



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
800-423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. 000010232171 has been issued to

Moravian University
(The Group Policyholder)

The Issue Date of the Policy is August 1, 2017.

Certificate of Insurance for Class 1

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. 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.

A handwritten signature in cursive script that reads "Dennis R. Glass".

PRESIDENT

CERTIFICATE OF GROUP LONG-TERM DISABILITY INSURANCE

Moravian University
000010232171
SCHEDULE OF BENEFITS
ELIGIBLE CLASS

Class 1 All Full-Time Employees Working 30 Hours or more per week

Moravian University
000010232171
SCHEDULE OF BENEFITS

For
Class 1 - All Full-Time Employees Working 30 Hours or more per week

MINIMUM HOURS: 30 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
1 year of continuous Active Work

CONTRIBUTIONS: Insured employees are not required to contribute to the cost of the Long-Term Disability coverage.

LONG-TERM DISABILITY BENEFITS

BENEFIT PERCENTAGE: 60%

MAXIMUM MONTHLY BENEFIT: \$10,000

MINIMUM MONTHLY BENEFIT: \$100 or 10% of the Insured Employee's Monthly Benefit, whichever is greater

Long-Term Disability Benefits for PRE-EXISTING CONDITIONS will be subject to the Pre-Existing Condition Exclusion on the Exclusion page.

The Maximum Monthly Benefit will not exceed the Benefit Percentage times Basic Monthly Earnings.

ELIMINATION PERIOD: 180 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 360 calendar day period.

MAXIMUM BENEFIT PERIOD: (For Sickness, Injury or Pre-Existing Conditions): The Insured Employee's Social Security Normal Retirement Age, or the Maximum Benefit Period shown below (whichever is later).

<u>Age at Disability</u>	<u>Maximum Benefit Period</u>
Less than Age 60	To Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

OWN OCCUPATION PERIOD means a period beginning at the end of the Elimination Period and ending 24 months later for Insured Employees.

RETIREMENT PROTECTION PERCENTAGE:

1. Lesser of 10%; or
2. An amount equal to contributions made by Moravian College at the time of Total Disability.

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DEFINITIONS

As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.

ACTIVE WORK or **ACTIVELY AT WORK** means an Employee's full-time performance of all Main Duties of his or her Own Occupation, for the regularly scheduled number of hours, at:

1. the Employer's usual place of business; or
2. any other business location where the Employer requires the Employee to travel.

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

1. a Saturday, Sunday or holiday that 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 Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is **not** due to the Employee's own health condition.

ANNUAL SALARY means the Insured Employee's **BASIC MONTHLY EARNINGS** or **PREDISABILITY INCOME** multiplied by 12.

BASIC MONTHLY EARNINGS or **PREDISABILITY INCOME** means the Insured Employee's average monthly base salary or hourly pay from the Employer before taxes on the Determination Date. The "**Determination Date**" is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Monthly Earnings permitted by the Policy; whichever is less. (Maximum Covered Monthly Earnings equals the Maximum Monthly Benefit divided by the Benefit Percentage shown in the Schedule of Benefits.) Exception: For purposes of determining the Residual Disability Monthly Benefit, Basic Monthly Earnings will not exceed the amount shown in the Employer's financial records.

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.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or **DISABLED** means Total Disability or Partial/Residual Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:

1. is payable under a Retirement Plan due to disability as defined in that plan; and
2. does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

DEFINITIONS
(Continued)

ELIMINATION PERIOD means the number of days of Disability during which no benefit is payable. The Elimination Period is shown in the Schedule of Benefits. It applies as follows.

1. The Elimination Period:
 - a. begins on the first day of Disability; and
 - b. is satisfied when the required number of days is accumulated within a period which does not exceed two times the Elimination Period.During a period of Disability, the Insured Employee may return to full-time work, at his or her own or any other occupation, for an accumulated number of days not to exceed the Elimination Period.
2. Only days of Disability caused by the same or a related Sickness or Injury will count towards the Elimination Period. Days on which the Insured Employee returns to full-time work will not count towards the Elimination Period.

EMPLOYEE or **FULL-TIME EMPLOYEE** means a person:

1. whose employment with the Employer is the person's main occupation;
2. whose employment is for regular wage or salary, on a full-time basis;
3. who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits;
4. who is a member of an Eligible Class which is eligible for coverage 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.

EMPLOYER means the Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of an Employee's medical history. The Company uses this to determine his or her acceptance for insurance or an increased amount of insurance. Such proof will be provided at the Employee's own expense.

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 Employer's leave policy and the law which applies; and
3. does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period, as defined by the Employer. The 12 weeks:

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

If an Employee 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 an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

FULL-TIME, as it applies to the Partial/Residual Disability Monthly Benefit, means the average number of hours the Insured Employee was regularly scheduled to work, at his or her Own Occupation, during the month just prior to:

1. the date the Elimination Period begins; or
2. the date an approved leave of absence begins, if the Elimination Period begins while the Insured Employee is continuing coverage during a leave of absence.

INJURY means an accidental bodily Injury that:

1. requires treatment by a Physician; and
2. directly, and independently of all other causes, results in a Disability that begins while the Insured Employee is insured under the Policy.

DEFINITIONS (Continued)

INSURANCE MONTH or POLICY MONTH means that period of time:

1. beginning at 12:01 a.m. Standard Time, at the Policyholder's place of business on the first day of any calendar month; and
2. ending at 12:00 midnight on the last day of the same calendar month.

INSURED EMPLOYEE means an Employee for whom Policy coverage is in effect.

MAIN DUTIES or MATERIAL AND SUBSTANTIAL DUTIES means those job tasks that:

1. are normally required to perform the Insured Employee's Own Occupation; and
2. could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:

1. the Employer is subject to the Act; or
2. the Insured Employee has requested such a job accommodation.

An Employer's failure to modify or omit other job tasks does **not** render the Insured Employee unable to perform the Main Duties of the job.

Main Duties include those job tasks:

1. as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
2. as performed in the general labor market and national economy.

Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing the Insured Employee's Disability. Such treatment must be rendered:

1. by a Physician whose license and any specialty are consistent with the disabling condition; and
2. according to generally accepted, professionally recognized standards of medical practice.

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 Employer's leave policy and the federal USERRA law; and
3. does not exceed the period required by that law.

MONTHLY BENEFIT means the amount payable monthly by the Company to the Insured Employee who is Totally Disabled or Partially/Residually Disabled.

OWN OCCUPATION or REGULAR OCCUPATION means the occupation, trade or profession:

1. in which the Insured Employee was employed with the Employer prior to Disability; and
2. which was his or her main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:

1. whether such work is with the Employer, with some other firm, or on a self-employed basis; or
2. whether a suitable opening is currently available with the Employer or in the local labor market.

OWN OCCUPATION PERIOD means a period as shown in the Schedule of Benefits.

DEFINITIONS (Continued)

PARTIAL DISABILITY or **PARTIALLY DISABLED** will be defined as follows.

