YOUR GROUP **WEEKLY DISABILITY INCOME** PLAN

For Employees of
8x8, Inc.

All Active Full Time Employees

CONTENTS

B-20794 (10-24)

ReliaStar Life Insurance Company acts only as an agent of the Employer. It is not liable or responsible for the payment of claims under the Plan, nor does it insure the Plan.

SCHEDULE OF BENEFITS

Disability Income Coverage – Weekly Income Benefits

Weekly Income Benefit Percentage for weeks 1-12 ..... 100%

Weekly Income Benefit Percentage for weeks 13-26 ..... 66.66%

Maximum Weekly Income Benefit for weeks 1-12 ..... no maximum

Maximum Weekly Income Benefit for weeks 13-26 ..... $2,800

The **Weekly Income Benefit** is calculated as follows:

Weekly Income Benefit (A divided by B) times C, minus Other Income.

A = your Basic Weekly Earnings minus Recovery Work Earnings.
B = your Basic Weekly Earnings.
C = your **Gross Weekly Benefit**, defined as follows:
• Take the Benefit Percentage and multiply by your Basic Weekly Earnings.
• Compare this result to the Maximum Weekly Income Benefit and take the lesser of the two amounts.

Other Income is described in the Disability Income Coverage section of this booklet.

Recovery Work Earnings is defined in the Definitions section of this booklet.

In no event will your Weekly Income Benefit plus Other Income be greater than your predisability Basic Weekly Earnings.

Basic Weekly Earnings – the basic salary or wage you received on the last day you worked for the Employer, before becoming disabled. Commission and bonuses with a 12 month average are included. It does not include overtime pay.

Benefit Waiting Period
• Disability caused by accidental injury ..... 7 days
• Disability caused by sickness ..... 7 days

Maximum Benefit Period ..... 26 weeks

EMPLOYEE'S COVERAGE

Eligibility
You are eligible on the later of the following dates:
• The Plan's Effective Date, January 1, 2025.
You must meet the following conditions to become covered:
• Be eligible for the coverage.
• Be actively at work.

Effective Date of Employee's Coverage
Your coverage starts on the later of the following dates:
• The date you become eligible.
• The date you return to active work if you are not actively at work on the date coverage would otherwise start. **Exception:** Your coverage starts on a nonworking day if you were actively at work on your last scheduled working day before the nonworking day.

You must be actively at work for 5 working days in a row before coverage starts. The fifth working day must fall on or after the effective date of Employee's Coverage.

Continuity of Coverage
If you are not actively at work on the date coverage would otherwise start, the Plan will waive the actively at work requirement if both of the following are true:
• You are eligible for coverage except for meeting the actively at work requirement on the Plan's Effective Date.
• You were covered under the Employer's prior group disability income plan on the day before the Plan's Effective Date.

Your coverage is subject to payment of cost contributions. Before you return to active work, any benefit will be limited to the amount that would have been paid under the prior plan. The Plan reduces the amount it pays by any amount for which the prior plan is liable. Your coverage will stop on the date benefits would have ended under the prior plan had it remained in force.

Effective Date of Change in Amount of Coverage
If there is an increase in the amount of your coverage, the increase will take effect on:
• The date of the increase, if you are actively at work on that date.
• The date you return to active work, if you are not actively at work on the date your coverage increases.
• The nonworking day on which the increase was effective, if you were actively at work on your last scheduled working day before the nonworking day.

A decrease in the amount of your coverage will take effect on the date of the decrease.

Termination of Coverage
Your coverage stops on the earliest of the following dates:
• The date you are no longer actively at work for the Employer.
• The date you are no longer eligible for coverage under the Plan.
• The date the Plan stops.

The Plan stops providing a specific benefit to you on the date that benefit is no longer provided under the Plan.

Family and Medical Leave Act of 1993
Certain employers are subject to the FMLA. If you have a leave from active work certified by your employer, then for purposes of eligibility and termination of coverage you will be considered to be actively at work. Your coverage will remain in force so long as you continue to meet the requirements as set forth in the FMLA.

