



COMBINED INSURANCE

Combined Insurance Company of America

111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

GROUP VISION INSURANCE CERTIFICATE

POLICY NUMBER: 9795105 / 9798836 / 1011042
POLICYHOLDER: Northwestern University
POLICY ANNIVERSARY DATE: January 1, 2012 and each January 1 thereafter

Combined Insurance Company of America represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of an Out-of-Network Provider for a covered service in non-emergency situations, benefit payments to such Out-of-Network Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule. YOU CAN EXPECT TO PAY MORE THAN THE BENEFIT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Out-of-Network Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. In-Network Providers have agreed to accept discounted payments for services.

Signed for Combined Insurance Company of America

Brad Bennett, President

Rebecca L. Collins, Secretary

THIS IS A LIMITED BENEFIT CERTIFICATE

Please read the Certificate carefully.

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DEFINITIONS

Please note certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Benefit Frequency means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Co-payment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for covered Vision Examination and Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each unmarried dependent child from birth to age 26. The company will continue to provide coverage for a dependent college student who takes a medical leave of absence or becomes a part-time student because of a catastrophic sickness or injury. Coverage may continue for a period not to extend beyond the date on which coverage would otherwise end under the terms of the Policy;
3. each unmarried dependent child under the age of 30 years who (i) is an Illinois resident; (ii) served as a member of the active or reserve components of any of the branches of the armed forces of the United States; and (iii) was not dishonorably discharged; or
4. each unmarried child at least 26 years of age who is primarily dependent upon the Insured for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is an Insured Person under the Policy on his or her 26th birthday; and who has been continuously so incapacitated since his or her 26th birthday.

Child includes stepchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A full-time student is one who is enrolled at least the minimum number of hours of class a week the school considers as full-time status.

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the Insured have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and the Insured are not related by blood;
5. the Domestic Partner and the Insured are not married to any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

The term "spouse", wherever used, will include a Domestic Partner.

Fundus Photography Examination means the recording of a portion(s) or complete retina surface and structures.

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder's application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured's Dependents, if enrolled.

IntraLase Initiated LASIK means a LASIK surgical procedure in which a special laser is used instead of a blade to create the stromal flap.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

LASEK (Laser Assisted Epithelium Keratomileusis) means a surgical procedure that utilizes a trephine to create an epithelial flap and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

Laser Vision Correction Procedures means surgical procedures which permanently alter the focusing power of the eye(s) in order to change refractive errors.

LASIK (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to create a stromal flap of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the stromal flap is replaced and is adhered without stitches.

Medically Necessary Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization (“PPO”) means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute towards the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible, provided:
 - a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
 - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or greater, if elected. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of placement for 31 days or greater, if elected. In order to continue coverage beyond this period, the Insured must provide notice to the Company and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The Insured Person must pay any Co-payment or any cost above the allowance shown in the Schedule of Benefits at the time the covered service is provided. Benefits will be paid to the In-Network Provider who will file a claim with the Company.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Vision Materials. If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frame(s)* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services or materials provided by any other group benefit plan providing vision care;
9. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; and:
10. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
 - a. does so without individual selection between Insureds; and
 - b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. on the date the Insured's coverage ends;
2. the date on which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

The Company may ask for proof of the eligible Dependent child's incapacity and dependency two months prior to the date the Dependent child would otherwise cease to be covered.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

CLAIMS

Notice of Claim. Written notice of claim must be given to the Company within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Right of Recovery. If payment for claims exceeds the amount for which the Insured Person is eligible under any benefit provision or rider of the Policy, the Company has the right to recover the excess of such payment from the Provider or the Insured.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform to the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the Office of the Policyholder during normal business hours. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured, the Insured's beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured, the Insured's beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