1. During the Elimination Period and Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee:
 - a. is unable to perform one or more of the Main Duties of his or her Own Occupation; or is unable to perform such duties full-time; and
 - b. is engaged in Partial Disability Employment.
2. After the Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee:
 - a. is unable to perform one or more of the Main Duties of any occupation which his or her training, education or experience will reasonably allow; or is unable to perform such duties full-time; and
 - b. is engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means the Insured Employee is working at his or her Own Occupation or any other occupation; however, because of a Partial Disability:

1. the Insured Employee's hours or production is reduced;
2. one or more Main Duties of the job are reassigned; or
3. the Insured Employee is working in a lower-paid occupation.

During Partial Disability Employment, his or her current earnings:

1. must be at least 20% of Predisability Income; and
2. may not exceed the percentage specified in the Partial Disability Benefit section.

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. He or she must be qualified to provide Medically Appropriate Treatment for the Insured Employee's disabling condition.

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

1. the Insured Employee's spouse, siblings, parents, children and grandparents; and
2. his or her spouse's relatives of like degree.

POLICY means this group insurance Policy issued by the Company to the Policyholder.

POLICYHOLDER means the person, company, trust or other organization as shown on the Face Page of the Policy.

PREDISABILITY INCOME—See Basic Monthly Earnings definition.

REGULAR CARE OF A PHYSICIAN or **REGULAR ATTENDANCE OF A PHYSICIAN** means the Insured Employee:

1. personally visits a Physician, as often as medically required according to standard medical practice to effectively manage and treat his or her disabling condition; and
2. receives Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION—See Own Occupation or Regular Occupation definition.

DEFINITIONS
(Continued)

RESIDUAL DISABILITY or **RESIDUALLY DISABLED** means that, due to Sickness or Injury, the Insured Employee is:

1. unable to perform one or more of the Main Duties of his or her Own Occupation, or is unable to perform such duties on a Full-Time Basis (or as long as it would normally take to do them); and
2. is engaged in Residual Disability Employment.

RESIDUAL DISABILITY EMPLOYMENT means the Insured Employee is working at his or her Own Occupation or any other occupation; however, because of a Residual Disability:

1. the Insured Employee's hours or production is reduced;
2. one or more Main Duties of the job are reassigned; or
3. the Insured Employee is working in a lower-paid occupation.

During Residual Disability Employment, his or her current earnings:

1. must be at least 20% of Predisability Income; and
2. may not exceed the percentage specified in the Residual Disability Benefit section.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:

1. is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
2. does not represent contributions made by an Insured Employee (Payments representing Employee contributions are deemed to be received over the Insured Employee's expected remaining life, regardless of when they are actually received.); and
3. is payable upon:
 - a. early or normal retirement; or
 - b. disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:

1. provides Retirement Benefits to Employees; and
2. is not funded wholly by Employee contributions.

The term shall **not** include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation; or that part of any Retirement Plan funded by Employee contributions.

An Employer's Retirement Plan is deemed to include any Retirement Plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
2. for which the Insured Employee is eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

1. is established and maintained by the Employer for the benefit of Employees; and
2. continues payment of all or part of an Insured Employee's Predisability Income for a specified period after he or she becomes Disabled.

It does **not** include compensation the Employer pays an Insured Employee for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL COVERED PAYROLL means the total amount of Basic Monthly Earnings for all Employees insured under the Policy.

DEFINITIONS
(Continued)

TOTAL DISABILITY or **TOTALLY DISABLED** will be defined as follows.

1. During the Elimination Period and Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee is unable to perform all of the Main Duties of his or her Own Occupation.
2. After the Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee is unable to perform all of the Main Duties of any occupation which his or her training, education, experience, or physical or mental capacity will reasonably allow.

The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time an Employee must be employed in an eligible class with the Employer, before he or she becomes eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:

1. the Policy and any amendments to it;
2. the Policyholder's application (a copy of which is attached to the Policy);
3. any Participating Employers' applications or Participation Agreements; and
4. any individual applications of the Insured Employees.

In the absence of fraud, all statements made by the Policyholder and by Insured Employees are representations and not warranties. No statement made by an Insured Employee will be used to contest the coverage provided by the Policy, unless:

1. it is contained in a written statement signed by that Insured Employee; and
2. a copy of the statement has been furnished to that Insured Employee.

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 Employee, after his or her coverage 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 coverage.

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

1. an Insured Employee incurs a claim during the first two years of coverage; and
2. the Company discovers that the Insured Employee 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 the Insured Employee's claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENTS OF FACTS. If relevant facts about any person 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 an Insured Employee's age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

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

CURRENCY. In administering the Policy:

1. all Predisability Income will be expressed in U.S. dollars; and
2. 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 disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Certificate may not be assigned.

CLAIMS PROCEDURES

NOTICE OF CLAIM. Written notice of claim must be given during the Elimination Period. The notice must be sent to the Company's Group Insurance Service Office. It should include:

1. the Insured Employee's name and address; and
2. the number of the Policy.

If this is not possible, written notice must be given as soon as it is reasonably possible.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms to the Insured Employee. If the Company does not send the forms within 15 days, the Insured Employee may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send the Insured Employee additional claim forms.

PROOF OF CLAIM. The Company must be given written proof of claim within 90 days after the end of the Elimination Period. When it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason, if the proof is filed:

1. as soon as reasonably possible; and
2. in no event later than one year after it was required.

These time limits will not apply while an Insured Employee lacks legal capacity.

Proof of claim must be provided at the Insured Employee's own expense. It must show the date the Disability began, its cause and degree. Documentation must include:

1. completed statements by the Insured Employee and the Employer;
2. a completed statement by the attending Physician, which must describe any restrictions on the Insured Employee's performance of the duties of his or her Regular Occupation;
3. proof of any other income received;
4. proof of any benefits available from other income sources, which may affect Policy benefits;
5. a signed authorization for the Company to obtain more information; and
6. any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

EXAMINATION. The Company may have the Insured Employee examined:

1. by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
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 Insured Employee has:

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.

TIME OF PAYMENT OF CLAIMS. Benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

1. Any benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month, they will be paid on a pro rata basis. The daily rate will equal 1/30 of the Monthly Benefit.
2. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

CLAIMS PROCEDURES
(Continued)

TO WHOM PAYABLE. All benefits are payable to the Insured Employee, while living. After his or her death, benefits will be payable as follows.

1. Any Survivor Benefit will be payable in accord with that section.
2. Any other benefits will be payable to the Insured Employee's estate.

If a benefit becomes payable to:

1. the Insured Employee's estate; or
2. a minor or any other person who is not legally competent to give a valid receipt;

then up to \$2,000 may be paid to any relative of the Insured Employee that the Company finds entitled to payment. If payment is made in good faith to such a relative, the Company will not have to pay that benefit again.

NOTICE OF CLAIM DECISION. The Company will send the Insured Employee a written notice of its 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 the Insured Employee 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.

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 Insured Employee 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 Insured Employee 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: The Company may need more information from the Insured Employee to process a 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, the Insured Employee 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.

The Insured Employee may review certain non-privileged information relating to the request for review.

