

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 47831
 Company Tracking Number: GL51
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: GL51 - Group Critical Illness - The Lincoln Natio
 Project Name/Number: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company /GL51 - Group Critical Illness - The Lincoln
 National Life Insurance Company

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: GL51 - Group Critical Illness - The Lincoln Natio
 SERFF Tr Num: MCHX-G127008323 State: Arkansas

TOI: H07G Group Health - Specified Disease - Limited Benefit
 SERFF Status: Closed-Approved- Closed State Tr Num: 47831

Sub-TOI: H07G.001 Critical Illness Co Tr Num: GL51 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting Disposition Date: 02/07/2011

Date Submitted: 01/28/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company Status of Filing in Domicile: Pending

Project Number: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company Date Approved in Domicile:

Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small and Large

Group Market Type: Employer Overall Rate Impact:

Filing Status Changed: 02/07/2011

State Status Changed: 02/07/2011

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

RE: The Lincoln National Life Insurance Company

NAIC # 0020-65676 FEIN # 35-0472300

Group Critical Illness Forms

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
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GL51-1-FP, et al (See enclosed list)

Dear Commissioner Bradford:

McHugh Consulting Resources has been requested to file the enclosed forms on behalf of The Lincoln National Life Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned Group Critical Illness forms for your review and approval. These forms are new and will not replace any previously approved forms with your Department.

The enclosed forms are designed to provide group critical illness coverage. The forms will be used for group policies and certificates in your state. They will be used in conjunction with group application GL2-APP.02/10 previously approved under State Tracking No. 45382, SERFF Tracking No. JEPT-126576276 on April 8, 2010. Group Policy Series GL 51 and Group Certificate Series GL52 will be marketed by licensed agents and brokers primarily to employer groups, but also may be used with labor union or professional association groups.

The forms are for use in traditional paper format or in an electronic format. Formatting and page numbers may change slightly when the document is assembled through an automated assembly system. Printing standards will never be less than those required by law. We request that bracketed and underlined material be variable. An Appendix of Variability describing the forms and variables is enclosed. A Readability Certification is also enclosed.

Thank you for your attention to this filing. Please do not hesitate to contact the undersigned at 215.230.7960 if there any question that we can answer regarding this filing.

Sincerely,

Katherine Hansen
Consultant
mcr@mchughconsulting.com

Company and Contact

Filing Contact Information

Tim Hager, Compliance Project Specialist mcr@mchughconsulting.com
McHugh Consulting Resources, Inc. 215-230-7960 [Phone]

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 National Life Insurance Company

2005 South Easton Road, Suite 207 215-230-7961 [FAX]
 Doylestown, PA 18901

Filing Company Information

(This filing was made by a third party - McHughConsulting)

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
 8801 Indian Hills Drive Group Code: Company Type:
 Omaha, NE 68114 Group Name: State ID Number:
 (800) 423-2765 ext. [Phone] FEIN Number: 35-0472300

Filing Fees

Fee Required? Yes
 Fee Amount: \$2,050.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|------------|----------------|---------------|
| The Lincoln National Life Insurance Company | \$2,050.00 | 01/28/2011 | 44172478 |

SERFF Tracking Number: MCHX-G127008323 *State:* Arkansas
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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 02/07/2011 | 02/07/2011 |

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Disposition

Disposition Date: 02/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Submission Letter | Approved-Closed | Yes |
| Supporting Document | Authorization Letter | Approved-Closed | Yes |
| Supporting Document | Form Listing | Approved-Closed | Yes |
| Supporting Document | Appendix of Variability | Approved-Closed | Yes |
| Form | Face Page | Approved-Closed | Yes |
| Form | Table of Contents | Approved-Closed | Yes |
| Form | Schedule of Benefits | Approved-Closed | Yes |
| Form | Definitions | Approved-Closed | Yes |
| Form | Provisions Applicable to Participating Organization | Approved-Closed | Yes |
| Form | General Provisions | Approved-Closed | Yes |
| Form | Eligibility and Effective Dates for Personal Critical Illness Insurance | Approved-Closed | Yes |
| Form | Termination of Personal Critical Illness Insurance | Approved-Closed | Yes |
| Form | Eligibility and Effective Dates for Dependent Critical Illness Insurance | Approved-Closed | Yes |
| Form | Termination of Dependent Critical Illness Insurance | Approved-Closed | Yes |
| Form | Premiums and Premium Rates | Approved-Closed | Yes |
| Form | Policy Termination | Approved-Closed | Yes |
| Form | Critical Illness Benefits | Approved-Closed | Yes |
| Form | Exclusions | Approved-Closed | Yes |
| Form | Beneficiary | Approved-Closed | Yes |
| Form | Claim Procedures for Critical Illness Insurance | Approved-Closed | Yes |
| Form | Prior Insurance Credit Upon Transfer of Insurance Carriers | Approved-Closed | Yes |
| Form | Policy Amendment | Approved-Closed | Yes |
| Form | Policy Amendment - Accident Benefit | Approved-Closed | Yes |
| Form | Policy Amendment - Permanent and Total Disability Benefit | Approved-Closed | Yes |

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 National Life Insurance Company

| | | | |
|-------------|--|-----------------|-----|
| Form | Policy Amendment - Treatment Care Benefit | Approved-Closed | Yes |
| Form | Policy Amendment - Occupational HIV/Occupational Hepatitis Benefit | Approved-Closed | Yes |
| Form | Face Page | Approved-Closed | Yes |
| Form | Table of Contents | Approved-Closed | Yes |
| Form | Schedule of Benefits | Approved-Closed | Yes |
| Form | Definitions | Approved-Closed | Yes |
| Form | General Provisions | Approved-Closed | Yes |
| Form | Eligibility and Effective Dates for Personal Critical Illness Insurance | Approved-Closed | Yes |
| Form | Termination of Personal Critical Illness Insurance | Approved-Closed | Yes |
| Form | Eligibility and Effective Dates for Dependent Critical Illness Insurance | Approved-Closed | Yes |
| Form | Termination of Dependent Critical Illness Insurance | Approved-Closed | Yes |
| Form | Critical Illness Benefits | Approved-Closed | Yes |
| Form | Exclusions | Approved-Closed | Yes |
| Form | Beneficiary | Approved-Closed | Yes |
| Form | Claim Procedures for Critical Illness Insurance | Approved-Closed | Yes |
| Form | Prior Insurance Credit Upon Transfer of Insurance Carriers | Approved-Closed | Yes |
| Form | Certificate Amendment | Approved-Closed | Yes |
| Form | Certificate Amendment - Accident Benefit | Approved-Closed | Yes |
| Form | Certificate Amendment - Permanent and Total Disability Benefit | Approved-Closed | Yes |
| Form | Certificate Amendment - Treatment Care Benefit | Approved-Closed | Yes |
| Form | Certificate Amendment - Occupational HIV/Occupational Hepatitis Benefit | Approved-Closed | Yes |

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
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 Project Name/Number: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company /GL51 - Group Critical Illness - The Lincoln
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Form Schedule

Lead Form Number: GL51-1-FP AR

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-------------------------------|--------------|-------------|--|---------|----------------------|-------------|--------------------------------|
| Approved-Closed 02/07/2011 | GL51-1-FP AR | Policy/Cont | Face Page ract/Fratern al Certificate | Initial | | 59.000 | GL51 Complete Policy.PDF |
| Approved-Closed 02/07/2011 | GL51-2-TC | Matrix | Table of Contents | Initial | | 0.000 | |
| Approved-Closed 02/07/2011 | GL51-3-SB | Matrix | Schedule of Benefits | Initial | | 50.000 | |
| Approved-Closed 02/07/2011 | GL51-4-DF | Matrix | Definitions | Initial | | 40.000 | |
| Approved-Closed 02/07/2011 | GL51-5.1-PE | Matrix | Provisions Applicable to Participating Organization | Initial | | 61.600 | |
| Approved-Closed 02/07/2011 | GL51-5-GP | Matrix | General Provisions | Initial | | 57.100 | |
| Approved-Closed 02/07/2011 | GL51-6-ELE | Matrix | Eligibility and Effective Dates for Personal Critical Illness Insurance | Initial | | 53.200 | |
| Approved-Closed 02/07/2011 | GL51-7-TE | Matrix | Termination of Personal Critical Illness Insurance | Initial | | 40.000 | |
| Approved-Closed 02/07/2011 | GL51-8-ELD | Matrix | Eligibility and Effective Dates for Dependent Critical | Initial | | 54.200 | |

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
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 Limited Benefit
 Product Name: GL51 - Group Critical Illness - The Lincoln Natio
 Project Name/Number: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company /GL51 - Group Critical Illness - The Lincoln
 National Life Insurance Company

| Approval Status | Policy/Cont | Matrix | Description | Initial | Value | Notes |
|---------------------|--------------------|-----------------------------------|--|---------|--------|---|
| Approved- Closed | GL51-9-TD | Matrix | Illness Insurance Termination of Dependent Critical Illness Insurance | Initial | 70.300 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-10- PR | Matrix | Premiums and Premium Rates | Initial | 57.800 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-11- PT | Matrix | Policy Termination | Initial | 59.900 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-12- CIB | Matrix | Critical Illness Benefits | Initial | 55.000 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-13- EX AR | Matrix | Exclusions | Initial | 42.000 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-14-B | Matrix | Beneficiary | Initial | 60.300 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-15- CP | Matrix | Claim Procedures for Critical Illness Insurance | Initial | 56.200 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51-16- PIC AR | Matrix | Prior Insurance Credit Upon Transfer of Insurance Carriers | Initial | 57.800 | |
| 02/07/2011 | | | | | | |
| Approved- Closed | GL51- AMEND | Policy/Cont ract/Fratern al | Policy Amendment | Initial | 51.300 | AMEND (policy version)- 11_17_10.PD F |
| 02/07/2011 | | | Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | | | |
| Approved- Closed | GL51- AMEND.AC | Policy/Cont ract/Fratern | Policy Amendment - Accident Benefit | Initial | 47.000 | AMEND_ACC [Accident |

| | | | |
|------------------------------------|--|------------------------|---------------------------|
| SERFF Tracking Number: | MCHX-G127008323 | State: | Arkansas |
| Filing Company: | The Lincoln National Life Insurance Company | State Tracking Number: | 47831 |
| Company Tracking Number: | GL51 | | |
| TOI: | H07G Group Health - Specified Disease - Limited Benefit | Sub-TOI: | H07G.001 Critical Illness |
| Product Name: | GL51 - Group Critical Illness - The Lincoln National Life Insurance Company | | |
| Project Name/Number: | GL51 - Group Critical Illness - The Lincoln National Life Insurance Company /GL51 - Group Critical Illness - The Lincoln National Life Insurance Company | | |
| 02/07/2011 C | al | | Rider]- |
| | Certificate: | | 11_17_10.PD |
| | Amendmen | | F |
| | t, Insert | | |
| | Page, | | |
| | Endorseme | | |
| | nt or Rider | | |
| Approved- GL51- Closed AMEND.PT | Policy/Cont Policy Amendment - Initial | 49.000 | AMEND_PTD |
| 02/07/2011 D | ract/Fratern Permanent and Total Disability Benefit | | [Perm and |
| | Certificate: | | Tot Dis |
| | Amendmen | | Rider]- |
| | t, Insert | | 11_17_10.PD |
| | Page, | | F |
| | Endorseme | | |
| | nt or Rider | | |
| Approved- GL51- Closed AMEND.TC | Policy/Cont Policy Amendment - Initial | 50.000 | AMEND_TCB |
| 02/07/2011 B | ract/Fratern Treatment Care Benefit | | [Treatment |
| | Certificate: | | Care Rider]- |
| | Amendmen | | 11_17_10.PD |
| | t, Insert | | F |
| | Page, | | |
| | Endorseme | | |
| | nt or Rider | | |
| Approved- GL51- Closed AMEND.O | Policy/Cont Policy Amendment - Initial | 47.600 | AMEND_OC |
| 02/07/2011 CHVHP | ract/Fratern Occupational HIV/Occupational | | HVHP [Occ |
| | Certificate: Hepatitis Benefit | | HIV-Hepatitis |
| | Amendmen | | Rider]- |
| | t, Insert | | 11_17_10.PD |
| | Page, | | F |
| | Endorseme | | |
| | nt or Rider | | |
| Approved- GL52-1-FP Closed AR | Certificate Face Page | 49.000 | GL52 |
| | Initial | | Complete |

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
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 National Life Insurance Company

02/07/2011

Certificate.PD
F

Approved- GL52-2-TC Matrix Table of Contents Initial 0.000
 Closed

02/07/2011

Approved- GL52-3-SB Matrix Schedule of Benefits Initial 52.000
 Closed

02/07/2011

Approved- GL52-4-DF Matrix Definitions Initial 40.000
 Closed AR

02/07/2011

Approved- GL52-5-GP Matrix General Provisions Initial 62.200
 Closed

02/07/2011

Approved- GL52-6- Matrix Eligibility and Initial 50.900
 Closed ELE Effective Dates for
 02/07/2011 Personal Critical
 Illness Insurance

Approved- GL52-7-TE Matrix Termination of Initial 50.000
 Closed Personal Critical
 02/07/2011 Illness Insurance

Approved- GL52-8- Matrix Eligibility and Initial 58.200
 Closed ELD AR Effective Dates for
 02/07/2011 Dependent Critical
 Illness Insurance

Approved- GL52-9-TD Matrix Termination of Initial 68.500
 Closed Dependent Critical
 02/07/2011 Illness Insurance

Approved- GL52-12- Matrix Critical Illness Initial 56.000
 Closed CIB Benefits
 02/07/2011

Approved- GL52-13- Matrix Exclusions Initial 42.000
 Closed EX AR
 02/07/2011

Approved- GL52-14-B Matrix Beneficiary Initial 50.500
 Closed

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| | | | | | | | |
|------------|---------------------|---------------------------|---|---|---------|--------|--|
| 02/07/2011 | Approved- Closed | GL52-15- CP | Matrix | Claim Procedures for Initial Critical Illness Insurance | Initial | 56.400 | |
| 02/07/2011 | Approved- Closed | GL52-16- PIC AR | Matrix | Prior Insurance Credit Upon Transfer of Insurance Carriers | Initial | 55.000 | |
| 02/07/2011 | Approved- Closed | GL52- AMEND | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | Certificate Amendment - Accident Benefit | Initial | 51.800 | GL52- AMEND- 11_17_10.PD F |
| 02/07/2011 | Approved- Closed | GL52- AMEND.AC C | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | Certificate Amendment - Accident Benefit | Initial | 48.000 | AMEND_ACC [Accident Rider]- 11_17_10.PD F |
| 02/07/2011 | Approved- Closed | GL52- AMEND.PT D | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | Certificate Amendment - Permanent and Total Disability Benefit | Initial | 49.000 | AMEND_PTD [Perm and Tot Dis Rider]- 11_17_10.PD F |
| 02/07/2011 | Approved- Closed | GL52- AMEND.TC B | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | Certificate Amendment - Treatment Care Benefit | Initial | 51.000 | AMEND_TCB [Treatment Care Rider]- 11_17_10.PD F |
| 02/07/2011 | Approved- Closed | GL52- AMEND.O CHVHP | Certificate Amendmen t, Insert Page, Endorseme | Certificate Amendment - Occupational HIV/Occupational Hepatitis Benefit | Initial | 42.700 | AMEND_OC HVHP [Occ HIV-Hepatitis Rider]- 11_17_10.PD |

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National Life Insurance Company
nt or Rider F

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

Group Policyholder: The ABC Company, Incorporated

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on Month Day, Year, and on the same day of each month after that. Policy anniversaries will be each Month Day; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

This Policy is delivered in the State of Arkansas.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. [The issue date of this Policy is Month Day, Year.]


Secretary


President

THIS IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND THE COMPANY. READ YOUR POLICY CAREFULLY.

This is a limited benefit policy. It provides Critical Illness insurance coverage. There is no coverage for hospital, medical-surgical or major medical expenses.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

[BENEFITS ARE SUBJECT TO AGE REDUCTIONS.]

[THIS POLICY CONTAINS A PRE-EXISTING EXCLUSION.]

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-423-2765]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

GROUP CRITICAL ILLNESS INSURANCE POLICY
[No. GL 000000000000]

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SCHEDULE OF BENEFITS

CLASSIFICATION

[Class 1 All Full-Time Employees]

ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section)

30 days of continuous Active Work

ANNUAL/OPEN ENROLLMENT PERIOD: November 1 – November 30

**SCHEDULE OF BENEFITS
(Continued)**

[BENEFITS FOR PLAN1/ CLASS 1]

ELIGIBLE CLASS means: [All Full-Time Employees]

[MINIMUM HOURS PER WEEK: 20]

[BENEFIT WAITING PERIOD: 30 days]

CONTRIBUTIONS: Insured Persons are required to contribute to the cost for Personal Critical Illness Insurance. Insured Persons are required to contribute to the cost for Dependent Critical Illness Insurance.

**SCHEDULE OF BENEFITS
(Continued)**

PERSONAL CRITICAL ILLNESS INSURANCE

Personal Critical Illness Principal Sum

Class 1

[A Person may elect Personal Critical Illness Insurance in any \$1,000 increment, subject to a minimum of \$1,000 and a maximum of \$250,000.]

[The Principal Sum will be reduced by 50% when an Insured Person attains age 70.]

**DEPENDENT CRITICAL ILLNESS INSURANCE
[(For Class 1)]**

Dependent

Dependent Critical Illness Principal Sum

Spouse

[A Person may elect Spouse Critical Illness Insurance in any \$1,000 increment, subject to a minimum of \$1,000 and a maximum of \$250,000.]

Dependent Child

[A Person may elect Child Critical Illness Insurance in any \$1,000 increment, subject to a minimum of \$1,000 and a maximum of \$250,000.]

The Dependent Critical Illness Principal Sum will be reduced by 50% when the [Insured Person/Spouse] attains age 70. Dependent Critical Illness Insurance may not exceed the amount of the Insured Person's Personal Critical Illness Principal Sum in effect under this Policy.

ORGAN CATEGORY [(Available for Insured Persons and Dependents)]

Event/Illness

Percentage of Principal Sum

End Stage Renal Failure

[1-100%]

Placement on United Network for Organ Sharing (UNOS) List for Major Organ Transplant [(excluding Heart)]*

[1-100%]

Acute Respiratory Distress Syndrome

[1-100%]

**SCHEDULE OF BENEFITS
(Continued)**

HEART CATEGORY [(Available for Insured Persons and Dependents)]

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|--|--|
| Heart Attack | [1-100%] |
| Placement on <u>United Network for Organ Sharing (UNOS) List for Heart Transplant*</u> | [1-100%] |
| Stroke | [1-100%] |
| Arteriosclerosis | [1-100%, subject to a lifetime maximum of <u>2</u> payments] |
| Aneurysm due to Arteriosclerosis | [1-100%, subject to a lifetime maximum of <u>2</u> payments] |

CHILD CATEGORY (Available only for Insured Dependent Children)

Benefits in this category are payable once per Event/Illness per Insured Dependent Child during his/her lifetime.

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|--------------------------------|------------------------------------|
| Structural Congenital Defects | [1-100%] |
| Genetic Disorders | [1-100%] |
| Type I Diabetes | [1-100%] |
| Congenital Metabolic Disorders | [1-100%] |

**SCHEDULE OF BENEFITS
(Continued)**

QUALITY OF LIFE CATEGORY [(Available for Insured Persons and Dependents)]

Benefits in this category are payable once per Event/Illness per Insured Person [or Insured Dependent] during his or her lifetime.

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|-------------------------------------|------------------------------------|
| ALS/Lou Gehrig's Disease | [1-100%] |
| Advanced Alzheimer's Disease | [1-100%] |
| Advanced Multiple Sclerosis | [1-100%] |
| Muscular Dystrophy | [1-100%] |
| Advanced Parkinson's Disease | [1-100%] |
| Loss of Sight | [1-100%] |
| Loss of Hearing | [1-100%] |
| Loss of Speech | [1-100%] |

**SCHEDULE OF BENEFITS
(Continued)**

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted [(at the Person's expense)] when:

- (1) Critical Illness Insurance amounts exceed the guarantee issue amount of \$(GI amount) for Insured Persons; \$(GI amount) for Insured Dependent Spouses; or \$(GI amount) for Insured Dependent Children at initial enrollment;; or]
- [(2) initial Critical Illness Insurance is elected]; or]
- [(3) the amount of Critical Illness Insurance in excess of the guarantee issue amount increases after the initial enrollment]; or]
- [(4) the amount of Critical Illness Insurance increases after the initial enrollment]; or]
- [(5) any increment/benefit option increase after the initial enrollment exceeds the amount of Critical Illness Insurance by more than [1-3] increment level(s)/benefit options over a 12-month period based on the month of the policy anniversary]; or]
- [(6) the amount of Critical Illness Insurance increases after the initial enrollment by more than \$(GI increase amount) for Insured Persons; \$(GI increase amount) for Insured Dependent Spouses; or \$(GI increase amount) for Insured Dependent Children]; or]
- [(7) the amount of Critical Illness Insurance in excess of the guarantee issue amount, increases after the initial enrollment by more than \$(GI increase amount) for Insured Persons; \$(GI increase amount) for Insured Dependent Spouses; or \$(GI increase amount) for Insured Dependent Children over a 12-month period based on the month of the policy anniversary]; or]
- [(8) the amount of Critical Illness Insurance increases after the initial enrollment by more than \$(GI increase amount) for Insured Persons; \$(GI increase amount) for Insured Dependent Spouses; or \$(GI increase amount) for Insured Dependent Children over a 12-month period based on the month of the policy anniversary.]

If any Evidence of Insurability is required, it will be provided at the Insured Person's own expense.

DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an [Employee's/member's] performance of all customary duties of his or her occupation at:

- (1) the [Group Policyholder's/Participating Organization's] place of business; or
- (2) any other business location designated by the [Group Policyholder/Participating Organization.]

Unless disabled on the prior workday or on the day of absence, an [Employee/member] will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

ACUTE RESPIRATORY DISTRESS SYNDROME means acute respiratory failure resulting in inadequate oxygenation, due to aspiration or infection. Diagnosis is determined by a Physician and based on:

- (1) demonstration of infiltrates in both lungs in the absence of clinical heart failure; and
- (2) acute lung injury demonstrated by testing of blood gases.

ADVANCED ALZHEIMER'S DISEASE means dementia of the Alzheimer's Type that has progressed to the point that the individual can be classified as Functional Assessment Staging (FAST) Scale Stage 6. Diagnosis is made by a board-certified or board-eligible neurologist on the basis of neurological examination and cognitive testing. Initial diagnosis of Alzheimer's Disease must occur while the Insured Person [or Insured Dependent] is covered under this Policy.

ADVANCED MULTIPLE SCLEROSIS (MS) means Multiple Sclerosis with demonstrated neurological deficits that have been present for six months or more. Diagnosis is made by a board-certified or board-eligible neurologist on the basis of:

- (1) neurological examination demonstrating functional impairments;
- (2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and
- (3) analysis of cerebrospinal fluid consistent with the diagnosis.

Initial diagnosis of Multiple Sclerosis must occur while the Insured Person [or Insured Dependent] is covered under this Policy.

ADVANCED PARKINSON'S DISEASE means Parkinson's Disease that has progressed to Stage 4, as diagnosed by a board-certified or board-eligible neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies. Initial diagnosis of Parkinson's Disease must occur while the Insured Person [or Insured Dependent] is covered under this Policy.

ALS/LOU GEHRIG'S DISEASE means amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) of the Middle Stage according to the Muscular Dystrophy Association. Definitive diagnosis must be made by a board-certified or board-eligible neurologist according to diagnostic criteria for the specific illness. Other motor neuron diseases are not considered to be ALS. Initial diagnosis of ALS/Lou Gehrig's Disease must occur while the Insured Person [or Insured Dependent] is covered under this Policy.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANEURYSM DUE TO ARTERIOSCLEROSIS means an abnormal widening or ballooning of a portion of an artery due to weakness of the arterial wall caused by Arteriosclerosis, of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Aneurysm is diagnosed by a Physician based on arteriography or other appropriate imaging studies.

DEFINITIONS (Continued)

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible [Employees/members] to purchase or make changes to their Personal [or Dependent] Critical Illness Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period [or Benefit Waiting Period].

ARTERIOSCLEROSIS means blockage of a coronary artery of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Diagnosis is made by a board-certified or board-eligible cardiologist and is accompanied by the demonstrated need for intervention.

BENEFIT WAITING PERIOD means the period of time an Insured Person [or Insured Dependent] must be covered under this Policy before becoming eligible for benefits (including benefits provided by Amendments).

BENIGN BRAIN TUMOR means a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. Diagnosis of the tumor and neurological deficit must be confirmed by imaging and examination findings conducted by a board-certified or board-eligible neurologist or other Physician appropriately licensed to diagnose the deficit.

BONE MARROW TRANSPLANT means a transplant necessitated by a compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis is made by a board-certified or board-eligible hematologist or board-certified or board-eligible oncologist who determines that the bone marrow transplant is necessary and places the Insured Person [or Insured Dependent] on the Be The Match registry. If the Insured Person [or Insured Dependent] is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the registry; the registry requirement will be waived. The registry requirement will also be waived if the Insured Person [or Insured Dependent] receives the transplant prior to placement on the registry.

CANCER means malignant cells or tumors characterized by uncontrolled growth with spread beyond the initial tissue. Diagnosis must be by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic tissue evaluation (biopsy). The following are not considered Cancer for purposes of this definition:

- (1) Cancer in Situ;
- (2) basal cell carcinoma and squamous cell carcinoma of the skin; and
- (3) melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm.

CANCER IN SITU means Cancer cells confined to the surface tissues (epithelium) without invasion of the basement membrane and with no spread to regional lymph nodes or other tissues. Diagnosis is made by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic examination of tissue (biopsy). Basal cell and squamous cell carcinomas of the skin are not considered Cancer in Situ.

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, adoption, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. [Change in Family Status also means:

- (1) a civil union or domestic partnership;
- (2) dissolution of a civil union or domestic partnership; or
- (3) the involuntary loss of comparable coverage under a spouse's, civil union partner's, or domestic partner's benefit plan.]