SCHEDULE OF BENEFITS

Policyholder: Northwestern University

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

| <u>Benefit</u> | <u>In-Network Cost Benefit Amount</u> | <u>Out-of-Network Reimbursement Benefit Amount</u> | <u>Benefit Frequency</u> |
|--|--|---|---------------------------------|
| VISION EXAMINATION | | | |
| Comprehensive Eye Examination | \$10 Co-payment | up to \$40 | 12 months |
| Contact Lenses Fit And Follow-Up | | | 12 months |
| Standard Contact Lens Fit & Follow-Up | \$10 Co-payment, paid in full and two follow-up visits | up to \$40 | |
| Premium Contact Lens Fit & Follow-Up | \$10 Co-payment, then apply \$55 allowance | up to \$40 | |
| VISION MATERIALS | | | |
| <i>Standard Plastic Lenses</i> | | | 12 months |
| Single Vision | \$10 Co-payment | up to \$40 | |
| Bifocal | \$10 Co-payment | up to \$60 | |
| Trifocal | \$10 Co-payment | up to \$80 | |
| Lenticular | \$10 Co-payment | up to \$80 | |
| Frames | \$150 retail allowance | up to \$65 | 12 months |
| Contact Lenses (only one option available per Benefit Frequency) | | | 12 months |
| Conventional | \$0 Co-payment up to \$200 allowance | up to \$160 | |
| Disposable | \$0 Co-payment up to \$200 allowance | up to \$160 | |
| Medically Necessary | \$0 Co-payment Paid in full | up to \$210 | |
| Lens Options | | | 12 months |
| Standard Polycarbonate | \$0 Co-payment | up to \$5 | |
| Standard Polycarbonate (For covered Dependent children under 19 years of age.) | \$0 Co-payment | up to \$5 | |
| Standard Plastic Scratch Coating | \$0 Co-payment | up to \$5 | |
| Standard Progressive Lenses (add on to Bifocal) "Brand Names" | \$75 Co-payment | up to \$60 | |
| Premium Progressive Lenses (add on to Bifocal) "Brand Names" | Tier 1 - \$95 Co-payment Tier 2 - \$105 Co-payment Tier 3 - \$120 Co-payment Tier 4 - \$75 Co-payment, less \$120 allowance | up to \$60 | |

COMBINED INSURANCE COMPANY OF AMERICA
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

POLICY/CERTIFICATE AMENDMENT

The rider is attached to and made part of Policy No. <VC-###> issued by **Combined Insurance Company of America** to <ABC Employer/ABC Association/ABC Company>.

Effective <Month Day, Year>, this Policy and Certificate as issued is amended as follows:

CIVIL UNION ENDORSEMENT

The term "spouse", wherever used in the Policy and Certificate will include a Civil Union Partner.

Definition:

"Civil Union Partner" means an adult who has entered into a legal relationship with an Insured pursuant to Illinois law. To qualify as a Civil Union Partner or Dependent under the Policy, the following conditions must be met:

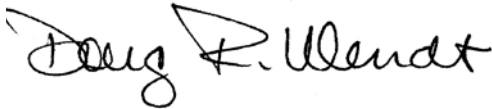
1. The Civil Union Partner and the Insured are of the same or opposite sex; and
2. The Civil Union Partner and the Insured are 18 years of age or older.

The following are prohibited civil unions:

1. The Civil Union Partner and the Insured are married, in a domestic partnership or a civil union with any other person;
2. The Civil Union Partner and the Insured are siblings by half or whole blood or adoption;
3. The Civil Union Partner and the Insured are aunt, uncle, niece or nephew by half or whole blood or adoption;
4. The Civil Union Partner and the Insured are first cousins.

This rider takes effect and expires concurrently with the Policy/Certificate to which it is attached and is subject to all the terms and conditions of the Policy.

Signed for **Combined Insurance Company of America**



Chairman and
Chief Executive Officer



Secretary

**ILLINOIS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION LAW**

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois 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 policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by insurers through the Association is not unlimited, however, as noted in below.

**ILLINOIS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION DISCLAIMER**

The Illinois 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 substantial limitations or exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

**Illinois Life and Health Insurance
Guaranty Association
8420 West Bryn Mawr Avenue, Suite 550
Chicago, Illinois 60631-3404
(773) 714-8050**

**Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767-0001
(217) 782-4515**

Summary of General Purposes and Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") [215 ILCS 5/531.01, et seq.]. The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association.

a) Coverage:

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

- 1) life insurance, health insurance, and annuity contracts;
- 2) life, health or annuity certificates under direct group policies or contracts;
- 3) unallocated annuity contracts; and
- 4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities.