The Company will review the claim and send the Insured Employee a written notice of its decision. The notice will state 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, 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.

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.

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 Insured Employee a written delay notice, by the 30th day after receiving the request for review.

CLAIMS PROCEDURES (Continued)

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: The Company may need more information from the Insured Employee 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.

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 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 long-term disability claim, the Company has the right to recover the excess from one or more of the following:

1. the Insured Employee, or his or her estate;
2. the Beneficiary, or his or her estate; or
3. an insurance company or other organization which has been overpaid.

Such reimbursement is required whether the overpayment is due to:

1. the Company's error in processing a claim;
2. the Insured Employee's receipt of Other Income Benefits;
3. fraud, misrepresentation or omission of relevant facts; or
4. 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 Policyholder or Employer, the Company has the authority to manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:

1. establish administrative procedures, determine eligibility and resolve claims questions;
2. determine what information the Company reasonably requires to make such decisions; and
3. resolve all matters when an internal claim review is requested.

Any decision the Company makes in the exercise of its authority shall be conclusive and binding; subject to the Insured Employee's rights to request a state insurance department review or to bring legal action.

This provision does not apply to residents of California.

ELIGIBILITY

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Benefits. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

ELIGIBILITY DATE. An Employee becomes eligible for coverage provided by the Policy on the later of:

1. the Policy's date of issue; or
2. the date the Waiting Period is completed.

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 is rehired within one year after his or her employment ends; or
2. an Employee returns from an approved Family or Medical Leave within:
 - a. the 12-week leave period required by federal law; or
 - b. any longer period required by a similar state law; or
3. an Employee returns from a Military Leave within the period required by federal USERRA law.

All other Policy provisions will apply.

Those Employees not employed with the Policyholder prior to the Policy Effective Date may apply for insurance and become covered in accord with the provisions outlined below.

EFFECTIVE DATES

EFFECTIVE DATE. An Employee's initial amount of coverage 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 the Employee becomes eligible for the coverage;
2. the date the Employee resumes Active Work, if not Actively at Work on the day he or she becomes eligible;
3. the date the Employee makes written application for coverage and signs:
 - a. a payroll deduction order, if the Employees pay any part of the Policy premium; or
 - b. an order to pay premiums from the Employee's Flexible Benefits Plan account, if premiums are paid through such an account; or
4. the date the Company approves the Employee's Evidence of Insurability, if required.

Any increased or additional coverage 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 Employee becomes eligible for the increase, if Actively at Work on that day;
2. the date the Insured Employee 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.

Any decrease will take effect on the day of the change, whether or not the Insured Employee is Actively at Work.

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted when:

1. an Employee makes written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
2. an Employee makes written application to enroll for coverage after he or she has requested:
 - a. to cancel insurance;
 - b. to stop payroll deductions for the insurance; or
 - c. to stop premium payments from the Flexible Benefits Plan account; or
3. coverage is elected after the Employee has caused insurance to lapse, by failing to pay the required premium when due.

EFFECTIVE DATES
(Continued)

EFFECTIVE DATE FOR CHANGE IN ELIGIBLE CLASS. An Insured Employee may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:

1. on the first day of the Insurance Month coinciding with or next following the date of the change;
2. except as stated in the Effective Date provision for increases or decreases.

REINSTATEMENT RIGHTS. If an Insured Employee's coverage terminates due to one of the following breaks in service, he or she will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

1. return from an approved Family or Medical Leave within:
 - a. the 12-week period required by federal law; or
 - b. any longer period required by a similar state law;
2. return from a Military Leave within the period required by federal USERRA law;
3. return from any other approved leave of absence within six months after the leave begins;
4. return within 12 months following a lay off; or
5. return within 12 months following termination of employment for any other reason.

To reinstate coverage, the Employee must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date the Insured Employee returns to Active Work.

If the above conditions are met, then:

1. the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
2. a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATION

INDIVIDUAL TERMINATION OF COVERAGE. An Insured Employee's coverage will terminate at 12:00 midnight on the earliest of:

1. the date the Policy or the Employer's participation terminates; but without prejudice to any claim incurred prior to termination;
2. the date the Insured Employee's Class is no longer eligible for insurance;
3. the date such Insured Employee ceases to be a member of an Eligible Class;
4. the last day of the Insurance Month in which the Insured Employee requests termination;
5. the last day of the Insurance Month for which premium payment is made on the Insured Employee's behalf;
6. the end of the period for which the last required premium has been paid;
7. with respect to a particular insurance benefit, the date the portion of the Policy providing that benefit terminates;
8. the date on which the Insured Employee's employment with the Employer terminates; unless coverage is continued as provided below; or
9. the date the Insured Employee enters the 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 Insured Employee sends proof of military service, the Company will refund any unearned premium.)

CONTINUATION RIGHTS. Ceasing Active Work results in termination of the Insured Employee's eligibility for insurance, but coverage may be continued as follows.

1. **Disability.** If an Insured Employee is absent due to Total Disability, or is engaged in Partial Disability Employment, coverage may be continued during:
 - a. the Elimination Period; provided the Company receives the required premium from the Employer; and
 - b. the period for which benefits are payable, without payment of premium.Premium payments will be waived from the satisfaction of the Elimination Period until the end of the period for which benefits are payable. If coverage is to be continued following a period for which premiums were waived, premium payments must be resumed, as they become due.
2. **Family or Medical Leave.** If an Insured Employee goes on an approved Family or Medical Leave, and is **not** entitled to the more favorable continuation available during Disability, coverage may be continued, until the earliest of:
 - a. the end of the leave period approved by the Employer;
 - b. the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
 - c. the date the Insured Employee notifies the Employer that he or she will not return; or
 - d. the date the Insured Employee begins employment with another employer.The required premium payments must be received from the Employer, throughout the period of continued coverage.
3. **Military Leave.** If an Insured Employee goes on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.
4. **Lay-off or Other Leave.** When an Insured Employee ceases work due to a temporary 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 Employer, throughout the period of continued coverage.

**INDIVIDUAL TERMINATION
(Continued)**

Conditions. In administering the above continuation, the Employer must not act so as to discriminate unfairly among Employees in similar situations. Insurance may **not** be continued when an Insured Employee ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of an Insured Employee's coverage during a Disability will have no effect on benefits payable for that period of Disability.

TOTAL DISABILITY MONTHLY BENEFIT

BENEFIT. The Company will pay a Total Disability Monthly Benefit to an Insured Employee, after the completion of the Elimination Period, if he or she:

1. is Totally Disabled;
2. becomes Disabled while insured for this benefit;
3. is under the Regular Care of a Physician; and
4. at his or her own expense, submits proof of continued Total Disability and Physician's care to the Company upon request.

The Total Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Totally Disabled or dies;
2. the date the Maximum Benefit Period ends; or
3. the date the Insured Employee is able, but chooses not to engage in Partial/Residual Disability Employment:
 - a. in his or her Own Occupation, during the Own Occupation Period; or
 - b. in any occupation, after the Own Occupation Period.

Proportional benefits will be paid for a partial month of Total Disability.