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DEFINITIONS
(Continued)

CONGENITAL METABOLIC DISORDER means:

- (1) Infantile Tay Sachs;
- (2) Zellweger Syndrome;
- (3) Gaucher Disease Types II and III;
- (4) Niemann-Pick Disease;
- (5) Lesch-Nyhan Syndrome; or
- (6) Glycogen Storage Disease Types I, II, IV, and VII.

Diagnosis must be made during childhood by a Physician based on blood tests, physical exams, and/or genetic testing.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the [Group Policyholder's/Participating Organization's] place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DEPENDENT CRITICAL ILLNESS INSURANCE means the coverage provided by this Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the period of time an Employee must be employed in an eligible class with the [Group Policyholder/Participating Organization], before he or she becomes eligible to enroll for insurance under this Policy. The period of service must be continuous, except as explained in the Eligibility section captioned Prior Service Credit Towards Waiting Period. / means the period of time a Person must be in an eligible class with the [Group Policyholder/Participating Organization], before he or she becomes eligible to enroll for insurance under this Policy.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the [Group Policyholder/Participating Organization].

END STAGE RENAL FAILURE means chronic and irreversible failure of the kidneys of such magnitude that permanent dialysis or transplant is required to sustain life.

EVENT/ILLNESS means a Critical Illness event or illness:

- (1) shown in the Schedule of Benefits; and
- (2) for which the Insured Person [or Insured Dependent] is covered under this Policy.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the [Group Policyholder's or Participating Organization's] leave policy and the law which applies; and
- (3) does not exceed the period approved by the [Group Policyholder or Participating Organization] and required by that law.

The leave period may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under this Policy takes effect, he or she is not considered Actively at Work.

DEFINITIONS
(Continued)

FULL-TIME EMPLOYEE means a person:

- (1) whose employment with the Group Policyholder/Participating Organization is the person's main occupation;
- (2) whose employment is for regular wage or salary;
- (3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
- (4) who is a member of an eligible class under this Policy;
- (5) who is not a temporary or seasonal employee; and
- (6) who is a citizen of the United States or legally works in the United States.

GENETIC DISORDER means:

- (1) Cystic Fibrosis;
- (2) Down's Syndrome;
- (3) Muscular Dystrophy;
- (4) Fragile X Syndrome;
- (5) Vascular Ehlers-Danlos Syndrome;
- (6) Infantile Onset Ascending Spastic Paralysis;
- (7) Juvenile Lateral Sclerosis;
- (8) Spinal Muscular Atrophy Type I or II ; or
- (9) Osteogenesis Imperfecta Type II, III, IV, V, VI, VII, or VIII.

Diagnosis must be made during childhood by a Physician and based on genetic testing.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of this Policy.

HEART ATTACK (MYOCARDIAL INFARCTION) means death of a portion of heart muscle due to inadequate circulation in coronary arteries. If no death of heart muscle occurs, this is not considered a heart attack. Diagnosis is made by a board-certified or board-eligible cardiologist and based on findings from an electrocardiogram (EKG) and elevation of cardiac enzymes associated with heart attack.

HEART TRANSPLANT means the transplantation of a healthy heart from a suitable donor, necessitated by the diagnosis of end-stage heart disease, as determined by a Physician appropriately specialized for the heart. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person [or Insured Dependent] is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person [or Insured Dependent] receives the transplant prior to placement on the network.

HOSPITAL means a general hospital which:

- (1) is licensed, approved or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat Inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

DEFINITIONS
(Continued)

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
 - (2) ending at 12:00 midnight on the last day of the same calendar month;
- at the [Group Policyholder's/Participating Organization's] primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED DEPENDENT SPOUSE means the Insured Person's spouse[, domestic partner, or civil union partner] for whom coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

LOSS OF HEARING means permanent reduction in both ears to a point that the Insured Person[Insured Dependent] is unable to hear sounds at or below 70 decibels. Diagnosis is made by a board-certified or board-eligible otolaryngologist as diagnosed by audiometric testing.

LOSS OF SIGHT means permanent loss of sight in both eyes such that corrected visual acuity is 20/200 or less, or the field of vision is less than 20 degrees. Diagnosis is made by a board-certified or board-eligible ophthalmologist or board-certified or board-eligible neuro-ophthalmologist based on the above criteria and noted to be of permanent duration.

LOSS OF SPEECH means loss of the ability to speak to the extent that the individual is unintelligible to another person with normal hearing, for at least 12 months. Diagnosis is made by a board-certified or board-eligible otolaryngologist or board-certified or board-eligible neurologist.

MAJOR ORGAN means the [heart,] liver, lungs, pancreas, intestines, or combinations of these organs.

MAJOR ORGAN TRANSPLANT means the transplantation of a healthy Major Organ from a suitable donor, necessitated by the diagnosis of end-stage organ disease (organ failure), as determined by a Physician appropriately specialized for the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person [or Insured Dependent] is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person [or Insured Dependent] receives the transplant prior to placement on the network.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the [Group Policyholder's or Participating Organization's] leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

PAYROLL PERIOD means that period of time established by the Group Policyholder/or Participating Organization for payment of employee wages.

PERSON means a Full-Time Employee of the Group Policyholder[:]

- [(1)] who is a member of a class that is eligible for insurance under this Policy[: and]
- [(2)] who has completed an enrollment form].

PERSONAL CRITICAL ILLNESS INSURANCE means the insurance provided by this Policy for Insured Persons.

DEFINITIONS
(Continued)

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partner's, or civil union partner's] relatives of like degree.

POLICY means this Group Critical Illness Insurance policy issued by the Company to the Group Policyholder.

PREMIUM means the amount charged for insurance coverage.

REGULAR PART-TIME EMPLOYEE means a person:

- (1) whose employment is for wage or salary;
- (2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
- (3) who is a member of a class which is eligible for insurance under this Policy;
- (4) who is not a temporary or seasonal employee; and
- (5) who is a citizen of the United States or legally works in the United States.

RETIREE means a former [full-time] Employee of the [Group Policyholder or Participating Organization] who is eligible for retirement benefits.

STROKE means permanent neurological damage to the brain due to inadequate blood flow in any of the cranial vessels, due to either blockage or rupture of the vessel and categorized as Score 3 on the Modified Rankin Scale. Diagnosis of permanent neurological damage should be made by a neurologist and demonstrated by imaging (CT or MRI) and examination demonstrating lasting neurological deficits (motor, cognitive, or sensory). Transient Ischemic Attacks (TIA) are not considered Strokes.

STRUCTURAL CONGENITAL DEFECT means any of the following:

- (1) cleft lip/palate;
- (2) club foot;
- (3) Patent ductus arteriosus;
- (4) coarctation;
- (5) transposition of the great arteries;
- (6) hypoplastic left heart system;
- (7) tetralogy of fallot;
- (8) diaphragmatic hernia;
- (9) pyloric stenosis;
- (10) Hirschsprung's disease;
- (11) gastroschisis and omphalocele;
- (12) anal atresia;
- (13) biliary atresia;
- (14) spina bifida; or
- (15) anencephaly.

Diagnosis must be made during childhood by a board-certified or board-eligible pediatrician.

DEFINITIONS
(Continued)

TYPE 1 DIABETES means diabetes that results from auto-immune destruction of insulin-producing cells in the pancreas. Diagnosis is made during childhood or adolescence by a board-certified or board-eligible endocrinologist or other specialist in the treatment of diabetes, based on blood tests, and requires the confirmation of the cause of low insulin production.

PROVISIONS APPLICABLE TO PARTICIPATING ORGANIZATIONS

A Participating Organization has no rights under this Policy except as provided in this section. The Participating Organization will be responsible for all premiums payable with respect to any of its [Employees/members] who are Insured Persons under this Policy.

PARTICIPATING ORGANIZATION means an organization that has been approved by the Company for participation in the insurance provided by this Policy. The following are Participating Organizations:

ABC Company, Incorporated

XYZ Company, P.C.

EFFECTIVE DATE. As it applies to any Participating Organization, the Effective Date of this Policy will be the later of:

- (1) the date this Policy is issued;
- (2) the first day of the Insurance Month following the Company's approval of the organization's Participation Agreement; or
- (3) a date agreed upon by the Company, the Participating Organization, and the Group Policyholder.

TERMINATION. A Participating Organization's participation under this Policy ends on the earliest of the following dates:

- (1) the date the organization no longer meets the definition of a Participating Organization;
- (2) the date the Participating Organization suspends active business operations, is placed in bankruptcy or receivership, dissolves, merges or relocates;
- (3) the date the Participating Organization, without good cause, fails to:
 - (a) promptly furnish the Company any information it may reasonably require; or
 - (b) perform its duties pertaining to this Policy in good faith;
- (4) the last day of the Insurance Month for which premium is paid;
- (5) the last day of the Insurance Month in which the Company receives the Participating Organization's written request to cease participation; or
- (6) the date this Policy terminates.

On the day participation ends, Policy insurance will terminate for all Insured Persons of the Participating Organization [and their Insured Dependents], unless eligible under the Portability section of this Policy.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) this Policy and any amendments to it[; and]
- (2) the Group Policyholder's application[; and]
- [(3) any Participating Organization's Application or Participation Agreement.]

In the absence of fraud, all statements made by the Group Policyholder [or Participating Organization] and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by this Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent]; and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:

- (1) determine the insurability of a group or any individual within a group;
- (2) make a contract in the Company's name;
- (3) amend or waive any provision of this Policy; or
- (4) extend the time for payment of any premium.

No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) this Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:

- (1) an Insured Person [or Insured Dependent] incurs a claim during the first two years of coverage; and
- (2) the Company discovers that the Insured Person [or Insured Dependent] made a Material Misrepresentation on his or her application.

A "**Material Misrepresentation**" is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. "**To rescind**" means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for Insured Person's [or Insured Dependent's] claims. The Company reserves the right to recover any claims paid in excess of such premiums.

NONPARTICIPATION. This is a non-participating policy. It will not share in the divisible surplus of any Company.

GENERAL PROVISIONS **(Continued)**

INFORMATION TO BE FURNISHED. The Group Policyholder [and any Participating Organization] may be required to furnish any information needed to administer this Policy, including:

- (1) information about persons:
 - (a) who become eligible for insurance;
 - (b) whose amounts of insurance change; or
 - (c) whose eligibility or insurance ends;
- (2) occupational information and other facts that may be needed to manage a claim; and
- (3) any other information that the Company may reasonably require.

The Company may inspect the Group Policyholder's [or any Participating Organization's] records that relate to this Policy, at any reasonable time.

Clerical error by the Group Policyholder or any Participating Organization:

- (1) will not void or terminate insurance that otherwise would be in effect;
- (2) will not result in insurance coverage that otherwise would not be in effect; and
- (3) will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof such an adjustment should be made.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made; and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependent's] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

ACTS OF THE POLICYHOLDER. In administering this Policy, the Group Policyholder must:

- (1) treat [Employees/members] the same in like situations; and
- (2) allow the Company, without inquiry, to rely on its acts.

GROUP POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CERTIFICATES. The [Group Policyholder/Participating Organization] will be furnished with individual certificates of insurance for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE

ELIGIBILITY. A Person becomes eligible for insurance provided by this Policy on the [later/latest of]:

- (1) the Policy's date of issue[; or]
- [(2) the date such Person's organization becomes a Participating Organization][; or]
- [(3) the date the Waiting Period is completed. (For Waiting Period, see Schedule of Benefits.)]

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

- (1) a [former employee/member] is rehired within one year after his or her employment ends; or
- (2) [an employee/a member] returns from an approved Family or Medical Leave within:
 - (a) the leave period required by federal law; or
 - (b) any longer period required by a similar state law; or
- (3) [an employee/a member] returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Critical Illness Insurance only:

- (1) when first eligible[; or]
- (2) during any Annual/Open Enrollment Period[; or]
- (3) within 31 days following a qualifying Change In Family Status.

EFFECTIVE DATE. Personal Critical Illness Insurance becomes effective on the latest of:

- (1) the date the Person becomes eligible for the insurance[; or]
- (2) the date the Person resumes Active Work, if not Actively at Work on the day he or she becomes eligible (The Person will be deemed Actively at Work on any regular non-working day, if he or she:
 - (a) is not totally disabled or Hospital confined on that day; and
 - (b) was Actively at Work on the regular working day before that day)[;or]
- (3) if the Person contributes to the cost of the Personal Critical Illness Insurance, the date the Person makes written application for insurance[; and signs:]
 - [(a) a payroll deduction order, if Insured Persons pay any part of the Policy premium for Personal Critical Illness Insurance; or]
 - [(b) an order to pay premiums from the Person's Section 125 Plan account, if any contributions are paid through a Section 125 Plan];]and pays the required premium to the Company[; or]
- (4) the date the Company approves the Person's Evidence of Insurability, if required. (See Schedule of Benefits.)

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which the Insured Person becomes eligible for the increase, if Actively at Work on that day; [or]
- (2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
- (3) the date any required Evidence of Insurability is approved by the Company. (See Schedule of Benefits.)

Any reduction in insurance or benefits will take effect on the day of the change, whether or not the Insured Person is Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Personal Critical Illness Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period. (See Schedule of Benefits.) [A Person who terminates coverage under this Policy and subsequently re-enrolls during an Annual/Open Enrollment Period will again be subject to the Policy's Benefit Waiting Period.]

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL CRITICAL ILLNESS INSURANCE
(Continued)**

REINSTATEMENT RIGHTS. If an Insured Person's insurance terminates due to one of the following breaks in service [or a reduction in hours], he or she will be entitled to reinstate the insurance upon resuming Active Work with the [Group Policyholder/Participating Organization] within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

- (1) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (2) return from a Military Leave within the period required by federal USERRA law[; or]
- (3) return from any other approved leave of absence within 12 months after the leave begins[; or]
- (4) return within one year following a lay off[; or]
- (5) return within one year following termination of employment for any other reason[; or]
- (6) return to an eligible class following a reduction in hours.

To reinstate insurance coverage, the Person must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class [unless the Group Policyholder/Participating Organization contributes the entire cost of the premium]. The required premium payments must be received from the Group Policyholder/Participating Organization for coverage to be reinstated. Reinstatement will take effect on the date the Person returns to Active Work.

TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE

TERMINATION. An Insured Person's insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date this Policy terminates [or the Participating Organization's participation terminates] (but without prejudice to any claim incurred prior to termination);
 - (2) the date the Insured Person's Class is no longer eligible for insurance;
 - (3) the date the Insured Person ceases to be a member of the Eligible Class;
 - (4) the last day of the Insurance Month in which the Insured Person requests termination;
 - (5) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
 - (6) the end of the period for which the last required premium has been paid;
 - (7) with respect to any particular insurance benefit, the date the portion of this Policy providing that type of benefit terminates;
 - (8) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category;
 - (9) the date the Insured Person ceases to be covered under at least one category other than the Wellness Category;
 - (10) the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates; or
 - (11) the date the Insured Person enters armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If the Person sends proof of military service, the Company will refund any unearned premium.);
- unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work [or reduction of Minimum Hours] results in termination of the Insured Person's eligibility for insurance, but insurance may be continued as follows.

Disability. If the Insured Person is disabled due to an event or illness shown in the Schedule of Benefits, then insurance may be continued until [the earlier of:]

- [(1) 12 Insurance Months after the disability begins;] [or]
- [(2)] the date the Person is no longer disabled.

The required premium payments must be received from the [Group Policyholder/Participating Organization], throughout the period of continued insurance.

Family or Medical Leave. If an Insured Person goes on an approved Family or Medical Leave and is **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

- (1) the end of the leave period approved by the [Group Policyholder/Participating Organization];
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date the Insured Person notifies the [Group Policyholder/Participating Organization] that he or she will not return; or
- (4) the date the Insured Person begins employment with another employer.

The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Military Leave If an Insured Person goes on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the [Group Policyholder/Participating Organization]. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Lay Off or Other Leave. When an Insured Person ceases work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued until the end of the Insurance Month following the month in which the lay off or leave begins. The required premiums must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE
(Continued)

Temporary Reduction in Hours. When an Insured Person's hours are temporarily reduced resulting in his or her loss of eligibility under this Policy, insurance may be continued for six Insurance Months after the temporary reduction in hours begins, provided the Insured Person works at least 30 hours in a two-week period. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Conditions. In administering the above continuations, the [Group Policyholder/Participating Organization] must not act so as to discriminate unfairly among Insured Persons in similar situations. [Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.]

PORTABILITY. If insurance under this Policy would end for any reason other than nonpayment of premiums, the Insured Person has the option to continue Personal Critical Illness Insurance [and Dependent Critical Illness Insurance]. To continue insurance under this section, the Insured Person must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

A direct billing fee will apply when insurance is continued in accord with the Portability provision. This fee will be based on the billing frequency chosen.

Portability is not available when insurance terminates solely because an Insured Person's spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

- (1) the last day of the period for which the Insured Person paid premiums; or
- (2) the date the Company receives a written request from the Insured Person to terminate the insurance; or
- (3) the date the Insured Person attains age 90, or dies.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for claims incurred by the Insured Person while he or she was insured under this Policy.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE

DEPENDENT means an Insured Person's:

- (1) legal spouse, who is not legally separated from the Insured Person;
- [(2) civil union partner, or domestic partner;]
- (3) unmarried child less than 19 years of age; [or]
- [(4) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (5) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon the Insured Person for support and maintenance.

The child must be covered by the [Group Policyholder's/Participating Organization's] Critical Illness plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the Dependent rate.

[Dependent will also include a child that is required to be provided insurance by the Insured Person under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) an Insured Person's natural child or legally adopted child;
- (2) a child placed under the Insured Person's charge, care or control for whom the Insured Person has filed a petition to adopt, from:
 - (a) the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or
 - (b) the date of the filing of a petition for adoption, if the Insured Person applies for coverage within 60 days after the filing of the petition for adoption;
- (3) a child for whom the Insured Person is required by court order to provide Critical Illness insurance;
- (4) a stepchild [or grandchild] who resides in the Insured Person's household; and who is chiefly dependent on the Insured Person for support; and
- (5) a foster child:
 - (a) who resides in the Insured Person's household;
 - (b) who is chiefly dependent on the Insured Person for support; and
 - (c) for whom the Insured Person has assumed full parental responsibility and control.

ELIGIBILITY. An Insured Person becomes eligible to enroll for Dependent Critical Illness Insurance on the latest of:

- (1) the date the Insured Person becomes eligible for Personal Critical Illness Insurance;
- (2) the issue date of this Policy; or
- (3) the date the Insured Person first acquires a Dependent.

An Insured Person again becomes eligible to enroll for Dependent Critical Illness Insurance under this Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual/Open Enrollment Period.

A Person must be insured for Personal Critical Illness Insurance to insure his or her Dependents. [Dependents to be insured by this Policy must be enrolled in and approved for the same plan of benefits as the Insured Person.]

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT CRITICAL ILLNESS INSURANCE
(Continued)**

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Dependent Critical Illness Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period. [If a Person terminates Dependent Critical Illness Coverage under this Policy and subsequently re-enrolls during an Annual/Open Enrollment Period, the Dependents will again be subject to the Policy's Benefit Waiting Period.]

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Critical Illness Insurance will become effective on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date the Insured Person becomes eligible for Dependent Critical Illness Insurance; or
- (2) the first day of the Insurance Month coinciding with or next following the date the Insured Person makes written application for Dependent Critical Illness Insurance; [and, if additional premium is required, the Insured Person signs:]
 - [(a) a payroll deduction order, if the Insured Person pays any part of the premium for Dependent Critical Illness Insurance; or]
 - [(b) an order to pay premiums from the Insured Person's Section 125 Plan account, if any contributions for Dependent Critical Illness Insurance are paid through a Section 125 Plan account;]and pays the required Dependent premium to the Company; or
- (3) the date the Company approves any Evidence of Insurability [on all of the Insured Person's Dependents], if required. (See Schedule of Benefits.)

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires the Insured Person to provide Critical Illness benefits for the child, the insurance will become effective on the date stated in the court order; subject to:

- (1) any eligibility and Evidence of Insurability requirements set forth in this Policy; and
- (2) payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) the Insured Person completes a written application; and
- (2) [a payroll deduction order or Section 125 Plan election is made and] the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If an Insured Person acquires a newborn Dependent child, the child will be automatically insured for the first 90 days following birth. If the Insured Person elects not to enroll the newborn child and pay any additional premium within 90 following birth, the newborn child's insurance will terminate.

**TERMINATION OF
DEPENDENT CRITICAL ILLNESS INSURANCE**

TERMINATION. Critical Illness Insurance on a Dependent will cease on the earliest of:

- (1) the date he or she ceases to be an eligible Dependent, as defined in this Policy;
- (2) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category; or
- (3) the date he or she ceases to be covered under at least one category other than the Wellness Category.

Dependent Critical Illness Insurance will cease for all of the Insured Person's Dependents on the earliest of:

- (1) the date the Insured Person's Critical Illness Insurance terminates;
- (2) the date Dependent Critical Illness Insurance is discontinued under this Policy;
- (3) the date the Insured Person ceases to be in a class eligible for Dependent Critical Illness Insurance;
- (4) the date the Insured Person requests that the Dependent Critical Illness Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of this Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Critical Illness Insurance terminates due to the Insured Person's death, Dependent Critical Illness Insurance may be continued:

- (1) for three Insurance Months; or any longer period, if required by state or federal law;
- (2) provided the [Group Policyholder/Participating Organization] submits the premium on behalf of the surviving Dependents; and this Policy remains in force.

REINSTATEMENT OF DEPENDENT INSURANCE If an Insured Person reinstates his or her Personal Critical Illness Insurance, the Insured Person may also reinstate Dependent's Critical Illness Insurance at the same time. To do so, the Insured Person must follow the same requirements that apply in the reinstatement of the Insured Person's Personal Critical Illness Insurance.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for claims incurred by the Insured Dependent while he or she was insured under this Policy.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No insurance provided by this Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The [Group Policyholder/Participating Organization] is responsible for paying all premiums as they become due.

GRACE PERIOD. A grace period of 60 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the [Group Policyholder/Participating Organization] gives the Company advance written notice of termination. [The Group Policyholder/Participating Organization] will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

PREMIUM RATE CHANGE. The Company may change any premium rate:

- (1) the date this Policy's terms are changed; or
- (2) the date the Company's liability is changed due to a change in federal, state or local law;
- (3) the date the Company's liability is changed because the [Group Policyholder/Participating Organization] (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy; or
- (4) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company[, for all policies of like class].

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the sum of the products obtained by multiplying each rate shown in the Premium Rate Schedule by the amount of insurance to which the rate applies [and then adding the billing fee, if any].

For premium purposes, the effective date of any change in insurance is the first day of the Insurance Month which coincides with or follows the change. Changes will not be pro-rated daily.

PREMIUM RATE SCHEDULE

Monthly Critical Illness Rates

| <u>Class 1 – All Full Time Hourly Employees</u> | Rates per \$1,000 of insurance | |
|---|--------------------------------|---------------------|
| | <u>Non-Tobacco User</u> | <u>Tobacco User</u> |
| Personal Critical Illness insurance | \$5.00* | \$7.00* |
| Dependent Spouse insurance | \$5.00* | \$7.00* |
| Dependent Children insurance | \$2.50* | N/A |

*includes Wellness, Heart, Organ, and Cancer Coverage

Optional Coverages

Quality of Life

Personal insurance
 Dependent Spouse insurance
 Dependent Children insurance

| | Rates per \$1,000 of insurance | |
|------------------------------|--------------------------------|---------------------|
| | <u>Non-Tobacco User</u> | <u>Tobacco User</u> |
| Personal insurance | \$1.00 | \$2.00 |
| Dependent Spouse insurance | \$1.00 | \$2.00 |
| Dependent Children insurance | \$0.50 | N/A |

Child

Dependent children insurance

\$1.00 per \$1,000 of insurance

POLICY TERMINATION

TERMINATION BY THE COMPANY. This Policy is issued for an indefinite term. The Policy will continue in force as long as premiums are paid when due, unless terminated for one of the following reasons:

- (1) the Group Policyholder [or Participating Organization], without good cause, fails to:
 - (a) promptly furnish any information which the Company may reasonably require; or
 - (b) perform its duties pertaining to this Policy in good faith; or
- (2) state law otherwise requires this Policy to be terminated.

To terminate this Policy, the Company must give the Group Policyholder [or Participating Organization] at least 31 days' advance written notice of its intent to do so.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Insurance will then terminate:

- (1) on the date the Company receives the notice; or
- (2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

EFFECT ON INCURRED CLAIMS. Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in effect.

CRITICAL ILLNESS BENEFITS [For Plan/Class 1]

GENERAL CRITICAL ILLNESS BENEFITS. The Company will pay a Critical Illness Benefit if an Insured Person [or Insured Dependent] sustains an Event/Illness shown in the Schedule of Benefits while covered under this Policy.

Benefit amounts payable are shown in the Schedule of Benefits.

For each Insured Person [or Insured Dependent], the lifetime total benefits payable in any category shown in the Schedule of Benefits [(except the Wellness Category)] are subject to an overall maximum, as shown in the Schedule of Benefits. Certain Events/Illnesses are also subject to separate lifetime maximums, as shown in the Schedule of Benefits. If benefits paid to an Insured Person [or Insured Dependent] reach the overall maximum for a category, his or her coverage for that category will terminate. [Benefits provided by this Policy and any Amendments are subject to the Benefit Waiting Period shown in the Schedule of Benefits.]

[Except for the Wellness Category,] benefits are not payable if an Event/Illness shown in the Schedule of Benefits occurs within:

- (1) 180 days of another Event/Illness in the same category; or
- (2) 90 days of an Event/Illness in a different category.

If the Insured Person [or Insured Dependent] sustains two or more Events/Illnesses simultaneously, the highest applicable benefit is payable. Certain Events/Illnesses are only payable once per the Insured Person's [or Insured Dependent's] lifetime, as shown in the Schedule of Benefits.

