

RELIANCE STANDARD

Life Insurance Company

Home Office: Chicago, Illinois • Administrative Office: Philadelphia, Pennsylvania

POLICYHOLDER: Xigent Automation Systems, Inc.

POLICY NUMBER: STD 161817

EFFECTIVE DATE: July 1, 2011

ANNIVERSARY DATES: July 1, 2012 and each July 1st thereafter.


PREMIUM DUE DATES: The first premium is due on the effective date. Further premiums are due monthly, in advance, on the first day of each month.


This Policy is delivered in Ohio and is governed by its laws and/or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, where applicable.

We agree to provide insurance to you in exchange for the payment of premium and a signed Application. The Policy provides benefits for loss of time due to disability from sickness or injury. It insures those eligible persons for the benefits shown on the Schedule of Benefits. The insurance is subject to the terms and conditions of the Policy.

The effective date of the Policy is shown above. Insurance starts and ends at 12:01 A.M., Local Time, at your main address. It stays in effect as long as premium is paid when due. The "TERMINATION OF THE POLICY" section of the GENERAL PROVISIONS explains when the insurance can be ended.

The Policy is signed by the President and Secretary.


Secretary


President

Countersigned _____

Licensed Resident Agent

**GROUP WEEKLY INCOME INSURANCE
NON-PARTICIPATING
NON-CONTRIBUTORY**

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

GROUP POLICY NUMBER: STD 161817 **POLICY EFFECTIVE DATE:** July 1, 2011

POLICY DELIVERED IN: Ohio **ANNIVERSARY DATE:** July 1st in each year

Application is made to us by: Xigent Automation Systems, Inc.

This Application is completed in duplicate, one copy to be attached to your Policy and the other returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Signed at _____ this _____ day of _____

Policyholder: _____ Agent: _____

By: _____ (Signature) _____ (Licensed Resident Agent)

_____ (Title)

Please sign and return.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.





*BC1COAPSTD 16181707/01/2011*RSL
*BC2COAPXigent Automation Systems, Inc.

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TABLE OF CONTENTS

	Page
SCHEDULE OF BENEFITS	1.0
DEFINITIONS	2.0
CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER	3.0
GENERAL PROVISIONS	4.0
Entire Contract	
Changes	
Incontestability	
Records Maintained	
Clerical Error	
Misstatement of Age	
Not in Lieu of Workers' Compensation	
Conformity With State Laws	
Certificate of Insurance	
Termination of the Policy	
CLAIMS PROVISIONS.....	5.0
Notice of Claim	
Claim Forms	
Written Proof of Loss	
Payment of Claims	
Physical Examination	
Legal Actions	
INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION.....	6.0
General Group	
Eligible Classes	
Effective Date of Individual Insurance	
Termination of Individual Insurance	
Individual Reinstatement	
WEEKLY INCOME INSURANCE	7.0
Benefits Payable	
Period of Disability	
Exclusions	
TRANSFER OF INSURANCE COVERAGE.....	8.0
PREMIUMS	9.0
Premium Payment	
Premium Rate	
Grace Period	
EXTENSION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)	10.0

SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: NONE

ELIGIBLE CLASSES: Each active, Full-time employee, except any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The first of the month coinciding with or next following the day the person becomes eligible.

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Percentage: 100% Number of Insureds: 10

WEEKLY INCOME BENEFIT

DAY BENEFITS BEGIN: Benefits, for one period of disability, will be paid as follows:

INJURY: We will pay benefits from the first day of disability.

SICKNESS: We will pay benefits from the eighth consecutive day of disability.

MAXIMUM BENEFIT PERIOD: Benefits, for one period of disability, will be paid up to a maximum of twenty-six (26) weeks.

WEEKLY INCOME BENEFIT: The Weekly Income Benefit for each Insured will be 66 2/3% of Earnings to a maximum benefit of \$1,500.

In the event that an Insured is covered under any state statutory disability benefit plan, our Benefit will be reduced by any benefit payable under such plan, including but not limited to the following: California Unemployment Compensation Disability Insurance, the Hawaii Temporary Disability Insurance Law, the New Jersey Temporary Disability Benefits Law, the New York Disability Benefits Law, Puerto Rico Disability Benefit Act or Rhode Island disability benefit.

Weekly Income Benefits terminate at Retirement.

CHANGES IN WEEKLY INCOME BENEFIT: Increases in the benefit amount are effective on the first of the Policy month coinciding with or next following the date of the change, provided the Insured is actively at work on the effective date of the change. If the Insured is not actively at work on that date, the effective date of the increase in the benefit amount will be deferred until the date the Insured returns to active work. Decreases in the benefit amount are effective on the first of the Policy month coinciding with or next following the date the change occurs.