DISABILITY INCOME COVERAGE

Weekly Income Benefits

Qualifying for Benefits

The Plan pays benefits if you become disabled and qualify to receive benefits. The benefit payable is based on the Schedule of Benefits in effect on the date you became disabled.

To qualify for benefits, all of the following conditions must be met:
You must –

- be covered on the date you become disabled and the condition causing your disability is not excluded from coverage.
- be covered on the date the benefit waiting period begins.
- send notice of the disability as described in the Claim Procedures Section.
- be receiving regular and appropriate care and treatment.
- have the length of your disability approved by the disability management program.

Disability Management

The disability management program evaluates disability to approve the length of disability and establish a target date for return to work. When you become disabled, you must call the number on your disability I.D. card to start the disability management process. If your disability is expected to continue beyond the number of approved days, your doctor must call to have the extended period of disability reviewed. Benefits are not payable until approval is obtained. Benefits are not payable for non-approved days.

Benefit Waiting Period

The benefit waiting period is the length of time you must be continuously disabled before you qualify to receive any benefits. **Exception:** For weekly income benefits, you may return to work for up to 5 days during the benefit waiting period without having to begin a new benefit waiting period. The days you work and are not disabled do not count toward meeting the benefit waiting period.

The benefit waiting period begins on the first day you see a doctor and he or she states in writing that you are disabled because of sickness or accidental injury.

The benefit waiting period is shown on the Schedule of Benefits.

Benefit Payments

Weekly income benefits are paid at the end of each week for the period for which you qualified. If you are disabled for part of a week the benefit payable is based on 1/7 of your weekly income benefit for each day you are disabled.
The weekly income benefits are determined as shown on the Schedule of Benefits. Benefits continue while you are disabled up to the maximum benefit period shown on the Schedule of Benefits. You must complete the benefit waiting period before any benefits are payable.

Other Income

Other Income is subtracted from the benefit you would otherwise receive, as shown on the Schedule of Benefits. Other Income includes any of the following:

- The amount you receive or are entitled to receive under:
  - Salary continuance benefits provided through the Employer.
  - Paid Time Off benefits provided through the Employer.
  - Sick leave benefits provided through the Employer.
  - Unemployment benefits under any law or compulsory program.
- The amount you receive or are entitled to receive as disability income payments under any:
  - Automobile liability insurance benefits.
  - Plan or arrangement of disability coverage, whether insured or not, resulting from your employment by or association with any employer, or resulting from your membership in or association with any group, association, union or other organization.

  - Group life or group accident insurance policy.
  - Individual insurance policy where the premium is wholly or partially paid by an employer or for which an employer makes payroll deductions.
- The amount of any judgments or settlements you receive as the result of the act or omission of a third party.
- The amount you and your dependents receive or are entitled to receive as disability payments because of your disability under:
  - The Federal Social Security Act.
  - The Canada Pension Plan.
  - The Quebec Pension Plan.
  - The Railroad Retirement Act.
  - The Jones Act.
  - State Disability benefits.
  - Any similar act or plan.
  - Other government disability income.
- The amount you receive as retirement payments or income your dependents receive as retirement payments because you are receiving retirement payments under:
  - The Federal Social Security Act.
  - The Canada Pension Plan.
  - The Quebec Pension Plan.
  - The Railroad Retirement Act.
  - The Jones Act.
  - Any similar act or plan.
  - Other government retirement income.

Other income includes the following benefits provided under an employer's retirement plan:

- Disability benefits.
- Retirement benefits attributable to employer contributions. These retirement benefits include only:
  - Early retirement benefits you are receiving that are voluntarily selected.
  - Retirement benefits that are unreduced by age for which you are eligible on the later of the following:
    - the date you reach age 62.
    - normal retirement age.

