NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

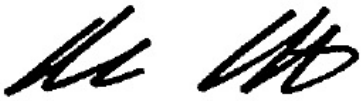
Policyholder: Lawrence Livermore National Security LLC
Policy Number: PAI 0009113067-A

GROUP ACCIDENT INSURANCE CERTIFICATE

ABOUT THIS CERTIFICATE. This certificate describes accident insurance the Company provides to Insured Persons under the Group Policy (herein called the Policy) issued to the Policyholder.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this certificate:

President



Secretary

PLEASE READ THIS CERTIFICATE CAREFULLY.

Non-Participating

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DEFINITIONS

Annual Salary - means the Insured's base annual salary exclusive of overtime, bonuses, tips, commissions and special compensation.

Eligible Dependent - means an Eligible Spouse or an Eligible Dependent Child.

Eligible Dependent Child(ren) - means the Insured's unmarried children, including natural, step, foster or adopted children from the moment of placement in the home of the Insured, under age 25 (26 if attending an accredited institution of higher learning on a full time basis) and primarily dependent on the Insured for support and maintenance.

Any unmarried Eligible Dependent Child(ren) before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if they remain continuously covered under the Policy. The Company may request that the Insured submit satisfactory proof of the Eligible Dependent Child(ren)'s incapacity and dependency to the Company within 31 days after the Eligible Dependent Child(ren) reach the age limit specified above. If the Insured fails to furnish the requested proof before the Eligible Dependent Child(ren) reach the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the Company may request that the Insured submit satisfactory proof of the Eligible Dependent Child(ren)'s continued incapacity and dependency to the Company on an annual basis. If the Insured fails to furnish the requested proof within 31 days of the request, coverage for the Eligible Dependent Child(ren) will terminate at the end of that 31-day period.

Eligible Spouse - means the Insured's legal spouse.

Family Coverage - means coverage in force under the Policy on an Insured's Eligible Dependents: 1) whom the Insured has elected to cover under the Policy; and (2) for whom premium has been paid.

Injury - means bodily injury caused by an accident occurring while the Policy is in force as to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a covered loss.

Insured - means the person named in the Schedule who has enrolled for coverage under the Policy, if required and for whom premium has been paid while covered under the Policy.

Insured Dependent - means an Insured Spouse or an Insured Dependent Child.

Insured Dependent Child(ren) - means the Insured's Eligible Dependent Child(ren): (1) whom the Insured has elected to cover under the Policy; (2) for whom premium has been paid; and (3) while covered under the Policy.

Immediate Family Member - means a person who is related to the Insured Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild.)

Insured Person - means an Insured or an Insured Dependent.

Insured Spouse - means the Insured's Eligible Spouse: (1) whom the Insured has elected to cover under the Policy; (2) for whom premium has been paid; and (3) while covered under the Policy.

Physician - means a licensed practitioner of the healing arts acting within the scope of his or her license who is not: 1) the Insured Person; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Schedule - means the enrollment form on file with the Policyholder.

INSURED'S EFFECTIVE AND TERMINATION DATES

Effective Date. The Insured's coverage under the Policy begins on the Effective Date of Coverage as shown in the Schedule.

A change in coverage due to a change in the Insured's class, Annual Salary, or election of Principal Sum amount will become effective on the later of the following dates: (1) if individual enrollment is required, the date the written enrollment form requesting the change is received by the Policyholder; or (2) if the change requires a change in premium, the date the first changed premium is paid when due. A change in coverage applies only with respect to accidents that occur on or after the effective date of the change.

Termination Date. An Insured's coverage under the Policy ends on the earliest of: (1) the date the Policy is terminated; (2) the premium due date if premiums are not paid when due; (3) the date the Insured requests, in writing, that his or her coverage be terminated; or (4) the date the Insured ceases to be eligible for coverage under the Policy.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force under this Policy.

Continuation of Eligibility. If premium payments are continued on a basis that precludes individual selection, an Insured who ceases to be a member of any eligible class of persons as described in the Master Application may still be regarded as in an eligible class of persons as follows: (1) if the Insured is on temporary lay-off or leave of absence (other than an authorized family or medical leave), for the full period of the lay-off or leave, but not for more than three months in a row; or (2) if the Insured is absent from work due to an authorized family or medical leave, for the full period of the leave, but not for more than three months in a row unless a longer period is agreed to by the Company and the Policyholder.