CRITICAL ILLNESS ASSESSMENT BENEFIT. The Company will pay a Critical Illness Assessment Benefit to an Insured Person [or Insured Dependent] who has one of the following Critical Illness Assessment Tests:

- (1) abdominal aortic aneurysm ultrasound;
- (2) blood test for triglycerides;
- (3) bone marrow testing;
- (4) bone density screening;
- (5) breast ultrasound;
- (6) CA 15-3 (blood test for breast cancer);
- (7) CA125 (blood test for ovarian cancer);
- (8) carotid ultrasound;
- (9) CEA (blood test for colon cancer);
- (10) chest x-ray;
- (11) colonoscopy;
- (12) CT Angiography;
- (13) EKG;
- (14) double contrast barium enema;
- (15) fasting blood glucose test;
- (16) flexible sigmoidoscopy;
- (17) hemoccult stool analysis;
- (18) mammography;
- (19) pap smear;
- (20) PSA (blood test for prostate cancer);
- (21) serum cholesterol HDL/LDL;
- (22) serum protein electrophoresis (blood test for myeloma);
- (23) stress test;
- (24) thermography;
- (25) annual physical examinations; or
- (26) immunizations.

The Critical Illness Assessment Test must be performed during the Critical Illness Assessment Period as shown in the Schedule of Benefits, while the Insured Person's [or Insured Dependent's] coverage under this Policy is in effect. The Critical Illness Assessment Benefit is subject to the maximums shown in the Schedule of Benefits.

CRITICAL ILLNESS BENEFITS

(Continued)

[For Plan/Class 1]

CHILD CARE EXPENSE BENEFIT. The Company will pay a Child Care Expense Benefit if an Insured Person [or Insured Dependent Spouse] incurs Child Care Expenses while confined as an Inpatient in a Hospital or Alternate Care or Rehabilitative Facility for an Event/Illness shown in the Schedule of Benefits.

"Child Care Expense" means an expense for the care of a Child, charged by a licensed care provider who:

- (1) is not a member of the Insured Person's immediate family; and
- (2) is not living in the Insured Person's home.

"Child," as used in the Child Care Expense Benefit, means the Insured Person's naturally born child, legally adopted child, stepchild, foster child, or child for whom the Insured Person is the legal guardian, if the child is:

- (1) less than age 16 and living with the Insured Person; or
- (2) age 16 years or older, who is:
 - (a) unmarried;
 - (b) living with the Insured Person; and
 - (c) incapable of independent living due to a mental or physical condition.

Amount. The amount of the Child Care Expense Benefit is shown in the Schedule of Benefits.

Proof. The Insured Person must submit to the Company satisfactory proof that a Child Care Expense has been incurred for a Child (as defined in this provision) and paid by the Insured Person [or Insured Dependent Spouse]. Satisfactory proof is a signed receipt from the Child care provider showing:

- (1) Child name;
- (2) Child age;
- (3) dates of care;
- (4) total charges for care;
- (5) total payments for care; and
- (6) provider name, address, telephone number, and Federal Employer Identification Number/Taxpayer Identification Number.

Duration. The Child Care Expense Benefit will be payable for up to a maximum of 30 days from the date the Insured Person [or Insured Dependent Spouse] was confined as an Inpatient in a Hospital. This Benefit will cease on the earliest of:

- (1) the date the Insured Person [or Insured Dependent Spouse] is released from Inpatient treatment;
- (2) the date an Insured Person's [or Insured Dependent Spouse's] Child(ren) no longer meet(s) the definition of Child in this provision; or
- (3) the date the maximum duration ends.

EXCLUSIONS
[For Plan/Class 1]

GENERAL EXCLUSIONS. Benefits are not payable for any Event/Illness or loss resulting, directly or indirectly, from or in any degree caused by:

- (1) intentional self-inflicted injury, self-destruction, or suicide, or any attempt thereof; whether sane or insane;
- (2) participation in, commission of or attempt to commit a felony;
- (3) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
- (4) duty as a member of any military, including Reserves or National Guard; or
- (5) an Event/Illness sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

Benefits are also not payable while an Insured Person [or Insured Dependent] is incarcerated in any type of penal or detention facility.

PRE-EXISTING CONDITION EXCLUSION. Benefits are not payable for any Event/Illness or loss:

- (1) resulting, directly or indirectly, from or in any degree caused by a Pre-Existing Condition; and
- (2) diagnosed in the first 12 months following the Insured Person's [or Insured Dependent's] Effective Date[; unless the Insured Person or Insured Dependent receives no Treatment for the Pre-Existing Condition for 12 consecutive months following his or her Effective Date].

"Pre-Existing Condition" means an illness or event for which the Insured Person [or Insured Dependent] received Treatment within the 12 months prior to his or her Effective Date.

"Treatment" means a Physician's consultation, care or services; diagnostic measures; and the prescription, refill or taking of prescribed drugs or medicines.

The above Pre-Existing Condition Exclusion will also apply to:

- (1) any increase in the Critical Illness Principal Sum;
- (2) the addition by amendment of a benefit or category of benefits under this Policy;
- (3) an Insured Person's election after initial enrollment of any category of benefits under this Policy; and
- (4) the election after initial enrollment of any benefit provided by an amendment to this Policy.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable under this Policy will be paid to the named Beneficiary who survives the Insured Person. If no named Beneficiary survives the Insured Person, payment will be made to the Insured Person's estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable under this Policy will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

- (1) surviving spouse[, domestic partner, or civil union partner]; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of the Insured Person's death; and
- (2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. An Insured Person's Beneficiary will be as shown on his or her enrollment form, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

CHANGING THE BENEFICIARY. Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to the Insured Person's death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under this Policy becomes payable to an Insured Person's estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of the Insured Person or Beneficiary;
- (2) a person who has incurred expense as a result of the Insured Person's last illness or death;
- (3) the personal representative of the Insured Person's estate; or
- (4) any person related by blood or marriage to the Insured Person.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) the Insured Person's name, address and certificate number, if available; and
- (3) the patient's name and relationship to the Insured Person.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then the Person may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after a claim is incurred; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While a Critical Illness claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Critical Illness benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All benefits payable under this Policy[, including any benefits for Insured Dependents,] will be paid to the Insured Person, while living, unless[:]

- [(1)] an overpayment has been made and the Company is entitled to reduce future benefits[; or]
- [(2)] state or federal law requires that benefits be paid to a Insured Dependent child's custodial parent or custodian.]

If any benefits remain to be paid after the Insured Person's death, such benefits will be paid in accord with the Beneficiary provision.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE (Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of a Critical Illness claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of a Critical Illness claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of a Critical Illness claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

- (1) any further appeal procedures available under this Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For a Critical Illness claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE
(Continued)

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that this Policy clearly reserves to the Group Policyholder, the Company has the authority to:

- (1) manage this Policy and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Policy and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

PRIOR INSURANCE CREDIT UPON TRANSFER OF INSURANCE CARRIERS

To prevent loss of coverage for an Insured Person because of a transfer of insurance carriers, this Policy will provide the following Prior Insurance Credit, when it replaces a Prior Plan.

"Prior Plan" means a Group Policyholder-sponsored group or Group Policyholder-sponsored individual Critical Illness policy, which this Policy replaced:

- (1) within 1 day of the prior plan's termination date; or
- (2) within 60 days of the prior plan's termination date, if the Employer has more than 15 Insured Persons covered under this Policy on its effective date.

It does not include any coverage under the Prior Plan that was continued under a portability or other coverage continuation provision.

FAILURE TO BE ACTIVELY-AT-WORK DUE TO AN EVENT/ILLNESS. Subject to premium payments, this Policy will provide coverage to a Person:

- (1) who was insured by the Prior Plan at the time of transfer; and
- (2) who was not Actively at Work due to an Event/Illness on this Policy's Effective Date.

The coverage will be that provided by the Prior Plan, had it remained in force. The Company will pay:

- (1) the benefit that the Prior Plan would have paid; minus
- (2) any amount for which the Prior Plan is liable.

CRITICAL ILLNESS DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a covered Event/Illness due to a Pre-Existing Condition for an Insured Person who:

- (1) was insured by the Prior Plan at the time of transfer; and
- (2) was Actively at Work and insured under this Policy on this Policy's Effective Date.

The benefits will be determined as follows:

- (1) The Company will apply this Policy's Pre-Existing Condition Exclusion. If the Insured Person qualifies for benefits, such Insured Person will be paid according to this Policy's benefit schedule.
- (2) If the Insured Person cannot satisfy this Policy's Pre-Existing Condition Exclusion, but can satisfy the Prior Plan's pre-existing condition exclusion giving consideration toward continuous time insured under both policies; then he or she will be paid in accord with the benefit schedule and all other terms, conditions and limitations of:
 - (a) this Policy without applying the Pre-Existing Condition Exclusion; or
 - (b) the Prior Plan;whichever is less.
- (3) If the Insured Person cannot satisfy the Pre-Existing Condition Exclusion of this Policy or that of the Prior Plan, no benefit will be paid.

POLICY AMENDMENT

TO BE ATTACHED AND MADE A PART OF GROUP POLICY NO.: 000000000000

ISSUED TO: ABC Company

[It is agreed that the above policy be amended as follows.

Class 2, as shown on the SCHEDULE OF BENEFITS, is deleted in its entirety.]

The effective date of this Policy Amendment is October 1, 2010; but only with respect to losses incurred on or after that date. Nothing contained in this Policy Amendment shall change any of the terms and conditions of the Policy, except as stated above.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

Accepted by the Group Policyholder this _____ day of _____ 20____

By _____ Title _____

POLICY AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Policy is amended by the addition of the following Accident Benefit provision.

ACCIDENT BENEFIT

[The Accident Benefit will apply if elected by the Insured Person and the required premium is paid.]

The Company will pay an Accident Benefit if an Insured Person [or Insured Dependent] sustains one of the following incidents as a result of an Accident:

- (1) Coma;
- (2) Severe Burn; or
- (3) Paralysis.

The Accident must occur while this Policy Amendment is in force for the Insured Person [or Insured Dependent]. The benefit is payable once per Accident.

The benefit does not affect any other benefits payable under the Policy.

AMOUNT. The amount of the Accident Benefit equals the Insured Person's [or Insured Dependent's] Critical Illness Principal Sum shown in the Policy's Schedule of Benefits.

DEFINITIONS. The following additional definitions apply to this Accident Benefit.

"Accident or Accidental" means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

"Coma" means a state of complete mental unresponsiveness, due to Accidental Injury, during which the Insured Person [or Insured Dependent]:

- (1) cannot be awakened;
- (2) does not respond to pain, light or sound; and
- (3) does not take voluntary actions.

It does not include a medically-induced coma. For the purpose of this definition, these traits must be met for a continuous period of time lasting at least 7 days. Diagnosis is made by a board-certified or board-eligible neurologist and based on findings from clinical diagnosis.

"Injury or Injuries" means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Accident.

"Paralysis" means complete and permanent loss of the use of two or more limbs. Diagnosis must be confirmed by findings from physical examination conducted by a board-certified or board-eligible neurologist, physiatrist, or other Physician.

"Severe Burn" means:

- (1) a third-degree (full thickness) burn covering at least 18% of the body; or
- (2) a second-degree (partial thickness) burn covering at least 36% of the body.

Diagnosis is made based on clinical examination findings conducted by a board-certified or board-eligible plastic surgeon or other Physician.

**POLICY AMENDMENT
(Continued)**

EXCLUSIONS. The Exclusions contained in the Policy apply to this Policy Amendment. In addition, no Benefits will be paid for any loss resulting, directly or indirectly, from or in any degree caused by:

- (1) disease, physical or mental infirmity, illness, infection (except when the infection is due to an Accidental cut or wound), or medical or surgical treatment of these;
- (2) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (3) an Injury arising out of, or in the course of any employment for wage or profit;
- (4) the Insured Person [or Insured Dependent] having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood;
- (5) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (6) cosmetic or elective surgery;
- (7) being incarcerated in any type of penal or detention facility;
- (8) participating in or practicing for, or officiating any semi-professional or professional sport;
- (9) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
- (10) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

POLICY AMENDMENT

**TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]**

The Policy is amended by the addition of the following Permanent and Total Disability Benefit provision.

PERMANENT AND TOTAL DISABILITY BENEFIT

The Permanent and Total Disability Benefit will apply if elected by the Insured Person and the required premium is paid.

BENEFIT. The Company will pay a Permanent and Total Disability Benefit to an Insured Person [or Insured Dependent Spouse] who:

- (1) becomes Permanently and Totally Disabled as a result of a payable Event/Illness shown in the Policy's Schedule of Benefits;
- (2) remains Permanently and Totally Disabled for at least [6 months] in a row; and
- (3) is covered under this Policy Amendment.

The Event/Illness must occur while this Policy Amendment is in effect for the Insured Person [or Insured Dependent Spouse]. The benefit does not affect any other benefits payable under the Policy.

AMOUNT. The amount of the Permanent and Total Disability Benefit equals the Insured Person's [or Insured Dependent Spouse's] Critical Illness Principal Sum shown in the Policy's Schedule of Benefits. The Company must receive written proof of the Insured Person's [or Insured Dependent Spouse's] Permanent and Total Disability before benefits are payable.

DEFINITION. The following additional definition applies to this Permanent and Total Disability Benefit.

"Permanently and Totally Disabled" (or "Permanent and Total Disability") means that, due to a payable Event/Illness shown in the Policy's Schedule of Benefits, the Insured Person [or Insured Dependent Spouse]:

- (1) is unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience;
- (2) does not engage in any employment or occupation; and
- (3) is expected to remain so disabled continuously for life, as certified by a Physician.

EXCLUSIONS. The Exclusions contained in the Policy apply to this Policy Amendment.

CLAIMS PROCEDURES. The following claims procedures will apply to this benefit in lieu of the Claims Procedures found in the Policy.

Notice of Claim. Written notice of a Permanent and Total Disability claim must be given within 20 days after the Permanent and Total Disability begins or as soon as reasonably possible. The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) the Insured Person's name, address, and certificate number, if available[; and]
- [(3) the Insured Dependent Spouse's name, if the Insured Dependent Spouse is the claimant.]

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, the Insured Person may send the Company written proof of Permanent and Total Disability in a letter.

POLICY AMENDMENT
(Continued)

Proof of Permanent and Total Disability. The Company must receive written proof of Permanent and Total Disability within 90 days after the day the benefit becomes payable. If it is not reasonably possible to give written proof in the time required, benefits will not be reduced or denied if the proof is filed as soon as reasonably possible. Failure to furnish written proof of Permanent and Total Disability within the time required shall not affect any claim if it was not reasonably possible to give proof within such time.

Proof of Permanent and Total Disability must be provided at the claimant's own expense. It must show the date the Permanent and Total Disability began, its cause and degree. Documentation must include the following:

- (1) completed statements by the claimant;
- (2) a completed statement by the attending Physician;
- (3) a certification by the attending Physician that the Permanent and Total Disability will last the Insured Person's [or Insured Dependent Spouse's] lifetime;
- (4) a signed authorization for the Company to obtain more information; and
- (5) any other items the Company may reasonably require in support of the claim.

Examination. The Company may have the claimant examined:

- (1) by a Physician or specialist of the Company's choice; and
- (2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the claimant has [, without Good Cause]:

- (1) failed to cooperate with an examiner;
- (2) failed to take an exam scheduled by the Company; or
- (3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed. [As used in this provision, "**Good Cause**" means completing the exam would seriously jeopardize the Insured Person's [or Insured Dependent Spouse's] life or health. Good Cause does **not** exist solely because completing the exam would cause fatigue, stress or discomfort; require transportation or child care arrangements; or conflict with personal business, family or social engagements.]

Time of Payment of Claims. Benefits payable under this Policy Amendment will be paid immediately after the Company receives complete proof of claim and confirms liability.

To Whom Payable. All Permanent and Total Disability benefits are payable to the Insured Person [or Insured Dependent Spouse], while living. After the Insured Person's death, such benefits will be payable in accord with the Beneficiary provision of the Policy. [After the Insured Dependent Spouse's death, such benefits will be paid to the Insured Person.]

Notice of Claim Decision. The Company will send the claimant a written notice of its Permanent and Total Disability claim decision. If the Company denies any part of the claim, the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how the Insured Person may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

POLICY AMENDMENT
(Continued)

Claim Decision Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) what additional information is needed to determine liability; and
- (2) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception to Claim Decision Delay Notice. The Company may need more information from the claimant to process a Permanent and Total Disability claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

Review Procedure. Within 180 days after receiving a denial notice for a Permanent and Total Disability claim, the claimant may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

He or she may review certain non-privileged information relating to the request for review.

Notice of Review Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy, this Amendment, and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

- (1) any further appeal procedures available;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Review Decision Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

- (1) an extension of up to 45 more days will be permitted; and
- (2) the Company will send the claimant a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception to Review Decision Delay Notice. The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

**POLICY AMENDMENT
(Continued)**

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy Amendment, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

- (1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
- (2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Right Of Recovery. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim; or
- (2) fraud or any other reason.

Legal Actions. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

Company's Discretionary Authority. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to:

- (1) manage this Policy Amendment and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Policy Amendment.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Policy Amendment and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

POLICY AMENDMENT

**TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]**

The Policy is amended by the addition of the following Treatment Care Benefit provision.

TREATMENT CARE BENEFIT

The Treatment Care Benefit will apply if elected by the Insured Person and the required premium is paid.

The Company will pay [one or more of] the following treatment care benefit[s] if an Insured Person [or Insured Dependent] meets the terms and conditions for any of the benefits listed below as the result of a payable Event/Illness shown in the Schedule of Benefits in the Policy. The Event/Illness must occur while this Policy Amendment is in effect for the Insured Person [or Insured Dependent].

The benefit does not affect any other benefits payable under the Policy.

AMOUNT. Benefit amounts payable for Treatment Care Benefits are shown below.

| <u>Benefit</u> | <u>Amount</u> |
|--|-----------------------------|
| [Ambulance Transportation] | [<u>\$50-500</u>] |
| [Air Ambulance Transportation] | [<u>\$200-5,000</u>] |
| [Hospital Admission] | [<u>\$100-3,000</u>] |
| [Hospital Confinement] | [<u>\$50-1,000</u>] |
| [Intensive Care Unit (ICU) Confinement] | [<u>\$50-1,000</u>] |
| [Follow-up Care] | [<u>\$10-100</u>] |
| [Transportation] | [<u>\$50-900</u>] |
| [Lodging] | [<u>\$50-350</u>] |
| [Reasonable Modification] | [<u>\$100-5,000</u>] |

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports an Insured Person [or Insured Dependent] by ground transportation to or from a Hospital or between medical facilities as the result of a payable Event/Illness shown in the Schedule of Benefits. The ambulance transportation must be within [180 days] of the Event/Illness. This benefit will be paid [once] per person per payable Event/Illness.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports an Insured Person [or Insured Dependent] by air ambulance to or from a Hospital or between medical facilities as the result of a payable Event/Illness shown in the Schedule of Benefits. The air ambulance transportation must be within [180 days] of the Event/Illness. This benefit will be paid [once] per person per Event/Illness. This benefit may be paid in addition to the Ambulance Transportation benefit.

POLICY AMENDMENT
(Continued)

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if an Insured Person [or Insured Dependent] is admitted to a Hospital as a result of a payable Event/Illness shown in the Schedule of Benefits. The admission must occur within 180 days of the Event/Illness. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Event/Illness.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day an Insured Person [or Insured Dependent] is confined in a Hospital as the result of a payable Event/Illness shown in the Schedule of Benefits. The initial confinement must begin within 180 days of the Event/Illness. This benefit is payable for up to 365 days per person per Event/Illness, which may be used over a two-year period from the date of the Event/Illness. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one payable Event/Illness. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day an Insured Person [or Insured Dependent] is confined in an ICU as the result of payable Event/Illness shown in the Schedule of Benefits. The confinement must begin within 180 days of the Event/Illness. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Event/Illness, which may be used over a two-year period from the date of the Event/Illness. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Event/Illness. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If an Insured Person [or Insured Dependent] exhausts the ICU benefit but is still confined, the Insured Person [or Insured Dependent] may be eligible for the Hospital Confinement benefit.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care for an Insured Person [or Insured Dependent] that results from a payable Event/Illness as shown in the Schedule of Benefits. Follow-up care must be received within 365 days of an Event/Illness. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Event/Illness. This benefit is not payable while the Insured Person [or Insured Dependent] is confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when the Insured Person [or Insured Dependent] must travel more than 100 miles one way:

- (1) for treatment of a payable Event/Illness shown in the Schedule of Benefits;
- (2) at a Hospital or other specialized freestanding treatment facility.

Transportation must occur within 365 days of the Event/Illness. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Event/Illness. This benefit is not payable when transportation is provided by ambulance or air ambulance.

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies an Insured Person [or Insured Dependent] who is Hospital confined more than 100 miles from the Insured Person's [or Insured Dependent's] principal place of residence due to a payable Event/Illness shown in the Schedule of Benefits. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Event/Illness.

POLICY AMENDMENT
(Continued)

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to an Insured Person's [or Insured Dependent's] principal place of residence due to one of the following payable Events/Illnesses:

- [(1) Stroke; or]
- [(2) ALS/Lou Gehrig's Disease; or]
- [(3) Advanced Alzheimer's Disease; or]
- [(4) Multiple Sclerosis; or]
- [(5) Stage 4 Parkinson's Disease; or]
- [(6) Loss of Sight; or]
- [(7) Loss of Hearing; or]
- [(8) Loss of Speech; or]
- [(9) Genetic Disorders.]

Modifications must be made within two years from the date of the Event/Illness. This benefit is payable once per person per Event/Illness.

DEFINITIONS. The following additional definitions apply to this Treatment Care Benefit.

"Companion" means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

"Home Health Care Agency" means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

"Hospital Confinement" means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Event/Illness.

"Intensive Care Unit (ICU)" means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

"Medical Health Professional" means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

"Observation Unit" means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

"Occupational Therapist" means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

**POLICY AMENDMENT
(Continued)**

"Outpatient Treatment" means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

"Physical Therapist" means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

POLICY AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Policy is amended by the addition of the following Occupational HIV/Occupational Hepatitis Benefit provision.

OCCUPATIONAL HIV/OCCUPATIONAL HEPATITIS BENEFIT

[The Occupational HIV/Occupational Hepatitis Benefit will apply if elected by the Insured Person and the required premium is paid.]

BENEFIT. The Company will pay an Occupational HIV/Occupational Hepatitis Benefit for an Insured Person who:

- (1) is a Medical Professional as defined below, a police officer, or a professional or volunteer fire fighter; and
- (2) first tests positive with Occupational HIV or Occupational Hepatitis while covered under the Occupational HIV/Occupational Hepatitis Benefit.

The benefit does not affect any other benefits payable under the Policy.

AMOUNT. The amount of the Occupational HIV/Occupational Hepatitis Benefit equals the Insured Person's Critical Illness Principal Sum shown in the Policy's Schedule of Benefits.

PROOF. The Company must receive proof of infection from the laboratory that performed the test. The Insured Person is responsible for any expenses incurred for testing for infection. The testing:

- (1) may not be self-administered; and
- (2) must be provided by a licensed laboratory.

DEFINITIONS. The following additional definitions apply to this Occupational HIV/Occupational Hepatitis Benefit.

"Hepatitis" means viral hepatitis, types B, C, and D. It does not include type-A hepatitis.

"HIV" means the Human Immunodeficiency Virus, whether HIV-1 or HIV-2.

"Medical Professional" means a person:

- (1) who is licensed to perform medical services under state law; and
- (2) who is practicing within the scope of the license.

"Occupational HIV" means Human Immunodeficiency Virus (HIV) that occurs as a result of a documented accidental exposure, in the workplace, to blood or other bodily fluids from a person known to be infected with HIV. Diagnosis of HIV infection must be confirmed by blood testing administered under the direction of and interpreted by a Physician. The accidental exposure must be documented by an appropriate accident report at the workplace. HIV infection acquired outside the workplace is not considered Occupational HIV.

"Occupational Hepatitis" means Hepatitis that occurs as a result of a documented accidental exposure, in the workplace, to blood or other bodily fluids from a person known to be infected with Hepatitis. Diagnosis of Hepatitis infection must be confirmed by blood testing administered under the direction of and interpreted by a Physician. The accidental exposure must be documented by an appropriate accident report at the workplace. Hepatitis infection acquired outside the workplace is not considered Occupational Hepatitis.

**POLICY AMENDMENT
(Continued)**

EXCLUSIONS. The Exclusions contained in the Policy apply to this Policy Amendment. In addition, no Benefits will be paid if the Insured Person:

- (1) first tests positive for Occupational HIV/Occupational Hepatitis prior to the effective date of his or her coverage under the Policy; or before the effective date of the Occupational HIV/Occupational Hepatitis Benefit, if added later by amending the Policy; or
- (2) has ever refused vaccination against or treatment for Occupational HIV/Occupational Hepatitis.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL000000000000 has been issued to
The ABC Company, Incorporated
(The Group Policyholder)

The Issue Date of the Policy is Month Day, Year.

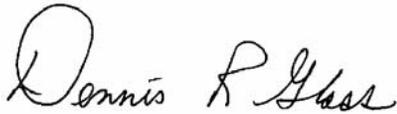
Participating Organization: XYZ Company

Participating Organization's Effective Date: _____

Certificate of Insurance for [for Plan 1/ Class 1]

[Insured Person's Name]
[Insured Person's Effective Date]
[Certificate Number]

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. [If you have elected Dependent coverage on your enrollment form, your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required premium has been paid.] This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.


President

READ YOUR CERTIFICATE CAREFULLY

This is a limited benefit certificate. It provides Critical Illness insurance coverage. There is no coverage for hospital, medical-surgical or major medical expenses.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

[BENEFITS ARE SUBJECT TO AGE REDUCTIONS.]

[THIS CERTIFICATE CONTAINS A PRE-EXISTING CONDITION EXCLUSION.]

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at [1-800-423-2765]. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at [Arkansas Insurance Department, 1200 West Third Street, Little Rock, Arkansas 72201] or phone them at [1-800-852-5494 or 1-501-371-2640]. Please have your policy number available.

CERTIFICATE OF GROUP CRITICAL ILLNESS INSURANCE

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[ABC Company, Incorporated]
[000000000000]

SCHEDULE OF BENEFITS

[For Plan 1/ Class 1]

ELIGIBLE CLASS means: [All Full-Time Employees]

[MINIMUM HOURS PER WEEK: 20]

ANNUAL/OPEN ENROLLMENT PERIOD: November 1 – November 30

ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section.)

