

# The Lincoln National Life Insurance Company

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

CERTIFIES THAT Group Policy No. GL 000400003002-02475 has been issued to  
The Commerce Trust Company as Trustee for The Lincoln National Life Insurance Company Voluntary  
Insurance Trust

The Issue Date is February 1, 2009 for the Participating Employer.

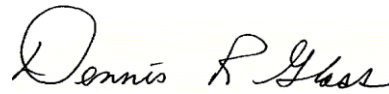
Participating Employer: Mountain Regional Services, Inc.

The insurance is effective only if the Employee is eligible for insurance and becomes and remains insured as provided in the Group Policy.

Certificate of Insurance for Class 1

The Employee is entitled to benefits described in this Certificate if the Employee is eligible for insurance under the provisions of the Policy and according to the records of the Employer.

This Certificate replaces any other certificate previously issued for the benefits described inside. As a Certificate of insurance, this does not constitute a contract of insurance, it summarizes the provisions of the Policy and is subject to the terms of the Policy

  
Dennis R. Glass  
President

**CERTIFICATE OF GROUP LONG TERM DISABILITY INSURANCE**

**SCHEDULE OF BENEFITS**

ELIGIBLE CLASS means: Class 1 All Full-Time Employees

MINIMUM HOURS PER WEEK: 30

**LONG-TERM DISABILITY BENEFITS**

WAITING PERIOD (For date insurance begins, refer to "Effective Dates" section)

- a. None for employees who were hired on or before the Policy Issue Date.
- b. 60 days of continuous Active Work for employees who were hired after the Policy Issue Date.

BENEFIT PERCENTAGE: 60%

MAXIMUM MONTHLY BENEFIT: \$3,000

MINIMUM MONTHLY BENEFIT: \$100 or 15% 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.

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 Condition):

<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.

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## DEFINITIONS

As used in the Policy, the following words and phrases shall have the meanings indicated:

**ACTIVE WORK** or **ACTIVELY-AT-WORK** means an Employee's full-time performance of all customary duties of such Employee's occupation at:

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

**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 Partial 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, whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

**DAY OR DATE** means the period of time which 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.

**DISABLED** or **DISABILITY** means Totally Disabled and/or Partially Disabled.

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

1. is payable under a Retirement Plan due to disability as defined in that plan; and
2. does not reduce the benefits which 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 shown in the Schedule of Benefits:

1. begins on the first day of Disability; and
2. is satisfied when the required number of days is accumulated within a period which does not exceed two times the Elimination Period.

Only days of Disability due to the same or a related Sickness or Injury will count towards the Elimination Period.

During a period of Disability, the Insured Employee may return to full-time work for an accumulated number of days not to exceed the Elimination Period. Such return to work may be at the Insured Employee's own or any other occupation. Exceptions are as follows:

1. If an Insured Employee becomes Disabled after a return to full-time work, at his or her own occupation, for a continuous period of six months or more; then:
  - (a) a new period of Disability will begin; and
  - (b) a new Elimination Period will be required;in accord with the Recurrent Disability provision.
2. If an Insured Employee becomes eligible for any other group long term disability insurance during the Elimination Period; then only continuous days of Disability will count towards that Elimination Period.

Days on which the Insured Employee returns to work on a full-time basis will not count towards the Elimination Period.

**EMPLOYEE** means a person:

1. whose employment with the Employer is:
  - (a) on a regular full-time basis;
  - (b) the person's principle occupation; and
  - (c) for regular wage or salary;
2. who is regularly scheduled to work at such occupation at least the minimum number of hours shown in the Schedule of Benefits;
3. who is a member of an Eligible Class which is eligible for coverage under the Policy; and
4. who is a permanent resident of the United States.

**EMPLOYER** means the Policyholder and includes any division, subsidiary or affiliated company named in the Application. It may also mean the Participating Employer shown on the Face Page of this Certificate.

**DEFINITIONS**  
**(continued)**

**FAMILY OR MEDICAL LEAVE** means a leave of absence which is approved in writing by the Employer; and which is subject to:

1. the federal Family and Medical Leave Act of 1993, and any amendments to it; or
2. any similar state law requiring the Employer to grant family or medical leaves.