The Plan considers retirement benefits received before age 62, or if later, before normal retirement age, to be voluntarily elected until you provide written proof satisfactory to the Plan that you did not elect to receive benefits voluntarily.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit that would have been paid if the disability had not occurred. If disability benefits reduce the retirement benefit under the plan, they will be considered a retirement benefit.

Except for Other Income retirement benefits, Other Income includes only income which is payable for the same period of disability for which you are claiming benefits under the Plan.

The Plan considers you to be eligible to receive Other Income benefits whether or not you apply for them, until you send the Plan written proof that the benefits were denied or contested. When the Plan receives written proof that Other Income benefits were denied or contested, the Plan will pay benefits you are qualified to receive. However, if the denial of Other Income benefits is not final, you must pursue the Other Income benefits to the fullest extent possible.

Exceptions: Benefits will not be reduced by –

- retirement benefits attributable to employee contributions.
- retirement or disability benefits you receive from a past employer, if these benefits have been paid continuously to you for more than 2 years before you become eligible to receive benefits under the Plan.
- benefits paid by a group or franchise creditor disability plan.

- income received from a profit sharing plan, thrift plan, individual retirement account, tax sheltered annuity, stock ownership plan, or a non-qualified plan of deferred compensation.
- disability or retirement benefits which are received under an employer's retirement plan but are rolled over or transferred to any eligible retirement plan as defined by the Internal Revenue Code.
- Federal Social Security benefits if your disability begins after age 70 and you were receiving Social Security benefits while continuing to work.
- a cost of living increase to any other income benefit after the initial other income benefit becomes payable.

Lump Sum Payments
Other Income you receive as a lump sum will be prorated into weekly amounts. The prorated amount will be subtracted from the benefit you would otherwise receive, until the total amount subtracted equals the lump sum payment. The Plan will determine the prorated amount using the first of the following methods that applies:
- Divide the Other Income lump sum into weekly amounts based on the amount of Other Income you were receiving from the same source prior to receiving the lump sum payment.
- Divide the Other Income lump sum into weekly amounts based on the weekly amount you could have received in lieu of the lump sum payment.
- Divide the Other Income lump sum into weekly amounts over the remaining maximum benefit period.

Overpayment
If the Plan pays you a larger benefit than you should have received, the Plan may recover any overpayments it made.

The Plan will recover from you the full amount of the overpayment through one or more of the following means:
- Require you to return the overpayment in one lump sum.
- Stop payment of benefits until the full overpayment is repaid.
- Require you to assign any Other Income to the Plan.

Waiver of Contribution
The Plan waives your contribution during any period for which benefits are payable. If the Plan waives your contribution it is the Employer's responsibility to refund to you any contribution you may make after qualifying for benefits.

Termination of Benefits
The Plan stops paying benefits on the earliest of the following:
- The date you are no longer disabled.
- The end of the maximum benefit period for any one period of disability. The maximum benefit period is shown on the Schedule of Benefits.
- The date you no longer qualify for benefits under all the conditions listed.
- The date of your death.
- The date you fail to provide written proof of disability that the Plan determines to be satisfactory.
- The date you cease to be under regular and appropriate care of a doctor, or refuse to undergo an examination or testing by a doctor of the Plan's choosing.
- The date you refuse to undergo vocational or rehabilitation testing that the Plan requires.
- The date you refuse to receive medical treatment that is generally acknowledged by doctors to cure or improve your condition so as to reduce its disabling effect.
- The date you refuse to work with the assistance of modifications made to your work environment, functional job elements or work schedule, or adaptive equipment or devices, that a qualified doctor has indicated will accommodate the limiting factors of your sickness or accidental injury.

DISABILITY INCOME COVERAGE

If the Plan or the Disability Income Coverage part of the Plan terminates after you qualify to receive benefits, the Plan continues your benefit payments. Benefits are paid as long as you continue to qualify according to the terms of the Plan in effect on the date you qualified.