The portion of premium payments paid by the Insured, if any, must continue to be paid during any period of leave as described above for coverage to remain in force.

INSURED DEPENDENT'S EFFECTIVE AND TERMINATION DATES

Effective Date. An Insured Dependent's coverage under the Policy begins on the latest of: (1) the date the Insured's coverage begins; (2) the date the first premium for the Insured Dependent's coverage is paid when due***;*** (3) if individual enrollment is required, the date the Insured enrolls the dependent for Family Coverage except if the Insured does not enroll within 31 days after the date the dependent becomes an Eligible Dependent, the Insured must wait until the next open enrollment period of the Policyholder to enroll the dependent; or (4) the date the person becomes an Eligible Dependent.

Termination Date. An Insured Dependent's coverage under the Policy ends on the earliest of: (1) the date the Insured's coverage ends; (2) the premium due date if premiums for the Insured Dependent are not paid when due; (3) the date the Insured requests, in writing, that coverage for the Insured Dependent be terminated; or (4) the date the Insured Dependent ceases to be an Eligible Dependent.

Termination of coverage will not affect a claim for a covered loss which is incurred while the Insured Dependent's coverage was in force under the Policy.

PREMIUM

Premiums. The Company provides insurance in return for premium payments. The premium shown in the Schedule is payable to the Company in the manner described in the Schedule. The Company may change the required premiums due by giving the Policyholder at least 31 days advance written notice. The Company may also change the required premiums at any time when any coverage change affecting premiums is made in the Policy.

Grace Period. A Grace Period of 31 days will be provided for the payment of any premium due after the first. An Insured Person's coverage will not be terminated for nonpayment of premium during the Grace Period if all premiums due are paid by the last day of the Grace Period. An Insured Person's coverage will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid by the last day of the Grace Period.

If the Company expressly agrees to accept late payment of a premium without terminating coverage under the Policy, the Company does so in accordance with the Noncompliance with Policy Requirements provision of the General Provisions section.

No Grace Period will be provided if the Company receives notice to terminate the Insured Person's coverage under the Policy prior to a premium due date.

BENEFITS AND COVERAGES

Principal Sum. As applicable to each Insured, Principal Sum means the amount of insurance in force under the Policy as described in the Schedule. Principal Sum amounts above $100,000 may not exceed 10 times the Insured's Annual Salary.

As applicable to an Insured Dependent, Principal Sum means the amount of insurance in force under the Policy as described in the Schedule.

If a husband and wife are both eligible to enroll for coverage under the Policy, one, but not both, may purchase Family Coverage. The other spouse may elect single coverage only.

In the event that a person is covered under the Policy as an Insured and as an Insured Dependent, the combined Principal Sum on that person may not exceed $500,000.

Reduction Schedule

The amount payable for a loss will be reduced if an Insured Person is age 70 or older on the date of the accident causing the loss with respect to any Benefit provided under the Policy where the amount payable for the loss is determined as a percentage of his or her Principal Sum. The amount payable for the Insured Person's loss under that Benefit is a percentage of the amount that would otherwise be payable, according to the following schedule:

AGE ON DATE OF ACCIDENT	PERCENTAGE OF AMOUNT OTHERWISE PAYABLE
70-74	65%
75-79	45%
80-84	30%
85 and older	15%

Premium for an Insured Person age 70 or older is based on 100% of the coverage that would be in effect if the Insured Person were under age 70.

"Age" as used above refers to the age of the Insured Person on the Insured Person's most recent birthday, regardless of the actual time of birth.

Limitation on Multiple Benefits

If an Insured Person suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits provided under the Policy, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit, Paralysis Benefit, Coma Benefit.

Accidental Death Benefit

If Injury to the Insured Person results in death within 365 days of the date of the accident that caused the Injury, the Company will pay 100% of the Principal Sum.

Accidental Dismemberment Benefit

If Injury to the Insured Person results, within 365 days of the date of the accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Principal Sum shown below for that Loss:

For Loss of	Percentage of Principal Sum
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If more than one Loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

Exposure and Disappearance

If by reason of an accident occurring while an Insured Person's coverage is in force under the Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Person has suffered accidental death within the meaning of the Policy.

