must be diagnosed according to a pathological or clinical diagnosis. For purposes of invasive cancer, pathological diagnosis means a diagnosis on a pathology report of invasive cancer based on a microscopic study of fixed tissue or preparations from the blood system.

If a previously diagnosed non-invasive cancer becomes invasive locally or with metastases, the insured is eligible to receive the invasive cancer benefit (subject to all the other listed requirements).

A definite diagnosis must be done by a physician whose diagnosis of malignancy conforms to the standards set by the American College of Pathology. The diagnosis must be confirmed with a valid pathology report from a certified pathologist and a report from a physician.

For purposes of invasive cancer, clinical diagnosis means a diagnosis based on the study of symptoms and diagnostic test results.

We will accept a clinical diagnosis of invasive cancer only if all three (3) of the following conditions are met:

(1) a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
(2) there is medical evidence to support the diagnosis; and
(3) a report from a physician who is treating or advising the insured for invasive cancer.

The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of invasive cancer that satisfies the policy definition above.

Legionnaires' disease

Pneumonia caused by *Legionella* bacteria.

There must be the definite diagnosis by a physician of Legionnaire's disease that must be proven by the clear detection of the *Legionella* organism in the urine, sample of lung tissue, sputum, or respiratory secretions. The pneumonia must be of sufficient severity as to have required inpatient hospitalization.

The date of diagnosis is the date the diagnosis of Legionnaires' disease is made by a physician satisfying the policy definition above.

Loss of hearing

The bilateral and permanent loss of hearing such that sounds at or below 90 decibels cannot be heard at all frequencies.

A definite diagnosis must be made by a physician and supported by audiometric testing. The deafness must not be correctable by aides or surgical procedures.

The date of diagnosis is the date the diagnosis of hearing loss is made by a physician satisfying the definition above.

Loss of speech

The total and permanent loss of the ability to produce intelligible speech as a result of permanent damage to the larynx or its nerve supply from the speech centers of the brain.

It does not include loss of speech due to stroke, invasive cancer, or psychiatric causes. The loss of speech must not be correctable by aides or surgical procedures.

The date of diagnosis is the date the diagnosis of speech loss is made by a physician satisfying the definition above.

Major organ failure

The permanent and irreversible failure of bone marrow, heart, liver, lung, pancreas, or small or large intestine.

If an insured has multiple organ failures (example: heart and lung), only a single benefit will be paid.

For the above definition, the following is not covered:

(1) transplant of any other organs, parts of organs, tissues, or cells;
(2) stem cell injections for orthopedic conditions; and
(3) registration on a transplant waiting list as a donor.

The date of diagnosis is the date the insured is diagnosed with permanent and irreversible major organ failure, and a transplant is deemed necessary by a physician that satisfies the policy definition above.

Malaria
A disease caused by a parasite. A person becomes infected with the parasite after being bitten by an infected mosquito.

A physician must make the definite diagnosis of malaria. This diagnosis must be supported by:

(1) signs and symptoms presented during a physical examination with a physician; and
(2) a parasitological test confirming the present of the parasite in the blood.

The date of diagnosis is the date the diagnosis of malaria is made by a physician satisfying the policy definition above.

Metastatic cancer
The spread of cancer cells from an initial invasive primary site to a different or secondary site within the body. The initial invasive cancer must have been diagnosed prior to the effective date of your coverage. The metastasis must have been diagnosed while the group policy is active.

This benefit is payable once per lifetime.

This benefit is only payable if the insured has never had an initial invasive cancer benefit paid out under the group policy.

A definitive diagnosis of metastatic cancer must be made by a physician and supported by the following:

(1) laboratory testing;
(2) tumor biopsy; or
(3) diagnostic imaging (ultrasound, bone scan, CT scan, MRI, and/or PET scan).

This benefit is limited to one benefit payment per insured per lifetime.

The date of diagnosis is the date the diagnosis of metastatic cancer is made by a physician satisfying the policy definition above.

Multiple sclerosis (MS)
A diagnosis made by a physician of definite multiple sclerosis.

Both of the following two (2) criteria must be present:

(1) there must be current neurologic abnormalities evident on physical examination consistent with the diagnosis of clinically definite MS; and
(2) the diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, evoked visual responses, evoked auditory responses, or magnetic resonance imaging (MRI) showing evidence of lesions of the central nervous system.

The date of diagnosis is the date the diagnosis of multiple sclerosis is made by a physician satisfying the policy definition above.

Muscular dystrophy
A muscle disorder causing motor dysfunction.

A physician must make the definite diagnosis of muscular dystrophy based on clinically accepted tests at the time of claim. The disease must cause permanent muscle weakness evident on physical examination.

The date of diagnosis is the date the diagnosis of muscular dystrophy is made by a physician satisfying the policy definition above.

Myasthenia gravis
A chronic neuromuscular autoimmune disease characterized by fluctuating muscle weakness, double vision, and difficulty swallowing.

There must be a definite diagnosis by a physician of myasthenia gravis with confirmatory evidence of myasthenia such as the detection of antibodies to the neuromuscular junction (connection between the nerve and muscle) or abnormal electromyography (EMG).

The date of diagnosis is the date the diagnosis of myasthenia gravis is made by a physician satisfying the policy definition above.

Necrotizing fasciitis

A progressive, rapidly spreading infection located in the deep fascia causing necrosis of the subcutaneous tissues and muscle, requiring surgical debridement.

A definite diagnosis of necrotizing fasciitis must be made by a physician and the diagnosis must be supported with laboratory evidence of the presence of bacteria that is a known cause of necrotizing fasciitis.

The date of diagnosis is the date the diagnosis of necrotizing fasciitis is made by a physician satisfying the policy definition above.

Niemann-Pick disease

A disease that affects the body's ability to metabolize fat (cholesterol and lipids) within cells. This disease affects the brain, nerves, liver, spleen, bone marrow, and lungs.

Both of the following two (2) criteria must be present:

(1) there must be a diagnosis of either type A, type B, or type C Niemann-Pick disease by a physician; and
(2) diagnostic testing either through MRI or genetic testing confirming the diagnosis of Niemann-Pick disease.

The date of diagnosis is the date the diagnosis of Niemann-Pick disease is made by a physician satisfying the policy definition above.

Non-invasive cancer

A diagnosis of one of the four (4) cancers defined below.

(1) any lesion described as carcinoma in-situ (cancer which has not spread to neighboring tissue) and that is classified as (Tis) by the AJCC Staging System, of all organs except skin;
(2) early malignant prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason that is less than or equal to 6, without lymph node or distant metastasis;
(3) early malignant melanoma that is less than or equal to 1.0 mm in Breslow thickness, without lymph node or distant metastasis; or
(4) early malignant thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

The diagnosis must be diagnosed according to a pathological diagnosis. For purposes of non-invasive cancer, pathological diagnosis means a diagnosis on a pathology report of non-invasive cancer based on a microscopic study of fixed tissue or preparations from the blood system.

This type of diagnosis must be done by a physician whose diagnosis of malignancy conforms to the standards set by the American College of Pathology. The diagnosis must be confirmed with a valid pathology report from a certified pathologist and a report from a physician.

The following cancers are excluded:

(1) all tumors which are histologically described as benign, borderline, dysplasia (all grades), intraepithelial neoplasia, low malignant potential, non-malignant, pre-malignant;
(2) carcinoma in-situ of the skin;
(3) melanoma in-situ; and
(4) non-melanoma skin cancer.

The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of non-invasive cancer that satisfies the policy definition above.

Paralysis

Paralysis refers to the total, permanent, and irrevocable loss of movement.

This includes:

(1) quadriplegia: paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet).
(2) paraplegia: paralysis of both lower limbs (from the waist down including total paralysis of both feet).

(3) hemiplegia: paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body.

Paralysis must be permanent with support by appropriate neurological evidence and must be present for more than 90 days.

Paralysis due to stroke or psychiatric related causes is excluded.

The date of diagnosis is the date the diagnosis of paralysis is made by a physician satisfying the definition above.

Parkinson's disease

A definite diagnosis of idiopathic Parkinson's disease by a physician.