The beneficiaries, payees or assignees of such persons are also protected, even if they live in another state.

b) Exclusions from Coverage:

The Guaranty Association does not provide coverage for:

- 1) any policy or portion of a policy for which the individual has assumed the risk;
- 2) any policy of reinsurance unless an assumption certificate was issued;
- 3) interest rate guarantees which exceed certain statutory limitations;
- 4) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association or natural persons benefit plan or government lottery;
- 5) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
- 6) any stop loss insurance.

In addition, persons are not protected by the Guaranty Association if:

- 1) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
- 2) their policy was issued by an organization which is not a member insurer of the Association.

c) Limits on Amounts of Coverage:

- 1) The law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
 - A) 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
 - B) with respect to any one life, regardless of the number of policies, contracts, or certificates:
 - i) in the case of life insurance, \$300,000 in death benefits but not more than \$100,000 in net cash surrender or withdrawal values;
 - ii) in the case of health insurance, \$300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
 - iii) with respect to annuities, \$100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and \$100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is \$5,000,000 in benefits per contract holder, regardless of the number of contracts.

- 2) However, in no event is the Guaranty Association liable for more than \$300,000 with respect to any one individual.



ACE GROUP OF COMPANIES U.S. PRIVACY NOTICE

FACTS WHAT DOES THE ACE GROUP OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?

| | |
|--------------|--|
| Why? | Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do. |
| What? | <p>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores <p>When you are no longer our customer, we continue to share information about you as described in this notice.</p> |
| How? | All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the ACE Group chooses to share; and whether you can limit this sharing. |

| Reasons we can share your personal information | Does ACE share? | Can you limit this sharing? |
|---|-----------------|-----------------------------|
| For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus | Yes | No |
| For our marketing purposes – to offer our products and services to you | Yes | No |
| For joint marketing with other financial companies | Yes | No |
| For our affiliates' everyday business purposes – information about your transactions and experiences | Yes | No |
| For our affiliates' everyday business purposes – information about your creditworthiness | No | We don't share |
| For our affiliates to market to you | No | We don't share |
| For nonaffiliates to market to you | No | We don't share |

| | |
|-------------------|---|
| Questions? | Call 1-800-352-4462 or go to www.acegroup.com/us-en/contact-us/general-inquiry-form.aspx |
|-------------------|---|

| Who we are | |
|--|---|
| Who is providing this notice? | The ACE Group of Companies. A list of these companies is located at the end of this document. |
| What we do | |
| How does ACE Group protect my personal information? | <p>To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.</p> <p>We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.</p> |
| How does ACE Group collect my personal information? | <p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> ▪ apply for insurance or pay insurance premiums ▪ file an insurance claim or provide account information ▪ give us your contact information <p>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p> |
| Why can't I limit all sharing? | <p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> ▪ sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ affiliates from using your information to market to you ▪ sharing for nonaffiliates to market to you <p>State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.</p> |
| Definitions | |
| Affiliates | <p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> ▪ Our affiliates include those with an ACE name and financial companies, such as Westchester Fire Insurance Company and ESIS, Inc. |
| Nonaffiliates | <p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> ▪ ACE does not share with nonaffiliates so they can market to you. |
| Joint Marketing | <p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> ▪ Our joint marketing partners include categories of companies such as banks. |

Other important information

For Insurance Customers in CA, CT, GA, IL, MA, ME, MN, MT, NC, NJ, OH, OR, and VA only: Under state law, you have the right see the personal information about you that we have on file. To see your information, write ACE US Customer Services, P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. ACE USA may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling **1-800-352-4462**, emailing us at info@acegroup.com, or writing to P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. You are being provided this notice under Nevada state law. In addition to contacting ACE, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

ACE Group of Companies legal entities

ACE Group of Companies use the names: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Property and Casualty Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, ESIS, Inc., Combined Insurance Company of America, Combined Life Insurance Company of New York, Penn Millers Insurance Company, Agri General Insurance Company