Bereavement and Trauma Counseling Benefit

Bereavement and Trauma Counseling Benefit. If an Insured Person suffers an accidental death or an accidental dismemberment or paralysis for which an Accidental Death or Accidental Dismemberment and Paralysis benefit is payable under the Policy, or if he or she goes into a coma for which a Coma benefit is payable under the Policy, the Company will pay Covered Bereavement and Trauma Counseling Expenses that are due to his or her death or dismemberment or paralysis or coma. The Covered Bereavement and Trauma Counseling Expenses must be incurred within one year after the date of the accident causing such loss(es), up to a maximum of $50 per session for up to 10 sessions for the Insured Person and all of his or her Immediate Family Members combined with respect to all such losses caused by the same accident.

"Covered Bereavement and Trauma Counseling Expense(s)" - means an expense that: (1) is charged for a Medically Necessary Bereavement or Trauma Counseling Session for the Insured Person and/or one or more of his or her Immediate Family Member(s) provided under the care, supervision or order of a Physician; (2) does not exceed the usual level of charges for similar counseling sessions in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

"Medically Necessary Bereavement or Trauma Counseling Session" - means any individual, joint or family mental health counseling session that: (1) is essential to assist the Insured Person and/or one or more Immediate Family Members in coping with the loss for which it is provided; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

Exclusions. In addition to the Exclusions in the Exclusions section of this Certificate, Covered Bereavement and Trauma Counseling Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

Carjacking Benefit (Percentage of Principal Sum Amount)

Carjacking Benefit. The Company will pay a benefit when the Insured Person suffers one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, Coma Benefit or Paralysis Benefit provided by the Policy as a result of a Carjacking of an Automobile while the Insured Person is operating, or riding as a passenger in, (including getting in or out of) such Automobile.

The amount payable for this benefit is the lesser of: (1) $10,000; or (2) 10% of the largest benefit payable under any one of the Benefits specified above due to the Carjacking. Only one benefit is payable for all losses as a result of the same Carjacking.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

"Automobile" - means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

"Carjacking" - means taking unlawful possession of an Automobile by means of force or threats against the person(s) then rightfully occupying such Automobile.

Child(ren)'s Additional Indemnity for Dismemberment and Paralysis Benefit

(Applicable to Eligible Dependent Children Only)

If an Insured has Family Coverage in effect under the Policy and an Insured Dependent Child suffers an accidental dismemberment or an accidental paralysis for which an Accidental Dismemberment benefit or a Paralysis benefit is payable under the Policy, the Company will pay this additional benefit to or on behalf of an Insured Dependent Child. It is payable with respect to the one Benefit specified above which provides the larger benefit for all Injuries suffered by the Insured Dependent Child in the same accident. The amount payable for this additional benefit is equal to the amount payable under the Accidental Dismemberment Benefit or Paralysis Benefit, subject to a maximum of $105,000.

Coma Benefit

If Injury renders an Insured Person Comatose within 365 days of the date of the accident that caused the Injury, and if the Coma continues for a period of 30 consecutive days, the Company will pay a monthly benefit of 1% of the Principal Sum. No benefit is provided for the first 30 days of Coma. The benefit is payable monthly as long as the Insured Person remains Comatose due to that Injury, but ceases on the earliest of: (1) the date the Insured Person ceases to be Comatose due to that Injury; (2) the date the Insured Person dies; or (3) the date the total amount of monthly Coma benefits paid for all Injuries caused by the same accident equals 100% of the Principal Sum. The Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Company is liable when the Insured Person is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured

Person is Comatose, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

"Coma/Comatose" - means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

Common Carrier Benefit

If the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the accident causing death occurs while the Insured Person is riding in or on (including getting in or out of, or on or off of) a Common Carrier, the Company will pay this additional benefit. The amount payable for this additional benefit is the lesser of: (1) $50,000; or (2) 100% of the Insured Person's Principal Sum.

"Common Carrier" - means any land, sea, or air conveyance operated under a license for the transportation of passengers for hire.