There must be supporting signs including resting tremor, rigidity, bradykinesia, or gait disturbance compatible with the diagnosis of idiopathic Parkinson's disease as assessed by a physician.

Drug-induced or toxic causes of Parkinson's are excluded.

The date of diagnosis is the date a physician diagnoses the insured with Parkinson's disease satisfying the policy definition above.

Phenylalanine hydroxylase deficiency

A disease in which the body is unable to properly process the amino acid phenylalanine due to a deficient enzyme called phenylalanine hydroxylase.

A clinical laboratory test must be collected from the insured with laboratory test results coming back positive for phenylalanine hydroxylase deficiency.

The date of diagnosis is the date the diagnosis of phenylalanine hydroxylase deficiency is made by a physician satisfying the policy definition above.

Poliomyelitis (Polio)

An acute infection caused by the polio virus that must result in paralysis that is evident by physical examination.

A definite diagnosis of poliomyelitis must be made by a physician and there must be laboratory confirmation of the polio virus as the cause for symptoms.

Post-polio syndrome which is the recurrence of paralysis years after the original infection has resolved is not covered under this definition.

The date of diagnosis is the date the diagnosis of poliomyelitis is made by a physician satisfying the policy definition above.

Pompe disease

A disease in which a complex sugar called glycogen builds up in the body's cells. The glycogen build is a result of an enzyme deficiency called acid alfa glucosidase (GAA), which breaks down complex sugars in the body. Buildup of complex sugars occurs in organs and tissues.

A physician must make the definite diagnosis of Pompe disease. This diagnosis must be supported by either blood samples, breathing tests, electromyography, MRI, heart studies, or sleep studies and confirmed with DNA testing.

The date of diagnosis is the date the diagnosis of Pompe disease is made by a physician satisfying the policy definition above.

Post-traumatic stress disorder (PTSD)

A diagnosis of PTSD by a physician that meets the diagnostic criteria for PTSD as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM).

Criteria include a combination of symptoms such as:

(1) intrusive thoughts;
(2) nightmares, flashbacks; and
(3) difficulty concentrating in response to a specific traumatic event.

The symptoms must last at least one month in duration and be of sufficient severity that counseling is recommended by a physician.

The date of diagnosis is the date the diagnosis of Post-traumatic stress disorder is made by a physician satisfying the definition above.

Rabies

An infectious disease caused by the rabies virus, transmitted by animal saliva, that results in multiple neurologic and other physical abnormalities.

There must be a definite diagnosis by a physician of rabies with diagnostic laboratory evidence of the rabies virus.

The date of diagnosis is the date the diagnosis of rabies is made by a physician satisfying the policy definition above.

Severe burns

The diagnosis by a physician that at least 20% of the body surface area has sustained third degree burns involving the full thickness of the skin.

The date of diagnosis is the date the diagnosis of severe burns is made by a physician satisfying the definition above.

Severe Lyme disease

A disease caused by being bitten by a tick that is a carrier of the borrelia bacteria.

All of the following criteria must be present:

(1) there must be a definite diagnosis of Lyme disease by a physician; and
(2) laboratory testing presenting disease fighting antibodies to the bacteria; and
(3) one or more of the following complications due to Lyme disease
    - Neurological, such as meningitis
    - Carditis (inflammation of the heart)
    - Arthritis indicated by joint swelling, warmth, and tenderness on exam and elevated ESR and CRP inflammatory markers

The date of diagnosis is the date the diagnosis of Lyme disease is made by a physician satisfying the definition above.

Sickle cell anemia

An inherited blood disorder of hemoglobin production that results in abnormally shaped (sickled) red blood cells, leading to multiple symptoms such as pain, fatigue, frequent infections, and delayed growth.

A physician must make the definite diagnosis of sickle cell anemia. Sickle cell anemia does not mean sickle cell trait (asymptomatic carriers of a single abnormal hemoglobin gene) and any other disorder of hemoglobin production is not covered under this definition.

The date of diagnosis is the date the diagnosis of sickle cell anemia is first confirmed by a physician satisfying the policy definition above.

Skin cancer (non-melanoma and carcinoma in-situ of the skin)

A diagnosis of one of the two (2) cancers listed below.

(1) carcinoma in-situ of the skin (melanoma in-situ or non-melanoma in-situ); or
(2) non-melanoma skin cancer.

The diagnosis must be confirmed with a valid pathology report from a certified pathologist and a report from a physician, or, where appropriate, by a suitable clinical diagnosis.

All lesions which are histologically described as benign, non-malignant, pre-malignant, dysplasia, or atypical moles are not considered skin cancer (non-melanoma and carcinoma in-situ of the skin).

The date of diagnosis is the date of biopsy or other pathological test, or the date of an appropriate clinical diagnosis that generates a diagnosis of cancer that satisfies the policy definition above.

Spina bifida
A malformation resulting in a protrusion of the meninges through an opening in the spinal canal (meningocele) or the protrusion of the spinal cord and nerves through an opening in the bones of the spinal cord (myelomeningocele).

A physician must make a definite diagnosis of spina bifida. Spina bifida occulta, which is a simple opening in the backbone covered by skin and without neurologic impairment, is not covered under this definition.

The date of diagnosis is the date the diagnosis of spina bifida is first confirmed by a physician after live birth satisfying the policy definition above.

Stroke
A cerebrovascular incident resulting in permanent death of brain tissue due to intracranial hemorrhage or cerebral infarction due to embolism or thrombosis in an intracranial vessel.

This event must result in permanent neurological deficit with persisting clinical signs and symptoms evidenced on physical examination by a physician at least 30 days after the event. The diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new stroke.

The following are excluded:

(1) asymptomatic silent stroke found on imaging;
(2) disorders of the blood vessels affecting the eye including infarction of the optic nerve or retina;
(3) ischemic disorders of the peripheral vestibular system; and
(4) transient ischemic attacks (TIA) or reversible ischemic neurologic deficit (RIND).

The date of diagnosis is the date of stroke, as confirmed by neurological evidence that satisfies the policy definition above.

Sudden cardiac arrest
The sudden loss of heart pumping function due to malfunction of the electrical system of the heart.

There must be a definite diagnosis by a physician of sudden cardiac arrest that must be evidenced by a disturbance in heart rhythm (arrhythmia) leading to absence of pulse, abnormal breathing, and loss of consciousness.

Sudden cardiac arrest does not mean heart attack (myocardial infarction) and in the event that heart attack, and sudden cardiac arrest occur within 48 hours of each other, the greater of the two benefits will be paid. If the benefit amount for the covered conditions is the same, you can choose the covered condition benefit to be paid.

The date of diagnosis is the date of the sudden cardiac arrest that satisfies the policy definition above.

Systemic lupus erythematosus (nephritis & cerebritis)
A definite diagnosis of systemic lupus erythematosus (SLE) made by a physician and based on clinically accepted criteria.

There must also be evidence of lupus cerebritis or lupus nephritis where one (1) of the following is present:

(1) lupus nephritis that has caused significant permanent impairment of kidney function as evidenced by a calculated glomerular filtration rate of less than 30 ml/min, as measured on two occasions, one month apart; or
(2) lupus cerebritis that has caused permanent neurological deficit with persisting clinical signs and symptoms that are present for at least 90 days.

Headaches and psychiatric abnormalities are not considered under this definition as evidence of permanent neurological deficit with persisting clinical signs and symptoms.

Discoid lupus and medication induced lupus are excluded.

The date of diagnosis is the date the diagnosis of systemic lupus erythematosus is made by a physician satisfying the policy definition above.

Systemic sclerosis (scleroderma)
A systemic connective tissue disease causing progressive diffuse fibrosis in the skin, blood vessels, and visceral organs.

A physician must make the definite diagnosis of systemic sclerosis. This diagnosis must be supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs, or kidneys.

The following are excluded:

(1) eosinophilic fasciitis; and
(2) localized scleroderma (linear scleroderma or morphea).

The date of diagnosis is the date the diagnosis of systemic sclerosis is made by a physician satisfying the policy definition above.

Tay-Sachs disease

A disorder caused by the absence of an enzyme that helps break down fatty substances. The fatty substance called gangliosides builds up toxic levels in the brain and spinal cord which affects the function of the nerve cells.