- (a) None for employees who were hired on or before the Policy Issue Date.
- (b) 30 days of continuous Active Work for employees who were hired after the Policy Issue Date.

[**BENEFIT WAITING PERIOD:** 30 days]

CONTRIBUTIONS: You are required to contribute to the cost for Personal Critical Illness Insurance and to the cost for Dependent Critical Illness Insurance.

**SCHEDULE OF BENEFITS
(Continued)**

PERSONAL CRITICAL ILLNESS INSURANCE

Personal Critical Illness Principal Sum

Class 1

[You may elect Personal Critical Illness Insurance in any \$1,000 increment, subject to a minimum of \$1,000 and a maximum of \$250,000.]

[The Principal Sum will be reduced by 50% when you attain age 70.]

**DEPENDENT CRITICAL ILLNESS INSURANCE
[(For Class 1)]**

Dependent

Dependent Critical Illness Principal Sum

Spouse

[You may elect Spouse Critical Illness Insurance in any \$1,000 increment, subject to a minimum of \$1,000 and a maximum of \$250,000.]

Dependent Child

[You may elect Child Critical Illness Insurance in any \$1,000 increment, subject to a minimum of \$1,000 and a maximum of \$250,000.]

The Dependent Critical Illness Principal Sum will be reduced by 50% when [you/your Spouse] attain[s] age 70. Dependent Critical Illness Insurance may not exceed the amount of your Personal Critical Illness Principal Sum in effect under the Policy.

ORGAN CATEGORY [(Available for Insured Persons and Dependents)]

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|---|------------------------------------|
| End Stage Renal Failure | [1-100%] |
| <u>Placement on United Network for Organ Sharing (UNOS) List for Major Organ Transplant [(excluding Heart)]*</u> | [1-100%] |
| Acute Respiratory Distress Syndrome | [1-100%] |

**SCHEDULE OF BENEFITS
(Continued)**

HEART CATEGORY [(Available for Insured Persons and Dependents)]

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|---|--|
| Heart Attack | [1-100%] |
| <u>Placement on United Network for Organ Sharing (UNOS) List for Heart Transplant*</u> | [1-100%] |
| Stroke | [1-100%] |
| Arteriosclerosis | [1-100%, subject to a lifetime maximum of <u>2</u> payments] |
| Aneurysm due to Arteriosclerosis | [1-100%, subject to a lifetime maximum of <u>2</u> payments] |

CHILD CATEGORY (Available only for Insured Dependent Children)

Benefits in this category are payable once per Event/Illness per Insured Dependent Child during his/her lifetime.

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|---------------------------------------|---|
| Structural Congenital Defects | [1-100%] |
| Genetic Disorders | [1-100%] |
| Type I Diabetes | [1-100%] |
| Congenital Metabolic Disorders | [1-100%] |

**SCHEDULE OF BENEFITS
(Continued)**

QUALITY OF LIFE CATEGORY [(Available for Insured Persons and Dependents)]

Benefits in this category are payable once per Event/Illness per Insured Person [or Insured Dependent] during his or her lifetime.

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|-------------------------------------|---|
| ALS/Lou Gehrig's Disease | [1-100%] |
| Advanced Alzheimer's Disease | [1-100%] |
| Advanced Multiple Sclerosis | [1-100%] |
| Muscular Dystrophy | [1-100%] |
| Advanced Parkinson's Disease | [1-100%] |
| Loss of Sight | [1-100%] |
| Loss of Hearing | [1-100%] |
| Loss of Speech | [1-100%] |

**SCHEDULE OF BENEFITS
(Continued)**

CANCER CATEGORY [(Available for Insured Persons and Dependents)]

| <u>Event/Illness</u> | <u>Percentage of Principal Sum</u> |
|---|------------------------------------|
| Cancer | [1-100%] |
| Cancer in Situ | [1-100%] |
| Benign Brain Tumor | [1-100%] |
| Placement on the <u>Be the Match Registry for Bone Marrow Transplant*</u> | [1-100%] |

WELLNESS CATEGORY [(Available for Insured Persons and Dependents)]

Critical Illness Assessment Benefit

| | |
|--------------------------------------|--|
| Critical Illness Assessment Period: | January 1 through December 31 |
| Critical Illness Assessment Benefit: | <u>\$50</u> for each Critical Illness Assessment Test performed, subject to a maximum of <u>2</u> Critical Illness Assessment Tests per person per Critical Illness Assessment Period[; subject to the Overall Maximum(s)] |
| Overall Maximum Of Tests: | <u>6</u> [per family] |
| Overall Maximum Benefit Amount: | <u>\$300</u> [per family] |

Child Care Expense Benefit \$25 per Child per day

For you or each of your Insured Dependents, the lifetime total benefits payable in any category shown in the Schedule of Benefits [(except the Wellness Category)] are subject to an overall maximum of 150% of the Principal Sum.

*A benefit for this Event may also be payable if you or your Insured Dependent:

- (1) is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the network/registry; or
- (2) receives a transplant prior to placement on the network/registry.

**SCHEDULE OF BENEFITS
(Continued)**

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted [(at your expense)] when:

- (1) Critical Illness Insurance amounts exceed the guarantee issue amount of \$(GI amount) for Insured Persons; \$(GI amount) for Insured Dependent Spouses; or \$(GI amount) for Insured Dependent Children at initial enrollment]; or]
- [(2) initial Critical Illness Insurance is elected]; or]
- [(3) the amount of Critical Illness Insurance in excess of the guarantee issue amount increases after the initial enrollment]; or]
- [(4) the amount of Critical Illness Insurance increases after the initial enrollment]; or]
- [(5) any increment/benefit option increase after the initial enrollment exceeds the amount of Critical Illness Insurance by more than [1-3] increment level(s)/benefit options over a 12-month period based on the month of the Policy anniversary]; or]
- [(6) the amount of Critical Illness Insurance increases after the initial enrollment by more than \$(GI increase amount) for Insured Persons; \$(GI increase amount) for Insured Dependent Spouses; or \$(GI increase amount) for Insured Dependent Children]; or]
- [(7) the amount of Critical Illness Insurance in excess of the guarantee issue amount, increases after the initial enrollment by more than \$(GI increase amount) for Insured Persons; \$(GI increase amount) for Insured Dependent Spouses; or \$(GI increase amount) for Insured Dependent Children over a 12-month period based on the month of the Policy anniversary]; or]
- [(8) the amount of Critical Illness Insurance increases after the initial enrollment by more than \$(GI increase amount) for Insured Persons; \$(GI increase amount) for Insured Dependent Spouses; or \$(GI increase amount) for Insured Dependent Children over a 12-month period based on the month of the Policy anniversary.]

If any Evidence of Insurability is required, it will be provided at your own expense.

DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an [Employee's/member's] performance of all customary duties of his or her occupation at:

- (1) the [Group Policyholder's/Participating Organization's] place of business; or
- (2) any other business location designated by the [Group Policyholder/Participating Organization.]

Unless disabled on the prior workday or on the day of absence, an [Employee/member] will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

ACUTE RESPIRATORY DISTRESS SYNDROME means acute respiratory failure resulting in inadequate oxygenation, due to aspiration or infection. Diagnosis is determined by a Physician and based on:

- (1) demonstration of infiltrates in both lungs in the absence of clinical heart failure; and
- (2) acute lung injury demonstrated by testing of blood gases.

ADVANCED ALZHEIMER'S DISEASE means dementia of the Alzheimer's Type that has progressed to the point that the individual can be classified as Functional Assessment Staging (FAST) Scale Stage 6. Diagnosis is made by a board-certified or board-eligible neurologist on the basis of neurological examination and cognitive testing. Initial diagnosis of Alzheimer's Disease must occur while the Insured Person [or Insured Dependent] is covered under the Policy.

ADVANCED MULTIPLE SCLEROSIS (MS) means Multiple Sclerosis with demonstrated neurological deficits that have been present for six months or more. Diagnosis is made by a board-certified or board-eligible neurologist on the basis of:

- (1) neurological examination demonstrating functional impairments;
- (2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and
- (3) analysis of cerebrospinal fluid consistent with the diagnosis.

Initial diagnosis of Multiple Sclerosis must occur while the Insured Person [or Insured Dependent] is covered under the Policy.

ADVANCED PARKINSON'S DISEASE means Parkinson's Disease that has progressed to Stage 4, as diagnosed by a board-certified or board-eligible neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies. Initial diagnosis of Parkinson's Disease must occur while the Insured Person [or Insured Dependent] is covered under the Policy.

ALS/LOU GEHRIG'S DISEASE means amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) of the Middle Stage according to the Muscular Dystrophy Association. Definitive diagnosis must be made by a board-certified or board-eligible neurologist according to diagnostic criteria for the specific illness. Other motor neuron diseases are not considered to be ALS. Initial diagnosis of ALS/Lou Gehrig's Disease must occur while the Insured Person [or Insured Dependent] is covered under the Policy.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANEURYSM DUE TO ARTERIOSCLEROSIS means an abnormal widening or ballooning of a portion of an artery due to weakness of the arterial wall caused by Arteriosclerosis, of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Aneurysm is diagnosed by a Physician based on arteriography or other appropriate imaging studies.

DEFINITIONS
(Continued)

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible [Employees/members] to purchase or make changes to their Personal [or Dependent] Critical Illness Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period [or Benefit Waiting Period].

ARTERIOSCLEROSIS means blockage of a coronary artery of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Diagnosis is made by a board-certified or board-eligible cardiologist and is accompanied by the demonstrated need for intervention.

BENEFIT WAITING PERIOD means the period of time an Insured Person [or Insured Dependent] must be covered under the Policy before becoming eligible for benefits (including benefits provided by Amendments).

BENIGN BRAIN TUMOR means a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. Diagnosis of the tumor and neurological deficit must be confirmed by imaging and examination findings conducted by a board-certified or board-eligible neurologist or other Physician appropriately licensed to diagnose the deficit.

BONE MARROW TRANSPLANT means a transplant necessitated by a compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis is made by a board-certified or board-eligible hematologist or board-certified or board-eligible oncologist who determines that the bone marrow transplant is necessary and places the Insured Person [or Insured Dependent] on the Be The Match registry. If the Insured Person [or Insured Dependent] is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the registry; the registry requirement will be waived. The registry requirement will also be waived if the Insured Person [or Insured Dependent] receives the transplant prior to placement on the registry.

CANCER means malignant cells or tumors characterized by uncontrolled growth with spread beyond the initial tissue. Diagnosis must be by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic tissue evaluation (biopsy). The following are not considered Cancer for purposes of this definition:

- (1) Cancer in Situ;
- (2) basal cell carcinoma and squamous cell carcinoma of the skin; and
- (3) melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm.

CANCER IN SITU means Cancer cells confined to the surface tissues (epithelium) without invasion of the basement membrane and with no spread to regional lymph nodes or other tissues. Diagnosis is made by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic examination of tissue (biopsy). Basal cell and squamous cell carcinomas of the skin are not considered Cancer in Situ.

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, adoption, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. [Change in Family Status also means:

- (1) a civil union or domestic partnership;
- (2) dissolution of a civil union or domestic partnership; or
- (3) the involuntary loss of comparable coverage under a spouse's, civil union partner's, or domestic partner's benefit plan.]

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DEFINITIONS (Continued)

CONGENITAL METABOLIC DISORDER means:

- (1) Infantile Tay Sachs;
- (2) Zellweger Syndrome;
- (3) Gaucher Disease Types II and III;
- (4) Niemann-Pick Disease;
- (5) Lesch-Nyhan Syndrome; or
- (6) Glycogen Storage Disease Types I, II, IV, and VII.

Diagnosis must be made during childhood by a Physician based on blood tests, physical exams, and/or genetic testing.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the [Group Policyholder's/Participating Organization's] place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DEPENDENT CRITICAL ILLNESS INSURANCE means the coverage provided by the Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the period of time an Employee must be employed in an eligible class with the [Group Policyholder/Participating Organization], before he or she becomes eligible to enroll for insurance under the Policy. The period of service must be continuous, except as explained in the Eligibility section captioned Prior Service Credit Towards Waiting Period. / means the period of time a Person must be in an eligible class with the [Group Policyholder/Participating Organization], before he or she becomes eligible to enroll for insurance under the Policy.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the [Group Policyholder/Participating Organization].

END STAGE RENAL FAILURE means chronic and irreversible failure of the kidneys of such magnitude that permanent dialysis or transplant is required to sustain life.

EVENT/ILLNESS means a Critical Illness event or illness:

- (1) shown in the Schedule of Benefits; and
- (2) for which the Insured Person [or Insured Dependent] is covered under the Policy.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

- (1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
- (2) is taken in accord with the [Group Policyholder's or Participating Organization's] leave policy and the law which applies; and
- (3) does not exceed the period approved by the [Group Policyholder or Participating Organization] and required by that law.

The leave period may:

- (1) consist of consecutive or intermittent work days; or
- (2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under the Policy takes effect, he or she is not considered Actively at Work.

DEFINITIONS
(Continued)

FULL-TIME EMPLOYEE means a person:

- (1) whose employment with the Group Policyholder/Participating Organization is the person's main occupation;
- (2) whose employment is for regular wage or salary;
- (3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
- (4) who is a member of an eligible class under the Policy;
- (5) who is not a temporary or seasonal employee; and
- (6) who is a citizen of the United States or legally works in the United States.

GENETIC DISORDER means:

- (1) Cystic Fibrosis;
- (2) Down's Syndrome;
- (3) Muscular Dystrophy;
- (4) Fragile X Syndrome;
- (5) Vascular Ehlers-Danlos Syndrome;
- (6) Infantile Onset Ascending Spastic Paralysis;
- (7) Juvenile Lateral Sclerosis;
- (8) Spinal Muscular Atrophy Type I or II ; or
- (9) Osteogenesis Imperfecta Type II, III, IV, V, VI, VII, or VIII.

Diagnosis must be made during childhood by a Physician and based on genetic testing.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

HEART ATTACK (MYOCARDIAL INFARCTION) means death of a portion of heart muscle due to inadequate circulation in coronary arteries. If no death of heart muscle occurs, this is not considered a heart attack. Diagnosis is made by a board-certified or board-eligible cardiologist and based on findings from an electrocardiogram (EKG) and elevation of cardiac enzymes associated with heart attack.

HEART TRANSPLANT means the transplantation of a healthy heart from a suitable donor, necessitated by the diagnosis of end-stage heart disease, as determined by a Physician appropriately specialized for the heart. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person [or Insured Dependent] is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person [or Insured Dependent] receives the transplant prior to placement on the network.

HOSPITAL means a general hospital which:

- (1) is licensed, approved or certified by the state where it is located;
- (2) is recognized by the Joint Commission;
- (3) is operated to treat Inpatients;
- (4) has a registered nurse always on duty; and
- (5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

- (1) is specialized solely in dentistry, mental illness or substance abuse;
- (2) is a rest home, home for the aged, convalescent home or nursing home; or
- (3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

INPATIENT means an Insured Person [or Insured Dependent] who is an overnight resident patient.

DEFINITIONS
(Continued)

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 a.m. on the first day of any calendar month; and
 - (2) ending at 12:00 midnight on the last day of the same calendar month;
- at the [Group Policyholder's/Participating Organization's] primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED DEPENDENT SPOUSE means the Insured Person's spouse[, domestic partner, or civil union partner] for whom coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

LOSS OF HEARING means permanent reduction in both ears to a point that the Insured Person[/Insured Dependent] is unable to hear sounds at or below 70 decibels. Diagnosis is made by a board-certified or board-eligible otolaryngologist as diagnosed by audiometric testing.

LOSS OF SIGHT means permanent loss of sight in both eyes such that corrected visual acuity is 20/200 or less, or the field of vision is less than 20 degrees. Diagnosis is made by a board-certified or board-eligible ophthalmologist or board-certified or board-eligible neuro-ophthalmologist based on the above criteria and noted to be of permanent duration.

LOSS OF SPEECH means loss of the ability to speak to the extent that the individual is unintelligible to another person with normal hearing, for at least 12 months. Diagnosis is made by a board-certified or board-eligible otolaryngologist or board-certified or board-eligible neurologist.

MAJOR ORGAN means the [heart,] liver, lungs, pancreas, intestines, or combinations of these organs.

MAJOR ORGAN TRANSPLANT means the transplantation of a healthy Major Organ from a suitable donor, necessitated by the diagnosis of end-stage organ disease (organ failure), as determined by a Physician appropriately specialized for the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person [or Insured Dependent] is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person [or Insured Dependent] receives the transplant prior to placement on the network.

MILITARY LEAVE means a leave of absence that:

- (1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
- (2) is taken in accord with the [Group Policyholder's or Participating Organization's] leave policy and the federal USERRA law; and
- (3) does not exceed the period required by that law.

PAYROLL PERIOD means that period of time established by the Group Policyholder/or Participating Organization for payment of employee wages.

PERSON means a Full-Time Employee of the Group Policyholder[:]

- [(1)] who is a member of a class that is eligible for insurance under the Policy[:]; and]
- [(2)] who has completed an enrollment form].

PERSONAL CRITICAL ILLNESS INSURANCE means the insurance provided by the Policy for Insured Persons.

DEFINITIONS
(Continued)

PHYSICIAN means:

- (1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
- (2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

- (1) the Insured Person's spouse, [domestic partner, civil union partner], siblings, parents, children and grandparents; and
- (2) his or her spouse's [, domestic partner's, or civil union partner's] relatives of like degree.

POLICY means this Group Critical Illness Insurance policy issued by the Company to the Group Policyholder.

PREMIUM means the amount charged for insurance coverage.

REGULAR PART-TIME EMPLOYEE means a person:

- (1) whose employment is for wage or salary;
- (2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
- (3) who is a member of a class which is eligible for insurance under the Policy;
- (4) who is not a temporary or seasonal employee; and
- (5) who is a citizen of the United States or legally works in the United States.

RETIREE means a former [full-time] Employee of the [Group Policyholder or Participating Organization] who is eligible for retirement benefits.

STROKE means permanent neurological damage to the brain due to inadequate blood flow in any of the cranial vessels, due to either blockage or rupture of the vessel and categorized as Score 3 on the Modified Rankin Scale. Diagnosis of permanent neurological damage should be made by a neurologist and demonstrated by imaging (CT or MRI) and examination demonstrating lasting neurological deficits (motor, cognitive, or sensory). Transient Ischemic Attacks (TIA) are not considered Strokes.

STRUCTURAL CONGENITAL DEFECT means any of the following:

- (1) cleft lip/palate;
- (2) club foot;
- (3) Patent ductus arteriosus;
- (4) coarctation;
- (5) transposition of the great arteries;
- (6) hypoplastic left heart system;
- (7) tetralogy of fallot;
- (8) diaphragmatic hernia;
- (9) pyloric stenosis;
- (10) Hirschsprung's disease;
- (11) gastroschisis and omphalocele;
- (12) anal atresia;
- (13) biliary atresia;
- (14) spina bifida; or
- (15) anencephaly.

Diagnosis must be made during childhood by a board-certified or board-eligible pediatrician.

DEFINITIONS
(Continued)

TYPE 1 DIABETES means diabetes that results from auto-immune destruction of insulin-producing cells in the pancreas. Diagnosis is made during childhood or adolescence by a board-certified or board-eligible endocrinologist or other specialist in the treatment of diabetes, based on blood tests, and requires the confirmation of the cause of low insulin production.

YOU and YOUR means an eligible [Employee/member] for whom the coverage provided by the Policy is in effect.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) the Policy and any amendments to it[; and]
- (2) the Group Policyholder's application[; and]
- [(3) any Participating Organization's Application or Participation Agreement.]

In the absence of fraud, all statements made by the Group Policyholder [or Participating Organization] and by Insured Persons [or Insured Dependents] are representations and not warranties. No statement made by an Insured Person [or Insured Dependent] will be used to contest the insurance provided by the Policy, unless:

- (1) it is contained in a written statement signed by that Insured Person [or Insured Dependent]; and
- (2) a copy of the statement has been furnished to that Insured Person [or Insured Dependent].

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person [or Insured Dependent], after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

- (1) the Policy's eligibility requirements, exclusions and limitations; and
- (2) other Policy provisions unrelated to the validity of insurance.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:

- (1) an Insured Person [or Insured Dependent] incurs a claim during the first two years of coverage; and
- (2) the Company discovers that the Insured Person [or Insured Dependent] made a Material Misrepresentation on his or her application.

A "**Material Misrepresentation**" is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. "**To rescind**" means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for Insured Person's [or Insured Dependent's] claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person [or Insured Dependent] were misstated:

- (1) a fair adjustment of the premium will be made; and
- (2) the true facts will decide if and in what amount insurance is valid under the Policy.

If any Insured Person's [or Insured Dependent's] age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:

- (1) Workers' Compensation laws; or
- (2) any state temporary disability insurance plan laws.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE

ELIGIBILITY. A Person becomes eligible for insurance provided by the Policy on the [later/latest of]:

- (1) the Policy's date of issue[; or]
- [(2) the date such Person's organization becomes a Participating Organization][; or]
- [(3) the date the Waiting Period is completed. (For Waiting Period, see Schedule of Benefits.)]

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

- (1) a [former employee/member] is rehired within one year after his or her employment ends; or
- (2) [an employee/a member] returns from an approved Family or Medical Leave within:
 - (a) the leave period required by federal law; or
 - (b) any longer period required by a similar state law; or
- (3) [an employee/a member] returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Critical Illness Insurance only:

- (1) when first eligible[; or]
- (2) during any Annual/Open Enrollment Period[; or]
- (3) within 31 days following a qualifying Change In Family Status.

EFFECTIVE DATE. Personal Critical Illness Insurance becomes effective on the latest of:

- (1) the date you become eligible for the insurance[; or]
- (2) the date you resume Active Work, if not Actively at Work on the day you become eligible (You will be deemed Actively at Work on any regular non-working day, if you:
 - (a) are not totally disabled or Hospital confined on that day; and
 - (b) were Actively at Work on the regular working day before that day)[; or]
- (3) if you contribute to the cost of the Personal Critical Illness Insurance, the date you make written application for insurance[; and sign:]
 - [(a) a payroll deduction order, if you pay any part of the Policy premium for Personal Critical Illness Insurance; or]
 - [(b) an order to pay premiums from your Section 125 Plan account, if any contributions are paid through a Section 125 Plan];and pays the required premium to the Company[; or]
- (4) the date the Company approves your Evidence of Insurability, if required. (See Schedule of Benefits.)

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date on which you become eligible for the increase, if Actively at Work on that day; [or]
- (2) the day you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
- (3) the date any required Evidence of Insurability is approved by the Company. (See Schedule of Benefits.)

Any reduction in insurance or benefits will take effect on the day of the change, whether or not you are Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Critical Illness Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period. (See Schedule of Benefits.) [If you terminate coverage under the Policy and subsequently re-enroll during an Annual/Open Enrollment Period, you will again be subject to the Policy's Benefit Waiting Period.]

**ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL CRITICAL ILLNESS INSURANCE
(Continued)**

REINSTATEMENT RIGHTS. If your insurance terminates due to one of the following breaks in service [or a reduction in hours], you will be entitled to reinstate the insurance upon resuming Active Work with the [Group Policyholder/Participating Organization] within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

- (1) return from an approved Family or Medical Leave within:
 - (a) the period required by federal law; or
 - (b) any longer period required by a similar state law[; or]
- (2) return from a Military Leave within the period required by federal USERRA law[; or]
- (3) return from any other approved leave of absence within 12 months after the leave begins[; or]
- (4) return within one year following a lay off[; or]
- (5) return within one year following termination of employment for any other reason[; or]
- (6) return to an eligible class following a reduction in hours.

To reinstate insurance coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class [unless the Group Policyholder/Participating Organization contributes the entire cost of the premium]. The required premium payments must be received from the Group Policyholder/Participating Organization for coverage to be reinstated. Reinstatement will take effect on the date you return to Active Work.

TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE

TERMINATION. Your insurance will terminate at 12:00 midnight on the earliest of:

- (1) the date the Policy terminates [or the Participating Organization's participation terminates] (but without prejudice to any claim incurred prior to termination);
 - (2) the date your Class is no longer eligible for insurance;
 - (3) the date you cease to be a member of the Eligible Class;
 - (4) the last day of the Insurance Month in which you request termination;
 - (5) the last day of the last Insurance Month for which premium payment is made on your behalf;
 - (6) the end of the period for which the last required premium has been paid;
 - (7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
 - (8) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category;
 - (9) the date you cease to be covered under at least one category other than the Wellness Category;
 - (10) the date your employment with the Group Policyholder or Participating Organization terminates; or
 - (11) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.);
- unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work [or reduction of Minimum Hours] results in termination of your eligibility for insurance, but insurance may be continued as follows.

Disability. If you are disabled due to an event or illness shown in the Schedule of Benefits, then insurance may be continued until [the earlier of:]

- [(1) 12 Insurance Months after the disability begins;] [or]
- [(2)] the date you are no longer disabled.

The required premium payments must be received from the [Group Policyholder/Participating Organization], throughout the period of continued insurance.

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

- (1) the end of the leave period approved by the [Group Policyholder/Participating Organization];
- (2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date you notify the [Group Policyholder/Participating Organization] that you will not return; or
- (4) the date you begin employment with another employer.

The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Military Leave If you go on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the [Group Policyholder/Participating Organization]. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Lay Off or Other Leave. When you cease work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued until the end of the Insurance Month following the month in which the lay off or leave begins. The required premiums must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE
(Continued)

Temporary Reduction in Hours. When your hours are temporarily reduced resulting in your loss of eligibility under the Policy, insurance may be continued for six Insurance Months after the temporary reduction in hours begins, provided you work at least 30 hours in a two-week period. The required premium payments must be received from the [Group Policyholder/Participating Organization] throughout the period of continued insurance.

Conditions. In administering the above continuations, the [Group Policyholder/Participating Organization] must not act so as to discriminate unfairly among Insured Persons in similar situations. [Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.]

PORTABILITY. If insurance under the Policy would end for any reason other than nonpayment of premiums, you have the option to continue Personal Critical Illness Insurance [and Dependent Critical Illness Insurance]. To continue insurance under this section, you must:

- (1) notify the Company within 31 days of the date the insurance would otherwise end; and
- (2) pay the applicable premium to the Company.