CONTRIBUTIONS: Person: 0%

Premium contributions will not be included in the Insured's gross income.

For purposes of filing the Insured's Federal Income Tax Return, this means that under the law as of the date this Policy was issued, the Insured's Weekly Income Benefit might be treated as taxable. It is recommended that the Insured contact his/her personal tax advisor.

DEFINITIONS

"We", "us" and "our" means Reliance Standard Life Insurance Company.

"You", "your" and "yours" means the employer, union or other entity to which this Policy is issued and which is deemed the Policyholder.

"Eligible Person" means a person who meets the eligibility requirements of this Policy.

"Insured" means a person who meets the eligibility requirements of this Policy and is enrolled for this insurance.

"Actively at work" and "active work" means the person actually performing on a full-time basis each and every duty pertaining to his/her job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of Injury or Sickness.

"Claimant" means the Insured or a duly authorized representative who makes a claim for benefits under this Policy for a loss covered by this Policy as a result of Injury or Sickness to the Insured.

"Full-time" means working for you for a minimum of 34 hours during a person's regular work week.

"Disabled" means the Insured is:

- (1) unable to do the material duties of his/her job; and
- (2) not doing any work for payment; and
- (3) under the regular care of a physician.

"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The injury must cause disability which begins while an Insured is covered under this Policy.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means the Insured's weekly salary received from you on the first of the Policy month just before the date of disability, prior to any deductions to a 401(k) or Section 125 plan. Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours worked during a regular work week, not to exceed forty (40) hours per week, will be used to determine weekly earnings.

"Physician" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which claim is made. The physician may not be the Insured or a member of his/her immediate family.

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by the Insured's Physician according to generally accepted medical standards in the Insured's locality, be of a demonstrable medical value and be necessary to meet his/her basic health needs.

"Retirement" means the effective date of an Insured's:

- (1) retirement pension benefits under any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with you;
- (2) retirement pension benefits under any plan which you sponsor, or make or have made contributions;
- (3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

Retirement Benefits do not include:

- (1) a federal government employee pension benefit;
- (2) a thrift plan;
- (3) a deferred compensation plan;
- (4) an individual retirement account (IRA);
- (5) a tax sheltered annuity (TSA);
- (6) a stock ownership plan;
- (7) a profit sharing plan; or
- (8) section 401(k), 403(b) or 457 plans.

"Sickness" means illness or disease causing disability which begins while an Insured is covered under this Policy. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

"Treatment" means care consistent with the diagnosis of the Insured's Injury or Sickness that has its purpose of maximizing the Insured's medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for the Injury or Sickness and conforms with generally accepted medical standards to effectively manage and treat the Insured's Injury or Sickness.

CERTAIN RESPONSIBILITIES OF THE POLICYHOLDER

For the purposes of this Policy, you act on your behalf or as the employee's agent. Under no circumstances will you be deemed our agent.

Compliance With Americans With Disabilities Act (ADA)

It is your responsibility to establish and maintain procedures which comply with the employer responsibilities of the Americans With Disabilities Act of 1990, as amended.

Compliance With The Employee Retirement Income Security Act (ERISA)

It is your responsibility to establish and maintain procedures which comply with the employer and/or Plan Administrator responsibilities of ERISA and the accompanying regulations, where applicable.

Distribution Of Certificates Of Insurance

A Certificate of Insurance will be provided to you for each Insured covered under this Policy. The Certificate will outline the insurance coverage, and explain the provisions, benefits and limitations of this Policy. It is your responsibility to distribute the appropriate Certificates and any updates or other notices from us to each Insured.

Maintenance Of Records

It is your responsibility to maintain sufficient records of each Insured's insurance, including additions, terminations and changes. We reserve the right to examine these records at the place where they are kept during normal business hours or at a place mutually agreeable to you and us. Such records must be maintained by you for at least 3 years after this Policy terminates.

Reporting Of Eligibility And Coverage Amounts

It is your responsibility to notify us on a timely basis of all individuals eligible for coverage under this Policy, of all individuals whose eligibility for coverage ends and of all changes in individual coverage amounts.

It is your responsibility to provide accurate census and salary information on all Insureds on or before each Anniversary Date, if we request such information.

Timely Payment Of Premiums

It is your responsibility to pay all premiums required under this Policy when due. Any change in the premium contribution basis must be approved by us.

GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract between you and us is this Policy, your application (a copy of which is attached at issue) and any endorsements and amendments.

CHANGES: No agent has the authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing. It must also be signed by one of our executive officers and attached to this Policy.