A physician must make a definite diagnosis of Tay-Sachs disease. This diagnosis must be supported by:

(1) signs and symptoms presented during a physical examination with a physician;
(2) a diagnostic blood test identifying low or absence levels of the enzyme hexosaminidase;
(3) an eye examination performed by a physician showing a cherry-red spot in the back of the eye.

The date of diagnosis is the date the diagnosis of Tay-Sachs disease is made by a physician that satisfies the policy definition above.

Tetanus

A disease of the nervous system caused by a toxin producing bacterium called Clostridium tetani which causes the muscles in the jaw and neck to contract. Tetanus is commonly known as “lockjaw”.

A definite diagnosis of tetanus must be made by a physician and be supported by physical examination, medical and vaccination history, and the signs and symptoms of muscle spasms, rigidity, and pain.

The date of diagnosis is the date the diagnosis of tetanus is made by a physician satisfying the policy definition above.

Transient ischemic attack (TIA)

The diagnosis of a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia, without acute infarction.

A definite diagnosis of TIA must be made by a physician in a hospital setting and must be consistent with the diagnosis of a transient ischemic attack (TIA). There must be a complete resolution of symptoms within 24 hours in the absence of any radiological evidence of stroke.

Transient ischemic attack (TIA) does not mean stroke and in the event that both transient ischemic attack (TIA) and stroke occur within 48 hours of each other, the greater of the two benefits will be paid. If the benefit amount for both covered conditions is the same, you can choose the covered condition benefit to be paid.

The date of diagnosis is the date the diagnosis of transient ischemic attacks (TIA) made by a physician satisfying the policy definition above.

Tuberculosis

A disease caused by a bacterium called Mycobacterium tuberculosis.

There must be a definite diagnosis by a physician of tuberculosis and must be supported by physical examination findings and positive laboratory testing or diagnostic imaging such as X-ray or CT scan. The diagnosis must be active Tuberculosis and not latent.

The date of diagnosis is the date the diagnosis of tuberculosis made by a physician satisfying the policy definition above.

Type 1 diabetes

A chronic autoimmune condition that develops primarily in children in which the cells of the pancreas are destroyed, resulting in the daily requirement of insulin treatment from the time of diagnosis.

There must be a definite diagnosis by a physician of type 1 diabetes. Type 1 diabetes does not mean type 2 diabetes.

The date of diagnosis is the date the diagnosis of type 1 diabetes is made by a physician satisfying the policy definition above.

Type 2 diabetes
A condition that results in an impairment in the way the body regulates and uses sugar (glucose) as a fuel, resulting in too much sugar circulating in the blood stream.

There must be a definite diagnosis by a physician and a confirmatory A1C result at a level as defined by the American Diabetes Association.

The following are excluded:

(1) gestational diabetes
(2) pre-diabetes
(3) type 1 diabetes

The date of diagnosis is the date the diagnosis of type 2 diabetes is made by a physician satisfying the policy definition above.

Zellweger syndrome
The most serious disorder within the Zellweger spectrum disorder causing serious problems with cellular metabolism.

There must be a definite diagnosis by a physician of Zellweger syndrome and must be supported by physical examination findings and positive laboratory testing, diagnostic imaging such as ultrasound or MRI, or genetic testing confirming the presence of the mutated PEX genes.

Other Zellweger spectrum disorders are excluded (adrenoleukodystrophy (NALD) & Refsum (IRD) disease).

The date of diagnosis is the date the diagnosis of Zellweger syndrome is made by a physician satisfying the policy definition above.

RELATED COVERED BENEFIT DEFINITIONS

Family care
A family care benefit as shown in the Related Covered Benefits section may be payable for each day the insured receives care or treatment in a hospital or treatment facility for a covered critical illness condition and the insured's child is provided child care for the same day. Children must be under age 13. Children age 13 or older are eligible if mentally or physically disabled.

The child for which child care is provided does not need to be insured under this certificate.

Child care refers to professional care by a licensed provider who charges a fee for the care of children. The term does not include child care provided by a family member.

This benefit is limited to one benefit per child per day for up to 30 days per payable covered critical illness condition. This is subject to a combined maximum of 75 benefits for all children per payable covered critical illness condition. If both you and your spouse are insured under this certificate, only one family care benefit claim will be paid per child. Proof must be provided that child care expenses were incurred for each day the benefit is payable.

Infertility treatment
An infertility treatment benefit as shown in the Related Covered Benefits section may be payable for treatment received for infertility. A physician must confirm the root cause of infertility with a diagnostic procedure that affirms the underlining cause of infertility. Covered diagnostic procedures include the following as recommended and performed by a physician:

- diagnostic laparoscopy;
- endometrial biopsy;
- hamster egg penetration assay;
- hormone evaluation;
- Huhner's test;
- Hysterosalpingogram;
- Hysteroscopy;
- imaging related to reproductive testing;
- laparoscopy;

- ovarian reserve testing;
- semen analysis; or
- testicular biopsy.

This benefit is not available to an insured who has undergone a voluntary procedure resulting in sterilization (vasectomy, tubal ligation, hysterectomy, etc.).

An insured must undergo one of the following fertility treatments as recommended and performed by a physician.

- Tier 1 – Medicines such as clomifene, tamoxifen, metformin, gonadotrophins, gonadotrophin-releasing hormone and dopamine agonists, artificial insemination (AI), and other medicines prescribed by a physician to improve fertility.
- Tier 2 – Surgical procedures such as fallopian tube surgery, endometriosis surgery, laparoscopic surgery, laparoscopic ovarian drilling, submucosal fibroid removal, epididymis blockage correction surgery or similar surgical procedures as recommended by a physician to improve fertility.
- Tier 3 – The following assisted conception procedures:
    - donor egg implantation
    - in vitro fertilization (IVF), including natural cycle IVF

This benefit is payable once per lifetime for an insured diagnosed with infertility. If an insured requires more than one tier to be paid, we will pay the amount equal to the highest eligible tier.

Outpatient mental health and substance use disorder diagnostic screening

If an insured receives an outpatient mental health or substance use disorder diagnostic screening listed below, we will pay the outpatient mental health and substance use disorder diagnostic screening benefit shown in the Related Covered Benefits section. For purposes of this benefit, care received through telemedicine meets the benefit description of an outpatient mental health and substance use disorder diagnostic screening.

Diagnostic screenings must be administered by a physician.

The following screenings or their equivalent are included:

(1) Depression Screening
- Patient Health Questionnaire (PHQ-9)

(1) Substance Use Disorder Screening
- Alcohol Use Disorders Identification Test (AUDIT)
- Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS)
- Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)
- Screening to Brief Intervention (S2BI)
- CAGE AID
- Drug Abuse Screen Test (DAST-10)

(2) Bipolar Disorder Screening
- Mood Disorder Questionnaire (MDQ)

(3) Suicide Risk Screening
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

(4) Anxiety Disorders Screening
- Generalized Anxiety Disorder (GAD-7)
- Primary Care PTSD Screen (PC-PTSD)

(5) Attention Deficit Hyperactive Disorder (ADHD) - This benefit only applies to insured children.
- DIVA 2.0
- Conners' Adult ADHD rating scale (CAARS)
- Adult ADHD Self Report Scale (ARS)
- Behavioral Assessment System for Children (BASC)
- Vanderbilt Assessment Scale
- The Conners' Rating Scale
- Child Attention Profile (CAP)

(6) Autism - This benefit only applies to insured children.
- Diagnostic Interview-Revised (ADI-R)
- Diagnostic Observation Schedule-2nd (ADOS-2)

- Childhood Autism Rating Scale 2nd Addition (CARS-2)

(7) Schizophrenia
- Schizophrenia must be evaluated by a psychiatrist

(8) Trauma Screening
- Life Event Checklist (LEC)
- PTSD Checklist – Civilian Version (PCL-C)

This benefit is limited to one benefit per insured per lifetime.