Common Disaster Benefit
(Applicable to Employees and Eligible Spouses Only)

If an Insured with Family Coverage in effect under the Policy and his or her Insured Spouse both suffer accidental death in the same accident within 90 days of the accident or from separate accidents occurring within a 24 hour period such that an Accidental Death benefit is payable under the Policy for both persons, the Insured Spouse's Principal Sum is increased to equal the lesser of: (1) $100,000; or (2) 100% of the Insured's Principal Sum.

Conversion Privilege
(Applies to the Accidental Death Benefit and Accidental Dismemberment Benefit Only)

If an Insured Person's coverage ends (prior to age 80) because he or she is no longer eligible for coverage under the Policy, coverage may be converted to an individual accidental death and dismemberment policy (herein called an Individual Policy). However, an Insured Dependent may convert only if he or she is the age of majority or over on the date coverage ends.

The Company must receive a written application and payment of the required premium within 31 days after coverage ends under the Policy. No evidence of insurability is required to obtain the Individual Policy. The Individual Policy will be a type the Company regularly makes available on its effective date. The initial premium for the Individual Policy will be based on the Insured Person's attained age, risk class, and amount of insurance provided, at the time of application for the Individual Policy.

Coverage under the Individual Policy will take effect on the later of: (1) the date the application and required premium payment are received by the Company; or (2) the date that the Insured Person's coverage under the Policy ends. In the event that the application and required premium are not received prior to termination of coverage under the Policy, coverage is not provided from the date coverage ends under the Policy until the date coverage under the Individual Policy becomes effective. Coverage under the Individual Policy may not be less than $100,000 and may not exceed the greater of: (1) the amount for which the Insured Person was covered under the Policy; or (2) $500,000.

Day Care Benefit
(Applicable to Employees and Eligible Spouses Only)

If an Insured or the Insured Spouse suffers accidental death such that an Accidental Death benefit is payable under the Policy and the Insured had Family Coverage in effect under the Policy on the date of the accident causing death, the Company will pay a benefit on behalf of any Insured Dependent Child under age 13 who was insured under the Policy on the date of the accident causing death and who: (1) is enrolled in a Day Care Center on the date of the Insured's or the Insured Spouse's death; or (2) enrolls in a Day Care Center within

365 days after the Insured's or the Insured Spouse's death. The benefit is payable for each year of the Insured Dependent Child's enrollment in a Day Care Center. The total amount of the benefit each year is equal to the least of:

1. the actual cost of care for that Insured Dependent Child charged by that Day Care Center for that year;
2. 5% of the Insured's or the Insured Spouse's Principal Sum on the date of the accident causing death; or
3. $5,000.

The applicable portion of the yearly benefit for each period of enrollment is payable upon receipt of due proof of enrollment, but not more frequently than monthly.

The benefit is not payable for any period of enrollment in a Day Care Center before the date of the accident that caused the Insured's or the Insured Spouse's death. The benefit is not payable for any period of enrollment after the earlier of: (1) the date the Insured Dependent Child reaches 13 years of age; or (2) the date four (4) years after the later of the date of the Insured's or the Insured Spouse's death or the date the Insured Dependent Child first enrolls in a Day Care Center.

"Day Care Center" - means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction.

Home Alteration and Vehicle Modification Benefit

Home Alteration and Vehicle Modification Benefit. If an Insured Person:

1. suffers an accidental dismemberment or paralysis for which an Accidental Dismemberment and Paralysis benefit is payable under the Policy;
2. did not, prior to the date of the accident causing such loss(es), require the use of a wheelchair to be ambulatory; and
3. as a direct result of such loss(es) is now required to use a wheelchair to be ambulatory;

the Company will pay Covered Home Alteration and Vehicle Modification Expenses that are incurred within one year after the date of the accident causing such loss(es), up to a maximum of $25,000 for all such losses caused by the same accident.