INCONTESTABILITY: Any statement made in your application will be deemed a representation, not a warranty. We cannot contest this Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium.

Any statements made by you, any Insured, or on behalf of any Insured to persuade us to provide coverage, will be deemed a representation not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

(1) No statement will be used in contest unless:

(a) it is in written form signed by the Insured, or on behalf of the Insured; and

(b) a copy of such written instrument is or has been furnished to the Insured, the Insured's beneficiary or legal representative.

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

RECORDS MAINTAINED: You must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR: Clerical Errors in connection with this Policy or delays in keeping records for this Policy, whether by you, us, or the Plan Administrator:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

MISSTATEMENT OF AGE: If an Insured's age is misstated, the premium will be adjusted. If the Insured's insurance is affected by the misstated age, it will also be adjusted. The insurance will be changed to the amount the Insured is entitled to at his/her correct age.

NOT IN LIEU OF WORKERS' COMPENSATION: This Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

CONFORMITY WITH STATE LAWS: Any section of this Policy, which on its effective date, conflicts with the laws of the state in which this Policy is issued, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE: We will send to you an individual certificate for each Insured. The certificate will outline the insurance coverage and to whom benefits are payable.

TERMINATION OF THE POLICY: You may cancel this Policy at any time. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy if:

- (1) the premium is not paid at the end of the grace period; or
- (2) the number of Insureds is less than the Minimum Participation Number on the Schedule of Benefits; or
- (3) the percentage of eligible persons insured is less than the Minimum Participation Percentage on the Schedule of Benefits.

If we cancel because of (1) above, this Policy will be cancelled at the end of the grace period. If we cancel because of (2) or (3) above, we will give you thirty-one (31) days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date this Policy is cancelled. We will return, pro-rata, any part of the premium paid beyond the date this Policy is cancelled.

Termination of this Policy will not affect any claim which began prior to termination.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized agent. The notice should include the Insured's name and the Policy Number.

CLAIM FORMS: When we receive notice of claim, we will send the claimant the forms to file the proof of loss. If we do not send them within fifteen (15) days after we receive notice, then the proof of loss requirements will be met by giving us a written statement of the nature and extent of the loss within ninety (90) days after the loss began.

WRITTEN PROOF OF LOSS: For any covered loss, written proof must be sent to us within ninety (90) days. If it is not reasonably possible to give proof within ninety (90) days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within one (1) year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable. We will pay benefits to the Insured, if living, or else to his/her estate.

If the Insured has died and we have not paid all benefits due, we may pay up to \$1,000 to any relative by blood or marriage, or to the executor or administrator of the Insured's estate. The payment will only be made to persons entitled to it. An expense incurred as a result of the Insured's last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have an Insured examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTIONS: No legal action may be brought against us to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of loss is required to be given.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance for an eligible Person will go into effect on the date stated on the Schedule of Benefits.

If an eligible Person pays a part of the premium, he/she must apply in writing for the insurance to go into effect. He/she will become insured on the date stated on the Schedule of Benefits, except that the insurance will go into effect:

- (1) on the first of the month coinciding with or next following the date he/she applies, if he/she applies within thirty-one (31) days of the date he/she is first eligible; or
- (2) on the first of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if a person applies:
 - (a) after thirty-one (31) days from the date he/she first becomes eligible; or
 - (b) after he/she terminated this insurance but remained in a class eligible for the insurance.

Changes in an Insured's amount of insurance are effective as shown on the Schedule of Benefits.

If the Person is not actively at work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to active work for one full day.

TERMINATION OF INDIVIDUAL INSURANCE: The insurance of an Insured will terminate on the first of the following to occur:

- (1) the date this Policy terminates; or
- (2) the last day of the Policy month in which the Insured ceases to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid for the Insured; or
- (4) the date the Insured enters military service (not including Reserve or National Guard).

INDIVIDUAL REINSTATEMENT: The insurance of a terminated person may be reinstated if he/she is:

- (1) on an approved leave of absence; or
- (2) on a temporary lay-off.

The Person must return to active work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

The Person will not be required to fulfill the eligibility requirements of this Policy again. The insurance will go into effect on the day he/she returns to active work. If a Person returns after having resigned or having been discharged, he/she will be required to fulfill the eligibility requirements of this Policy again.

If a Person returns after terminating at his/her request or for failure to pay premium when due, proof of good health must be approved by us before he/she may be reinstated.

WEEKLY INCOME INSURANCE

BENEFITS PAYABLE: We will pay Weekly Income Benefits if an Insured:

- (1) is disabled due to Sickness or Injury; and
- (2) becomes disabled while insured by this Policy.