EXCLUSIONS

In no event will we pay benefits where the insured's covered condition is caused directly or indirectly by, results in whole or in part from, or for which there is contribution from any of the following:

(1) intentionally self-inflicted injury, self-destruction, or autoeroticism, while sane;
(2) suicide or attempted suicide, while sane;
(3) the insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto;
(4) the insured's use of alcohol;
(5) the insured's use of prescription drugs, non-prescription drugs, or medications unless taken or used as prescribed by a physician or as directed by the manufacturer, illegal drugs, as well as intentional or voluntary inhalation of poisons, gases, fumes, or other substances taken, absorbed, ingested, or injected;
(6) motor vehicle collision or accident where the insured is the operator of the motor vehicle and the insured's blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
(7) war or any act of war, whether declared or undeclared.

Benefits are not payable for any care, treatment, or diagnostic measures which were received outside of the United States or United States Territories.

CERTIFICATE TERMINATION

Your coverage ends on the earliest of the following:

(1) the last day of the month in which you no longer meet the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium which is not paid; or
(3) the last day for which premium contributions have been paid following your request to cancel your coverage; or
(4) the date the group policy ends, unless coverage is continued according to the terms of the Portability Benefit.

Your insured dependent's coverage ends on the earliest of the following:

(1) the last day of the month in which the dependent no longer meets the eligibility requirements; or
(2) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(3) the last day for which premium contributions have been paid following your written request that insurance on your eligible dependents be terminated; or
(4) the date you are no longer covered under the group policy, unless the dependent's coverage is continued according to the terms of the Portability Benefit.

You must notify us or your employer when you no longer have dependents eligible for coverage under this certificate so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this certificate will be refunded without any payment of claim.

ADDITIONAL BENEFITS

If you are insured under the provisions applicable to critical illness insurance coverage under this certificate you are eligible for insurance under the following Additional Benefits below. In addition, your spouse, your dependent children, or your dependent parent are eligible if they are insured under this certificate. Insurance under these Additional Benefits become effective on the date you, your spouse, your dependent child, or dependent parent becomes insured under this certificate as outlined in the Certificate Specification section. Coverage under these Additional Benefits are subject to all terms, conditions, exclusions, limitations, and provisions of this certificate unless otherwise expressly provided for herein.

Dependent Parent Benefit

The Dependent Parent Benefit provides dependent parent coverage. The payable amount of the dependent parent benefit is shown in the Plan of Insurance – Additional Benefits section of this certificate. We will pay the benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form that a dependent parent suffered a critical illness. Benefits will be paid according to the Claims section of the certificate.

Benefits

All covered benefits listed in the Covered Critical Illness Conditions section applicable to you are covered under the Dependent Parent Benefit. Dependent Parent Benefits are limited to only the covered critical illness conditions expressly stated below.

Covered Critical Illness Conditions

Addison's disease*
Alzheimer's disease*
Amyotrophic lateral sclerosis (ALS) and other motor neuron disease*
Aneurysm
Autism spectrum disorder*
Bacterial meningitis
Benign brain tumor
Blindness*
Cerebral palsy*
Cleft lip or cleft palate needing surgery*
Coma
Coronary artery disease needing surgery or angioplasty
COVID-19 disease of specified severity
Creutzfeldt-Jakob disease/progressive multifocal leukoencephalopathy*
Cystic fibrosis*
Diphtheria
Down syndrome*
End Stage Renal disease (kidney failure)
Gaucher disease (type II or III)*
Glycogen storage disease (type IV)*
Heart attack
Huntington's disease*
Infectious encephalitis
Invasive cancer
Legionnaires' disease
Loss of hearing*
Loss of speech*
Major organ failure
Malaria
Metastatic cancer*
Multiple sclerosis*
Muscular dystrophy*
Myasthenia gravis*
Necrotizing fasciitis
Niemann-Pick disease*
Non-invasive cancer
Paralysis
Parkinson's disease*
Phenylalanine hydroxylase deficiency*
Poliomyelitis (Polio)*
Pompe disease*
Post-traumatic stress disorder (PTSD)*
Rabies*
Severe burns
Severe Lyme disease*
Sickle cell anemia*
Skin cancer (non-melanoma and carcinoma in-situ of the skin)
Spina bifida*
Stroke
Sudden cardiac arrest
Systemic lupus erythematosus (nephritis & cerebritis)*
Systemic sclerosis (scleroderma)*
Tay-Sachs*
Tetanus
Transient ischemic attacks (TIA)
Tuberculosis
Type 1 diabetes*
Type 2 diabetes*
Zellweger syndrome*

*****Not all benefits are medically able to meet the definition of recurrence, including Addison's disease, Alzheimer's disease, Amyotrophic lateral sclerosis (ALS) and other motor neuron diseases, Autism spectrum disorder, Blindness, Cerebral palsy, Cleft lip or cleft palate needing surgery, Creutzfeldt Jakob disease/progressive multifocal leukoencephalopathy, Cystic fibrosis, Down syndrome, Gaucher disease (type II or III), Glycogen storage disease (type IV), Huntington's disease, Loss of hearing, Loss of speech, Metastatic cancer, Multiple sclerosis, Muscular dystrophy, Myasthenia gravis, Niemann-Pick disease, Parkinson's disease, Phenylalanine hydroxylase deficiency, Poliomyelitis (polio), Pompe disease, Post-traumatic stress disorder (PTSD), Rabies, Severe Lyme disease, Sickle cell anemia, Spina bifida, Systemic lupus erythematosus (nephritis & cerebritis), Systemic sclerosis (scleroderma), Tay-Sachs disease, Type 1 diabetes, Type 2 diabetes and Zellweger syndrome.

Related Covered Benefits

Family Care
Infertility treatment
Outpatient mental health and substance use disorder diagnostic screening

Refer to the Plan of Insurance section for the covered critical illness condition amounts.

Eligibility

A dependent parent is a parent who satisfies one of the following:

(1) is claimed as a dependent on IRS income tax forms; or
(2) is financially dependent on you for more than half of their out-of-pocket support costs, including, but not limited to, food, housing, clothing, and medical services.

Evidence of insurability is not required for Dependent Parents.

A parent is a biological parent, stepparent, or adoptive parent of you or your spouse. The parent must reside in the United States.

If a dependent parent is otherwise eligible under the policy, or is insured under the portability benefit, they are not eligible as a dependent parent. Only one person can insure an eligible dependent parent.

Any dependent parent who, subsequent to the effective date of your dependent parent coverage, meets the eligibility requirements will become insured on the date they so qualify. A dependent parent claim may only be filed under one insured employee.

Additional Information

No other Additional Benefits within this certificate apply to insured dependent parents.

Termination

Insurance continued under this benefit will terminate on the earliest of the following:

(1) the last day of the month in which the dependent parent no longer meets the eligibility requirements;
(2) the date requested by the policyholder to cancel the dependent parent coverage for its plan; or
(3) the terminating events outlined in the Certificate Termination section.

Health and Wellness Benefit

This benefit provides for an additional benefit to be paid to you if you, your covered spouse, or your covered child, undergo one of the health and wellness activities listed below while not in a hospital on an inpatient basis. The payable amount of the Health and Wellness Benefit is shown in the Plan of Insurance – Additional Benefits section of the certificate. We will pay the benefit after receipt at our home office of proofsatisfactory to us that you, your covered spouse, or your covered child, have undergone one of the covered screenings or preventive cares listed in this benefit. The benefit will be paid in a single sum. Benefits will be paid according to the Claims section of the certificate.

Wellness screenings or Preventive care

- annual physical exam;
- mental health screening recommended and performed by a physician;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- BRCA1/BRCA2 genetic testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- CA 15-3 breast cancer test;
- CA 125 ovarian cancer test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing exam;
- hemoccult stool specimen;
- hemoglobin A1C;
- herpes simplex virus (HSV) test;
- human papillomavirus (HPV) test;
- lipid panel;
- lung cancer CT;
- mammogram;
- non-diagnostic vascular screening;
- nucleic acid test (NAT);
- oral cancer screening;
- pandemic testing (excluding at home testing);

- carotid Doppler;
- CEA colon cancer test;
- chest x-ray;
- clinical testicular exam;
- colonoscopy;
- dental exam;
- digital rectal exam (DRE);
- DNA stool analysis;
- doppler screening for cancer;
- doppler screening for peripheral vascular disease;
- double-contrast barium enema;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- pap smears or thin prep pap test;
- pharmacologic stress testing;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STI's);
- thermography;
- two-hour post-load plasma glucose test;
- ultrasounds;
- urinalysis;
- vaccinations approved by the FDA; or
- virtual colonoscopy.