At the Company's option, Total Disability Monthly Benefit payments may also be denied or suspended on any of the following dates:

1. the date the Insured Employee (without good cause):
 - a. fails to take a required medical exam;
 - b. fails to cooperate with the examiner; or
 - c. postpones a required exam more than twice;
2. the 45th day after the Company mails a request for additional proof, if not given; or
3. the 45th day after the Company mails a request for proof of the Insured Employee's application for any Other Income Benefits to which he or she may be entitled, if not given.

AMOUNT. The amount of the Total Disability Monthly Benefit equals:

1. the Insured Employee's Basic Monthly Earnings multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
2. Other Income Benefits.

The amount of the Total Disability Monthly Benefit will not be less than the Minimum Monthly Benefit, unless the Minimum Monthly Benefit plus Other Income Benefits would exceed 100% of the Insured Employee's Basic Monthly Earnings.

The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

RESIDUAL DISABILITY MONTHLY BENEFIT

BENEFIT. The Company will pay a Residual Disability Monthly Benefit to an Insured Employee, after completion of the Elimination Period, if he or she:

1. is Disabled;
2. becomes Disabled while insured for this benefit;
3. is engaged in Residual Disability Employment;
4. is earning at least 20% of Predisability Income when Residual Disability Employment begins;
5. is under the Regular Care of a Physician; and
6. at his or her own expense, submits proof of continued Residual Disability, Physician's care and reduced earnings to the Company upon request.

The Insured Employee does not have to be Totally Disabled prior to receiving Residual Disability Monthly Benefits. The Elimination Period may be satisfied by days of Total Disability, Residual Disability or any combination of these.

The Residual Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Residually Disabled or dies;
2. the date the Maximum Benefit Period ends;
3. the date the Insured Employee earns more than:
 - a. 99% of Predisability Income, until Residual Disability Monthly Benefits have been paid for 24 months for the same period of Disability; or
 - b. 85% of Predisability Income, after Residual Disability Monthly Benefits have been paid for 24 months for the same period of Disability;
4. the date the Insured Employee is able, but chooses not to work full-time:
 - a. in his or her Own Occupation, during the Own Occupation Period; or
 - b. in any occupation, after the Own Occupation Period.

Proportional benefits will be paid for a partial month of Residual Disability.

At the Company's option, Residual Disability Monthly Benefit payments may also be denied or suspended on any of the following dates:

1. the date the Insured Employee (without good cause):
 - a. fails to take a required medical exam;
 - b. fails to cooperate with the examiner; or
 - c. postpones a required exam more than twice;
2. the 45th day after the Company mails a request for additional proof, if not given; or
3. the 45th day after the Company mails a request for proof of the Insured Employee's application for any Other Income Benefits to which he or she may be entitled, if not given.

RESIDUAL DISABILITY MONTHLY BENEFIT
(Continued)

PROGRESSIVE CALCULATION METHOD. The Residual Disability Monthly Benefit is determined using the Progressive Calculation Method. This means the Residual Disability Monthly Benefit will replace the Insured Employee's Lost Income; provided it does not exceed the Total Disability Monthly Benefit, which would otherwise be payable during Total Disability without the Residual Disability Employment.

BENEFIT AMOUNT. The amount of the Residual Disability Monthly Benefit will equal the lesser of A or B below.

- A. **LOST INCOME:** The Insured Employee's Predisability Income, minus all Other Income Benefits (including earnings from Residual Disability Employment).

- B. **TOTAL DISABILITY MONTHLY BENEFIT** otherwise payable:
 - 1. The Insured Employee's Predisability Income multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
 - 2. Other Income Benefits, except for earnings from Residual Disability Employment.

The Residual Disability Monthly Benefit will never be less than the Minimum Monthly Benefit; except when the Minimum Monthly Benefit plus benefits received under Worker's Compensation and/or wage loss replacement benefits under the Pennsylvania Motor Vehicle Financial Responsibility Law would equal or exceed 100% of Predisability Income.

The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

Progressive Calculation
of Residual Disability Benefit

OTHER INCOME BENEFITS

OTHER INCOME BENEFITS means benefits, awards, settlements or Earnings from the following sources. These amounts will be offset, in determining the amount of the Insured Employee's Monthly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Monthly Benefit is payable under the Policy.

Workers' Compensation. Any benefits for which the Insured Employee is eligible under a law that compensates for job related Injury or Sickness. This includes:

1. any Workers' Compensation or occupational disease law;
2. the Jones Act;
3. the Longshoreman's and Harbor Worker's Act;
4. the Maritime Doctrine of Maintenance, Wages or Cure; or
5. any plan provided in place of one of the above plans.

It includes any benefits for partial or total disability, whether temporary or permanent. It also includes any benefits for vocational rehabilitation.

Other Compulsory Benefits. Any disability income benefits the Insured Employee is eligible to receive under any other compulsory benefit act or law. This includes (but is not limited to):

1. state temporary disability income benefit laws;
2. state no fault auto insurance laws; or
3. any other compulsory benefit act or law.

Other Insurance Plans. Any disability income benefits for which the Insured Employee is eligible under:

1. any other group insurance plan (except credit or mortgage insurance); or
2. any no fault auto plan.

Employee Benefit Plans. Any disability income benefits for which the Insured Employee is eligible under the Employer's Sick Leave or Salary Continuance Plan. This does **not** include vacation pay, severance pay or pay for work actually performed during a Disability.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits the Insured Employee receives under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:

1. **disability benefits** for which the Insured Employee is eligible; and for which any spouse or child is eligible, because of the Insured Employee's Disability;
2. **unreduced retirement benefits** for which the Insured Employee is eligible; and for which any spouse or child is eligible, because of the Insured Employee's eligibility for unreduced retirement benefits; or
3. **reduced retirement benefits** actually received by the Insured Employee; and by any spouse or child, because of the Insured Employee's receipt of reduced retirement benefits.

As used above, "**Government Retirement Plans**" include disability and retirement benefits under:

1. the federal Social Security Act, Jones Act or Railroad Retirement Act;
2. the Canada Pension Plan or Quebec Pension Plan;
3. any similar plan or act of any country, state, province or other political unit; or
4. any plan provided in place of one of the above plans.

OTHER INCOME BENEFITS (Continued)

"Earnings", as used in this provision, means pay the Insured Employee earns or receives from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:

1. salaried or hourly Employee's gross earnings (shown on Form W-2); including:
 - a. wages, tips, commissions, bonuses and overtime pay; and
 - b. any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
2. proprietor's net profit (figured from Form 1040, Schedule C);
3. professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
4. partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
5. Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Monthly Benefit:

1. a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
2. reimbursement for hospital, medical or surgical expense;
3. reimbursement for attorney fees and other reasonable costs of claiming Other Income Benefits;
4. group credit or mortgage disability insurance benefits;
5. early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
6. any amounts under the Employer's Retirement Plan that:
 - a. represent the Insured Employee's contributions; or
 - b. are received upon termination of employment without being disabled or retired;
7. benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
8. vacation pay, holiday pay, or severance pay; or
9. disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES FOR OTHER INCOME BENEFIT OFFSETS. If the Insured Employee may be entitled to Other Income Benefits that affect Policy benefits, the following rules will apply.