Covered Home Alteration and Vehicle Modification Expenses - means one-time expenses that:

1. are charged for:
   (a) alterations to the Insured Person's residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person; or
   (b) modifications to a motor vehicle owned or leased by the Insured Person or modifications to a motor vehicle newly purchased for the Insured Person that are necessary to make the vehicle accessible to and/or driveable by the Insured Person; and
2. do not include charges that would not have been made if no insurance existed; and
3. do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;

but only if the alterations to the Insured Person's residence and the modifications to his or her motor vehicle are:

1. made on behalf of the Insured Person;
2. recommended by a nationally-recognized organization providing support and assistance to wheelchair users;
3. carried out by individuals experienced in such alterations and modifications; and

4. in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

Exclusions. In addition to the Exclusions in the Exclusions section of this Certificate, Covered Home Alteration and Vehicle Modification Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

Natural Disaster Benefit (Percentage of Principal Sum Amount)

Natural Disaster Benefit. The Company will pay a benefit when the Insured Person suffers one or more losses as a result of an accident that occurred in the declared disaster area and for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, Coma Benefit, Paralysis Benefit provided by the Policy as a direct result of a Natural Disaster.

The amount payable under this benefit is the lesser of: (1) $25,000; or (2) 10% of the largest benefit payable under any one of the Benefits specified above due to the Natural Disaster. Only one benefit is payable for all losses as a result of the same Natural Disaster.

"Natural Disaster" - means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event that: (1) is due to natural causes; and (2) results in such severe and widespread damage that the area of damage is officially declared a disaster area by a state government or the federal government if the event occurs in the United States of America, or by a corresponding governmental authority if the event occurs outside of the United States of America.

Paralysis Benefit

If Injury to the Insured Person results, within 365 days of the date of the accident that caused the Injury, in any one of the types of paralysis specified below, the Company will pay the percentage of the Principal Sum shown below for that type of paralysis:

Type of Paralysis	Percentage of Principal Sum
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%

"Quadriplegia" means the complete and irreversible paralysis of both upper and both lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. "Limb" means entire arm or entire leg.

If the Insured Person suffers more than one type of paralysis as a result of the same accident, only one amount, the largest, will be paid.

Rehabilitation Benefit

If an Insured Person suffers an accidental dismemberment or an accidental paralysis for which an Accidental Dismemberment or Paralysis benefit is payable under the Policy, the Company will reimburse the Insured Person for Covered Rehabilitative Expenses that are due to the Injury causing the dismemberment or paralysis. The Covered Rehabilitative Expenses must be incurred within two years after the date of the accident causing that Injury, up to a maximum of $10,000 for all Injuries caused by the same accident.

"Hospital" - for purposes of this benefit, means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities

available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N.); and (4) is supervised by one or more Physicians. A Hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

"Medically Necessary Rehabilitative Training Service" - means any medical service, medical supply, medical treatment or Hospital confinement (or part of a Hospital confinement) that: (1) is essential for physical rehabilitative training due to the Injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a Physician.

"Covered Rehabilitative Expense(s)" - means an expense that: (1) is charged for a Medically Necessary Rehabilitative Training Service of the Insured Person performed under the care, supervision or order of a Physician; (2) does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a Hospital room and board charge, does not exceed the most common charge for Hospital semi-private room and board in the Hospital where the expense is incurred); and (3) does not include charges that would not have been made if no insurance existed.

Exclusions. In addition to the Exclusions in the Exclusions section of this Certificate, Covered Rehabilitative Expenses do not include any expenses for or resulting from an Injury for which the Insured Person is entitled to benefits paid or payable by Workers' Compensation or other similar law.

Repatriation of Remains Benefit

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, the Company will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $50,000.

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard Group, Inc. in advance.

"Emergency Sickness" – means an illness or disease, diagnosed by a Physician, which meets all of the following criteria: (1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Insured Person's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the Policy is in force as to the Insured Person suffering the symptom.

Exclusion 2 in the Exclusions section of this Certificate does not apply with respect to this benefit. In addition to the Exclusions in the Exclusions section of this Certificate, Repatriation of Remains benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Insured Person is entitled to benefits under any Workers' Compensation Act or similar law.

Seat Belt and Air Bag Benefit

Seat Belt Benefit (Percentage of Principal Sum). If the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the accident causing death occurs while the Insured Person is operating, or riding as a passenger in, an Automobile and wearing a properly fastened, original, factory-installed seat belt or, if the Insured Person is a child, a properly installed and fastened child

restraint device as defined by state law**,** the Company will pay this additional benefit. The amount payable for this additional benefit is the lesser of: (1) $25,000; or (2) 10% of the Insured Person's Principal Sum.