A direct billing fee will apply when insurance is continued in accord with the Portability provision. This fee will be based on the billing frequency chosen.

Portability is not available when insurance terminates solely because your spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

- (1) the last day of the period for which you paid premiums; or
- (2) the date the Company receives a written request from you to terminate the insurance; or
- (3) the date you attain age 90, or die.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for claims incurred by you while you were insured under the Policy.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE

DEPENDENT means your:

- (1) legal spouse, who is not legally separated from you;
- [(2) civil union partner, or domestic partner;]
- (3) unmarried child less than 19 years of age; [or]
- [(4) unmarried child, who is at least 19 years of age but less than 23 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or]
- (5) unmarried child age 19 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon you for support and maintenance.

The child must be covered by the [Group Policyholder's/Participating Organization's] Critical Illness plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the Dependent rate.

[Dependent will also include a child that you are required to provide insurance for under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) your natural child or legally adopted child;
- (2) a child placed under your charge, care or control for whom you have filed a petition to adopt, from:
 - (a) the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or
 - (b) the date of the filing of a petition for adoption, if you apply for coverage within 60 days after the filing of the petition for adoption;
- (3) a child for whom you are required by court order to provide Critical Illness insurance;
- (4) a stepchild [or grandchild] who resides in your household; and who is chiefly dependent on you for support; and
- (5) a foster child:
 - (a) who resides in your household;
 - (b) who is chiefly dependent on you for support; and
 - (c) for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Critical Illness Insurance on the latest of:

- (1) the date you become eligible for Personal Critical Illness Insurance;
- (2) the issue date of the Policy; or
- (3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Critical Illness Insurance under the Policy:

- (1) within 31 days following a qualifying Change in Family Status; or
- (2) during any Annual/Open Enrollment Period.

You must be insured for Personal Critical Illness Insurance to insure your Dependents. [Dependents to be insured by the Policy must be enrolled in and approved for the same plan of benefits as you.]

**ELIGIBILITY AND EFFECTIVE DATES FOR
DEPENDENT CRITICAL ILLNESS INSURANCE
(Continued)**

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Critical Illness Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period. [If you terminate Dependent Critical Illness Coverage under the Policy and subsequently re-enroll during an Annual/Open Enrollment Period, the Dependents will again be subject to the Policy's Benefit Waiting Period.]

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Critical Illness Insurance will become effective on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date you become eligible for Dependent Critical Illness Insurance; or
- (2) the first day of the Insurance Month coinciding with or next following the date you make written application for Dependent Critical Illness Insurance; [and, if additional premium is required, you sign:]
 - [(a) a payroll deduction order, if you pay any part of the premium for Dependent Critical Illness Insurance; or]
 - [(b) an order to pay premiums from your Section 125 Plan account, if any contributions for Dependent Critical Illness Insurance are paid through a Section 125 Plan account;]and pay the required Dependent premium to the Company; or
- (3) the date the Company approves any Evidence of Insurability [on all of your Dependents], if required. (See Schedule of Benefits.)

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Critical Illness benefits for the child, the insurance will become effective on the date stated in the court order; subject to:

- (1) any eligibility and Evidence of Insurability requirements set forth in the Policy; and
- (2) payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

- (1) you complete a written application; and
- (2) [a payroll deduction order or Section 125 Plan election is made and] the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured for the first 90 days following birth. If you elect not to enroll the newborn child and pay any additional premium within 90 days following birth, the newborn child's insurance will terminate.

**TERMINATION OF
DEPENDENT CRITICAL ILLNESS INSURANCE**

TERMINATION. Critical Illness Insurance on a Dependent will cease on the earliest of:

- (1) the date he or she ceases to be an eligible Dependent, as defined in the Policy;
- (2) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category; or
- (3) the date he or she ceases to be covered under at least one category other than the Wellness Category.

Dependent Critical Illness Insurance will cease for all of your Dependents on the earliest of:

- (1) the date your Critical Illness Insurance terminates;
- (2) the date Dependent Critical Illness Insurance is discontinued under the Policy;
- (3) the date you cease to be in a class eligible for Dependent Critical Illness Insurance;
- (4) the date you request that the Dependent Critical Illness Insurance be terminated;
- (5) with respect to a benefit or a specific type of benefit, the date the portion of the Policy providing that type of benefit terminates; or
- (6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Critical Illness Insurance terminates due to your death, Dependent Critical Illness Insurance may be continued:

- (1) for three Insurance Months; or any longer period, if required by state or federal law;
- (2) provided the [Group Policyholder/Participating Organization] submits the premium on behalf of the surviving Dependents; and the Policy remains in force.

REINSTATEMENT OF DEPENDENT INSURANCE If you reinstate your Personal Critical Illness Insurance, you may also reinstate Dependent Critical Illness Insurance at the same time. To do so, you must follow the same requirements that apply in the reinstatement of your Personal Critical Illness Insurance.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for claims incurred by the Insured Dependent while he or she was insured under the Policy.

CRITICAL ILLNESS BENEFITS

GENERAL CRITICAL ILLNESS BENEFITS. The Company will pay a Critical Illness Benefit if you [or an Insured Dependent] sustain[(s)] an Event/Illness shown in the Schedule of Benefits while covered under the Policy.

Benefit amounts payable are shown in the Schedule of Benefits.

For each Insured Person [or Insured Dependent], the lifetime total benefits payable in any category shown in the Schedule of Benefits [(except the Wellness Category)] are subject to an overall maximum, as shown in the Schedule of Benefits. Certain Events/Illnesses are also subject to separate lifetime maximums, as shown in the Schedule of Benefits. If benefits paid to you [or an Insured Dependent] reach the overall maximum for a category, you [or your Insured Dependent's] coverage for that category will terminate. [Benefits provided by the Policy and any Amendments are subject to the Benefit Waiting Period shown in the Schedule of Benefits.]

[Except for the Wellness Category,] benefits are not payable if an Event/Illness shown in the Schedule of Benefits occurs within:

- (1) 180 days of another Event/Illness in the same category; or
- (2) 90 days of an Event/Illness in a different category.

If you [or your Insured Dependent] sustain[(s)] two or more Events/Illnesses simultaneously, the highest applicable benefit is payable. Certain Events/Illnesses are only payable once per your [or your Insured Dependent's] lifetime, as shown in the Schedule of Benefits.

CRITICAL ILLNESS ASSESSMENT BENEFIT. The Company will pay a Critical Illness Assessment Benefit to an Insured Person [or Insured Dependent] who has one of the following Critical Illness Assessment Tests:

- (1) abdominal aortic aneurysm ultrasound;
- (2) blood test for triglycerides;
- (3) bone marrow testing;
- (4) bone density screening;
- (5) breast ultrasound;
- (6) CA 15-3 (blood test for breast cancer);
- (7) CA125 (blood test for ovarian cancer);
- (8) carotid ultrasound;
- (9) CEA (blood test for colon cancer);
- (10) chest x-ray;
- (11) colonoscopy;
- (12) CT Angiography;
- (13) EKG;
- (14) double contrast barium enema;
- (15) fasting blood glucose test;
- (16) flexible sigmoidoscopy;
- (17) hemoccult stool analysis;
- (18) mammography;
- (19) pap smear;
- (20) PSA (blood test for prostate cancer);
- (21) serum cholesterol HDL/LDL;
- (22) serum protein electrophoresis (blood test for myeloma);
- (23) stress test;
- (24) thermography;
- (25) annual physical examinations; or
- (26) immunizations.

The Critical Illness Assessment Test must be performed during the Critical Illness Assessment Period as shown in the Schedule of Benefits, while your [or your Insured Dependent's] coverage under the Policy is in effect. The Critical Illness Assessment Benefit is subject to the maximums shown in the Schedule of Benefits.

CRITICAL ILLNESS BENEFITS
(Continued)

CHILD CARE EXPENSE BENEFIT. The Company will pay a Child Care Expense Benefit if you [or your Insured Dependent Spouse] incur[(s)] Child Care Expenses while confined as an Inpatient in a Hospital or Alternate Care or Rehabilitative Facility for an Event/Illness shown in the Schedule of Benefits.

"Child Care Expense" means an expense for the care of a Child, charged by a licensed care provider who:

- (1) is not a member of your immediate family; and
- (2) is not living in your home.

"Child," as used in the Child Care Expense Benefit, means your naturally born child, legally adopted child, stepchild, foster child, or child for whom you are the legal guardian, if the child is:

- (1) less than age 16 and living with you; or
- (2) age 16 years or older, who is:
 - (a) unmarried;
 - (b) living with you; and
 - (c) incapable of independent living due to a mental or physical condition.

Amount. The amount of the Child Care Expense Benefit is shown in the Schedule of Benefits.

Proof. You must submit to the Company satisfactory proof that a Child Care Expense has been incurred for a Child (as defined in this provision) and paid by you [or your Insured Dependent Spouse]. Satisfactory proof is a signed receipt from the Child care provider showing:

- (1) Child name;
- (2) Child age;
- (3) dates of care;
- (4) total charges for care;
- (5) total payments for care; and
- (6) provider name, address, telephone number, and Federal Employer Identification Number/Taxpayer Identification Number.

Duration. The Child Care Expense Benefit will be payable for up to a maximum of 30 days from the date you [or your Insured Dependent Spouse] were confined as an Inpatient in a Hospital. This Benefit will cease on the earliest of:

- (1) the date you [or your Insured Dependent Spouse] are released from Inpatient treatment;
- (2) the date your [or your Insured Dependent Spouse's] Child(ren) no longer meet(s) the definition of Child in this provision; or
- (3) the date the maximum duration ends.

EXCLUSIONS

GENERAL EXCLUSIONS. Benefits are not payable for any Event/Illness or loss resulting, directly or indirectly, from or in any degree caused by:

- (1) intentional self-inflicted injury, self-destruction, or suicide, or any attempt thereof; whether sane or insane;
- (2) participation in, commission of or attempt to commit a felony;
- (3) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
- (4) duty as a member of any military, including Reserves or National Guard; or
- (5) an Event/Illness sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

Benefits are also not payable while you [or your Insured Dependent] are incarcerated in any type of penal or detention facility.

PRE-EXISTING CONDITION EXCLUSION. Benefits are not payable for any Event/Illness or loss:

- (1) resulting, directly or indirectly, from or in any degree caused by a Pre-Existing Condition; and
- (2) diagnosed in the first 12 months following your [or your Insured Dependent's] Effective Date; unless you or your Insured Dependent received no Treatment for the Pre-Existing Condition for 12 consecutive months following your [or your Insured Dependent's] Effective Date].

"Pre-Existing Condition" means an illness or event for which you [or your Insured Dependent] received Treatment within the 12 months prior to your [or your Insured Dependent's] Effective Date.

"Treatment" means a Physician's consultation, care or services; diagnostic measures; and the prescription, refill or taking of prescribed drugs or medicines.

The above Pre-Existing Condition Exclusion will also apply to:

- (1) any increase in the Critical Illness Principal Sum;
- (2) the addition by amendment of a benefit or category of benefits under the Policy;
- (3) an Insured Person's election after initial enrollment of any category of benefits under the Policy; and
- (4) the election after initial enrollment of any benefit provided by an amendment to the Policy.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable under the Policy will be paid to the named Beneficiary who survives you. If no named Beneficiary survives you, payment will be made to your estate or in accord with the Facility of Payment section.

PAYMENTS TO BENEFICIARY. At your death, any amount payable under the Policy will be paid to the named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made to your:

- (1) surviving spouse[, domestic partner, or civil union partner]; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

- (1) within 15 days of your death; and
- (2) before the Company receives satisfactory proof of your death;

payment will be made as if you had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment form, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the Beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only your or your assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change [with the Company at its Group Insurance Service Office/Group Policyholder] prior to your death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of you or a Beneficiary;
- (2) a person who has incurred expense as a result of your last illness or death;
- (3) the personal representative of your estate; or
- (4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address and certificate number, if available; and
- (3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after a claim is incurred; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

- (1) the nature, date and cause of the claim;
- (2) a description of the services provided; and
- (3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

- (1) any study models, treatment records or charts;
- (2) copies of any x-rays or other diagnostic materials; and
- (3) any other items the Company may reasonably require.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While a Critical Illness claim is pending, the Company may have the claimant examined:

- (1) by a Physician of its choice;
- (2) as often as is reasonably required.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Critical Illness benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All benefits payable under the Policy[, including any benefits for Insured Dependents,] will be paid to you, while living, unless[:]

- [(1)] an overpayment has been made and the Company is entitled to reduce future benefits[; or]
- [(2)] state or federal law requires that benefits be paid to a Insured Dependent child's custodial parent or custodian.]

If any benefits remain to be paid after your death, such benefits will be paid in accord with the Beneficiary provision.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE (Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of a Critical Illness claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of a Critical Illness claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of a Critical Illness claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For a Critical Illness claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE
(Continued)

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim;
- (2) the claimant's receipt of benefits or services under another plan;
- (3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder, the Company has the authority to:

- (1) manage the Policy and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering the Policy and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

PRIOR INSURANCE CREDIT UPON TRANSFER OF INSURANCE CARRIERS

To prevent loss of coverage for you because of a transfer of insurance carriers, the Policy will provide the following Prior Insurance Credit, when it replaces a Prior Plan.

"Prior Plan" means a Group Policyholder-sponsored group or Group Policyholder-sponsored individual Critical Illness policy, which the Policy replaced:

- (1) within 1 day of the prior plan's termination date; or
- (2) within 60 days of the prior plan's termination date, if the Employer has more than 15 Insured Persons covered under the Policy on its effective date.

It does not include any coverage under the Prior Plan that was continued under a portability or other coverage continuation provision.

FAILURE TO BE ACTIVELY-AT-WORK DUE TO AN EVENT/ILLNESS. Subject to premium payments, the Policy will provide coverage if you:

- (1) were insured by the Prior Plan at the time of transfer; and
- (2) were not Actively at Work due to an Event/Illness on the Policy's Effective Date.

The coverage will be that provided by the Prior Plan, had it remained in force. The Company will pay:

- (1) the benefit that the Prior Plan would have paid; minus
- (2) any amount for which the Prior Plan is liable.

CRITICAL ILLNESS DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a covered Event/Illness due to a Pre-Existing Condition if you:

- (1) were insured by the Prior Plan at the time of transfer; and
- (2) were Actively at Work and insured under the Policy on the Policy's Effective Date.

The benefits will be determined as follows:

- (1) The Company will apply the Policy's Pre-Existing Condition Exclusion. If you qualify for benefits, you will be paid according to the Policy's benefit schedule.
- (2) If you cannot satisfy the Policy's Pre-Existing Condition Exclusion, but can satisfy the Prior Plan's pre-existing condition exclusion giving consideration toward continuous time insured under both policies; then you will be paid in accord with the benefit schedule and all other terms, conditions and limitations of:
 - (a) the Policy without applying the Pre-Existing Condition Exclusion; or
 - (b) the Prior Plan;whichever is less.
- (3) If you cannot satisfy the Pre-Existing Condition Exclusion of the Policy or that of the Prior Plan, no benefit will be paid.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000000000000

ISSUED TO: ABC Company

[FOR: Class 1]

[Your Certificate is amended as follows.

The Minimum Hours as shown on the SCHEDULE OF BENEFITS is amended to read:

MINIMUM HOURS PER WEEK: 30]

The effective date of this Certificate Amendment is October 1, 2010; but only with respect to losses incurred on or after that date. Nothing contained in this Certificate Amendment shall change any of the terms and conditions of the Certificate, except as stated above.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR POLICY NO. 00-000000

ISSUED TO: ABC Company

[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Certificate is amended by the addition of the following Accident Benefit provision.

ACCIDENT BENEFIT

[The Accident Benefit will apply if elected by you and the required premium is paid.]

The Company will pay an Accident Benefit if you [or an Insured Dependent] sustain one of the following incidents as a result of an Accident:

- (1) Coma;
- (2) Severe Burn; or
- (3) Paralysis.

The Accident must occur while this Certificate Amendment is in force for you [or your Insured Dependent]. The benefit is payable once per Accident.

The benefit does not affect any other benefits payable under the Policy.

AMOUNT. The amount of the Accident Benefit equals your [or your Insured Dependent's] Critical Illness Principal Sum shown in the Policy's Schedule of Benefits.

DEFINITIONS. The following additional definitions apply to this Accident Benefit.

"Accident or Accidental" means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

"Coma" means a state of complete mental unresponsiveness, due to Accidental Injury, during which you [or your Insured Dependent]:

- (1) cannot be awakened;
- (2) do not respond to pain, light or sound; and
- (3) do not take voluntary actions.

It does not include a medically-induced coma. For the purpose of this definition, these traits must be met for a continuous period of time lasting at least 7 days. Diagnosis is made by a board-certified or board-eligible neurologist and based on findings from clinical diagnosis.

"Injury or Injuries" means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Accident.

"Paralysis" means complete and permanent loss of the use of two or more limbs. Diagnosis must be confirmed by findings from physical examination conducted by a board-certified or board-eligible neurologist, physiatrist, or other Physician.

"Severe Burn" means:

- (1) a third-degree (full thickness) burn covering at least 18% of the body; or
- (2) a second-degree (partial thickness) burn covering at least 36% of the body.

Diagnosis is made based on clinical examination findings conducted by a board-certified or board-eligible plastic surgeon or other Physician.

CERTIFICATE AMENDMENT
(Continued)

EXCLUSIONS. The Exclusions contained in the Policy apply to this Certificate Amendment. In addition, no Benefits will be paid for any loss resulting, directly or indirectly, from or in any degree caused by:

- (1) disease, physical or mental infirmity, illness, infection (except when the infection is due to an Accidental cut or wound), or medical or surgical treatment of these;
- (2) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
- (3) an Injury arising out of, or in the course of any employment for wage or profit;
- (4) you [or an Insured Dependent] having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood;
- (5) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
- (6) cosmetic or elective surgery;
- (7) being incarcerated in any type of penal or detention facility;
- (8) participating in or practicing for, or officiating any semi-professional or professional sport;
- (9) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
- (10) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on your effective date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

**TO BE ATTACHED TO THE CERTIFICATE FOR POLICY NO. 00-000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]**

The Certificate is amended by the addition of the following Permanent and Total Disability Benefit provision.

PERMANENT AND TOTAL DISABILITY BENEFIT

The Permanent and Total Disability Benefit will apply if elected by you and the required premium is paid.

BENEFIT. The Company will pay a Permanent and Total Disability Benefit if you [or your Insured Dependent Spouse]:

- (1) become Permanently and Totally Disabled as a result of a payable Event/Illness shown in the Policy's Schedule of Benefits;
- (2) remain Permanently and Totally Disabled for at least [6 months] in a row; and
- (3) are covered under this Certificate Amendment.

The Event/Illness must occur while this Certificate Amendment is in effect for you [or your Insured Dependent Spouse]. The benefit does not affect any other benefits payable under the Policy.

AMOUNT. The amount of the Permanent and Total Disability Benefit equals your [or your Insured Dependent Spouse's] Critical Illness Principal Sum shown in the Policy's Schedule of Benefits. The Company must receive written proof of your [or your Insured Dependent Spouse's] Permanent and Total Disability before benefits are payable.

DEFINITION. The following additional definition applies to this Permanent and Total Disability Benefit.

"Permanently and Totally Disabled" (or "Permanent and Total Disability") means that, due to a payable Event/Illness shown in the Policy's Schedule of Benefits, the Insured Person [or Insured Dependent Spouse]:

- (1) is unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience;
- (2) does not engage in any employment or occupation; and
- (3) is expected to remain so disabled continuously for life, as certified by a Physician.

EXCLUSIONS. The Exclusions contained in the Policy apply to this Certificate Amendment.

CLAIMS PROCEDURES. The following claims procedures will apply to this benefit in lieu of the Claims Procedures found in the Policy.

Notice of Claim. Written notice of a Permanent and Total Disability claim must be given within 20 days after the Permanent and Total Disability begins or as soon as reasonably possible. The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) the Group Policyholder's [or Participating Organization's] name and Policy number;
- (2) your name, address, and certificate number, if available[; and]
- [(3) your Insured Dependent Spouse's name, if the Insured Dependent Spouse is the claimant.]

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Permanent and Total Disability in a letter.

CERTIFICATE AMENDMENT
(Continued)

Proof of Permanent and Total Disability. The Company must receive written proof of Permanent and Total Disability within 90 days after the day the benefit becomes payable. If it is not reasonably possible to give written proof in the time required, benefits will not be reduced or denied if the proof is filed as soon as reasonably possible. Failure to furnish written proof of Permanent and Total Disability within the time required shall not affect any claim if it was not reasonably possible to give proof within such time.

Proof of Permanent and Total Disability must be provided at the claimant's own expense. It must show the date the Permanent and Total Disability began, its cause and degree. Documentation must include the following:

- (1) completed statements by the claimant;
- (2) a completed statement by the attending Physician;
- (3) a certification by the attending Physician that the Permanent and Total Disability will last your [or your Insured Dependent Spouse's] lifetime;
- (4) a signed authorization for the Company to obtain more information; and
- (5) any other items the Company may reasonably require in support of the claim.

Examination. The Company may have the claimant examined:

- (1) by a Physician or specialist of the Company's choice; and
- (2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the claimant has [, without Good Cause]:

- (1) failed to cooperate with an examiner;
- (2) failed to take an exam scheduled by the Company; or
- (3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed. [As used in this provision, "**Good Cause**" means completing the exam would seriously jeopardize your [or your Insured Dependent Spouse's] life or health. Good Cause does **not** exist solely because completing the exam would cause fatigue, stress or discomfort; require transportation or child care arrangements; or conflict with personal business, family or social engagements.]

Time of Payment of Claims. Benefits payable under this Certificate Amendment will be paid immediately after the Company receives complete proof of claim and confirms liability.

To Whom Payable. All Permanent and Total Disability benefits are payable to you [or your Insured Dependent Spouse], while living. After your death, such benefits will be payable in accord with the Beneficiary provision of the Policy. [After your Insured Dependent Spouse's death, such benefits will be paid to you.]

Notice of Claim Decision. The Company will send the claimant a written notice of its Permanent and Total Disability claim decision. If the Company denies any part of the claim, the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how you may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

CERTIFICATE AMENDMENT
(Continued)

Claim Decision Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain:

- (1) what additional information is needed to determine liability; and
- (2) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception to Claim Decision Delay Notice. The Company may need more information from the claimant to process a Permanent and Total Disability claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

Review Procedure. Within 180 days after receiving a denial notice for a Permanent and Total Disability claim, the claimant may request a claim review by sending the Company:

- (1) a written request; and
- (2) any written comments or other items to support the claim.

He or she may review certain non-privileged information relating to the request for review.

Notice of Review Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy, this Amendment, and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

- (1) any further appeal procedures available;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Review Decision Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

- (1) an extension of up to 45 more days will be permitted; and
- (2) the Company will send the claimant a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception to Review Decision Delay Notice. The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

**CERTIFICATE AMENDMENT
(Continued)**

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Certificate Amendment, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section.

After the required reviews:

- (1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
- (2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Right Of Recovery. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

- (1) the Company's error in processing a claim; or
- (2) fraud or any other reason.

Legal Actions. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

Company's Discretionary Authority. Except for the functions that the Policy clearly reserves to the Group Policyholder [or Participating Organization], the Company has the authority to:

- (1) manage this Certificate Amendment and administer claims under it; and
- (2) interpret the provisions and to resolve questions arising under this Certificate Amendment.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering this Certificate Amendment and claims under it;
- (2) determine eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to the claimant's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

**TO BE ATTACHED TO THE CERTIFICATE FOR POLICY NO. 00-0000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]**

The Certificate is amended by the addition of the following Treatment Care Benefit provision.

TREATMENT CARE BENEFIT

The Treatment Care Benefit will apply if elected by you and the required premium is paid.

The Company will pay [one or more of] the following treatment care benefit[s] if you [or your Insured Dependent] meet the terms and conditions for any of the benefits listed below as the result of a payable Event/Illness shown in the Schedule of Benefits in the Policy. The Event/Illness must occur while this Certificate Amendment is in effect for you [or your Insured Dependent].

The benefit does not affect any other benefits payable under the Policy.

AMOUNT. Benefit amounts payable for Treatment Care Benefits are shown below.

| <u>Benefit</u> | <u>Amount</u> |
|--|-----------------------------|
| [Ambulance Transportation] | [<u>\$50-500</u>] |
| [Air Ambulance Transportation] | [<u>\$200-5,000</u>] |
| [Hospital Admission] | [<u>\$100-3,000</u>] |
| [Hospital Confinement] | [<u>\$50-1,000</u>] |
| [Intensive Care Unit (ICU) Confinement] | [<u>\$50-1,000</u>] |
| [Follow-up Care] | [<u>\$10-100</u>] |
| [Transportation] | [<u>\$50-900</u>] |
| [Lodging] | [<u>\$50-350</u>] |
| [Reasonable Modification] | [<u>\$100-5,000</u>] |

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by ground transportation to or from a Hospital or between medical facilities as the result of a payable Event/Illness shown in the Schedule of Benefits. The ambulance transportation must be within [180 days] of the Event/Illness. This benefit will be paid [once] per person per payable Event/Illness.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports you [or your Insured Dependent] by air ambulance to or from a Hospital or between medical facilities as the result of a payable Event/Illness shown in the Schedule of Benefits. The air ambulance transportation must be within [180 days] of the Event/Illness. This benefit will be paid [once] per person per Event/Illness. This benefit may be paid in addition to the Ambulance Transportation benefit.

CERTIFICATE AMENDMENT
(Continued)

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if you [or your Insured Dependent] is admitted to a Hospital as a result of a payable Event/Illness shown in the Schedule of Benefits. The admission must occur within 180 days of the Event/Illness. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Event/Illness.

HOSPITAL CONFINEMENT. The Company will pay a Hospital Confinement benefit for each day you [or your Insured Dependent] [are/is] confined in a Hospital as the result of a payable Event/Illness shown in the Schedule of Benefits. The initial confinement must begin within 180 days of the Event/Illness. This benefit is payable for up to 365 days per person per Event/Illness, which may be used over a two-year period from the date of the Event/Illness. The Company will pay for only one Hospital Confinement at a time, even if it is caused by more than one payable Event/Illness. In the event this Hospital Confinement benefit and an Intensive Care Unit Confinement benefit are payable on the same day, only the Intensive Care Unit Confinement benefit will be paid.