Recurrent Disability
If you are receiving weekly income benefits, a recurrent disability is a disability due to the same cause which occurs after you have returned to full-time work for the Employer for less than 10 working days.
The Plan pays benefits for a recurrent disability which is a continuation of a previous disability.

A recurrent disability has –
- no additional benefit waiting period.
- the same maximum benefit period as the previous disability.

Benefits payable under this recurrent disability provision will stop if benefits are payable to you under any other group disability plan.

Exclusions
The Plan will not pay benefits if your disability results from any of the following:
- Sickness or injury which occurs in any armed conflict, whether declared as war or not, involving any country or government.
- Sickness or injury which occurs while you are on military service for any country or government.
- Intentionally self-inflicted injury or illness, whether you are sane or insane.
- Injury which occurs when you commit or attempt to commit a felony.
- Injury suffered in a fight in which you are the aggressor.
- Sickness or injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by sickness or accidental injury.
- Sickness or accidental injury for which you have or had a right to payment under a workers' compensation or similar law. This includes payment you would have been entitled to receive if the Employer had not declined to provide workers' compensation insurance as allowed by the Employer's state of domicile.
- Sickness or accidental injury arising out of or in the course of work for pay, profit, or gain.

The Plan will not pay benefits for the portion of any period of disability that you are confined in a penal or correctional institution as a result of conviction for a criminal or other public offense.

The Plan will not pay an additional benefit for disability caused by both sickness and accidental injury or by more than one sickness or accidental injury.

CLAIM PROCEDURES

Submitting a Claim
You or someone on your behalf must contact the Plan as instructed on your disability I.D. card in order to submit a claim.

The Plan will gather information from you, your employer and your doctor to determine eligibility and verify proof of loss.

Benefit Payments
Benefits under the Plan are paid when proof of loss is received.
Benefits are paid to you. Any weekly income benefit remaining unpaid at the time of your death will be paid to your survivors or your estate in the following order:
1. Your spouse.
2. Your children.
3. Your estate.

Time of Payment of Claims
Subject to due proof of loss, all accrued benefits payable under the Plan will be paid at the end of each week during the period for which the Plan is liable. Any balance remaining unpaid at the end of such period will be paid as soon as possible after receipt of proof of loss.

GENERAL PROVISIONS

Free Choice of Doctor
You have the right to choose any doctor.

Assignment
You may not transfer to anyone else –
• ownership of any booklet issued under the Plan.
• Disability Income Coverage under the Plan.

Legal Action
Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the Plan. Legal action must be taken within 3 years after the date proof of loss must be submitted.

If the Employer's state requires longer time limits, the Plan will comply with the state's time limits.

Exam
When reasonably necessary, the Plan may have you examined while you are claiming benefits. The exam will be conducted by one or more doctors or vocational experts of the Plan's choice. The exam may include vocational testing and evaluations, or any other type of testing and evaluations the Plan determines necessary. This right will only be exercised as often as the Plan reasonably believes necessary to properly evaluate your claim and your potential for rehabilitation. The Plan has the right to defer or suspend payment of benefits if you fail to attend an exam or fail to cooperate with the doctor. Benefits may be resumed, provided that the required exam occurs within a reasonable time and benefits are otherwise payable.

Reimbursement
If the Plan pays Disability Income benefits for sickness or accidental injury caused in whole or part by the act or omission of another, you must –
• reimburse the Plan for the benefits paid if you recover damages for lost income by settlement, court order, judgment or otherwise.
• provide the Plan with a lien and order directing reimbursement for benefits. The lien and order may be filed with –
  – the person whose act caused the sickness or accidental injury,
  – their agent,
  – the court, or
  – your attorney.
• cooperate with the Plan, including execution, completion, and filing of any document deemed by the Plan necessary to protect its reimbursement rights.

The Plan has a first priority claim against –
• amounts which are or may be subject to reimbursement.
• any person who is or may be obligated to pay damages for lost income. This includes any insurer of you.