Weekly Income Benefits are paid from the Day Benefits Begin as shown on the Schedule of Benefits. Benefits are paid up to the Maximum Benefit Period as shown on the Schedule of Benefits, for one period of disability.

The Weekly Income Benefit is shown on the Schedule of Benefits.

If we have underpaid any benefit for any reason, we will make a lump sum payment. If we have overpaid any benefit for any reason, the overpayment must be repaid to us. At our option, we may reduce the Weekly Income Benefit or ask for a lump sum refund. If we reduce the benefit, the Minimum Benefit, if any, as shown on the Schedule of Benefits page, would not apply. Interest does not accrue on any underpaid or overpaid benefit unless required by applicable law.

PERIOD OF DISABILITY: Each period of disability starts from the first day benefits are due. It will end when:

- (1) the Insured is no longer disabled; or
- (2) all benefits due have been paid.

Two or more disabilities will be deemed the same period of disability if they are from:

- (1) the same or related causes and are not separated by one (1) week of active work; or
- (2) a different cause and are not separated by one (1) full day of active work.

EXCLUSIONS: Weekly Income Benefits are not paid for any period of disability caused by:

- (1) an intentionally self-inflicted Injury; or
- (2) an act of war, declared or undeclared; or
- (3) the Insured committing a felony; or
- (4) Sickness which is covered by a Workers' Compensation Act, or other worker's disability law; or
- (5) Injury which occurs out of or in the course of work for wage or profit.

TRANSFER OF INSURANCE COVERAGE

If an employee was covered under any group weekly income insurance plan maintained by you prior to this Policy's effective date, that employee will be insured under this Policy, provided that he/she is Actively At Work and meets all of the requirements for being an Eligible Person under this Policy on its effective date.

If an employee was covered under the prior group weekly income disability plan maintained by you prior to this Policy's Effective Date, but was not Actively at Work due to Injury or Sickness on the Effective Date of this Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

- (1) The employee must have been insured with the prior carrier on the date of the transfer;
- (2) Premiums must be paid; and
- (3) Disability must begin on or after this Policy's Effective Date.

If an employee is receiving weekly income benefits, becomes eligible for coverage under another group weekly income disability insurance plan, or has a period of recurrent disability under the prior group weekly income insurance plan, that employee will not be covered under this Policy. If premiums have been paid on the employee's behalf under this Policy, those premiums will be refunded.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the Policy face page.

PREMIUM RATE: The Premium due will be the rate per \$10.00 of benefit multiplied by the entire amount of benefit then in force. We will furnish to you the premium rate on the Policy effective date and when it is changed. We have the right to change the premium rate:

- (1) on any premium due date after this Policy is in force for twenty-four (24) months; or
- (2) when the extent of coverage is changed by amendment; or
- (3) on any Premium Due Date on or after the first Policy Anniversary if your entire group's benefit changes by 15% or more from such group's benefit on the last Policy Anniversary.

We will not change the premium rate due to (1) above more than once in any twelve (12) month period. We will tell you in writing at least thirty-one (31) days before the date of a change due to (1) above.

GRACE PERIOD: You may pay the premium up to thirty-one (31) days after the date it is due. The Policy stays in force during this time. If the premium is not paid during the grace period, the Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date the Policy is cancelled.

**EXTENSION OF COVERAGE UNDER THE UNIFORMED SERVICES
EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Military Services Leave of Absence:

We will continue the Insured's coverage in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

This Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While the Insured is on a Military Services Leave of Absence he or she will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective for an Insured who is not considered Actively at Work until the Insured has returned to Active Work for one (1) full day.

A leave of absence taken in accordance with USERRA will run concurrently with any other applicable continuation of insurance provision in this Policy.

The Insured's coverage will cease under this extension on the earliest of:

- (1) the date this Policy terminates; or
- (2) the end of the period for which premium has been paid for the Insured; or
- (3) the date such leave should end in accordance with your policies regarding Military Services Leave of Absence in compliance with USERRA. Coverage will not be terminated for an Insured who becomes Disabled during the period of the leave and who is eligible for benefits according to the terms of this Policy. Any Weekly Benefit which becomes payable will be based on the Insured's Earnings immediately prior to the date of Disability.

Should you choose not to continue the Insured's coverage during a Military Services Leave of Absence, the Insured's coverage will be reinstated.

RELIANCE STANDARD LIFE INSURANCE COMPANY

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

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

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

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

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

**Ohio Life and Health Insurance Guaranty Association
1840 MacKenzie Drive
Columbus, Ohio 43220**

**Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215**

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

(please refer to next page)

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group 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. Also, for any one insured life, the association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$250,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under Sections 401(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 \$1,000,000 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.