Claiming Other Income Benefits. An Insured Employee who may be entitled to some Other Income Benefit is required to actively pursue it. For example, if benefits may be payable under the federal Social Security Act, the Insured Employee:

1. must apply for such benefits on a timely basis;
2. must file a request for reconsideration, if benefits are denied; and
3. must request a hearing before an Administrative Law Judge, if denied again (unless the Company waives this in writing).

An Employer whose Insured Employee may be entitled to Workers' Compensation or similar benefits is also required to cooperate in filing that claim. If the Insured Employee fails to pursue Other Income Benefits on a timely basis, the Company has the option to:

1. deny or suspend Monthly Benefits; or
2. reduce Monthly Benefits by an estimated amount.

OTHER INCOME BENEFITS
(Continued)

Estimating Offsets. While a claim for Social Security or other Government Retirement Plan benefits is pending, the Insured Employee must elect one of the following options in writing. (If no written election is made, Monthly Benefits will be reduced in accord with Option 1.)

1. **Reduced Monthly Benefits.** The Insured Employee may receive Monthly Benefits reduced by estimated Social Security or other Government Retirement Plan benefits. The Company will adjust Policy benefits and will refund any underpayment, in a lump sum, upon receiving proof of:
 - a. the amount actually awarded; or
 - b. the claim denial and completion of any appeal the Company requires.

2. **Unreduced Monthly Benefits.** The Insured Employee may receive unreduced Monthly Benefits while the claim is pending. He or she must agree in writing to promptly refund any overpayment that results, in a lump sum, upon receiving Social Security or other Government Retirement Plan benefits. If he or she does not promptly refund an overpayment:
 - a. the Company will reduce or eliminate future payments; and
 - b. the Minimum Monthly Benefit will not apply, until the amount is repaid.

Lump Sum Payments. Other Income Benefits that are paid in a lump sum will be pro rated as follows.

1. The lump sum will be pro rated on a monthly basis, over the time period for which it is given.
2. If no time period is stated, the Company will continue its estimated monthly offset for that benefit, until full amount is offset.
3. If no estimated monthly offset was being made for that benefit, the lump sum will be pro rated on a monthly basis over a reasonable time period. It will not exceed 60 months or the Maximum Benefit Period (whichever occurs first).

Cost-of-Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Monthly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY

"Recurrent Disability" means a Disability caused by an Injury or Sickness that is the same as, or related to, the cause of a prior Disability for which Monthly Benefits were payable. A Recurrent Disability will be treated as follows.

1. **New Disability.** A Recurrent Disability will be treated as a new Disability, if the Recurrent Disability begins after the Insured Employee returns to his or her Own Occupation with the Employer:
 - a. on a full-time basis working at least the Minimum Number of Hours Per Week as shown in the Schedule of Benefits; and
 - b. for six consecutive months or more following the date the prior Disability benefits ended.

A new Elimination Period must be completed before further Monthly Benefits become payable. A new Maximum Benefit Period will apply.

2. **Prior Disability.** A Recurrent Disability will be treated as part of the prior Disability, if the Recurrent Disability begins after the Insured Employee returns to his or her Own Occupation with the Employer:
 - a. on a full-time basis working at least the Minimum Number of Hours Per Week as shown in the Schedule of Benefits; but
 - b. for less than six consecutive months following the date the prior Disability benefits ended.

The completion of a new Elimination Period is not required before further Monthly Benefits become payable. The same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability. The Predisability Income used in determining the prior Disability benefit will apply as well.

In addition, a Recurrent Disability will be treated as a prior Disability if all of the subsequent events occur in less than six consecutive months following the date the prior Disability benefits end under the Policy:

- a. a job opening is not available for the Insured Employee to return to work with the Employer;
- b. the Insured Employee's coverage under the Policy terminates;
- c. the former Employee returns to his or her Own Occupation with a new employer on a full-time basis working at least the Minimum Number of Hours Per Week as shown in the Schedule of Benefits;
- d. benefits are not payable under any other group long-term disability plan; and
- e. a Recurrent Disability begins.

Benefits for the former Employee will be reinstated for the Recurrent Disability and the completion of a new Elimination Period will not be required before further Monthly Benefits become payable. The same Maximum Benefit Period, Exclusions, and Limitations will apply to the Recurrent Disability as to the prior Disability. The Predisability Income used in determining the prior Disability benefit will apply as well. Benefits reinstated under this provision are subject to the Policy's terms and conditions that were in effect at the time the prior Disability began.

To qualify for a Monthly Benefit, the Insured Employee or former Employee must earn less than the percentage of Predisability Income specified in the Partial Disability Monthly Benefit section. Monthly Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability.

PROGRESSIVE INCOME BENEFIT

EFFECTIVE DATE. An Insured Employee will become insured for the Progressive Income Benefit on:

1. the effective date of his or her coverage for Long Term Disability Benefits under the Policy; or
2. the effective date of this provision, if it is added later by amending the Policy.

Exception: The effective date will be delayed for an Insured Employee who is unable to perform one or more Activities of Daily Living or suffers from a Cognitive Impairment on that date. In that event, the Insured Employee will become insured for this benefit on the first day he or she:

1. is able to safely and completely perform all of the Activities of Daily Living without another person's active, hands-on help; or
2. no longer suffers from a Cognitive Impairment.

BENEFIT. After completion of the Elimination Period shown in the Schedule of Insurance, the Company will pay an additional monthly benefit to an Insured Employee; if he or she:

1. is receiving Total Disability or Partial Disability Monthly Benefits under the Policy; and
2. submits proof of suffering the Loss of Activities of Daily Living or a Cognitive Impairment (as defined below).

Proof must be submitted at the Insured Employee's own expense.

AMOUNT. The amount of the Progressive Income Benefit:

1. will equal 20% of the Insured Employee's Basic Monthly Earnings; but
2. will not exceed the Maximum Monthly Benefit for Long Term Disability Benefits, or \$5,000 per month (whichever is less).

The Maximum Monthly Benefit for Long Term Disability Benefits is shown in the Schedule of Insurance. The Progressive Income Benefit will not be reduced by any Other Income Benefits, or by earnings from any form of employment.

DURATION. This Progressive Income Benefit will cease on the earliest of:

1. the date the Insured Employee no longer suffers from the Loss of Activities of Daily Living or Cognitive Impairment (as defined below);
2. the date the Insured Employee is no longer entitled to Total Disability or Partial Disability Monthly Benefits under the Policy;
3. the date the Maximum Benefit Period ends; or
4. the date the Insured Employee dies.

If the Policy includes a Family Income Benefit, the amount paid to the Eligible Surviving Spouse or Children will not increase due to the Insured Employee's receipt of this Progressive Income Benefit.

DEFINITIONS

"Loss of Activities of Daily Living" means that, due to an Injury or Sickness, the Insured Employee has lost the ability to safely and completely perform **two or more** of the following six Activities of Daily Living without another person's active, hands-on help with all or most of the activity.