Employer sponsored wellness screening or preventive care benefits conducted at the employer's place of business are not eligible for payment.

Benefit Limitations
You, your spouse, and each child, can receive one Health and Wellness Benefit per year**.**

Termination
Insurance continued under this benefit will terminate on the earliest of the following:

(1) the date requested by the policyholder to cancel the health and wellness coverage for its plan; or
(2) the terminating events outlined in the Certificate Termination section.

Portability Benefit

This benefit provides for continuation of insurance if an insured no longer meets the eligibility requirements of the certificate, except as provided for herein.

To continue insurance under this benefit, an insured must make a written request and make the first premium payment within 31 days after insurance provided by the group policy would otherwise terminate. Evidence of insurability will not be required. Coverage will remain in effect during the 31 day election period but not beyond this unless all continuation requirements are met. Upon satisfactory completion of all portability election requirements, coverage provided by this benefit will then be deemed effective retroactive to the beginning of the 31 day period. This date is considered to be the insured's portability date and the insured then is considered to have portability status.

If you elect to continue your own coverage according to the provisions of this benefit, you may elect to continue insurance for any other individual insured under your certificate. If your former spouse continues their own coverage they may elect to continue insurance on any insured children, provided you are not otherwise insuring the children. Benefits will be paid according to the Claims section of the certificate.

Eligibility
You are eligible to continue group critical illness insurance under the terms of this benefit if you no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or on a leave or layoff;
(4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy; or
(5) termination of the group policy where there is no successor plan for the group policy. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy.

Your dependents are eligible to continue group critical illness insurance under this benefit if they no longer meet the eligibility requirements due to any of the following:

(1) your termination of employment, including retirement;
(2) your number of working hours are reduced;
(3) you are no longer in a class eligible for insurance or on a leave or layoff;
(4) a class or group of employees insured under the policy are no longer considered eligible and there is no successor plan for that class or group. Successor plan means an insurance policy or policies provided by us or another insurer that replaces insurance provided under the policy;
(5) legal separation or divorce;
(6) the dependent ceases to be an eligible dependent; or
(7) your death.

Regardless of whether an insured is otherwise eligible under this benefit to continue, an insured will not be eligible to request coverage under this benefit if they:

(1) have attained age 120;
(2) are an employee and were not actively at work due to illness or injury on the date immediately preceding the portability date;
(3) lose eligibility due to a class or group of employees no longer being eligible under the policy and there is a successor plan for that class or group of employees;
(4) lose eligibility due to termination of the group policy unless there is no successor plan; or
(5) do not reside in the United States or United States Territory.

If an insured is continuing coverage under the terms of this benefit, and again meets the eligibility requirements of the plan the insured shall no longer be considered to have portability status. Insurance may be continued only under the terms of the certificate, not including this benefit, unless and until the insured no longer meets the eligibility requirements of the plan and again returns to portability status as provided for herein.

Benefit Amounts
The benefit amounts that can be continued under this additional benefit shall be the amounts shown on the Plan of Insurance section applicable to the insured based on the benefit plan selected by you.

An insured employee and a dependent who ports coverage on their own as provided under the terms of this Additional Benefit may change the benefit plan to one that provides a lower benefit amount but may not change the benefit plan to one that provides a higher benefit amount.

Additional Benefits
All Additional Benefits will terminate upon porting.

Premiums
Premiums will be paid directly to us on a monthly, quarterly, semi-annual, or annual basis and will be subject to an administrative charge per billing period.

The premium rates for ported coverage may be different than the premium rates for active employees and are not subject to the premium rate provision of the policy.

Termination
Anything in the group policy notwithstanding, termination of the group policy by the policyholder or us will not terminate critical illness insurance for any person with coverage under the terms of this benefit. The group policy will remain in force solely for the purpose of continuing such insurance. No individual may elect coverage under this benefit on or after the date of termination of the group policy unless there is no successor plan.

Any insurance continued under the terms of this benefit will remain in force until terminated.

An insured's Insurance continued under this benefit will remain in force until terminated on the earliest of the following:

(1) the insured's 120th birthday;
(2) the date the insured again meets the eligibility requirements of the certificate, not including the terms of this benefit;

(3) in the case of a dependent spouse or child the date your coverage is no longer being continued under this benefit or the date the spouse or child ceases to be eligible as defined under the terms of your plan, unless the spouse or child has ported coverage on their own as provided for under the terms of this benefit;
(4) 31 days after the due date of any premium contribution which is not made;
(5) 31 days after we give written notice of our intent to terminate ported coverage for a group or class of individuals; or
(6) the date the insured requests to terminate their coverage being continued under this benefit.

Premiums

Premium due date
Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a periodic basis.

Premium determination
The premium will be the applicable premium rate in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Grace period
The group policy has a 31 day grace period after the first premium. If a premium is not paid on or before the date it is due, that premium may be paid during the 31 day period following the due date. The insurance under the group policy will remain in effect during the 31 day grace period.

Reinstatement
If coverage terminates due to non-payment of premium, it may be reinstated.

Reinstatement must occur while the insured is living and within 6 months from the date of coverage termination. To reinstate, all back due premiums must be paid. After all back due premiums are paid, your coverage will be reinstated as if there were no lapse in coverage. Any loss that occurred during the lapse period will be covered.

Claims

We are providing notice that Securian Financial Group, Inc. is subject to economic and trade sanctions, laws, and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control (OFAC), prevent Securian Financial Group, Inc. from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

Notice of claim
Written notice of claim must be given to us within 365 days of the date of a loss, or as soon thereafter as reasonably possible. Failure to give notice within this time will not invalidate or reduce a claim if it was not reasonably possible to provide such notice and that notice was given as soon as reasonably possible. Notice given by or on the insured's behalf to us at our home office or to any authorized agent of ours, with information to identify the insured, shall be deemed notice to us.

Claim forms
Upon receipt of notice of claim, we will provide a claim form. If the claim form is not provided within 15 days after the insured has given notice of claim, we will deem the insured to have complied with the requirements for filing proof of a loss if the insured submits, within the time period for filing proof of the loss, written proof of the occurrence, character, and extent of the loss for which claim is made.

Proof of loss
Written proof of a loss satisfactory to us must be provided to us within 180 days of the date of the loss or as soon as reasonably possible. Failure to provide proof of the loss within this time will not invalidate or reduce a claim if it was not reasonably possible to provide proof within this 180 day period. However, proof must be provided within 15 months of the date of the loss, except in the absence of legal capacity.

Physical examination and autopsy
After an insured has filed a claim and provided at their expense all requested claim forms and records, we have the right to have the insured examined by a physician of our choice and at our expense. This right may be exercised as often as reasonably necessary while an insured has a claim pending with us.

We, at our own expense, may reasonably require during the pendency of a claim an autopsy in case of death, where it is not forbidden by law.

Payment of claims
We will pay a benefit for a loss within 30 days after receipt at our home office of written proof of the loss which meets all policy requirements and is satisfactory to us. All benefits including dependent's benefits will be paid to you, if you are living. This benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. You are responsible for all costs associated with claim form(s) completion, records, and the submission of your claim.

Recovery of overpayment
We have the right to recover from you or the recipient of benefits, any benefit amount paid that we determine to be an overpayment under this certificate. You or the recipient of benefits has the obligation to refund to us any amount of overpayment.

If benefits are overpaid on any claim, you or the recipient of benefits must refund us within 90 days. If the refund is not made in a timely manner, we have the right to offset future benefits payable under this certificate by an amount equal to the overpayment. The right to request a refund of an overpayment is limited to 12 months from the date we paid the claim except in cases of fraud or misrepresentation by a health care provider.

Beneficiary
If you die before the claim is paid, benefits will be paid to your estate.

ADDITIONAL INFORMATION

Changes to policy or certificate
We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Contestability
If an insured experiences a loss within two years of the original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided during the application process. If we discover a material misrepresentation, the affected coverage will be rescinded and an otherwise valid claim will be denied. This two-year period will be extended by fraud or as otherwise allowed by applicable laws.