The Plan will be reimbursed first before other claims against amounts recovered or recoverable from persons who are or may be obligated to pay damages for lost income, even if the amounts are not enough to reimburse the Plan in full or compensate you in full for damages sustained.

The Plan has no obligation to pay attorney's fees or other legal fees to your attorney for recovery of amounts subject to reimbursement.

The Plan will have the right to intervene in any suit or other proceedings to protect its reimbursement rights. Any settlement proceeds received by you or your attorney will be held in trust for the Plan's benefit. The Plan's rights herein are binding upon and enforceable against your legal representatives, heirs, next of kin, and successors in interest.

GENERAL PROVISIONS

Subrogation
If the Plan pays Disability Income benefits for sickness or accidental injury caused in whole or part by the act or omission of another, the Plan will have a right of subrogation against any person, any insurer, you or any insurer of you, should you receive, or have a right to receive, any damages or payments.

You will do nothing to prejudice the Plan's subrogation rights and will cooperate with the Plan to protect such rights. This includes –
- providing information.
- signing an agreement documenting the Plan's subrogation rights.
- taking other action the Plan requests. This includes execution, completion, and filing of any document deemed by the Plan necessary to protect its rights.

The Plan's subrogation rights and amounts recoverable or recovered pursuant to such rights are a first priority claim. Such amounts will be reimbursed first even if all amounts recovered from whatever source are insufficient to compensate you in part or whole for all damages sustained.

At the Plan's option, action may be taken to preserve its subrogation rights. This includes –
- the right to bring any legal action in your name.
- seeking reimbursement out of any amount from any source recovered by you.

Any settlement proceeds received by you, or your attorney will be held in trust for the Plan's benefit. The Plan has no obligation to pay any attorney or other legal fees to your attorney for any subrogation recovery received. The Plan will have the right to intervene in any suit or proceeding to protect its subrogation rights. The Plan's rights herein are binding upon and enforceable against your legal representatives, heirs, next of kin, and successors in interest.

Incontestability
Any statement you make to obtain coverage or an increase in coverage is a representation and not a warranty. No misrepresentation by you will be used to reduce or deny a claim or to deny the validity of your coverage or an increase in coverage unless all of the following are true:
- Your coverage or increase in coverage would not have been approved if the truth had been known.
- Your misrepresentation is contained in a written instrument signed by you.
- You or your beneficiary, if applicable, have been given a copy of the written instrument containing your misrepresentation.

After your coverage or increase in coverage under the Plan has been in effect for two continuous years during your lifetime, the Plan will not use a misrepresentation by you to reduce or deny a claim or to deny the validity of your coverage or increase in coverage unless it was a fraudulent misrepresentation made with an actual intent to deceive. However, the Plan has the right at any time to assert as a defense to a claim that you were not eligible for coverage or for the increase because you did not meet the requirements of the Plan. These requirements include, but are not limited to any requirements that you:
- Satisfy the eligibility requirements.
- Submit and have approved proof of good health.
- Meet the actively at work requirement.

DEFINITIONS

Accidental Injury – bodily injury resulting from a sudden, violent, unexpected and external event. All injuries are considered to be received in one accident as one accidental injury. Infection resulting from a cut or wound caused by an accident is also an accidental injury.

Accidental injury does not include poisoning, disease or any other type of infection, except as stated above.

Active Work, Actively at Work – the employee is physically present at his or her customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of his or her job on that day.

Damages for Lost Income – any payments which in whole or part can reasonably be considered compensatory for lost income, regardless of designation.

Disability, Disabled – Weekly Income Benefits - The Plan's determination that a change in your functional capacity to work due to sickness or accidental injury has caused your inability to perform the essential duties of your regular occupation or a reasonable employment option offered to you by the Employer, and as a result you are unable to earn more than 80% of your basic weekly earnings.

Economic factors such as, but not limited to, recession, job obsolescence, paycuts, and job sharing will not be considered in determining whether you meet the requirements stated above.