The six Activities of Daily Living are:

1. **Bathing** - washing self in a tub, in a shower or by sponge bath; with or without equipment.
2. **Dressing** - putting on, taking off, fastening or unfastening garments, any medically necessary braces, or any artificial limbs normally worn.
3. **Toileting** - getting to, from, on and off toilet and performing related personal hygiene.
4. **Transferring** - moving in and out of bed, chair or any wheelchair; with or without equipment such as canes, walkers, crutches, grab bars, other support devices, or mechanical or motorized devices.
5. **Continence** - voluntarily maintaining control of bladder and bowel function; or performing related personal hygiene, including care of any catheter or colostomy bag, if not continent.
6. **Eating** - once food is prepared and made available, getting nourishment into one's body by any means. This includes eating from a table, tray or container (such as a bowl or cup); or using special equipment (such as a feeding tube or intravenous tube).

PROGRESSIVE INCOME BENEFIT
(Continued)

"Cognitive Impairment" means that due to an Injury or Sickness, the Insured Employee:

1. has suffered a permanent deterioration or loss of cognitive or intellectual capacity; and
2. requires another person's active, hands-on help or verbal cues to prevent harm to self or others, due to that impairment.

The impairment must be diagnosed by a Physician, based upon clinical evidence and reliable standardized tests of short or long-term memory; orientation as to person, place and time; and deductive or abstract reasoning. It may result from moderate to severe head trauma, stroke, Alzheimer's disease or other form of irreversible dementia.

"Mental Sickness," as used in this provision, means any emotional, behavioral, psychological, personality, adjustment, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome; regardless of its cause. It includes, but is not limited to:

1. schizophrenia or schizoaffective disorder;
2. bipolar affective disorder, manic depression, or other psychosis; and
3. obsessive-compulsive, depressive, panic or anxiety disorders.

These conditions are usually treated by a psychiatrist, a clinical psychologist or other qualified mental health care provider. Treatment usually involves psychotherapy, psychotropic drugs or similar methods of treatment.

Mental Sickness does **not** include irreversible dementia resulting from stroke; trauma; viral infection; Alzheimer's disease; or other conditions which are not usually treated by a mental health care provider using psychotherapy, psychotropic drugs, or similar methods of treatment.

"Pre-Existing Condition," as used in this provision, means a Sickness or Injury for which the Insured Employee received treatment within 3 months prior to his or her effective date for this benefit. Treatment includes a Physician's consultation, care and services; diagnostic measures; and the prescription, refill or taking of prescribed drugs or medicines.

EXCLUSIONS AND LIMITATIONS

Prior Disability. This benefit will not be payable during a period of Disability which begins before the Insured Employee's effective date of coverage under this benefit.

Pre-Existing Conditions. This benefit will not be payable for a Loss of Activities of Daily Living or Cognitive Impairment:

1. which is caused or contributed to by, or results from a Pre-Existing Condition (as defined above); and
2. which begins in the first 12 months after the Insured Employee's effective date under this benefit.

Mental Sickness and Substance Abuse. This benefit will not be payable during a period of Disability which is caused or contributed to by or results from a Mental Sickness, alcoholism, or voluntary use of a Controlled Substance; unless prescribed by a Physician. Controlled Substances are those defined as such in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and any amendments to it.

Other Provisions. This benefit will be subject to all of the Definitions, Exclusions, Proof of Claim, Waiver of Premium and other provisions of the Policy.

EXCLUSIONS

GENERAL EXCLUSIONS. The Policy will not cover any period of Total or Residual Disability:

1. due to war, declared or undeclared, or any act of war;
2. due to intentionally self-inflicted injuries;
3. due to active participation in a riot;
4. due to the Insured Employee's committing of or the attempting to commit a felony;
5. during which the Insured Employee is incarcerated for the commission of a felony;
6. during which the Insured Employee is not under the Regular Care of a Physician; or
7. after the Insured Employee has resided outside the United States or Canada for more than 12 consecutive benefit months for purposes other than employment with the Employer.

PRE-EXISTING CONDITION EXCLUSION. The Policy will not cover any Total or Residual Disability:

1. which is caused or contributed to by, or results from a Pre-Existing Condition; and
2. which begins in the first 12 months after the Insured Employee's Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which the Insured Employee received medical advice or treatment within 3 months prior to the Insured Employee's Effective Date.

SPECIFIED INJURIES OR SICKNESSES LIMITATION

LIMITATION. If an Insured Employee is Disabled primarily due to one or more of the Specified Injuries or Sicknesses defined below; then Partial or Total Disability Monthly Benefits:

1. will be payable subject to the terms of the Policy; but
2. will be limited to 24 months for any one period of Disability; unless the Insured Employee is confined to a Hospital.

"Specified Injuries or Sicknesses" include any Mental Sickness, as defined below.

CONDITIONS

1. If the Insured Employee is confined in a Hospital at the end of the 24th month for which Policy benefits are paid for the Specified Injury or Sickness; then benefits will be payable until he or she is discharged from that facility.
2. In no event will the Monthly Benefit be paid beyond the Maximum Benefit Period shown in the Schedule of Insurance, however.

DEFINITIONS

"Hospital," as used in this provision, means:

1. a general hospital which:
 - (a) is licensed, approved or certified by the state where it is located;
 - (b) is recognized by the Joint Commission on the Accreditation of Hospitals; or
 - (c) is operated to treat resident inpatients; has a registered nurse always on duty; and has a lab, x-ray facility and place where major surgery is performed; and
2. a skilled nursing care facility or unit, which provides convalescent or nursing care; and which is recognized as a skilled nursing care facility under Medicare.

The term Hospital also includes:

1. a Mental Hospital when treatment is for a Mental Sickness.

"Mental Hospital" means a health care facility (or its psychiatric unit) which:

1. is licensed, certified or approved as a mental hospital by the state where it is located;
2. is equipped to treat resident inpatients' mental diseases or disorders; and
3. has a resident psychiatrist on duty or on call at all times.

"Mental Sickness" means any emotional, behavioral, psychological, personality, adjustment, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome; regardless of its cause. It includes, but is not limited to:

1. schizophrenia or schizoaffective disorder;
2. bipolar affective disorder, manic depression, or other psychosis; and
3. obsessive-compulsive, depressive, panic or anxiety disorders.

These conditions are usually treated by a psychiatrist, a clinical psychologist or other qualified mental health care provider. Treatment usually involves psychotherapy, psychotropic drugs or similar methods of treatment.

Mental Sickness does **not** include irreversible dementia resulting from:

1. stroke, trauma, viral infection, Alzheimer's disease; or
2. other conditions which are not usually treated by a mental health care provider using psychotherapy, psychotropic drugs, or similar methods of treatment.

VOLUNTARY VOCATIONAL REHABILITATION BENEFIT PROVISION

BENEFIT. If an Insured Employee is Disabled and is receiving Policy benefits; then he or she may be eligible for a Vocational Rehabilitation Benefit. This Benefit consists of services which may include:

1. vocational evaluation, counseling, training or job placement;
2. job modification or special equipment; and
3. other services which the Company deems reasonably necessary to help the Insured Employee return to work.