Air Bag Benefit (Percentage of Principal Sum). If a Seat Belt Benefit is payable and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the Company will pay this additional benefit. The additional amount payable for this benefit is the lesser of: (1) $25,000; or (2) 10% of the Insured Person's Principal Sum.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

"Automobile" - means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

"Supplemental Restraint System" - means an air bag which inflates for added protection to the head and chest areas.

Severe Burn Benefit

Severe Burn Benefit. If an Insured Person suffers an Injury that is a Severe Burn, the Company will pay a benefit as described in this benefit. The benefit payable is based on the Maximum Percentage of Principal Sum shown below with respect to the Specified Body Area shown below:

Specified Body Area	Maximum Percentage of Principal Sum
Face and Neck and Head	99%
Hand and Forearm Below Elbow Joint (Right)	22.5%
Hand and Forearm Below Elbow Joint (Left)..	.....22.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Right)	13.5%
Upper Arm Below Shoulder Joint to Elbow Joint (Left)	13.5%
Torso Below Neck to Shoulder Joints and Hip Joints (Front)	36%
Torso Below Neck to Shoulder Joints and Hip Joints (Back)	36%
Thigh Below Hip Joint to Knee Joint (Right)	9%
Thigh Below Hip Joint to Knee Joint (Left)	9%
Foot and Lower Leg Below Knee Joint (Right)	27%
Foot and Lower Leg Below Knee Joint (Left)	27%

If only one of the Insured Person's Specified Body Areas is Severely Burned in an accident:

1. and 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is 100% of the Maximum Percentage of Principal Sum shown for that Specified Body Area.

2. and a lesser proportion of the surface of that Specified Body Area is Severely Burned, the benefit payable is that same lesser proportion of the Maximum Percentage of Principal Sum shown above for that Specified Body Area.

(For example: The Maximum Percentage of Principal Sum shown for the "foot and lower leg below knee joint (right)" Specified Body Area is 27%. If 100% of the surface of that Specified Body Area is Severely Burned, the benefit payable is 100% of 27%, or 27%, of the Principal Sum. If 50% of that surface is Severely Burned,

the benefit payable is 50% of 27%, or 13.5%, of the Principal Sum. If 1/3 of that surface is Severely Burned, the benefit payable is 1/3 of 27%, or 9%, of the Principal Sum.)

If more than one of the Insured Person's Specified Body Areas is Severely Burned as a result of the same accident, the benefit payable is the lesser of: (1) the sum of the benefit amounts calculated separately, according to the above rules, with respect to each such Specified Body Area; or (2) 100% of the Principal Sum.

The determination of whether or not a Specified Body Area is Severely Burned, and what proportion of its surface is Severely Burned, must be made by a Physician. The Company has a right, at its own expense, to have the determination verified by a Physician of the Company's choice.

"Severe Burn/Severely Burned" - means cosmetic disfigurement of the surface of a body area due to an Injury that is a full-thickness or third-degree burn, as determined by a Physician. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).

Tuition Benefit

(Applicable to Employees and Eligible Spouses Only)

If an Insured or the Insured Spouse suffers accidental death such that an Accidental Death benefit is payable under the Policy and the Insured had Family Coverage in effect under the Policy on the date of the accident causing death, the Company will pay the following benefit:

A. **For the Insured Dependent Children under Age 23.** The Company will pay a benefit to or on behalf of any Insured Dependent Child under age 23 who was insured under the Policy on the date of the accident causing death and who, on the date of the Insured's or the Insured Spouse's death: (1) is a full-time student in any Institution of Higher Learning above grade 12; or (2) is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Insured's or the Insured Spouse's death. The benefit will be paid for each year of the Insured Dependent Child's continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of four (4) consecutive years. The total amount of the benefit each year is equal to the least of:

1. the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Insured Dependent Child;
2. 5% of the Insured's or the Insured Spouse's Principal Sum on the date of the accident causing death; or
3. $2,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

An Insured Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if he or she reenrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Insured's or the Insured Spouse's death. If there is no Insured Dependent Child under age 23 eligible for the benefit within 365 days after the date of the Insured's or the Insured Spouse's death, the Company will pay a one-time lump sum benefit of $10,000 to the Insured or Insured Spouse's designated beneficiary.