Maintaining records
The policyholder is required to maintain adequate records of any information necessary for us to administer the policy and shall provide access to such records when required for us to administer the policy. If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance.

Clerical or administrative errors
If a clerical or administrative error is made in keeping records on or administering the insurance under this certificate, it will not affect otherwise valid insurance.

A clerical or administrative error, however, does not continue insurance which is otherwise stopped, make insurance effective when it should not have been, or change the benefit amount provided by the provisions of the policy and no claim shall be paid on amounts put into effect as a result of a clerical or administrative error. If an error causes a change in premium payment, a fair adjustment will be made.

Misstatement of Age
If an insured's age has been misstated, all amounts payable will be adjusted to that amount which the premium would have purchased at the correct age. This will be determined by applying the ratio of the paid premium over the required premium to the initial benefit amount.

Assignment
Insurance coverage under the group policy cannot be assigned.

Conformity of state laws

The provisions of this certificate will conform to state law. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the applicable laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

SUMMARY CONCERNING COVERAGE, LIMITATIONS, AND EXCLUSIONS UNDER THE ALASKA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not limited. 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 a portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;
- a credit given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

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

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

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

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

Alaska Life and Health Insurance Guaranty Association
PO 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

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

This notice is to advise you that should any questions arise regarding this insurance, you may contact the following:

Securian Life Insurance Company
Group Division
400 Robert Street North
St. Paul, Minnesota 55101-2098
TEL: 651-665-3500

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy 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 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 Avenue
Little Rock, AR 72201

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

The state law that provides for this safety-net coverage 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 anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

California Contact Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

IT IS IMPORTANT TO US THAT YOU ARE SATISFIED WITH THIS POLICY AND THE SERVICE YOU RECEIVE FROM US.

IF YOU HAVE AN UNRESOLVED COMPLAINT, THE CALIFORNIA INSURANCE DEPARTMENT SUGGESTS THAT YOU NOTIFY THEIR CONSUMER AFFAIRS OFFICE. CONTACT SHOULD BE MADE ONLY AFTER COMMUNICATIONS BETWEEN YOU AND US (THE AGENT OR OTHER REPRESENTATIVE) HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM.

CONTACT: YOUR AGENT
OR
SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST. PAUL, MN 55101-2098
651-665-3500

QUESTIONS ABOUT THIS NOTICE OR ANY UNRESOLVED COMPLAINT MAY BE DIRECTED TO:

DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS DEPARTMENT
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
213-897-8921

TOLL FREE TELEPHONE FOR CALIFORNIA ONLY:
800-927-4357

OFFICE HOURS: 9 AM TO 5 PM

THIS NOTICE PROVIDES CONTACT INFORMATION ONLY AND IS NOT A CONDITION OF THE POLICY.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 coverage, 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 right or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

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

Amounts of Coverage

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

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

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

  - **Life Insurance**

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

  - **Annuities and Structured Settlement Annuities**

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

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

- **Health Insurance**

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If a 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 Medicate 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 coverage provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

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

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 and withdrawal values

Health Insurance

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

Annuities

- $250,000 in withdrawal and cash values

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
Robert S. Kerr Avenue, Suite 600
Oklahoma City, OK 73102
1-800-337-7796

Colorado Division of Insurance
1560 Broadway, Suite 201
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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

DISTRICT OF COLUMBIA
LIFE & HEALTH INSURANCE GUARANTY
ASSOCIATION ACT OF 1992
Summary Of General Purposes And
Current Limitations Of Coverage

Residents of the District of Columbia should know that licensed insurers or health maintenance organizations who sell health benefit plans, disability income insurance, long-term care 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 subject to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep the coverage in-force, with no change in contractual rights or benefits.

COVERAGE

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

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

COVERAGE LIMITATIONS

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

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

- With respect to any one life, regardless of the number of policies, contracts, or certificates:

  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term care insurance benefits;
  - $300,000 for disability income insurance benefits;
  - $500,000 for health benefit plans;
  - $100,000 for coverage 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.

In no event (except in the event of health benefit plans in which the Guaranty Association is liable for no more than $500,000), is the Guaranty Association liable for more than $300,000 in benefits with respect to any one life.

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

EXCLUSIONS EXAMPLES

Policy or contract holders are not protected by this 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 law protects insureds who live outside of that state); or
- their insurer was not authorized to do business in the District of Columbia at the time the policy or contract was issued; 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, or a risk retention group.

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;
- 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 either:

District of Columbia
Department of Insurance, Securities and Banking
(T) 202-727-8000
disb.dc.gov

District of Columbia Life and Health
Insurance Guaranty Association
(T) 410-248-0407
www.dclifega.org

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

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

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

If you have any questions regarding your coverage, or if you need assistance in resolving a complaint, you can contact us at:

Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098

Telephone Number: 651-665-3500
Business hours 7am - 5pm Central Time Monday - Friday

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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
PO Box 3614
Honolulu, Hawaii 96811

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Iowa law, 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 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 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 excluded 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 1300
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 supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

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

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

This notice is required by the Illinois Religious Freedom Protection and Civil Union Act ("the Act"). Effective June 1, 2011 Securian Life Insurance Company is required to comply with the Act. We have implemented policies and procedures to comply with the Act.

You should be aware that the Act:

- Creates a legal relationship between two persons of the same or opposite sex who form a civil union. According to the Act, parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by laws of Illinois to spouses.

- Provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon.

- Requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

- Does not alter any current federal law.

For more information about existing Illinois law and the Act, please refer to the Consumer Fact Sheet available at the Illinois Department of Insurance website at www.insurance.illinois.gov.

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

This notice is to advise you that should any complaints arise regarding this Insurance, you may contact the following:

Securian Life Insurance Company

400 Robert Street North

St. Paul, Minnesota 55101-2098

TEL: 651-665-3500

OR

Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

You may also contact the Illinois Department of Insurance at http://insurance.illinois.gov/ 312-814-2420 or 217-782-4515.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 taken over by its Insurance Department. 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 insolvency are:

Life Insurance

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

Health Insurance

- $500,000 for health benefit plan benefits*
- $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(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 residency requirements and other limitations under Illinois 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.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.

Contact Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

Questions regarding your policy or coverage should be directed to:

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Telephone: 651-665-3500

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

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hot Line:	800-622-4461
In the Indianapolis Area:	317-232-2395

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to companies placed in rehabilitation or liquidation on or after July 1, 2018.

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

- Health Insurance
  - $500,000 in health benefit plans (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 a 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 and 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 West 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. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

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

Disclaimer

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 OR 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 MAY HAVE REGARDING THIS DOCUMENT.

KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
534 South Kansas Avenue, Suite 1410
Topeka, KS 66603

KANSAS INSURANCE DEPARTMENT
1300 SW Arrowhead Road
Topeka, KS 66604

This is a brief summary of the Kansas Life and Health Guaranty Association ("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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 (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 should happen, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

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

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

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

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

Louisiana Life and Health
Insurance Guaranty Association
PO Box 3337
Baton Rouge, Louisiana 70821

Louisiana Department of Insurance
PO 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 Act or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a direct, non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these or an unallocated annuity contract issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are 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 direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, is not protected by LLHIGA, if:

(1) 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 profit or non-profit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

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

(a) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
(b) 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 of life insurance.
(c) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and 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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This Notice provides a brief summary of the Maryland Life and Health 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 amount 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 or 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 Corporations are:

Life Insurance

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

Health Insurance

- $500,000 for coverage provided by health benefit plans
- $300,000 for disability insurance
- $300,000 for long-term care insurance
- $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

Annuities

- $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values.

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

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

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

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

Maryland Life and Health Insurance Guaranty Corporation
6210 Guardian Gateway, Suite 195 APG
Aberdeen, Maryland 21055
410-248-0407

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

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.

THERESE M. GOLDSMITH
Insurance Commissioner

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

If the insurer or health maintenance organization that issued your life insurance, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance organization coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

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

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway
Suite 101
White Bear Lake, Minnesota 55110
651-407-3149

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

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

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY, CONTRACT, OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

Missouri Notice

In the event you need to contact someone regarding this policy, you may contact the insurance company issuing this policy at the following address and telephone number.