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day you [or your Insured Dependent] [are/is] confined in an ICU as the result of payable Event/Illness shown in the Schedule of Benefits. The confinement must begin within 180 days of the Event/Illness. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Event/Illness, which may be used over a two-year period from the date of the Event/Illness. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Event/Illness. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If you [or your Insured Dependent] exhaust the ICU benefit but are still confined, you [or your Insured Dependent] may be eligible for the Hospital Confinement benefit.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care for you [or your Insured Dependent] that results from a payable Event/Illness as shown in the Schedule of Benefits. Follow-up care must be received within 365 days of an Event/Illness. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Event/Illness. This benefit is not payable while you [or your Insured Dependent] [are/is] confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when you [or your Insured Dependent] must travel more than 100 miles one way:

- (1) for treatment of a payable Event/Illness shown in the Schedule of Benefits;
- (2) at a Hospital or other specialized freestanding treatment facility.

Transportation must occur within 365 days of the Event/Illness. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Event/Illness. This benefit is not payable when transportation is provided by ambulance or air ambulance.

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies you [or your Insured Dependent] who is Hospital confined more than 100 miles from the your [or your Insured Dependent's] principal place of residence due to a payable Event/Illness shown in the Schedule of Benefits. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Event/Illness.

**CERTIFICATE AMENDMENT
(Continued)**

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to your [or your Insured Dependent's] principal place of residence due to one of the following payable Events/Illnesses:

- [(1) Stroke; or]
- [(2) ALS/Lou Gehrig's Disease; or]
- [(3) Advanced Alzheimer's Disease; or]
- [(4) Multiple Sclerosis; or]
- [(5) Stage 4 Parkinson's Disease; or]
- [(6) Loss of Sight; or]
- [(7) Loss of Hearing; or]
- [(8) Loss of Speech; or]
- [(9) Genetic Disorders.]

Modifications must be made within two years from the date of the Event/Illness. This benefit is payable once per person per Event/Illness.

DEFINITIONS. The following additional definitions apply to this Treatment Care Benefit.

"Companion" means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

"Home Health Care Agency" means an agency that provides skilled nursing and other home health care services according to state and/or local laws on a visiting basis in the Insured Person's temporary or principal place of residence.

"Hospital Confinement" means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Event/Illness.

"Intensive Care Unit (ICU)" means a designated part of a Hospital that:

- (1) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- (5) is assigned a Physician on a full-time basis.

"Medical Health Professional" means a person, other than a Physician, that renders medical care and performs services that are within the scope of such person's license. Included in this definition are registered nurses, physician's assistants, and nurse practitioners.

"Observation Unit" means a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician and which:

- (1) is under the direct supervision of a Physician or registered nurse;
- (2) is staffed by nurses assigned specifically to that unit; and
- (3) provides care seven days per week, 24 hours per day.

"Occupational Therapist" means a person other than the Insured Person who:

- (1) is licensed by the state to practice occupational therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Occupational Therapy Association.

**CERTIFICATE AMENDMENT
(Continued)**

"Outpatient Treatment" means medical services that an Insured Person [or Insured Dependent] receives when not confined as an Inpatient in a Hospital.

"Physical Therapist" means a person other than the Insured Person who:

- (1) is licensed by the state to practice physical therapy;
- (2) performs services within the scope of his/her license; and
- (3) practices according to the Code of Ethics of the American Physical Therapy Association.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on your effective date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR POLICY NO. 00-000000
ISSUED TO: ABC Company
[FOR: Plan 1/Class 1/Participating Organization XYZ]

The Certificate is amended by the addition of the following Occupational HIV/Occupational Hepatitis Benefit provision.

OCCUPATIONAL HIV/OCCUPATIONAL HEPATITIS BENEFIT

[The Occupational HIV/Occupational Hepatitis Benefit will apply if elected by you and the required premium is paid.]

BENEFIT. The Company will pay an Occupational HIV/Occupational Hepatitis Benefit if you:

- (1) are a Medical Professional as defined below, a police officer, or a professional or volunteer fire fighter; and
- (2) first test positive with Occupational HIV or Occupational Hepatitis while covered under the Occupational HIV/Occupational Hepatitis Benefit.

The benefit does not affect any other benefits payable under the Policy.

AMOUNT. The amount of the Occupational HIV/Occupational Hepatitis Benefit equals your Critical Illness Principal Sum shown in the Policy's Schedule of Benefits.

PROOF. The Company must receive proof of infection from the laboratory that performed the test. You are responsible for any expenses incurred for testing for infection. The testing:

- (1) may not be self-administered; and
- (2) must be provided by a licensed laboratory.

DEFINITIONS. The following additional definitions apply to this Occupational HIV/Occupational Hepatitis Benefit.

"Hepatitis" means viral hepatitis, types B, C, and D. It does not include type-A hepatitis.

"HIV" means the Human Immunodeficiency Virus, whether HIV-1 or HIV-2.

"Medical Professional" means a person:

- (1) who is licensed to perform medical services under state law; and
- (2) who is practicing within the scope of the license.

"Occupational HIV" means Human Immunodeficiency Virus (HIV) that occurs as a result of a documented accidental exposure, in the workplace, to blood or other bodily fluids from a person known to be infected with HIV. Diagnosis of HIV infection must be confirmed by blood testing administered under the direction of and interpreted by a Physician. The accidental exposure must be documented by an appropriate accident report at the workplace. HIV infection acquired outside the workplace is not considered Occupational HIV.

"Occupational Hepatitis" means Hepatitis that occurs as a result of a documented accidental exposure, in the workplace, to blood or other bodily fluids from a person known to be infected with Hepatitis. Diagnosis of Hepatitis infection must be confirmed by blood testing administered under the direction of and interpreted by a Physician. The accidental exposure must be documented by an appropriate accident report at the workplace. Hepatitis infection acquired outside the workplace is not considered Occupational Hepatitis.

**CERTIFICATE AMENDMENT
(Continued)**

EXCLUSIONS. The Exclusions contained in the Policy apply to this Certificate Amendment. In addition, no Benefits will be paid if you:

- (1) first test positive for Occupational HIV/Occupational Hepatitis prior to the effective date of your coverage under the Policy; or before the effective date of the Occupational HIV/Occupational Hepatitis Benefit, if added later by amending the Policy; or
- (2) have ever refused vaccination against or treatment for Occupational HIV/Occupational Hepatitis.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all other provisions of the Policy.

This amendment takes effect on October 1, 2010, or on the Insured Person's effective date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 47831
 Company Tracking Number: GL51
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: GL51 - Group Critical Illness - The Lincoln Natio
 Project Name/Number: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company /GL51 - Group Critical Illness - The Lincoln National Life Insurance Company

Supporting Document Schedules

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Satisfied - Item: Flesch Certification | Approved-Closed | 02/07/2011 |
| Comments: | | |
| Attachments: | | |
| AR Readability Certification.PDF | | |
| AR Cert of Compliance_23-79-138 and R&R 49.PDF | | |
| AR Cert of Compliance_Rule & Reg 19.PDF | | |

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Satisfied - Item: Application | Approved-Closed | 02/07/2011 |
| Comments: | | |
| GL2-APP.02/10, State Tracking No. 45382, SERFF Tracking No. JEPT-126576276, Approved April 8, 2010 | | |

| | Item Status: | Status Date: |
|--|---------------------|---------------------|
| Satisfied - Item: Submission Letter | Approved-Closed | 02/07/2011 |
| Comments: | | |
| Attachment: | | |
| AR Lincoln CI_Cover Letter.PDF | | |

| | Item Status: | Status Date: |
|---|---------------------|---------------------|
| Satisfied - Item: Authorization Letter | Approved-Closed | 02/07/2011 |
| Comments: | | |
| Attachment: | | |
| Lincoln SERFF Auth Letter 2011.PDF | | |

| | Item Status: | Status |
|--|---------------------|---------------|
|--|---------------------|---------------|

SERFF Tracking Number: MCHX-G127008323 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 47831
 Company Tracking Number: GL51
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: GL51 - Group Critical Illness - The Lincoln Natio
 Project Name/Number: GL51 - Group Critical Illness - The Lincoln National Life Insurance Company /GL51 - Group Critical Illness - The Lincoln National Life Insurance Company

| | | | |
|--------------------------|---------------------------------|-----------------|----------------------------|
| Satisfied - Item: | Form Listing | Approved-Closed | Date: 02/07/2011 |
| Comments: | | | |
| Attachment: | | | |
| | AR Lincoln CI_Forms Listing.PDF | | |

| | | | |
|--------------------------|-----------------------------------|---------------------|----------------------------|
| | | Item Status: | Status |
| Satisfied - Item: | Appendix of Variability | Approved-Closed | Date: 02/07/2011 |
| Comments: | | | |
| Attachment: | | | |
| | AR CI Appendix of Variability.PDF | | |

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: The Lincoln National Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| Form Number | Score |
|--------------------|--------------|
| GL51-1-FP AR | 59 |
| GL51-2-TC | 0 |
| GL51-3-SB | 50 |
| GL51-4-DF AR | 40 |
| GL51-5.1-PE | 61.6 |
| GL51-5-GP | 57.1 |
| GL51-6-ELE | 53.2 |
| GL51-7-TE | 40 |
| GL51-8-ELD AR | 54.2 |
| GL51-9-TD | 70.3 |
| GL51-10-PR | 57.8 |
| GL51-11-PT | 59.9 |
| GL51-12-CIB | 55 |
| GL51-13-EX AR | 42 |
| GL51-14-B | 60.3 |
| GL51-15-CP | 56.2 |

STATE OF ARKANSAS
READABILITY CERTIFICATION

| Form Number | Score |
|--------------------|--------------|
| GL51-16-PIC AR | 57.8 |
| GL51-AMEND | 51.3 |
| GL51-AMEND.ACC | 47 |
| GL51-AMEND.PTD | 49 |
| GL51-AMEND.TCB | 50 |
| GL51-AMEND.OCHVHP | 47.6 |
| GL52-1-FP AR | 49 |
| GL52-2-TC | 0 |
| GL52-3-SB | 52 |
| GL52-4-DF AR | 40 |
| GL52-5-GP | 62.2 |
| GL52-6-ELE | 50.9 |
| GL52-7-TE | 50 |
| GL52-8-ELD AR | 58.2 |
| GL52-9-TD | 68.5 |
| GL52-12-CIB | 56 |
| GL52-13-EX AR | 42 |
| GL52-14-B | 50.5 |
| GL52-15-CP | 56.4 |
| GL52-16-PIC AR | 55 |

STATE OF ARKANSAS
READABILITY CERTIFICATION

| Form Number | Score |
|--------------------|--------------|
| GL52-AMEND | 51.8 |
| GL52-AMEND.ACC | 48 |
| GL52-AMEND.PTD | 49 |
| GL52-AMEND.TCB | 51 |
| GL52-AMEND.OCHVHP | 42.7 |



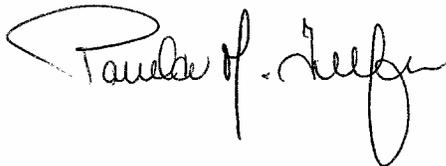
Signed: _____
Name: Pamela Telfer
Title: Assistant Vice President, Product Compliance
Date: 1/28/2011 _____

CERTIFICATE OF COMPLIANCE

Insurer: The Lincoln National Life Insurance Company

Form Numbers: GL51-1-FP AR, et al.

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Pamela M. Telfer

Name

Assistant Vice President, Product
Compliance

Title

January 24, 2011

Date

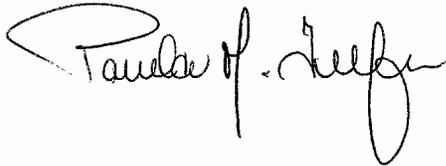
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The Lincoln National Life Insurance Company

Form GL51-1-FP AR, et al.

Number(s):

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Pamela M. Telfer

Name

Assistant Vice President, Product
Compliance

Title

January 24, 2011

Date

.....
McHugh Consulting Resources, Inc.

January 28, 2011

SUBMITTED VIA SERFF

Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: The Lincoln National Life Insurance Company
NAIC # 0020-65676 FEIN # 35-0472300

Group Critical Illness Forms
GL51-1-FP, et al (See enclosed list)

Dear Commissioner Bradford:

McHugh Consulting Resources has been requested to file the enclosed forms on behalf of The Lincoln National Life Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned Group Critical Illness forms for your review and approval. These forms are new and will not replace any previously approved forms with your Department.

The enclosed forms are designed to provide group critical illness coverage. The forms will be used for group policies and certificates in your state. They will be used in conjunction with group application GL2-APP.02/10 previously approved under State Tracking No. 45382, SERFF Tracking No. JEPT-126576276 on April 8, 2010. Group Policy Series GL 51 and Group Certificate Series GL52 will be marketed by licensed agents and brokers primarily to employer groups, but also may be used with labor union or professional association groups.

The forms are for use in traditional paper format or in an electronic format. Formatting and page numbers may change slightly when the document is assembled through an automated assembly system. Printing standards will never be less than those required by law. We request that bracketed and underlined material be variable. An Appendix of Variability describing the forms and variables is enclosed. A Readability Certification is also enclosed.

Thank you for your attention to this filing. Please do not hesitate to contact the undersigned at 215.230.7960 if there any question that we can answer regarding this filing.

Sincerely,

A handwritten signature in cursive script that reads "Katherine Hansen".

Katherine Hansen
Consultant
mcr@mchughconsulting.com



Lincoln Financial Group
One Granite Place
P.O. Box 515
Concord, NH 03302
phone 603 226-5000

January 3, 2011

NAIC Company Code: 65676

Re: See Attached Forms Listing

Please accept this letter as authorization from Lincoln Financial Group for McHugh Consulting Resources, Inc. to file any or all policy forms and/or rates as referenced in the corresponding SERFF filing on behalf of The Lincoln National Life Insurance Company.

Sincerely,

A handwritten signature in black ink, appearing to read 'Paula P. Kelly', written in a cursive style.

AVP, State Filing and Product Compliance
Lincoln Financial Group

**CRITICAL ILLNESS FORMS LISTING
ARKANSAS**

| POLICY PAGE | CERTIFICATE PAGE | DESCRIPTION |
|--------------------|-------------------------|--|
| GL51-1-FP AR | GL52-1-FP AR | Face Page |
| GL51-2-TC | GL52-2-TC | Table of Contents |
| GL51-3-SB | GL52-3-SB | Schedule of Benefits |
| GL51-4-DF AR | GL52-4-DF AR | Definitions |
| GL51-5.1-PE | | Provisions Applicable to Participating Organizations |
| GL51-5-GP | GL52-5-GP | General Provisions |
| GL51-6-ELE | GL52-6-ELE | Eligibility and Effective Dates for Personal Critical Illness Insurance |
| GL51-7-TE | GL52-7-TE | Termination of Personal Critical Illness Insurance |
| GL51-8-ELD AR | GL52-8-ELD AR | Eligibility and Effective Dates for Dependent Critical Illness Insurance |
| GL51-9-TD | GL52-9-TD | Termination of Dependent Critical Illness Insurance |
| GL51-10-PR | | Premiums and Premium Rates |
| GL51-11-PT | | Policy Termination |
| GL51-12-CIB | GL52-12-CIB | Critical Illness Benefits |
| GL51-13-EX AR | GL52-13-EX AR | Exclusions |
| GL51-14-B | GL52-14-B | Beneficiary |
| GL51-15-CP | GL52-15-CP | Claim Procedures for Critical Illness Insurance |
| GL51-16-PIC AR | GL52-16-PIC AR | Prior Insurance Credit Upon Transfer of Insurance Carriers |
| GL51-AMEND | GL52-AMEND | Policy/Certificate Amendment |
| GL51-AMEND.ACC | GL52-AMEND.ACC | Policy/Certificate Amendment - Accident Benefit |
| GL51-AMEND.PTD | GL52-AMEND.PTD | Policy/Certificate Amendment - Permanent and Total Disability Benefit |
| GL51-AMEND.TCB | GL52-AMEND.TCB | Policy/Certificate Amendment - Treatment Care Benefit |
| GL51-AMEND.OCHVHP | GL52-AMEND.OCHVHP | Policy/Certificate Amendment – Occupational HIV/Occupational Hepatitis Benefit |

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

APPENDIX OF VARIABILITY

For Forms:

| | |
|-------------------|-------------------|
| GL51-1-FP AR | GL52-1-FP AR |
| GL51-2-TC | GL52-2-TC |
| GL51-3-SB | GL52-3-SB |
| GL51-4-DF AR | GL51-4-DF AR |
| GL51-5-GP | GL52-5-GP |
| GL51-5.1-PE | |
| GL51-6-ELE | GL52-6-ELE |
| GL51-7-TE | GL52-7-TE |
| GL51-8-ELD AR | GL52-8-ELD AR |
| GL51-9-TD | GL52-9-TD |
| GL51-10-PR | |
| GL51-11-PT | |
| GL51-12-CIB | GL52-12-CIB |
| GL51-13-EX AR | GL52-13-EX AR |
| GL51-14-B | GL52-14-B |
| GL51-15-CP | GL52-15-CP |
| GL51-16-PIC AR | GL52-16-PIC AR |
| GL51-AMEND.ACC | GL52-AMEND.ACC |
| GL51-AMEND.OCHVHP | GL52-AMEND.OCHVHP |
| GL51-AMEND.PTD | GL52-AMEND.PTD |
| GL51-AMEND.TCB | GL52-AMEND.TCB |
| GL51-AMEND | GL52-AMEND |

The above forms are for use with Group Policy Series GL51 and Group Certificate Series GL52.

Statement of Variable Material. Variable material is denoted in the forms by underlining or bracketing. The text for the certificate is expressed in second person (you/your) language. The variability indicated in this Appendix applies to both the policy version and certificate version of forms, unless otherwise indicated. Any alternate variations included in this memorandum that are in third person for the policy would be expressed in second person in the certificate. The following variability is requested.

The Lincoln National Life Insurance Company

I. FACE PAGES.

- A. On **policy** face page GL51-1-FP AR, we request variable filing of:
1. The underlined term group insurance service office and its address.
 2. The underlined/bracketed Group Policyholder's name, dates, premium mode, policy number, and signatures.
 3. The bracketed text regarding age reductions and pre-existing condition exclusion, so that they may be removed when not applicable.
- The underlined state of delivery will be the situs state of the group policy.
- B. On **certificate** face page GL52-1-FP AR, we request variable filing of:
1. The underlined term group insurance service office and its address.
 2. The underlined/bracketed policy number, Group Policyholder's name, issue date, and bracketed signature.
 3. The bracketed center section of the form, so that:
 - a. "no name" certs can be issued by showing the particular applicable class number/classification;
 - b. "personalized" certs can be printed on our issuance system (by substituting the insured's name and information specific to the insured such as cert number and effective date);
 - c. specific information as it pertains to the certificate being issued may be included, such as Class number/description, Plan number/description, a Participating Organization's name (subsidiary, division, or affiliate of the Group Policyholder), Participating Organization's Effective Date; or
 - d. a sticker may be affixed in this space with the pertinent information.
 4. The bracketed text regarding age reductions and pre-existing condition exclusion, so that they may be removed when not applicable.

- II. **CONTENTS.** On Table of Contents forms GL51-2-TC and 52-2-TC we request variable filing of the entire body, so that the applicable insert page titles and page numbers can be inserted.

- III. **SCHEDULES.** Schedule forms GL51-3-SB and GL52-3-SB include hypothetical information. We request variable filing of the Schedules to reflect the case specific information as it applies to the group, class, and insureds. The fields that may be included on the Schedules are outlined below with an explanation and any variations for the content of these fields. The variability described in items B through H may apply to both the policy form GL51-3-SB and the certificate form GL52-3-SB.

- A. In form GL52-3-SB, the following items are to be filed as variable:
1. **Group Policyholder Name** (legal name of the group)
 2. **Policy Number** (number assigned to the policy)
 3. **Plan** (if there is more than one plan: numeric or plan type/description)
 4. **Class #** (numeric: 1, 2, 3, etc./classification description)
 5. **Participating Organization** (subsidiary, division, or affiliate of Group Policyholder may be included, if applicable)
- B. **Classifications:** Class descriptions may be based upon job category or title, salary level, hours worked, years of service, union membership, exempt/nonexempt status, geographic location, date first enrolled, type of account holder/member or similar criteria.
- C. **Eligibility Waiting Period:** The eligibility waiting period can be a specific number of hours, days, or months based on continuous Active Work, continuous service, employment, continuous active member, or some other basis as provided by the Group Policyholder. It may be reflected as "None" or it can be omitted in its entirety, if not applicable.

The Lincoln National Life Insurance Company

- D. **Annual/Open Enrollment Period:** An annual or open enrollment period may be added, if applicable. The timeframe for the annual or open enrollment period is generally 30 days but may range from 30 days to 91 days.

If the Annual/Open Enrollment Period is included, the following language represents variables that may be included if there is an Open Enrollment Period. The reference to Month, Day, and Year are to be filed as variable. The type of coverage may be Personal Critical Illness Insurance or Dependents (Spouse/Child) Critical Illness Insurance. The underlined "day" may reflect the next day following, first day of the Insurance/calendar month coinciding with or next following, first day of the Insurance/calendar month following, the first day of the payroll cycle/pay period following, or specified day. The underlined percentages, amounts, and benefit levels will reflect the increases agreed upon by the Group Policyholder and an underwriter. Any of the bracketed items may be omitted, if not applicable.

There will be [a one time only Annual/Open Enrollment Period/ an Annual/Open Enrollment Period] beginning [January 1, 2010] and ending [January 31, 2010] for eligible employees/members to [enroll for (Personal Critical Illness) Insurance or to change their benefit categories/amounts of (Personal Critical Illness) Insurance]. During this enrollment period, the Insured Employee/employee/member may:

- [(1) elect an amount of insurance or an increase to the Insured Person's/employee's/your current Principal Sum;]
- [(2) elect an increase not to exceed [\$1,000-50,000] of the Insured Person's/employee's/your current Principal Sum;]
- [(3) elect an increase of not more than [1-3] increment level(s)/benefit option(s);]
- [(4) elect to add a benefit category; and]
- [(4) enroll for coverage during the [Annual/Open] Enrollment Period in which the Insured Person/employee/you first become(s) eligible.]

Coverage elected during this period will become effective on the later of:

- (1) [January 1st] following the enrollment period, if Actively at Work on that day; [or]
- (2) the day the Insured Person/employee/you resume(s) Active Work, if not Actively at Work on the day the elected [coverage or increase] would otherwise take effect; [or]
- (3) the date any required Evidence of Insurability is approved by the Company.]

- E. **Benefits for Plan/Class:** The Plan and/or Class may be shown. (If there are multiple plans or classes, a description is needed for clarification.)
- F. **Eligible Class:** Classification description is shown, as provided by the Group Policyholder.
- G. **Minimum Hours:** The minimum hours may range from 10 – 40 hours per week or may be on some other basis, such as required for an hours bank, academic schedule, or an atypical work schedule (i.e. health professionals). The hours may be reflected as per week, biweekly, month, semi-monthly, quarter, year, pay period, service period, qualifying quarter or period, semester or some other specified period as provided by the group policyholder; or reflected as none or omitted entirely, if not applicable (i.e. Retirees, members).
- H. The **Benefit Waiting Period** may be omitted or shown as "None" when not applicable. If included, the Benefit Waiting Period will range from 15 to 60 days. A statement may be added, "Benefits provided by [this Policy/this Certificate] and any Amendments [added hereafter/in effect on are after specified date] are subject to the Benefit Waiting Period shown in the Schedule of Benefits."
- I. **Contributions** sentence may state that:
1. insureds are or are not required to make contributions; or
 2. insureds are not required to make contributions for personal coverage, but are required to do so for dependent coverage.

Example: Insured Persons are required to make contributions for Personal Critical Illness Insurance and Dependent Critical Illness Insurance.

To accommodate employers that include contribution statements in their Employee Handbook, ERISA plan documents or Summary Plan Description, a statement may be added following one of the above statements: See Employer/Summary Plan Description for contribution [levels or amounts].

The Lincoln National Life Insurance Company

- J. **Amounts, categories, benefits:** The benefits applicable to the plan/class of insureds will be shown. The categories may appear in a different order or may reference if they are optional benefits to be elected by the insured or base or core benefits.
1. The Principal Sum for Personal Critical Illness may vary as follows, as requested by the Group Policyholder
 - a. Any increment, ranging from \$1,000 to \$10,000, elected by the Person, subject to a minimum ranging from \$1,000 to \$10,000, and a maximum ranging from \$1,000 to \$250,000.
 - b. A flat amount, or a choice of flat amounts, ranging from \$1,000 to \$250,000.
 - c. Any combination of a and b.Reductions may range from 0-50%, taking effect from ages ranging from 50-100, or may be omitted when not applicable.
 2. The Principal Sum for Dependent Critical Illness, for spouses, children, or both, may vary as follows, as requested by the Group Policyholder
 - a. Any increment, ranging from \$1,000 to \$10,000, elected by the Person, subject to a minimum ranging from \$1,000 to \$10,000, and a maximum ranging from \$1,000 to \$250,000.
 - b. A flat amount, or a choice of flat amounts, ranging from \$1,000 to \$250,000.
 - c. Any combination of a and b.Reductions for spouses may range from 0-50%, taking effect from ages ranging from 50-100, or may be omitted when not applicable. Reductions may be based on either the Insured Person's or the Spouse's attained age. This section may be omitted in whole or in part if Dependent or Child coverage is not elected.
 3. The Organ Category may be omitted or included if selected by the Group Policyholder. The parenthetical availability language will be omitted if the policy does not cover Dependents. The Events/Illnesses in the category may be omitted or included. The benefit percentages may range from 1-100%. The underlined "United Network for Organ Sharing (UNOS) list" is variable to accommodate any potential future changes in the network or its name. The bracketed "(excluding Heart)" may be omitted if the policy provides a Major Organ Transplant benefit but not a Heart Transplant benefit.
 4. The Heart Category may be omitted or included if selected by the Group Policyholder. The parenthetical availability language may be omitted if the policy does not cover Dependents. The Events/Illnesses in the category may be omitted or included. The benefit percentages may range from 1-100%. The underlined "United Network for Organ Sharing (UNOS) list" is variable to accommodate any potential future changes in the network or its name. The maximum number of payments for Arteriosclerosis and Aneurysm due to Arteriosclerosis may range from 1-20, or the text may be omitted, if not applicable.
 5. The Child Category may be omitted or included if selected by the Group Policyholder. The Events/Illnesses in the category may be omitted or included. The benefit percentages may range from 1-100%.
 6. The Quality of Life Category may be omitted or included if selected by the Group Policyholder. The parenthetical availability language will be omitted if the policy does not cover Dependents. The Events/Illnesses in the category may be omitted or included. The benefit percentages may range from 1-100%.
 7. The Cancer Category may be omitted or included if selected by the Group Policyholder. The parenthetical availability language will be omitted if the policy does not cover Dependents. The Events/Illnesses in the category may be omitted or included. The benefit percentages may range from 1-100%. The underlined "Be the Match Registry " is variable to accommodate any potential future changes in the registry or its name.
 8. The Wellness Category may be omitted or included if selected by the Group Policyholder. The parenthetical availability language will be omitted if the policy does not cover Dependents.
 - a. The Critical Illness Assessment Period may show the beginning and end date. The assessment period may range from a six month to 24-month period, as elected by the Group Policyholder.
 - b. The Critical Illness Benefit amount may range from \$10 - \$100 per test (\$50 as standard). The maximum number of tests to be payable in a given assessment period may range from 1 to 10. The bracketed text for Overall Maximums may be omitted if not included.
 - c. Overall Maximum of Tests, if included, may range from 1-10. If the benefit is extended to include Dependents, "per family" will be added.
 - d. Overall Maximum Benefit Amount, if included, may range from \$25 to \$1,000. If the benefit is extended to include Dependents, "per family" will be added.