You will not be considered disabled solely because of the loss or restriction of your license to engage in your regular occupation.

Doctor – a medical practitioner of a healing art which is recognized by applicable state law, who meets all of the following conditions:
- He or she is practicing within the scope of his or her license.
- He or she is certified or credentialed by the appropriate medical or professional board that provides certification or credentialing for practitioners who perform the type of treatment or service the practitioner is providing for your sickness or injury.
- He or she possesses the necessary training and qualifications, according to generally accepted medical standards, to evaluate and treat your condition.

The term doctor does not include you, an employee of the Employer, anyone related to you by blood or marriage, or anyone living in your household.

Employee – an active employee residing in the United States who is employed by the Employer and is regularly scheduled to work on at least a 20-hour-per-week basis. Such employees of companies and affiliates controlled by the Employer are included. Temporary and seasonal employees are excluded.

Employer – 8x8, Inc.

Essential Duties – duties which are normally required for the performance of an occupation as it is normally performed in the national economy and which cannot be reasonably omitted or modified. If you were normally required to perform essential duties in excess of 40 hours per week or 8 hours per day prior to becoming disabled, the Plan will consider you still able to perform the essential duties if you are working or have the capacity to perform such duties at least 40 hours weekly or 8 hours daily.

Nonworking Day – a day on which the employee is not regularly scheduled to work, including time off for the following:
- Vacations.
- Personal holidays.
- Weekends and holidays.
- Approved nonmedical leave of absence.
- Paid Time Off for nonmedical-related absences.

Nonworking day does not include time off for any of the following:
- Medical leave of absence. Time off for a medical leave of absence will be considered a scheduled working day.
- Temporary layoff.

DEFINITIONS

- The Employer suspending its operations, in part or total.
- Strike.

Period of Disability – a new period of disability begins if the new disability results from a cause or causes unrelated to that of any previous disability, separated by active work with the Employer. All periods of disability which have the same cause are considered one period of disability. **Exception:** A new period of disability begins when you become disabled due to the same cause after you have been actively at work on a full-time basis with the Employer continuously for at least 10 working days.

Plan – 72358-4SFDIS.

Reasonable Employment Option – an employment position for which you are able to perform the essential duties given your education, training and experience.

Recovery Work Earnings – is any of the following:
- Income you receive while working for the Employer.
- The excess of income you receive while working for another employer above the average income you received from the Employer prior to becoming disabled.

Regular and Appropriate Care – means:
- You personally visit a doctor as often as is medically required, according to generally accepted medical standards and consistent with the stated severity of your medical condition, to effectively manage and treat your sickness or injury.
- You are receiving care which conforms with generally accepted medical standards for treating your sickness or injury and is consistent with the stated severity of your medical condition.
- Care is rendered by a doctor whose specialty or experience is the most appropriate for your disability according to generally accepted medical standards.
- You are receiving or actively seeking appropriate physical or psychological rehabilitative services.

Regular Occupation – the activity which, immediately prior to disability, you were regularly performing and which was your source of income from the Employer. The Plan will assess this occupation as it is normally performed in the national economy, rather than how the duties and tasks are performed for a specific employer or at a specific location.

Sickness – any physical illness, mental disorder, normal pregnancy or complication of pregnancy.

Spouse – the legal husband or wife of an employee.

Written, In Writing – signed, dated and received by the Plan in a form the Plan accepts.

You, Your – an employee covered for Employee's Coverage under the Plan.

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

This notice provides a **brief summary** regarding the protections provided to the 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 contract holder;
- 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 contract holders, 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 provided by this notice and on the Association's website 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 website are for general information purposes and should not be relied upon as legal advice.

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

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

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

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

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

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

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

(Please turn to back of page)

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

- any policy or contract or portion of a policy or contract which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract by a group 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 that $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health benefit plans, not more than $500,000, but not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance, and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to health benefit plans, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

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

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

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

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

The basic protections provided by the Association are:

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

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

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

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Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
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