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Telephone: 651-665-3500

APPENDIX ONE
NOTICE OF PROTECTION PROVIDED BY THE 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
630 Bolivar Street, Suite 204
Jefferson City, Missouri 65101
Phone: 573-634-8455
Fax: 573-634-8488

Missouri Department of
Commerce and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101
Phone: 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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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.

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

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

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

This Notice provides a **brief summary** description of the Montana Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders.

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

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

Life Insurance

- $300,000 in death benefits, but limited to $100,000 in cash surrender and net cash withdrawal values.

Health Insurance

- $500,000 in health insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 present value, including net cash surrender and net cash withdrawal values

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

NOTE: Other 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 website at www.mtlifega.org, or contact:

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

Office of the Montana State Auditor
Commissioner of Securities and Insurance
840 Helena Avenue
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 will control.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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

The North Carolina Life and Health Insurance Guaranty Association may or 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, North Carolina 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer 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 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 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;

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 the number of 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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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, health, or annuity 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:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or 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; 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.

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
651-665-3500

You can also contact the **NEW HAMPSHIRE INSURANCE DEPARTMENT,** a state agency which enforces New Hampshire's insurance laws, and file a complaint. Assistance is available by writing to:

NEW HAMPSHIRE INSURANCE DEPARTMENT
CONSUMER DIVISION
21 SOUTH FRUIT STREET, SUITE 14
CONCORD NH 03301-7317
PHONE: 1-800-852-3416 or 1-603-271-2261
FAX: 1-603-271-1406

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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 financial 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)
- $100,000 in disability (income) insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

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

With respect to any one life, the Association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages, except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance, in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.

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

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

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

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

This information is provided by:

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

NOTICE CONCERNING YOUR RIGHTS TO APPEAL DISPUTED CLAIMS

In the event of a claim where you are not satisfied with the claim decision, you may request a review of that decision by writing to our Internal Appeals Panel at the address listed below.

Internal Appeals Panel
Attn: Station 21-3055
Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Benefit Services Telephone: 1-800-328-9442
Telefax: 651-665-7979

Your appeal will be reviewed by our Securian Life Internal Appeals Panel.

Please include the following in your written notice to us:

1. **Contract number**
2. **Claim number**
3. **Insured's name**
4. **Your name, address, telephone number and relationship to the insured**
5. **The insured's name, address and telephone number, if different from yours**
6. **Your reason(s) to dispute the decision by our Benefit Services Department**
7. **Documentation to support your request**

We will make a decision on your appeal within 10 business days of receiving your written request. Once we have made a decision, we will notify you within three working days.

If you are not satisfied with the final disposition of your claim and the response from Securian Life's Internal Appeals Panel, you have the right to contact the Office of the Insurance Claims Ombudsman at the address and phone listed below.

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
PO Box 472
Trenton, NJ 08625-0472
Telephone: 1-800-446-7467
Telefax: 609-292-2431
E-mail: ombudsman@dobi.state.nj.us

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

If you have any questions regarding your insurance, or if you need assistance in resolving a complaint, you can contact us at:

Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098
Telephone: 651-665-3500

If we at Securian Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Consumer Inquiry and Case Preparation Unit
20 West State Street
PO Box 471
9th Floor
Trenton, New Jersey 08625

Telephone: 609-292-7272 or 1-800-446-7467
Fax: 609-777-0508
Webpage: http://www.state.nj.us/dobi/consumer.htm

Important Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

DISCLAIMER

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

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

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

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.

Generally, 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, and subject to other limitations imposed by the Act, for life insurance policies, the Association will not pay more than $100,000 in cash surrender values or $500,000 in life insurance death benefits; for annuity contracts, the Association will not pay more than $250,000 in cash surrender value or, for annuity contracts with no cash surrender value, benefit payments of up to $500,000 in present value. These limits apply no matter how many policies and contracts 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.

Securian Life Insurance Company – a Securian Financial company
400 Robert Street North, St. Paul, MN 55101-2098

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

https://www.osi.state.nm.us/ConsumerAssistance/index.aspx

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTEE 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.nmlifeg.org or contact:

New Mexico Life Insurance Guaranty Association
PO Box 2880
Santa Fe, NM 87504-2880
505-820-7355

Insurance Division
Public Relations Commission
PO Box 1269
Santa Fe, NM 87504-1269
888-427-5772

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

To make or file a complaint or file a grievance, you may write or call Securian Life Insurance Company at:

Securian Life Insurance Company
400 Robert Street North
St. Paul, Minnesota 55101-2098

Toll Free: 1-866-293-6047

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 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, 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 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 Guaranty 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 of Insurance
Department of Business and Industry
1818 E. College Parkway, 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.

APPENDIX I

Pursuant to Ohio Law, the Ohio Life and Health Insurance Guaranty Association (OLHIGA) may provide coverage of claims under certain life insurance policies, health insurance policies, including sickness and accident and health insuring corporation agreements, annuity contracts, and supplemental contracts to any of the preceding, if the member insurer or health insuring corporation becomes impaired or insolvent.

OLHIGA 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 OLHIGA 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 or health insuring corporation coverage.

Information about the financial condition of insurers can be accessed by visiting the Department's website. For additional information or if you have concerns about a violation of Ohio insurance law or would like to file a complaint, please contact:

Ohio Department of Insurance
50 W. Town Street, Suite 300
Columbus, Ohio 43215
1-800-686-1526
www.insurance.ohio.gov

If you have questions about the obligations of OLHIGA, you may contact:

Ohio Life and Health Insurance Guaranty Association
485 Metro Place South, Suite 270
Dublin, Ohio 43017
614-442-6601
www.olhiga.org

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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

The basic protections provided by the Association are:

Life Insurance

- $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

- $300,000 in withdrawal and cash values

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

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

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

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

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

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

Important Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
651-665-3500

You can also contact the **DIRECTOR OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES,** a state agency which enforces Oregon's insurance laws, and file a complaint. Assistance is available by writing to:

OREGON AGENCY
CONSUMER PROTECTION UNIT
350 WINTER STREET NE
ROOM 440-2
SALEM OR 97301-3883

by calling (503) 947-7984 or the toll free message line at (888) 877-4894; through the Internet at http://www.cbs.state.or.us/external/ins/; or by email at: DCBS.INSMAIL@STATE.or.us

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400 Robert Street North, St. Paul, MN 55101-2098

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

- 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):

- 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 $100,000 for all other types of health insurance

Individual Annuities

- 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.

Important Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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, 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.

IMPORTANT DISCLAIMER

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

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 availabiltiy of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Division of Insurance
222 Richmond Street, Providence, RI 02903
Telephone (426) 222-2223

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 §27-34.3-1. 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 that 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"), and 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 net 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, or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- $300,000 or 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, of the 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 to a beneficiary of the individual if the individual is 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 §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 Important Disclaimer above.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

SUMMARY OF THE SOUTH CAROLINA LIFE AND ACCIDENT AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

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

DISCLAIMER

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

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

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

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

SCLAHIGA also does not provide coverage for:

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

LIMITS ON AMOUNTS OF COVERAGE

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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

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

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

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

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

South Dakota Division of Insurance
124 South Euclid Avenue, 2nd Floor
Pierre, SD 57501-5070
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. 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 this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the Guaranty Association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than $500,000 for basic hospital, medical and surgical insurance, not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $250,000 in the present value benefits, including net cash surrender and net cash withdrawal values.

However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the Guaranty Association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitation are set forth in South Dakota law.

ADDITIONAL INFORMATION

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

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., 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 contract the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

Tennessee Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

In the event you need to contact someone regarding this policy, you may contact the insurance company issuing this policy at the following address and telephone number.

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098

Telephone: 651-665-3500

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 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.

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's, 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:

- 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 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.

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 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.

With these overall limits, the Guaranty Association cannot guarantee payment of benefits 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

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 or for which you have assumed the risk, such as a variable contract sold by prospectus.