The Company will determine the Insured Employee's eligibility and the amount of any Benefit payable.

ELIGIBILITY. An Insured Employee may be eligible for this Benefit, if the Company finds that he or she:

1. has a Disability that prevents the performance of his or her regular occupation; and, after the Own Occupation Period, also lacks the skills, training or experience needed to perform any other gainful occupation;
2. has the physical and mental abilities needed to complete a Program; and
3. is reasonably expected to return to work after completing the Program; in view of his or her degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under the Insured Employee's health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. Either the Company, the Insured Employee, or his or her Physician may first propose vocational rehabilitation. When a Program is approved by the Company, the Policy's definition of "Disability" will be waived during the rehabilitation period; but it will be reapplied after the Program ends. The Company will determine the amount and duration of any Long Term Disability benefits payable after the Program ends.

DEFINITION

"Program" means a written vocational rehabilitation program:

1. which the Company develops with input from the Insured Employee; his or her Physician; and any current or prospective employer, when appropriate; and
2. which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

PRIOR INSURANCE CREDIT UPON TRANSFER OF INSURANCE CARRIERS

To prevent loss of coverage for an Employee because of a transfer of insurance carriers, the Policy will provide Prior Insurance Credit for employees insured under the prior carrier's policy on its termination date as follows.

FAILURE TO BE ACTIVELY-AT-WORK DUE TO INJURY OR SICKNESS. Subject to premium payments, the Policy will provide coverage to an Employee:

1. who was insured by the prior carrier's policy at the time of transfer; and
2. who was not Actively-At-Work due to Injury or Sickness on the Policy's Effective Date.

The coverage will be that provided by the prior carrier's policy, had it remained in force. The Company will pay:

1. the benefit that the prior carrier would have paid; minus
2. any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a Total Disability due to a Pre-Existing Condition for an Employee who:

1. was insured by the prior carrier's policy at the time of transfer; and
2. was 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 the Insured Employee qualifies for benefits, such Insured Employee will be paid according to the Policy's benefit schedule.
2. If the Insured Employee cannot satisfy the Policy's Pre-Existing Condition Exclusion, but can satisfy the prior carrier's pre-existing condition exclusion giving consideration towards 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) the Policy without applying the Pre-Existing Condition Exclusion; or
 - (b) the prior carrier's policy;whichever is less.
3. If the Insured Employee cannot satisfy the Pre-Existing Condition Exclusion of the Policy or that of the prior carrier, no benefit will be paid.

FAMILY INCOME BENEFIT

The Company will pay a lump sum benefit to the Eligible Survivor when proof is received that an Insured Employee died:

1. after Disability had continued for 180 or more consecutive days; and
2. while receiving a Monthly Benefit.

The benefit will be equal to three times the Insured Employee's Last Monthly Benefit.

"Last Monthly Benefit" means the gross Monthly Benefit which:

1. was payable to the Insured Employee immediately prior to death; or
2. would have been payable to the Insured Employee had he or she survived until the end of the 30-day benefit period in which death occurred.

Any reductions for Other Income Benefits, or for earnings from Partial Disability Employment, will not apply.

"Eligible Survivor" means the Insured Employee's:

1. surviving spouse; or, if none
2. surviving children who are under age 25 on the Insured Employee's date of death.

If payment becomes due to the Insured Employee's surviving children; then payment will be made:

1. in equal shares to the children; or their legal or court appointed guardian, if any; or
2. to the Insured Employee's estate on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, the children.

Three Month Survivor Benefit

RETIREMENT PROTECTION BENEFIT

EFFECTIVE DATE. The Retirement Protection Benefit will take effect on the later of:

1. the effective date of the Insured Employee's coverage for Long Term Disability Benefits under the Policy; or
2. the effective date of this provision, if it is added later by amending the Policy.

BENEFIT. The Company will pay a monthly Retirement Protection Benefit while an Insured Employee:

1. is Totally Disabled or Partially Disabled; and
2. receives a Total Disability or Partial Disability Monthly Benefit under the Policy.

To qualify, the Insured Employee must have been contributing to an Employer Sponsored Qualified Plan for a minimum of three consecutive months prior to the date of Total or Partial Disability.

AMOUNT. The monthly Retirement Protection Benefit amount will be based on a percentage of the Insured Employee's Basic Monthly Earnings. The Retirement Benefit Percentage is shown in the Schedule of Insurance.

If an Insured Employee is Totally Disabled, the benefit amount will equal the Retirement Benefit Percentage multiplied by the Insured Employee's Basic Monthly Earnings.

If an Insured Employee is Partially Disabled, the benefit amount will equal the Retirement Benefit Percentage multiplied by the Insured Employee's Basic Monthly Earnings and then pro-rated based upon the amount of the Partial Disability Benefit the Insured Employee receives for that month.

PAYMENT OPTIONS. The Insured Employee may choose to have the benefit paid:

1. to the Employer for deposit to the Employer Sponsored Qualified Plan for the benefit of the Insured Employee, provided the Insured Employee is eligible to contribute to the plan;
2. to a non-qualified annuity then issued by the Company at the time application for such annuity is made; or
3. to an annuity or trust designated by the Insured Employee upon making a written request to the Company.

If the Insured Employee chooses Option 1 above, the Employer is responsible for determining the Insured Employee's eligibility to contribute to the Employer Sponsored Qualified Plan. When the Insured Employee's eligibility under the Employer Sponsored Qualified Plan ends while still receiving a Disability Monthly Benefit, he or she may choose one of the remaining options above by making a written request to the Company.

The Insured Employee should consult with a tax advisor before choosing any payment option.

DURATION. This Retirement Protection Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be an eligible participant in the Employer Sponsored Qualified Plan and does not have a non-qualified annuity issued by the Company or an alternate annuity or trust in which payments may be applied;
2. the date the Insured Employee is no longer entitled to a Total Disability or Partial Disability Monthly Benefit under the Policy;
3. the date the Maximum Benefit Period under the Policy ends; or
4. the date the Insured Employee dies.

EXCLUSIONS AND LIMITATIONS

Prior Disability. This benefit will not be payable during a period of Total Disability or Partial Disability which begins before the Insured Employee's effective date of coverage under the Policy or before the effective date of this Retirement Protection Benefit provision, if added later by amending the Policy.

Pre-Existing Condition Limitation. This benefit will not be payable for any Total Disability or Partial Disability which:

1. is caused or contributed to by, or results from a Pre-Existing Condition (as defined in this provision); and
2. begins in the first 12 months after the Insured Employee's effective date under this provision.

**RETIREMENT PROTECTION BENEFIT
(Continued)**

Prior Insurance Credit. Prior Insurance Credit will be applied toward satisfying the Pre-Existing Condition Limitation under this Retirement Protection Benefit provision if a similar benefit was included under the Employer's prior group long term disability plan in which the Insured Employee was covered on the date prior to the effective date of this provision.