"Institution of Higher Learning" - means any accredited institution that provides education or training beyond the 12th grade level, including, but not limited to, any state university, private college, or trade school.

EXCLUSIONS

The Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury;

2. sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning;

3. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Person is:

    a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

    b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

    c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or by the Insured Person's employer;

4. declared or undeclared war, or any act of declared or undeclared war; or

5. full-time active duty in the armed forces of any country or international authority, except the National Guard or organized reserve corps duty (unearned premium will be returned if the Insured Person enters military service).

CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after the occurrence or commencement of an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at AIG, Accident & Health Claims Department, PO Box 25987, Shawnee Mission, KS 66225, with information sufficient to identify the Insured Person, is deemed notice to the Company.

Claim Forms. The Company will send such claim forms as are usually sent by it for filing proof of loss to the claimant upon receipt of a written notice of claim. If such forms are not sent within 15 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in this Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured's name, the Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to the Company, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Time of Payment of Claims. Benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon the Company’s receipt of due written proof of the loss. Subject to the Company’s receipt of due written proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured Person will be made to the Insured Person’s beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured. If an Insured dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee’s property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at the Company’s option, to any relative by blood or connection by marriage of the payee, who, in the Company’s opinion, has assumed the custody and support of the minor or responsibility for the incompetent person’s affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

GENERAL PROVISIONS

Entire Contract; Changes. The Policy, the Master Application, and any attached Riders, Endorsements and Amendments constitute the entire contract between the parties, and any statement made by the Policyholder or by any Insured Person shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application.

No change in the Policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Time Limit on Certain Defenses. After three years from the effective date of the coverage with respect to which any claim is made, no misstatement of any Insured Person eligible for coverage under the Policy, except a fraudulent misstatement, made in an application under the Policy shall be used to deny a claim for loss incurred commencing after expiration of such three years.

Physical Examination and Autopsy. The Company at its own expense has the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy when and as often as it may reasonably require during the pendency of the claim and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of 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.

Insured's Beneficiary Designation and Change. The Insured's designated beneficiary(ies) is (are) the person(s) so named by the Insured for the Policyholder's group life insurance policy as shown on the Policyholder's records kept on that policy, unless the Insured has named a beneficiary specifically for the Policy as shown on the Company's records kept on the Policy.

An Insured over the age of majority and legally competent may change his or her beneficiary designation at any time, unless an irrevocable designation has been made, without the consent of the designated beneficiary(ies), by providing the Company with a written request for change. When the request is received by the Company whether the Insured is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment made by it prior to receipt of the request.

If there is no designated beneficiary or no designated beneficiary is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: the Insured's (1) spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured's estate.

Insured Dependent's Beneficiary Designation and Change. The Insured Dependent's beneficiary is the Insured unless the Insured has named (a) different beneficiary(ies) for the Insured Dependent's coverage as shown on the Company's records kept on the Policy.

An Insured over the age of majority and legally competent may change the beneficiary designation for an Insured Dependent's coverage at any time, unless an irrevocable beneficiary designation has been made, without the consent of the Insured Dependent or the designated beneficiary(ies), by providing the Company with a written request for change. When the request is received by the Company whether the Insured or the Insured Dependent is then living or not, the change of beneficiary will relate back to and take effect as of the

date of execution of the written request, but without prejudice to the Company on account of any payment made by it prior to receipt of the request.

If no beneficiary is living on the date of an Insured Dependent's death, the beneficiary is the Insured's estate.

Misstatement of Age. If premiums for the Insured Person are based on age and the Insured Person has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

Conformity With State Statutes. Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of those statutes.

Noncompliance with Policy Requirements. Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Workers' Compensation. The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. Clerical error, whether by the Policyholder or the Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

Assignment. An Insured may not assign any of his or her rights, privileges or benefits under the Policy. An Insured may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her designated beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.
Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: Lawrence Livermore National Security LLC
Policy Number: PAI 0009113067-A

INJURY DEFINITION AND EXCLUSIONS AMENDATORY ENDORSEMENT

This Endorsement is attached to and made part of this Certificate effective January 1, 2019. It applies only with respect to accidents and Emergency Sicknesses and losses of life that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of this Certificate except as they are specifically modified by this Endorsement.