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

Tennessee Life and Health Insurance Guaranty Association
PO Box 190434
Nashville, TN 37219
Website: www.tnlifega.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
1717 West 6th Street, Suite 230
Austin, Texas 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
PO Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

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

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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

The Association was established to provide protection in the unlikely event that your life, 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 funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

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

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

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

Benefits provided by a long-term care rider to a life insurance policy 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 Association
450 S. Simmons Way, Suite 650
Kaysville, UT 84037
(801) 320-9955

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

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

Securian Life Insurance Company
400 Robert Street North
St. Paul, MN 55101-2098
Telephone: 651-665-3500

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
PO Box 1157
Richmond, VA 23218
Telephone: 1-877-310-6560
Fax: 1-804-371-9944

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

Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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 licensed in the Commonwealth of Virginia (including a 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 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 https://www.valifega.org, or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION
c/o DSH Consulting LLC
P.O. Box 606
534 Main Street
Hampden, MA 01036-9998
571-438-9408

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-877-310-6560
https://www.scc.virginia.gov/pages/Home

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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

VERMONT MANDATORY CIVIL UNIONS ENDORSEMENT

PURPOSE:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:

The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationships created by a civil union established according to Vermont law.

"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child or covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/ employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Renée D. Moutz
Secretary

President

APPENDIX A

This notice provides a **brief summary** of the Vermont Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Vermont 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 Vermont 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 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

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 8 V.S.A. Section 4175 (11) 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 Vermont 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 as well as protections relating to group contracts or retirement plans, please visit the Association’s website at www.vtlifega.org or contact:

Vermont Life and Health Insurance Guaranty Association
One National Life Drive, Suite M585
Montpelier, Vermont 05604
802-552-3698

Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620
802-828-3301

Insurance companies and agents are not allowed by Vermont 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 Vermont law, then Vermont law will control.

Important Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

SECURIAN LIFE INSURANCE COMPANY
400 ROBERT STREET NORTH
ST PAUL MN 55101-2098
651-665-3500

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

OFFICE OF THE COMMISSIONER OF INSURANCE
COMPLAINTS DEPARTMENT
PO BOX 7873
MADISON WI 53707-7873
1-800-236-8517
608-266-0103

Important Notice

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy 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. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

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

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy 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
PO Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
900 Pennsylvania Avenue
PO 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 insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the member insurer was not authorized to do business in this state;
- the policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- their policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contractholder 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 which is not guaranteed by the insurer or for which the individual or contractholder has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy, plan or contract by a group contractholder;
- employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  i. multiple employer welfare arrangement;
  ii. minimum premium group insurance plan;
  iii. stop loss group insurance plan; or
  iv. administrative services only contract.
- any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- any portion of any unallocated contract which 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 for penalties or consequential or incidental damages;
- a contractual agreement that establishes the member insurer's obligation to provide a book value guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;
- structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

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

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability 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 or 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 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 contractholder, 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.

Securian Life Insurance Company
400 Robert Street North, St. Paul, MN 55101-2098

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

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

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

The basic protections provided by the Association are:

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

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

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

EXCLUSIONS FROM COVERAGE

Policy owners, contract owners, policyholders, certificateholders 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 policyholder is subject to future assessments, or by an insurance exchange or by any 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 by a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- 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 Road, 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.

Summary Plan Description

Your Rights Under ERISA

This document, along with the separate Group Critical Illness Certificate of Insurance, describing required employee contributions, is intended to be the Summary Plan Description (SPD) for the group Critical Illness coverage. This document is provided to you to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator.

General Information

Name of Plan

Critical Illness Insurance Benefits under the Children's Mercy Hospital Take Care Benefits Plan

Plan Sponsor/Employer

Name: The Children's Mercy Hospital
Address: 2401 Gillham Road
Kansas City, MO 64108

Participants may receive from the Plan Sponsor, on written request, information as to whether a particular employer is a participating employer in the Plan, and if it is, its address.

Employer ID

Employer Identification Number (EIN): 44-0605373

Plan Number

Plan Number: 501

Type of Plan

Welfare plan providing Critical Illness insurance and associated benefits for eligible employees, spouses and dependents.

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Securian Life Insurance Company, herein known as the "Insurer", 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of the Plan.

Plan Administrator/ Named Fiduciary

Name: The Children's Mercy Hospital

Address: 2401 Gillham Road
Kansas City, MO 64108

Telephone Number**:** 816-234-3145

Agent for Service of Legal Process

Name: The Children's Mercy Hospital
Office of the General Counsel

Address: 2401 Gillham Road
Kansas City, MO 64108

Service may also be made upon the Plan Administrator or the Trustee,

	if applicable.
Plan Year	July 1 through June 30 each year
Plan Funding	The Plan has an insurance policy(ies) with the insurer. The premiums for the policy(ies) are paid by contributions from the employee contributions
Trustee Information	No
Interpretation	The Plan Administrator delegates to the insurer the discretionary authority to interpret the Plan in order to make benefit determinations and to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.
Amendment and Termination	The Plan Sponsor reserves the right to amend or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.
QMCSO Procedures	Participants and beneficiaries can obtain, without charge, a copy of the Plan's qualified medical child support order procedures from the Plan Administrator.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained by contacting the Insurer.

Contact your Plan Administrator if you have any questions or to initiate a claim. You may also contact the insurer directly to initiate a claim. Upon the receipt of notification of a claim the Insurer will provide claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments. Completed forms must be sent to Claims, PO Box 64114, St. Paul, MN 55164-0114. After your claim has been processed by the Insurer you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, the insurer will notify you in writing within 30 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 15 days (30 days for disability claims). You will be notified in writing of this extension within the original review period. For disability claims, the review period may be extended up to an additional 30 days provided the written notice described above is sent to the claimant before the expiration of the first 30-day extension period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and the claimant will be given at least 45 days to provide the information. Where the

timeframe to process a disability claim is extended because the claim was incomplete, the time for the claim determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the insurer within 45 days of the date on the notice, the Insurer may deny the claim.

Notification of Claim Denial

Any denial of a claim for benefits will be provided by the Insurer and will include the content required by law.

C. Appealing the Denial of a Claim

You may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurer at Claims, PO Box 64114, St. Paul, MN, 55164-0114. In connection with such a request, documents relevant to the appeal may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure, if you submit written proof of the representation to the Insurer. An appeal must be filed by 180 days after receipt of the written notice of denial of a claim. Before the Insurer can deny a claim on appeal, the insurer shall provide the claimant with any new evidence considered, relied upon, or generated during the appeal, as well as any new rationale for the decision. Any new evidence or rationale will be provided to the claimant free of charge, as soon as possible before the date by which the appeal is to be decided, so the claimant may respond to the evidence or rationale before that date. The full and fair review will be held and notification of a decision rendered by the Insurer will be provided no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances beyond the control of the Plan Administrator require more time, the review period may be extended up to an additional 45 days for disability claims. You will be notified in writing of this extension within the original appeal period. The notice of extension will explain the circumstances requiring the extension and indicate the date by which the Insurer expects to render the benefit determination.

The notice of extension will include a description of any missing information and shall specify a timeframe, no less than 180 days for disability claims in which the necessary information must be provided. Where the timeframe to process an appeal is extended because additional information to render an appeal decision is needed, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 180 days for disability claims of the date on the notice the Plan may close the appeal and no further consideration will take place.

During all steps of the claims appeal procedure, you can write or call the insurer and ask to see all documents relevant to your claim. In addition, you may have an attorney or other representative write letters or otherwise act on your behalf, but you may need to provide written proof of designation of the representative.

Notification of Appeal Decision

Written notification of the Insurer’s decision on an appeal shall be provided to the claimant and will include the information required by law.

D. Legal Action Following Appeals

After completing the claims and appeal procedures, you have the right to dispute the determination by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed after two years from the

date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not exhaust these claims procedures, unless exhaustion is not required.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including the insurance contract, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents and the latest annual report form for the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. In addition, if you disagree with the Plan’s decision concerning the qualified status of a medical child support order, you may file suit in Federal court. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to or receive from the Plan Administrator.

Securian Life Insurance Company • A Stock Company

400 Robert Street North • St. Paul, Minnesota 55101-2098

GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE • NONPARTICIPATING