DEFINITIONS, as used in this provision.

"Employer Sponsored Qualified Plan" includes, but is not limited to, a 401(k), 403(b), 457, Money Purchase Plan, Profit Sharing Plan, ESOP, or Stock Plan. It does not include an individual retirement account (IRA) or a non-qualified plan of deferred compensation.

"Pre-Existing Condition" means a Sickness or Injury for which the Insured Employee received Treatment within 3 months prior to the Insured Employee's effective date under this Retirement Protection Benefit provision.

"Treatment" means consultation, care or services provided by a Physician. It includes diagnostic measures and the prescription, refill of prescription, or taking of any prescribed drugs or medicines.

OTHER PROVISIONS. Unless stated otherwise, this benefit will be subject to all the Definitions, Exclusions, Claims Procedures, Waiver of Premium and other provisions of the Policy.

FAMILY CARE EXPENSE BENEFIT

BENEFIT. The Company will reimburse an Insured Employee's Family Care Expenses as described below, while he or she is:

1. receiving a Partial Disability Monthly Benefit under the Policy; or
2. receiving a Total Disability Benefit under the Policy, and:
 - a. is Terminally Ill;
 - b. has suffered a Cognitive Impairment; or
 - c. has suffered a Loss of Activities of Daily Living.

The Family Care Expense Benefit is paid in addition to all other Policy benefits and will not be offset by Other Income Benefits.

PROOF. The Insured Employee must submit to the Company satisfactory proof that a Family Care Expense has been incurred for a Dependent and paid by the Insured Employee. Proof must be submitted on a monthly basis. Satisfactory proof is a signed receipt from the Dependent care provider showing:

1. Dependent name;
2. Dependent age;
3. if Dependent age exceeds the maximum shown in definition of "Dependent" below, reason for care;
4. dates of care;
5. total charges for care;
6. total payments for care; and
7. provider name, address, telephone number, and Federal Employer Identification Number/Taxpayer Identification Number.

AMOUNT. The Family Care Expense Benefit will equal actual Family Care Expenses paid by the Insured Employee that are not reimbursable from other sources, up to \$250 per month for each eligible Dependent.

DURATION. The Family Care Expense Benefit will cease on the earliest of:

1. the date the Insured Employee's Total or Partial Disability Benefits under the Policy cease;
2. the date an Insured Employee's Dependents no longer meet the definition of Dependent in this provision; or
3. the date the Company has made 12 monthly Family Care Expense Benefit payments.

DEFINITIONS.

"Child" includes the Insured Employee's naturally born child, legally adopted child, stepchild, foster child, or child for whom the Insured Employee is the legal guardian.

"Cognitive Impairment" means that the Insured Employee or Dependent:

1. has suffered a permanent deterioration or loss of cognitive or intellectual capacity; and
2. requires another person's active, hands-on help or verbal cues to prevent harm to self or others, due to that impairment.

The impairment must be diagnosed by a Physician, based upon clinical evidence and reliable standardized tests of short or long-term memory; orientation as to person, place and time; and deductive or abstract reasoning. It may result from moderate to severe head trauma, stroke, Alzheimer's disease or other form of irreversible dementia.

**FAMILY CARE EXPENSE BENEFIT
(Continued)**

"Dependent" means the Insured Employee's:

1. legal spouse, who is:
 - a. living with the Insured Employee; and
 - b. Incapable of Independent Living due to a mental or physical condition;
2. Child less than age 16;
3. unmarried Child age 16 years or older, who is:
 - a. living with the Insured Employee; and
 - b. Incapable of Independent Living due to a mental or physical condition; or
4. parent or parent-in-law, who is:
 - a. living with the Insured Employee; and
 - b. Incapable of Independent Living due to a mental or physical condition.

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

1. is not a member of the Insured Employee's immediate family; and
2. is not living in the Insured Employee's home.

"Incapable of Independent Living" means the Dependent:

1. is Terminally Ill;
2. suffers a Cognitive Impairment; or
3. suffers a Loss of Activities of Daily Living.

"Loss of Activities of Daily Living" means that the Insured Employee or Dependent has lost the ability to safely and completely perform **two or more** of the following six Activities of Daily Living without another person's active, hands-on help with all or most of the activity.

The six Activities of Daily Living are:

1. **Bathing** - washing self in a tub, in a shower or by sponge bath; with or without equipment.
2. **Dressing** - putting on, taking off, fastening or unfastening garments, any medically necessary braces, or any artificial limbs normally worn.
3. **Toileting** - getting to, from, on and off toilet and performing related personal hygiene.
4. **Transferring** - moving in and out of bed, chair or any wheelchair; with or without equipment such as canes, walkers, crutches, grab bars, other support devices, or mechanical or motorized devices.
5. **Contenance** - voluntarily maintaining control of bladder and bowel function; or performing related personal hygiene, including care of any catheter or colostomy bag, if not continent.
6. **Eating** - once food is prepared and made available, getting nourishment into one's body by any means. This includes eating from a table, tray or container (such as a bowl or cup); or using special equipment (such as a feeding tube or intravenous tube).

"Terminally Ill" means the Insured Employee or Dependent has a medical condition which is expected to result in death in 6 months or less, despite appropriate medical treatment.

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

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association (“the Association”). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

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

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to \$300,000 (or \$500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

o Up to \$300,000 in death benefits including up to \$100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to \$500,000 for health benefit plans, with some exceptions.
- Up to \$300,000 for disability income benefits.
- Up to \$300,000 for long-term care insurance benefits.
- Up to \$100,000 for all other types of health insurance.

Individual annuities

- Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;

- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

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

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
 Guaranty Association
 290 King of Prussia Road
 Radnor Station Building 2, Suite 218
 Radnor, PA 19087
 (610) 975-0572

Pennsylvania Insurance Department
 1209 Strawberry Square
 Harrisburg, PA 17120
 1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. We do not sell your personal information to third parties. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

Information We May Collect And Use

We collect personal information about you to help us identify you as a consumer, our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; to analyze in order to enhance our products and services; to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on your relationship and on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history. We may also collect voice recordings or biometric data for use in accordance with applicable law.
- **Information about your transactions:** We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.
- **Information from outside our family of companies:** If you are applying for or purchasing insurance products, we may collect information from consumer reporting agencies, such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information, from other individuals or businesses.
- **Information from your employer:** If your employer applies for or purchases group products from us, we may obtain information about you from your employer or group representative in order to enroll you in the plan.

How We Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you, your employer, or your group representative have requested; to provide customer service; to analyze in order to enhance our products and services; to gain customer insight; and to inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers), regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your Rights Regarding Your Personal Information

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy electronically or by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

Accounting of Disclosures: If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions;
- Included in a limited data set; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than six years from the date of your request.

Basis for Adverse Underwriting Decision: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

If you would like to act upon your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial Group, Attn: Corporate Privacy Office, 7C-01, 1300 S. Clinton St., Fort Wayne, IN 46802. The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice. For general account service requests or inquiries, please call 1-877-ASK-LINC.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company
Lincoln Investment Advisors Corporation

Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company