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9. The Child Care Expense Benefit, if included, will range from \$5 to \$100, with \$25 as the standard.
10. The bracketed paragraph pertaining to the overall maximum will be omitted if not applicable. The bracketed exception may be omitted or may include one or more other categories. The underlined percentage may range from 100% to 300%.
11. The bracketed paragraph pertaining to transplants will be omitted if the Organ, Heart, and/or Cancer Categories are not elected by the Group Policyholder.

K. **Evidence of Insurability**, if applicable, will include any of the statements listed. The Evidence of Insurability section may be omitted if not applicable. The items in the numbered list may be included or omitted as applicable. The underlined Guarantee Issue amounts and Guarantee Issue increase amounts will be the amount or percentage approved by an underwriter. The bracketed number of benefit levels may range from 1 to 3. The bracketed sentence at the end of the section may be included or omitted, but not reworded. In addition, the following statement may be added with the enrollment period filed with a range of 31 to 90 days: "initial coverage is elected more than [31-90] days after first becoming eligible;"

IV. **DEFINITIONS.** Forms GL51-4-DF AR and GL52-4-DF AR include the following variability. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

A. The **ACTIVE WORK or ACTIVELY AT WORK** definition is variable to accommodate the following situations:

1. It may be adapted to atypical work sites and schedules (such as telecommuters, academic years or union hour banks). The variable numbers underlined below are hypothetical numbers.
 - a. If the group includes atypical work sites, the Actively at Work definition may include the following item: an alternate work site at the direction of/ approved by the [Group Policyholder/Participating Organization].
 - b. If the group includes teachers, an item may be added to the days considered Actively at Work to state: a school/academic break or school/academic vacation. An Active Member definition may be included to mean a member of the Group Policyholder/Participating Organization who is employed as a teacher with a workload of at least 30% full-time during the teacher contract year.
 - c. If members are included (union, professional trade), Active Member may be included (in addition to or in lieu of the Active Work definition) to mean a member in good standing with the Group Policyholder or Participating Organization/ a member who has accumulated at least 240 contribution hours in a contribution quarter or Hour Bank/ a member who has worked 240 hours in a work quarter, work period, eligibility quarter, or eligibility period or 240 hours in a Hour Bank; who is not confined in a hospital or other health care facility on his or her eligibility date/effective date of coverage.
 - d. If members are included, Active Work may be revised to read:

ACTIVE WORK or ACTIVELY AT WORK means a member of the Group Policyholder who is engaged in employment [on a part-time/or full-time basis for the Minimum Hours shown in the Schedule of Insurance and performing all customary duties of his or her occupation].

Unless disabled on the prior workday or on the day of absence, a member will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

2. The underlined references to employee/member may reflect the appropriate class of insureds in which the definition applies.
3. The bracketed references to Group Policyholder/Participating Organization may reflect either or both as applicable.

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4. The exception for non-medical leaves of absence in item (3) of the second paragraph may range from 2 weeks to 60 months, or may be omitted.
 5. the provision may be omitted if retiree coverage is provided.
- B. The **ACUTE RESPIRATORY DISTRESS SYNDROME** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - C. The **ADVANCED ALZHEIMER'S DISEASE** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - D. The **ADVANCED MULTIPLE SCLEROSIS (MS)** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - E. The **ADVANCED PARKINSON'S DISEASE** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - F. The **ALS/LOU GEHRIG'S DISEASE** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - G. The **ALTERNATE CARE or REHABILITATE FACILITY** definition will be included in its entirety if the Child Care Expense Benefit and/or Treatment Care Benefit are provided.
 - H. The **ANEURYSM DUE TO ARTERIOSCLEROSIS** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - I. The **ANNUAL/OPEN ENROLLMENT PERIOD** may be included if requested by the Group Policyholder and agreed upon by an underwriter. The underlined duration may range from 30 to 91 days. The underlined reference to employees/members may include the appropriate descriptions of the eligible members of the group in which such an enrollment period may apply. The bracketed reference to a Benefit Waiting Period will be omitted when not applicable.
 - J. The **ARTERIOSCLEROSIS** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - K. The **BENEFIT WAITING PERIOD** definition will be included in its entirety if applicable.
 - L. The **BENIGN BRAIN TUMOR** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - M. The **BONE MARROW TRANSPLANT** definition will be included in its entirety if the policy provides a benefit for that Event/Illness. The underlined "Be the Match Registry " is variable to accommodate any potential future changes in the registry or its name.
 - N. The **CANCER** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
 - O. The **CANCER IN SITU** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.

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- P. **CHANGE IN FAMILY STATUS** includes the following variability.
1. The definition may be included or omitted, depending on whether the Group Policyholder's administrative practices allow such changes for a Critical Illness plan.
 2. The following additional status changes may be added to match a group's administrative practices:
 - a. domestic partnership or civil union, or the dissolution thereof (language as shown in the form);
 - b. involuntary loss of coverage under a spouse's, domestic partner's, or civil union partner's plan (language as shown in the form); or
 - c. change in classification from part-time to full-time or full-time to part-time.

In the latter event, the following statement will be added to the end of the definition:

Change in Family Status also includes a change in classification from part-time to full-time or from full-time to part-time.

3. References to Section 125 Plans can be changed to reflect the appropriate plan for the group, such as Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account/Plan/Fund or it may reference the name of the Group Policyholder's specific plan.
- Q. In the definition of **COMPANY**, we request variability for the underlined group insurance service office and its address.
- R. The **CONGENITAL METABOLIC DISORDER** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- S. In the **DAY OR DATE** definition, the Group Policyholder or the Participating Organization may be shown.
- T. The **DEPENDENT CRITICAL ILLNESS INSURANCE** definition will be included in its entirety if benefits are provided for dependents.
- U. **ELIGIBILITY WAITING PERIOD** is to be filed as variable so the text prior to the slash can be included if the eligibility waiting periods are continuous, or the text following the slash may be included (standard). The bracketed reference to Participating Organization may be included if the Group Policyholder has subsidiaries or affiliates to be covered; or the definition may be omitted in its entirety if no eligibility waiting period applies. Alternate version:
- ELIGIBILITY WAITING PERIOD** means the period of time that [an Employee/description of eligible members in which an eligibility waiting period applies] must be [in an eligible class with the Group Policyholder or Participating Organization/ a member in good standing with the Group Policyholder or Participating Organization], before he or she becomes eligible to enroll for coverage under this Policy.
- V. **EMPLOYEE** is to be filed as variable so it can include Full-Time Employees, Full-Time Employees or Regular Part-Time Employees, or can be extended to other descriptions of the members to be included as denoted in the class descriptions provided by the Group Policyholder (Associate, Participant, Member, Owner, Partner, Retiree, etc.). If coverage is provided to a class of non-employees (i.e. union members, retirees) the definition may be omitted. If the Group Policyholder has subsidiaries or affiliates, "or Participating Organization" may be included in the sentence. If only Full-Time Employees are included, the definition of Employee may be omitted to avoid redundancy.
- W. The **END STAGE RENAL FAILURE** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- X. **FAMILY OR MEDICAL LEAVE** may be omitted if the group is not subject to FMLA law or similar state law or if such a leave is not applicable to a particular class of insureds. We request the ability to re-word this definition to reflect any change to federal requirements. The reference to Participating Organization may be included or omitted, as applicable, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies.

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- Y. In the definition of **FULL-TIME EMPLOYEE** the following variability applies.
1. Clarification may be added to specify if a Partner or Owner or specific type of professional is also to be included.
 2. Reference to Participating Organization may be included, if applicable, or the specific employer, subsidiary, affiliate or affiliates to which the definition applies may be named.
 3. The minimum hours may be reflected in the definition in lieu of the Schedule of Benefits and may range from 10 – 40 hours per week (or hours over some longer period, such as a union hour bank or teaching schedule may require). The "per week" may be changed to reflect some other basis as required for an hours bank, academic schedule, or an atypical work schedule (i.e. health professionals). The hours may be reflected as per week, biweekly, month, semi-monthly, quarter, year, pay period, service period, qualifying quarter or period, semester or some other specified period as provided by the group policyholder.
 4. The temporary or seasonal employee item may also include contracted employees. The item may be omitted if the group does not employ such employees or may be omitted if such employees are to be covered for the group.
 5. The last item may be omitted if an employer has employees also working in a business location outside the United States.
 6. The definition may be omitted if eligibility is based on membership (such as a union class of employees) or retirees are covered.
- Z. The **GENETIC DISORDER** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- AA. The **HEART ATTACK (MYOCARDIAL INFARCTION)** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- BB. The **HEART TRANSPLANT** definition will be included in its entirety if the policy provides a benefit for that Event/Illness. The underlined references to the United Network for Organ Sharing (UNOS) list are variable to accommodate any potential future changes in the network or its name.
- CC. In the definition of **HOSPITAL**, the underlined reference to Joint Commission is filed as variable in the event the commission's name is changed. If the definition is not needed, it will be omitted.
- DD. The **INPATIENT** definition will be included in its entirety if needed.
- EE. The underlined material in the definition of **INSURANCE MONTH** is variable so it may be changed if the insurance month falls on a date other than the 1st of the month. The bracketed reference to Group Policyholder/Participating Organization may reflect either or both. Example: (1) beginning at 12:01 a.m. on the 15th day of any calendar month; and (2) ending at 12:00 midnight on the 14th day of the next calendar month; at the Group Policyholder's primary place of business.
- FF. The **INSURED DEPENDENT** definition will be included in its entirety if benefits are provided for dependents.
- GG. The **INSURED DEPENDENT SPOUSE** definition will be included in its entirety if benefits are provided for spouses.
- HH. The **LOSS OF HEARING** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- II. The **LOSS OF SIGHT** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- JJ. The **LOSS OF SPEECH** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- KK. The **LOSS OF SPEECH** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.

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- LL. The **MAJOR ORGAN** definition will be included in its entirety if the policy provides a benefit for that Event/Illness. The bracketed "heart" will be included if the policy provides a Major Organ Transplant benefit but not a Heart Transplant benefit.
- MM. The **MAJOR ORGAN TRANSPLANT** definition will be included in its entirety if the policy provides a benefit for that Event/Illness. The underlined references to the United Network for Organ Sharing (UNOS) list are variable to accommodate any potential future changes in the network or its name.
- NN. **MILITARY LEAVE** may be omitted if the group/class of insured is not subject to USERRA law or similar state law. We request the ability to re-word this definition to reflect any change to federal requirements. The reference to Participating Organization may be included or omitted, as applicable, or a specific employer, subsidiary, affiliate or affiliates to which the definition applies may be named.
- OO. **PAYROLL PERIOD** may be omitted when a group is not deducting contributions from its employees' payroll or if individual termination is not based on the end of the payroll period/cycle. The reference to Participating Organization may be included or omitted, as applicable, or a specific employer, subsidiary, affiliate or affiliates to which the definition applies may be named.
- PP. The **PERSON** definition is variable so it may reference the applicable eligible members as described by the Group Policyholder and reflected in the Class Descriptions, such as: Full-Time Employee, Regular Part-Time Employee, Active Member, Active Employee, Elected Official, Owner, etc. Item (2) may be omitted for noncontributory or takeover plans where enrollment is automatic.
- QQ. **REGULAR PART-TIME EMPLOYEE** definition is variable as described below.
1. The definition may be included if part-time employees are to included.
 2. Clarification may be added to properly describe such employees.
 3. The applicable minimum hour requirement may be reflected in the definition in lieu of the Schedule of Benefits and the per week may be changed if based on some other basis, as required for an hours bank, academic schedule, or an atypical work schedule (i.e. health professionals). The hours may be per week, biweekly, month, semi-monthly, quarter, year, pay period, service period, qualifying quarter or period, or other specified period as provided by the group policyholder.
 4. The temporary or seasonal employee item may also include contracted employees. The item may be omitted if the group does not employ such employees or may be omitted if the such employees are to be covered for the group.
 5. The last item may be omitted if an employer has employees also working in a business location outside the United States.
 6. The definition may be omitted if eligibility is based on membership (such as a union class) or if retirees are covered.
- RR. The **RETIREE** definition may be added if retiree coverage is to be provided. **Retiree** definition is variable, so that case-specific information can be substituted. Examples ("Early" or "Normal" may be used in describing the type of Retiree; underlined variable numbers are hypothetical):

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who is eligible for retirement benefits.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) is [over the age of 65/ at least age 65/ has attained age 65]; and
- (2) has completed 10 or more years of service with the Group Policyholder/Participating Organization.

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RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) has attained age 65;
- (2) has completed 10 or more years of service with the Group Policyholder/Participating Organization; and
- (3) has retired on or after [specific date provided by Group Policyholder].

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who has

- (1) 10 years of seniority with the Group Policyholder/Participating Organization as of [specific date provided by Group Policyholder];
- (2) reached age 65; and
- (3) retired without prejudice.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization:

- (1) who has attained age 65; or
- (2) whose employment has ceased due to retirement by the Group Policyholder/Participating Organization; and
- (3) who was insured under the Policy immediately prior to retirement.

[EARLY] RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who retired early under the Group Policyholder's/Participating Organization's retirement plan at age 55 through age 60 with at least 10 years of continuous service.

[NORMAL] RETIREE means a former employee of the Group Policyholder/Participating Organization who:

- (1) retired under the Group Policyholder's/Participating Organization's retirement plan on or after attaining 65 years of age; and
- (2) has incurred 10 or more years of creditable service with the Group Policyholder/Participating Organization; or
- (3) has incurred 10 years of service (this can include credit for military service) with the Group Policyholder/Participating Organization.

[EARLY] RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) took early retirement prior to attaining age 60; and
- (2) has incurred 10 or more years of creditable service with the Group Policyholder/Participating Organization.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) has completed 10 or more years of service prior to retirement; and
- (2) is eligible to receive benefits under the school board's retirement plan.

RETIREE means a former [full-time] employee of the Group Policyholder/Participating Organization who:

- (1) retired under the early or normal (age 65 with 10 years of credited service) retirement provisions of the Group Policyholder's/Participating Organization's retirement plan; or
- (2) retired on or after age 65 with less than 10 years of credited service, provided employment with the Group Policyholder/Participating Organization commenced prior to age 60.

RETIRED MEMBER means a Person who qualifies for a pension under [description provided by Group Policyholder].

RETIREE (see the Participating Organization/Group Policyholder for this information).

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- SS. The **STROKE** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- TT. The **STRUCTURAL CONGENITAL DEFECT** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- UU. The **TYPE 1 DIABETES** definition will be included in its entirety if the policy provides a benefit for that Event/Illness.
- VV. In the certificate version, the bracketed reference to Employee/member in the definition of **YOU and YOUR** may reference the appropriate descriptions of the members eligible for coverage.
- V. **GENERAL PROVISIONS.** Form GL51-5-GP includes the General Provisions of the Policy and GL52-5-GP includes the General Provisions applicable to the Certificate. GL51-5.1-PE is used when the Group Policyholder has Participating Organizations that are to be covered under the Policy. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.
- A. GL51-5-GP includes the following variability.
1. In the **ENTIRE CONTRACT** section, item (3) may be omitted if not applicable. The bracketed reference to Participating Organization may be omitted if not applicable
 2. The **RESCISSION** section may be omitted if not applicable.
 3. In the **INFORMATION TO BE FURNISHED** section, the bracketed reference to Participating Organization may be omitted if not applicable and the underlined period in which adjustments may be made may range from 12 to 60 months.
 4. In the **ACTS OF THE POLICYHOLDER** section, the bracketed reference to employees/members may reflect the appropriate description of the members of the group.
 5. In the **CERTIFICATES** section, the underlined reference to Group Policyholder/Participating Organization may reflect either the Group Policyholder or Participating Organization.
- B. In the certificate form GL52-5-GP, item (3) of the **ENTIRE CONTRACT** section may be omitted if not applicable. The **RESCISSION** section may be omitted if not applicable.
- C. Group policy form GL51-5.1-PE, **PROVISIONS APPLICABLE TO PARTICIPATING ORGANIZATIONS**, is to be used when a group policyholder has an affiliate or subsidiary to be insured under the policy or if more than one union or professional association or a combination are participating under the policy. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent. We request the following variability.
1. In the first sentence of the form, the bracketed "employees or members" may reflect the appropriate description of the members of the group.
 2. Under the definition of the **PARTICIPATING ORGANIZATION**, the bracketed list of Participating Organizations is to be filed as variable to list the actual names of those organizations to be included under the Policy.
 4. Under the **EFFECTIVE DATE** section, the underlined "the first day of the Insurance Month following" may be reworded to reflect the appropriate date (the date of, the next day following, the first day of the Insurance Month coinciding with or next following, or other specified date).
 5. Under the section entitled **TERMINATION**, the underlined dates under this section are variable so that coverage may end on the date, the next day following, the last day of the Insurance Month following, the last day of the payroll cycle/pay period, or on a specified day following the events listed.

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VI. ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE. Forms GL51-6-ELE and GL52-6-ELE contain the Eligibility and Effective Date provisions for the individual group member. We request that any reference to Group Policyholder or Participating Organization throughout the forms may reflect one or both terms, or we may name a specific employer, subsidiary, affiliate or affiliates to which the definition applies. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

A. The **ELIGIBILITY** section includes the following variability.

1. In the first sentence, if only two items apply, the bracketed "latest of" may be changed to "later of" and the applicable punctuation will be reflected. If only one item remains, the "latest of" will be omitted.
2. Item (2) includes the following variability.
 - a. The item may be included if there are Participating Organizations included. The appropriate punctuation for the items included will be reflected.
 - b. The underlined date is to be filed as variable so a person may become eligible on the day, day following, first of month following, or any other specified day following the events listed.
3. Item (3) includes the following variability.
 - a. The underlined date is to be filed as variable so a person may become eligible on the day, day following, first of month following, or any other specified day following the events listed.
 - b. Item (3) may be omitted in its entirety if there is no Eligibility Waiting Period to be satisfied. The appropriate punctuation for the items remaining will be reflected.
4. In the bracketed **Prior Service Credit Towards Waiting Period**, if included, the following variability applies.
 - a. The bracketed reference to former employee/member may include the appropriate description of the members eligible for the credit.
 - b. The underlined duration in item (1) may range from 30 days to 2 years, if agreed upon by an underwriter.
 - c. Item (2) may be omitted if the group/class of insureds is not subject to FMLA or similar state requirement.
 - d. Item (3) may be omitted if the group/class of insureds is not subject to USERRA.
 - e. The section may be omitted if an Eligibility Waiting Period is not applicable or alternate language may be included to accommodate a group's administrative handling.
Example:

"Prior Service in an ineligible class will apply toward the Waiting Period when:

- (1) an employee's employment status with the [Group Policyholder/Participating Organization] changes; and
- (2) such employee becomes a member of an eligible class."

"If a person is working as an ineligible Employee for the [Group Policyholder/Participating Organization] and then becomes a regular [Full-time] Employee of the Group Policyholder/Participating Organization], any time incurred with the [Group Policyholder/Participating Organization] as an ineligible Employee will be applied toward the Waiting Period." The bracketed "Full-Time" may be omitted.

"Prior Service with XYZ Company will apply toward the Waiting Period." This would be used when employees are transferring from one division or subsidiary to another or to the policyholder or in the event the policyholder purchases a company and wants a smooth transition for those employees transferring to the policyholder's plan of benefits.

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- B. The bracketed **ENROLLMENT** section includes the following variability.
1. This section may be included when one or more of the items listed are applicable.
 2. Item (2) may be included if an Annual Enrollment Period or an Open Enrollment Period are included.
 3. In item (2) of this section, the underlined "Annual" may be changed to "Open" if an Open Enrollment Period is permitted in lieu of an Annual Enrollment Period.
 4. Item (3) of this section may be omitted if the Group Policyholder does not allow status changes. If included, the underlined 31 days may range from 30 to 91 days.
- C. Under the **EFFECTIVE DATE** section, the following variability applies.
1. The underlined dates are to be filed as variable throughout this section, so coverage can begin on the day, day following, first day of the Coverage Month/calendar coinciding with or next following, first day of the month following, or any other specified day following the events listed.
 2. In item (2), the Active Work rule can be omitted, or the following "Non-confinement" or "Period of Limited Activity" language can be added or substituted for non-employee classes (retirees, union members, etc.)
 - (2) the date the Person resumes Active Work, if not Actively at Work on the day his or her insurance would otherwise take effect;
 - (2) the day after the Person's final discharge from a hospital or other health care facility, if [the Person/a retiree] is confined to such a facility on the date he or she would otherwise become eligible; and
 - (2) the day after the Person's resumption of the normal activities of a healthy person of the same age and sex, if [the Person/a retiree] is in a Period of Limited Activity and unable to perform such activities the date he or she would otherwise become eligible; and
 3. In item (3), the following variability applies.
 - a. The item may be omitted in its entirety if the coverage is non-contributory.
 - b. The bracketed "and signs" may be omitted along with items (a) or (b) or both (a) and (b) may be omitted if the group does not have any payroll deductions or Section 125 Plan.
 - c. The underlined Section 125 Plan may reference the appropriate plan for the group: Flexible Benefit Plan, Cafeteria Plan, Flexible Spending Account/Plan/Fund, or the specific name of the group's plan.
 4. Item (4) may be omitted in its entirety if not applicable.
 5. The second paragraph regarding increases may be omitted if the group does not permit any increases to coverage. The active work language may be omitted or changed to the non-confinement period or period of limited activity language shown below for non-employee classes (retirees, union members, etc.):

Any increase in coverage or benefits becomes effective at 12:01 a.m. on the latest of:

 - (1) the day after the Person's final discharge from a hospital or other health care facility, if he or she is confined to such a facility on the date the increase would otherwise take effect; or
 - (2) the day after the Person's resumption of the normal activities of a healthy person of the same age and sex, if he or she is in a Period of Limited Activity and unable to perform such activities on the date the increase would otherwise take effect; or
 - (3) the date any required Evidence of Insurability is approved by the Company. (See Schedule of Benefits.)

Item (3) may be omitted in its entirety if not applicable.
 6. The last paragraph regarding decreases may be omitted if not applicable to the group. The active work language may be omitted for non-employee classes (retirees, union members, etc.):

Any reduction in coverage or benefits will take effect on the day of the change.

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- D. The bracketed **ANNUAL/OPEN ENROLLMENT PERIOD** may be omitted in its entirety if neither an annual nor an open enrollment period is applicable to the group. The underlined "Annual/Open" may be changed to reflect one or the other as applicable. The bracketed last sentence of this paragraph will be omitted if not applicable.
- E. The **REINSTATEMENT RIGHTS** section may be omitted in its entirety if not applicable to the group or the class of eligible members covered (i.e. retirees, members, or no Eligibility Waiting Period to waive). If included, one or more periods may be waived, as applicable to the group. Reinstatement may be permitted upon return to work within 1 to 60 months, if enrolled within 31 to 91 days, or for other events to coincide with a group's administrative handling of various types of leaves. If included, the following variability applies.
1. The bracketed reference to reductions in hours may be included if requested by a group policyholder and agreed upon by an underwriter.
 2. The bracketed reference to Group Policyholder/Participating Organization throughout this section may show either or both, as applicable.
 3. Item (1) may be omitted if the group is not subject to FMLA law or similar state law in which coverage would be required to be reinstated.
 4. Item (2) may be omitted if the group/class is not subject USERRA.
 5. Items (3), (4), or (5) can be omitted or show different time periods to agree with the group's leave practices or union contracts. The time period may range from one month to 60 months or some other duration as agreed upon by an underwriter.
 6. Item (6) may be included if reinstatement is permitted when a person meets the minimum hours to return to an eligible class.
 7. The events listed may be expanded to include additional reinstatements due to a return to eligible status, sabbatical leaves, or other types of leaves to coincide with a group's administrative practices. In this event, the additional types of leaves and the applicable duration may be listed showing the specific description of the type of leave, sabbatical, or ineligible status and the duration subject to the same variability as indicated above.
 8. In the second paragraph, the following variability applies.
 - a. The underlined re-enrollment period can range from 31 to 91 days, to agree with the group's enrollment practices.
 - b. The underlined Active Work may be changed to reflect active status (as for a member).
 - c. The bracketed text in the first sentence of this paragraph may be included when the group policyholder or participating organization pay for the entire cost of the premium.

VII. TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE. Forms GL51-7-TE and GL52-7-TE contain the Individual Termination provisions for Personal Critical Illness Insurance. Any reference to Group Policyholder or Participating Organization throughout the forms may reflect one or both terms, or a specific employer, subsidiary, affiliate or affiliates to which the definition applies may be named. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent.