1. The definition of Injury in the Definitions section of this Certificate is deleted and replaced by the following:

> **Injury** - means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force, and (2) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

2. The Exclusions section of the Certificate is deleted and replaced by the following:

Exclusions

No coverage shall be provided under the Policy and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily Injury.

1 suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury or auto-eroticism.

2. sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.

3. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Person is:

   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

   c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or the Insured Person's employer.

4. declared or undeclared war, or any act of declared or undeclared war.

5. infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.

6. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.).

7. the Insured Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.

8. the Insured Person being under the influence of drugs unless taken under the advice of and as specified by a Physician.

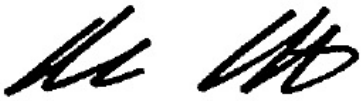
9. the Insured Person's commission of or attempt to commit a crime.

10. the medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.

11. stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:

President



Secretary

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.
Executive Offices: 175 Water Street, 15th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

THIS ENDORSEMENT CHANGES THE POLICY
PLEASE READ IT CAREFULLY

Policyholder: Lawrence Livermore National Security LLC
Policy Number: PAI 0009113067-A
Effective Date: January 1, 2019

CIVIL UNIONS/STATE REGISTERED DOMESTIC PARTNERSHIP ENDORSEMENT

This Endorsement is issued in consideration of the premium paid and is attached to and made part of the Policy or Certificate as of the Effective Date shown above at 12:01 AM Standard Time at the address of the Policyholder. It applies only with respect to coverages that are in effect on or after that date. Any changes in the premium apply as of the first premium due date on or after the effective date of this Endorsement. It is subject to all of the provisions, benefits, limitations, and exclusions of the Policy or Certificate except as they are specifically modified by this Endorsement. If there is a conflict between the Policy or Certificate and this Endorsement, the terms of this Endorsement will govern. This Endorsement amends the Policy or Certificate in the following manner:

- The following definitions are added to and made a part of the Policy or Certificate. They replace any definitions pertaining to Domestic Partnership that may already be contained in the Policy or Certificate.

  Civil Union Partner or **State Registered Domestic Partner** means a person who has entered into a Civil Union or a State Registered Domestic Partnership.

  Civil Union or **State Registered Domestic Partnership** means an arrangement under which two persons have established a relationship as defined by and pursuant to the laws of the state in which such relationship has been recognized and under which both persons are entitled to receive the benefits and protections, and be subject to the responsibilities, of spouses.

- The definitions, terms, conditions or any other provisions of the Policy, including any Application, the Certificate, and/or any Riders and Endorsements to which this Endorsement is attached are hereby amended and superseded as follows:

  Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as “marriage”, “spouse”, “husband”, “wife”, “dependent”, “next of kin”, “relative”, “beneficiary”, “survivor”, “immediate family” and any other such terms include the relationship created by a Civil Union or a State Registered Domestic Partnership.

  Terms that mean or refer to the inception or dissolution of a marriage, such as “date of marriage”, “divorce decree”, “termination of marriage” and any other such terms include the inception or dissolution of a Civil Union or a State Registered Domestic Partnership.

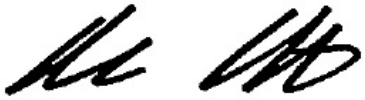
  Terms that mean or refer to family relationships arising from a marriage, such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include family relationships created by a Civil Union or a State Registered Domestic Partnership.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

State law may grant Civil Union Partner or State Registered Domestic Partners the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to Civil Union Partners or State Registered Domestic Partners. For example, federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of Civil Union Partners or State Registered Domestic Partners in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of Civil Union Partners or State Registered Domestic Partners if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, Civil Union Partners or State Registered Domestic Partners and their families may or may not have access to certain benefits under the Policy, Certificate (if applicable), Rider, or Endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under the Policy.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Endorsement:

President



Secretary

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

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

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

COVERAGE

- **Persons Covered**

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

- **Amounts of Coverage**

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

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

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

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

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

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

- **Health Insurance**

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

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org or contact either of the following:

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

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

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