- A.. Under the **TERMINATION** section, the underlined terms "day" or "date" are variable throughout, so that coverage may end on the day, the day following, the last day of the month following, last day of the payroll cycle/pay period, or any other specified day following the events listed. Variability is requested to support non-standard handling due to policyholders' administrative guidelines regarding terminations.
1. In Items (1) & (10), the references to Participating Organizations may be omitted when not applicable.
 2. Item (2) may be omitted at the policyholder's request if only one class is included under the Policy.
 3. In Items (3) and (10), language can be added or substituted to handle non-employee classes (retirees, union members, etc.).
- Examples:
- (3) the date such Insured Person ceases to be in a class which is eligible for coverage under this Policy or dies;
 - (3) the date such Insured Person ceases to be in a class which is eligible for coverage under this Policy, attains age [70 - 100], or dies;
 - (3) the date the Insured Person ceases to be an member with the [Group Policyholder/Participating Organization];
 - (10) the date the Insured Person's membership with the [Group Policyholder/Participating Organization] terminates;

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4. At the policyholder's request, Item (5) may be omitted and Item (10) reworded to coincide with the group's billing cycle or administrative handling of terminations. Example:
 - (10) (a) the last day of the Insurance Month in which the Insured Person's employment with the Group Policyholder or Participating Organization terminates, if employment terminates on or before the 15th of the month;
 - (b) the last day of the Insurance Month in which the Insured Person's employment with the Group Policyholder or Participating Organization terminated if employment terminates after the 15th of the month;
 5. At the policyholder's request, Item (6) may be reworded to coincide with a policyholder's payroll cycle:
 - (6) the last day of the Insurance Month in which the Insured Person's employment with the Group Policyholder or Participating Organization terminates, or the last day of the payroll period for which premium payment is made on the Insured Person's behalf (whichever is later);
 6. At the policyholder's request Item (10) may be reworded for layoff situations:
 - (10) (a) if termination is due to a layoff, the last day of the Insurance Month which follows the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates;
 - (b) if termination is due to other than a layoff, the date the Insured Person's employment with the Group Policyholder or Participating Organization terminates;
 7. Item (10) may also be reworded or split for specific classes to accommodate a group's administrative handling with respect to termination of employment, elected position, membership.
 8. At the policyholder's request, an item may be added to address coverage ending upon retirement:
the day after the Insured Person retires with the Group Policyholder or Participating Organization;
 9. At the policyholder's request, an item may be added to address the exhaustion of paid time off or vacation time upon termination:
the day after any paid time off (PTO) and/or vacation time is exhausted due to termination of the Insured Person's employment with the Group Policyholder or Participating Organization;
 10. In Item (11), military service of 30 days to 5 years may be exempted or the item may be omitted.
- B. The **CONTINUATION RIGHTS** section may be included or it may be omitted if it not applicable to the particular group (i.e. retirees, members). The continuations may be included or omitted as applicable to the particular class of insureds (i.e. retirees, members). If applicable to certain classes, a phrase may be added before the particular continuation to denote the class in which the continuation applies. If included, the following variability applies.
1. Throughout this section, references to Group Policyholder/Participating Organization may include one or both terms; or we may name a specific employer, subsidiary, affiliate or affiliates to which the provision applies.
 2. The bracketed reference to the reduction in hours in the first paragraph may be omitted if such continuation is not applicable.
 3. In the **Disability** section, item (1) may be included or omitted. The underlined duration of the continuation may range from the end of the month or up to 24 months or some other specified period to accommodate a group's administrative guidelines or union contracts.
 4. The **Family or Medical Leave** and the **Military Leave** sections can be omitted for groups not subject to these federal laws or any similar state laws or if such leaves are not applicable to the class of eligible members covered. We request the ability to re-word these provisions to reflect any change to federal requirements.
 5. The **Lay-Off Or Leave Of Absence** section includes the following variability.
 - a. The Lay-Off or Leave of Absence continuation may be omitted when the group does not allow continuation during such absences or if such absences are not applicable to the type of eligible members covered.
 - b. The underlined duration may range from the end of the month in which the leave began to 60 Insurance/ calendar months. For example, if the continuation is for one month, the last sentence may read: "The required premium payment must be received from the Group Policyholder. If the continuation period is longer than one month, the last sentence will read: "The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage."

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- c. If the duration is different between lay-off and leave of absence, this section may be divided to reflect the continuation period specific to the type of absence or show one or the other if either is not applicable:
6. In the **Temporary Reduction in Hours** section, if included, the underlined duration may range from the end of the month in which the reduction occurred to 24 months. The underlined minimum hours language may range from 10 to 80 hours in a one-week to four-week period.
7. In the **Conditions** section, the last sentence may be omitted if a union agreement requires coverage or with underwriter approval.
8. Additional continuation periods may be added (as may be required by federal or local law, the group's compensation program or union agreements, a prior carrier's contract, etc.). Examples (the underlined durations typically range from one month to three months but may be extended up to 24 months):
 - a. **Sabbatical Leave.** If [an Insured Person/you] cease(s) work due to an approved sabbatical, coverage may be continued [for three Insurance Months after the sabbatical begins or until the end of an approved sabbatical]. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
 - b. **Plant Closing or Mass Lay Off.** If [an Insured Person is/ you are] not provided a 60-day notice by the Group Policyholder/Participating Organization of a plant closing or of a mass lay off and [the Insured Person/you] cease(s) work due to a lay off as a result of a plant closing or of a mass lay off, then coverage may be continued:
 - (1) for up to 60 days after the lay off begins;
 - (2) provided premium payments are made on [the Insured Person's/your] behalf.
 - c. **Lay Off (other than due to a Plant Closing or Mass Lay Off) or Other Leave.** If [an Insured Person/you] cease(s) work due to a temporary lay off (not as a result of a plant closing or of a mass lay off), or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
 - d. **Coverage Continuation Agreements.** If [an Insured Person is/you are] severed from employment, retire, or terminate employment, then coverage may be continued until the end of [the Insured Person's/your] contract period in accord with any severance agreement, consulting agreement, or union agreement. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
 - e. **Severance.** If [an Insured Person's/your] position with the Group Policyholder/Participating Organization is eliminated, then coverage may be continued for three Insurance Months following the date employment terminated [based upon the Insured Person's/your length of service and position with the Group Policyholder/Participating Organization]. The required premium payments must be received from the Group Policyholder, throughout the period of continued coverage.
- C. In the **PORTABILITY** section, the underlined 31 days may range from 30 to 91 days. The underlined age may range from 60 to 100, or be omitted when not applicable. The bracketed reference to the billing fee will be omitted when not applicable. The references to Dependents may be removed when not applicable.

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VIII. ELIGIBILITY FOR DEPENDENT CRITICAL ILLNESS COVERAGE. Policy form GL51-8-ELD AR and GL52-8-ELD AR contain the definitions, eligibility, and effective dates for Dependents. We request the following to be filed as variable.

- A. In the **DEPENDENT** section, the following variability applies.
1. Item (2) of the first paragraph may be omitted when not applicable.
 2. In Item (3) of the first paragraph:
 - a. the underlined ages in item (3) are filed as variable so that they may be increased but not decreased (19 – 30); and
 - b. "regardless of student status" may be included at the end of item (3) if dependent coverage is extended to cover dependent children regardless of student status to match the group's medical plan or administrative guidelines.
 3. Item (4) of the first paragraph:
 - a. may be omitted if the dependent coverage is extended to cover dependent children regardless of student status to match the group's medical plan or administrative guidelines; or
 - b. the underlined ages may be increased (19-30).
 4. In item (5) of the first paragraph:
 - a. the underlined age may be increased (19–30); and
 - b. the underlined timeframe for providing proof may range from 31 to 91 days.
 5. The bracketed text at the end of the first paragraph regarding a QMCSO may be omitted if not applicable.
 6. If domestic partner or civil union partner coverage is included, the definition of "Child" will include coverage for a domestic partner's or civil union partner's child, as follows:

"a child of a civil union partner or domestic partner;"
 7. In item (4) of the "Child" includes:" section, the bracketed reference of "or grandchild" may be omitted if not applicable.

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An alternate definition of the bracketed definition of a DEPENDENT, with the same variability as requested above, may be applied for groups wanting to match the group's medical plan for PPACA. That definition will read as follows:

DEPENDENT means an Insured Person's:

- (1) legal spouse, who is not legally separated from the Insured Person;
- [(2) civil union partner, or domestic partner;]
- (2) child less than 26 years of age; or
- (3) child age 26 years or older, who is:
 - (a) continuously unable to earn a living because of a physical or mental disability;
and
 - (b) chiefly dependent upon the Insured Person for support and maintenance.

The child must be covered by the [Group Policyholder's/Participating Organization's] Critical Illness plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:

- (a) within 31 days of the day coverage would otherwise end due to age; and
- (b) thereafter, when the Company requests (but not more than once every two years).

[Dependent will also include a child that is required to be provided insurance by the Insured Person under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).]

"Child" includes:

- (1) a Insured Person's natural child, legally adopted child, or stepchild;
- (2) a child placed under the Insured Person's charge, care or control for whom the Insured Person has filed a petition to adopt, from:
 - (a) the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or
 - (b) the date of the filing of a petition for adoption, if the Insured Person applies for coverage within 60 days after the filing of the petition for adoption;
- (3) a child for whom the Insured Person is required by court order to provide Critical Illness insurance; and
- (4) a stepchild [or grandchild] who resides in the Insured Person's household; and who is chiefly dependent on the Insured Person for support; [and]
- [(5) a child of a civil union partner or domestic partner; and]
- (6) a foster child:
 - (a) who resides in the Insured Person's household;
 - (b) who is chiefly dependent on the Insured Person for support; and
 - (c) for whom the Insured Person has assumed full parental responsibility and control.

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- B. The **ELIGIBILITY** section includes the following variability.
1. In the first paragraph of this section, the underlined dates are variable so they can be the day, the next day of the Coverage Month, the first day of the Coverage Month, or other specified date following the events listed.
 2. The second paragraph of the **ELIGIBILITY** section may be omitted in its entirety if there is no Change in Family Status or Annual or Open Enrollment Period included. If it is included, the following variability applies.
 - a. Either or both of items (1) and (2) may be included.
 - b. The underlined enrollment period in item (1) may range from 30 to 91 days.
 - c. The underlined "Annual/Open" in item (2) of the second paragraph of this section may reflect either "Annual" or "Open" for the type of enrollment applicable.
 3. In the third paragraph of this section, the last sentence may be omitted.
- C. **ANNUAL/OPEN ENROLLMENT PERIOD** may be included if the group has an Annual or Open Enrollment Period. The underlined "Annual/Open" may reflect either "Annual" or "Open" for the type of enrollment applicable. The bracketed last sentence of this paragraph will be omitted if not applicable.
- D. Under **EFFECTIVE DATES**, the following variability applies.
1. The underlined dates may be the day, the day following, first of the Insurance Month following, or any other specified day following the events listed.
 2. In item (2), the bracketed language regarding additional premium may be omitted if additional premium is not required or if the group policyholder does not do payroll deduction or has a Section 125 plan, or similar plan. If applicable, the underlined Section 125 may specify the particular plan applicable to the group: Flexible Benefit Plan, Cafeteria Plan, or Flexible Spending Account/Plan/Fund or it may name the group policyholder's specific plan. (a) or (b) may be included or omitted as applicable to the group.
 3. Item (3) may be deleted if not applicable. The bracketed "on all of an Insured Person's Dependents" may be omitted if not applicable.
- E. Under the **NEW DEPENDENTS** section, the following variability applies.
1. In item (2), if the group does not have payroll deduction or the group does not have a Section 125 Plan or similar plan, either or both of these references may be omitted.
 2. The underlined reference to Section 125 Plan (Cafeteria Plan, Flexible Spending Account, specific name of group's plan) may specify the applicable plan to the group or be omitted.
 3. The underlined timeframe may range from 30 to 91 days.

IX. TERMINATION OF DEPENDENT CRITICAL ILLNESS INSURANCE. GL51-9-TD and certificate form GL52-9-TD contain the termination provisions for Dependents. We request the following to be filed as variable.

- A. In the **TERMINATION** section, the underlined dates are variable so coverage can end on the day, the last day of the Insurance Month, or other specified date following the events listed.
- B. Under the **SURVIVING DEPENDENTS** section, the following variability applies.
1. The underlined duration of item (1) may be changed with a range of 1 to 60 months.
 2. The **Surviving Dependents** paragraph may be omitted in its entirety.
- C. The **REINSTATEMENT OF COVERAGE** section may be omitted in its entirety if reinstatement of coverage is not applicable to the group/class.

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- X. PREMIUMS AND PREMIUM RATES.** Form GL51-10-PR includes the Premium provisions, a Grace Period provision, and a Premium Rates Schedule. We request variable filing of the following underlined or bracketed material.
- A. We request the bracketed references to Group Policyholder/Participating Organization to be variable throughout this form so either or both may be included as applicable to the group.
 - B. In the **GRACE PERIOD** section, the underlined period is to be filed as variable so it may range from 31 to 91 days.
 - C. Under the **PAYMENT RATE CHANGE** section, the following variability applies.
 - 1. The underlined "first" in reference to the anniversary may be changed to reflect the appropriate applicable anniversary in which the rates will change (first, second, third).
 - 2. The bracketed text in item (4) may be omitted when not applicable.
 - 3. In the last sentence of this section, the underlined notice period for a rate-up may range from 31 days to 180 days.
 - D. In the **PREMIUM AMOUNT** section, the bracketed text may be omitted when a billing fee is not included. Billing fees may be applied depending upon the billing mode requested by the Group Policyholder. In the final paragraph of this section, the effective date can be the first day of the Insurance month or any other specified date.
 - E. The bracketed **PREMIUM RATE SCHEDULE** is to be filed as variable so that the applicable coverages and rates are reflected for the specific group.
- XI. POLICY TERMINATION.** Policy form GL51-11-PT includes Policy Termination provisions.
- A. We request the bracketed references to Participating Organization to be variable throughout this form so Participating Organization may be included or omitted as applicable to the group.
 - B. In the **TERMINATION BY THE COMPANY** section, the underlined notice period may range from 31 to 180 days.
 - C. Under the **TERMINATION BY GROUP POLICYHOLDER** section, the underlined date may be changed to be the day following, the last day following, the last day of the Insurance Month, quarter, etc. to coincide with the billing mode for the group, or other specified day.
- XII. CRITICAL ILLNESS BENEFITS.** Forms GL51-12-CIB and GL52-12-CIB describe the policy's Critical Illness benefits. The bracketed plan/class in the header may be included to describe the appropriate plan/class to which the benefits apply. The bracketed references to Dependents may be omitted throughout if the coverage is not to be extended to include Dependents. We also request variable filing of the following bracketed or underlined text:
- A. Under **GENERAL CRITICAL ILLNESS BENEFITS**, the bracketed references to the Wellness category may be omitted if not applicable. The bracketed reference to the Benefit Waiting Period will be omitted if not applicable. The underlined periods in items (1) and (2) of the fourth paragraph may range from 30 to 365 days.
 - B. Under **CRITICAL ILLNESS ASSESSMENT BENEFIT**, the list of Critical Illness Assessment Tests is variable so items may be included or omitted.
 - C. Under **CHILD CARE EXPENSE BENEFIT**, the underlined ages in the definition of "Child" may range from 1 to 16. The underlined duration in the last paragraph may range from 1 to 90 days.

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XIII. EXCLUSIONS. Forms GL51-13-EX AR and GL52-13-EX AR list the exclusions. The bracketed plan/class in the header may be included to describe the appropriate plan/class to which the limitations apply. The bracketed references to Dependents may be omitted throughout if the coverage is not to be extended to include Dependents. We also request variable filing of the following bracketed or underlined text:

- A. Under **GENERAL EXCLUSIONS**, we request the following variability, in item (5), the underlined jurisdictions may be included or omitted or other countries may be added and the underlined duration may range from 3 months to two years.
- B. In the **PRE-EXISTING CONDITION EXCLUSION**, the underlined exclusionary period in Item No. (2) of the first paragraph may range from 3 to 24 months. The bracketed treatment-free period language in this same item may be omitted if not applicable. If the treatment-free period language is included, the underlined period may range from 3 to 24 months. The look-back period in the second paragraph may range from 3 to 12 months. The entire exclusion may be omitted if not applicable.

XIV. BENEFICIARY. Forms GL51-14-B and GL52-14-B include the Beneficiary provisions. The following variability applies.

- A. **PAYMENTS TO BENEFICIARY.**
 - 1. Either the first or second bracketed **PAYMENTS TO BENEFICIARY** text will be included. The first bracketed **PAYMENTS TO BENEFICIARY** text, which is the traditional beneficiary provision, may be included if payments are to be made to the estate when no beneficiary is named or survives. The second bracketed **PAYMENTS TO BENEFITS** text, which is the preferential beneficiary provision and the standard provision, may be included if payments are to be made to the relatives listed when no beneficiary is named or survives.
 - 2. In the second bracketed **PAYMENTS TO BENEFICIARY** text, the bracketed domestic partner or civil union partner may be included if requested by the group policyholder.
 - 3. The fourth paragraph shown on the form will be included, regardless of which bracketed **PAYMENTS TO BENEFICIARY** text will be included. Within this fourth paragraph, the underlined 15 days, denoting the time between deaths of insured and beneficiary, may range from 1 to 15 days.
- B. **CHANGING THE BENEFICIARY.** The underlined text may reflect where written notice of the change in beneficiary is to be sent.
- C. **FACILITY OF PAYMENT.** The underlined facility of payment amount may range from \$250 to \$2,500.

XV. CLAIMS PROCEDURES. Group policy form GL51-15-CP and certificate form GL52-15-CP describe the Claims Procedures for Critical Illness insurance benefits. These claims procedures incorporate both the state and federal requirements. The bracketed references to a Dependent may be omitted throughout if the coverage is not to be extended to include a Dependent; and the appropriate verb will be used to agree with the subject. We request variable filing of the following.

- A. In the **Notice of Claim** under the **NOTICE AND PROOF OF CLAIM** section, the underlined "Company's Group Insurance Service Office" is to be filed as variable so that requests can be directed elsewhere when other claims processing arrangements have been made. The bracketed reference to Participating Organization may be included or omitted as applicable to the group.
- B. Within the **TO WHOM PAYABLE** section, if dependent coverage is not provided by the policy, item (2) will be omitted and the punctuation will be adjusted accordingly.
- C. The bracketed **Claims Subject to ERISA** paragraph is to be filed as an omit-only variable so it may be removed (but not reworded) for non-ERISA groups.
- D. Under the **RIGHT OF RECOVERY** provision, the underlined time limit for reimbursement may be increased but not decreased with a range of 60 days to 90 days.
- E. The bracketed **COMPANY'S DISCRETIONARY AUTHORITY** may be omitted in its entirety but not reworded.

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XVI. PRIOR INSURANCE CREDIT UPON TRANSFER OF INSURANCE CARRIERS. Group policy form GL51-16-PIC AR and certificate form GL52-16-PIC AR describe the Prior Insurance Credit provision, which prevents loss of coverage for Insured Persons due to a transfer of insurance carriers. The underlined replacement period may range from 1-30 days. The underlined "Actively at Work" may be changed to reflect active status (as for a member).

XVII. ACCIDENT BENEFIT. Amendment forms GL51-AMEND.ACC and GL52-AMEND.ACC may be attached to the Critical Illness insurance policy and certificate to provide an additional benefit for insureds who sustain Paralysis, a Coma, or a Severe Burn as the result of an Accident.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed references to Insured Dependent may be omitted throughout if the benefit provided by the amendment is not to be extended to include Dependents. The appropriate verb will be used to agree with the subject.
- C. The bracketed first sentence under **ACCIDENT BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
- D. In the definition of **Coma**, the underlined period may range from 1 to 15 days.
- E. In the definition of **Severe Burn**, the underlined percentages may range from 9% to 36%.
- F. In item (4) under **EXCLUSIONS**, the blood alcohol level may range from .08 to .10. In item (10), the underlined jurisdictions may be included or omitted or other countries may be added and the underlined duration may range from 3 months to two years.

XVIII. OCCUPATIONAL HIV/OCCUPATIONAL HEPATITIS BENEFIT. Amendment forms GL51-AMEND.OCHVHP and GL52-AMEND.OCHVHP may be attached to the Critical Illness insurance policy and certificate to provide an additional benefit for an Insured Person who contracts Occupational HIV or Occupational Hepatitis.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed first sentence under **OCCUPATIONAL HIV/OCCUPATIONAL HEPATITIS BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.

XIX. PERMANENT AND TOTAL DISABILITY BENEFIT. Amendment forms GL51-AMEND.PTD and GL52-AMEND.PTD may be attached to the Critical Illness insurance policy and certificate to provide an additional benefit for Insured Persons or Spouses who, as the result of a payable Illness/Event, become Permanently and Totally Disabled.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed references to Insured Dependent Spouse may be omitted throughout if the benefit provided by the amendment is not to be extended to include Spouses. The appropriate verb will be used to agree with the subject.
- C. The bracketed first sentence under **PERMANENT AND TOTAL DISABILITY BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
- D. In the **BENEFIT** section, the underlined duration may range from 3 to 12 months.

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E. **CLAIMS PROCEDURES.**

1. In the **Notice of Claim** section, the underlined "Company's Group Insurance Service Office" is to be filed as variable so that requests can be directed elsewhere when other claims processing arrangements have been made.
2. Under the **Examination** section, the underlined "more than twice" in the third paragraph may range from 2 to 3 times. The bracketed "Good Cause" text may be omitted.
3. In the **To Whom Payable** section, the last sentence may be omitted if the benefit provided by the amendment is not extended to include a Spouse.
4. The bracketed **Claims Subject to ERISA** paragraph is to be filed as an omit-only variable so it may be removed (but not reworded) for non-ERISA groups.
5. Under the **Right of Recovery** section, the underlined time limit for reimbursement may be increased but not decreased with a range of 60 days to 90 days.
6. The bracketed **COMPANY'S DISCRETIONARY AUTHORITY** may be omitted in its entirety but not reworded.

XX. TREATMENT CARE BENEFIT. Amendment forms GL51-AMEND.TCB and GL52-AMEND.TCB may be attached to the Critical Illness insurance policy and certificate to provide an additional benefit for Insured Persons or Dependents who, as the result of a payable Illness/Event, meet the terms and conditions for any of the benefits described in the Amendment.

- A. We request variable filing of the group policy number, group policyholder name, plan/class number (if applicable), participating organization name (if to be included), amendment effective date and signature block.
- B. The bracketed references to Insured Dependents may be omitted throughout if the benefit provided by the amendment is not to be extended to include Dependents. The appropriate verb will be used to agree with the subject.
- C. The bracketed first sentence under **TREATMENT CARE BENEFIT** may be included when the inclusion of the benefit is elected at the individual's level in lieu of the group policyholder electing the benefit to be included for the group/class as a whole.
- D. In the **AMOUNT** section, the bracketed benefits may be omitted or included. The bracketed benefit amounts may range as shown in the form.
- E. The bracketed benefits and their respective descriptions may be omitted if not applicable.
- F. **AMBULANCE TRANSPORTATION.**
 1. The underlined 180 days may range from 90 to 365 days.
 2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."
- G. **AIR AMBULANCE TRANSPORTATION.**
 1. The underlined 180 days may range from 90 to 365 days.
 2. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."
- H. **HOSPITAL ADMISSION.**
 1. The underlined 180 days may range from 90 to 365 days.
 2. The underlined 20 hours may range from 18 to 23 hours.
 3. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."
- I. **HOSPITAL CONFINEMENT.**
 1. The underlined 180 days may range from 90 to 365 days.
 2. The underlined 365 days may range from 90 days to two years.
 3. The underlined two-year period may range from one to three years.

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J. **INTENSIVE CARE UNIT (ICU) CONFINEMENT.**

1. The underlined 180 days may range from 90 to 365 days.
2. The underlined 15 days may range from 5 to 30 days.
3. The underlined two-year period may range from one to three years.

K. **FOLLOW-UP CARE.**

1. The underlined 365 days may range from 90 days to two years.
2. The underlined 6 times may range from 1 to 15 (6 is the standard).

L. **TRANSPORTATION.**

1. The underlined 100 miles may range from 50 to 150 miles.
2. The underlined 365 days may range from 90 days to two years.
3. The underlined "up to three times" may range from once to 5 times. If once, "up to three times" will be replaced with "once."

M. **LODGING.**

1. The underlined 100 miles may range from 50 to 150 miles.
2. The underlined 30 days may range from 15 to 60 days.
3. The underlined 365 days may range from 90 days to two years.

N. **REASONABLE MODIFICATIONS.**

1. The bracketed items (1) through (9) may be omitted or included, depending on the categories of benefits available under the Policy. If items are omitted, the list will be renumbered accordingly.
2. The underlined two-year period may range from one to three years.
3. The underlined once may range from 1 to 5 times. If more than once, "once" will be replaced with "up to [#] times."

O. The **Companion** definition will be included in its entirety if Lodging benefits are provided.

P. The **Home Health Care Agency** definition will be included in its entirety if Follow-Up Care benefits are provided.

Q. The **Hospital Confinement** definition will be included in its entirety if the Hospital Confinement benefits are provided.

R. The **Intensive Care Unit (ICU)** definition will be included in its entirety if Intensive Care Unit (ICU) Confinement benefits are provided.

S. The **Medical Health Professional** definition will be included in its entirety if Follow-Up Care benefits are provided.

T. The **Observation Unit** definition will be included in its entirety if Hospital Admission benefits are provided.

U. The **Occupational Therapist** definition will be included in its entirety if Follow-up Care benefits are provided.

V. The **Outpatient Treatment** definition will be included in its entirety if Hospital Admission benefits are provided.

W. The **Physical Thereapist** definition will be included in its entirety if Follow-Up Care benefits are provided.

XXI. AMENDMENT (General Amendment). GL51-AMEND and GL52-AMEND are for amending variable information after issuance, at the request of the Group Policyholder. We request the bracketed body, underlined effective date, and officer signature to be filed as variable; and the bracketed "Accepted By" signature block to be filed as drop-out variable so it may be omitted in those situations where a unilateral amendment is permissible.