It does not include a period of Disability which applies toward the Elimination Period; or for which Policy benefits are paid.

**HOSPITAL or INSTITUTION** means a facility licensed to provide care and treatment for the condition causing the Insured Employee's disability.

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

**INJURY** means bodily injury which is caused by and results directly from an accident, independently of all other causes. For purposes of determining benefits under the Policy, a Disability will be considered due to an Injury only if:

1. the Disability begins within 90 days after the Injury; and
2. the Injury occurred while the Employee was insured under the Policy.

The term "Injury" shall not include any:

1. condition to which a physical or mental sickness, the natural progression of a sickness, or the treatment of a sickness is a substantial contributing factor (based upon the preponderance of medical evidence);
2. condition caused solely by emotional stress or mental trauma;
3. repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time;
4. pregnancy; except for complications which result from a covered Injury;
5. condition caused by infection; except for a pyogenic bacterial infection of a covered Injury; or
6. condition caused by medical or surgical treatment; except when the treatment is needed solely because of a covered Injury.

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

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

**PARTIAL DISABILITY or PARTIALLY DISABLED** shall be as defined in the Partial Disability Monthly Benefit provision.

**DEFINITIONS**  
**(continued)**

PHYSICIAN means a medical practitioner who:

1. is a legally qualified Physician or surgeon (or is a professional person deemed by state law to be the same as a legally qualified physician); and
2. is acting within the lawful scope of his or her license.

Physician does not include a person who:

1. is the Insured Employee receiving treatment; or
2. is a relative of the Insured Employee receiving treatment.

POLICY means the Group Long Term Disability Insurance Policy issued by the Company to the Policyholder.

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

PREDISABILITY INCOME - See Basic Monthly Earnings definition.

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

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 Employee (payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments 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 which provides Retirement Benefits to Employees and which 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. 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 Employee is eligible as a result of employment with the Employer.

SICKNESS means illness, pregnancy or disease.

**DEFINITIONS**  
**(continued)**

TOTAL DISABILITY or TOTALLY DISABLED means that an Insured Employee, due to an Injury or Sickness is unable:

1. during the Elimination Period and the Own Occupation Period, to perform each of the main duties of the Insured Employee's regular occupation; and
2. after the Own Occupation Period, to perform each of the main duties of any gainful occupation for which the Insured Employee's training, education or experience will reasonably allow.

For Insured Employees employed as pilots, co-pilots or crew of aircraft, Total Disability or Totally Disabled means that the Insured Employee due to an Injury or Sickness is unable:

1. to perform the material and substantial duties of such Insured Employee's regular occupation; and
2. after benefits have been paid for 12 months, to perform the material and substantial duties of any gainful occupation for which the Insured Employee's training, education or experience will reasonably allow. The loss of a pilot's license for any reason does not, by itself, constitute Total Disability.

WAITING PERIOD means the period of time that begins with an Employee's most recent date of employment with the Employer and ends on the day prior to the day such Employee is eligible for coverage under the Policy.



## CLAIMS PROCEDURES

**NOTICE OF CLAIM.** Written notice of claim must be given within 20 days after the loss occurs, or by the end of the Elimination Period, if later. 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; then 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.

**EXAM OR AUTOPSY.** At anytime while a claim is pending, 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.

The Company may deny or suspend benefits for an Insured Employee who fails to attend an exam or to cooperate with the examiner, without good cause. The Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

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

1. Any Long Term Disability benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month; then 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.

**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.

## CLAIMS PROCEDURES (continued)

If a benefit becomes payable to the Insured Employee's estate, 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; then 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; then the written notice will explain:

1. the reason for the denial, under the terms of the Policy and any internal guidelines; and
2. how the Insured Employee may request a review of the Company's decision.

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.** If the Company needs more than 15 days to process the claim, due to matters beyond its control; then an extension will be permitted. If needed, the Company will send the Insured Employee a written delay notice:

1. by the 15<sup>th</sup> 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 resolve the claim; and
2. when a decision can be expected.

If the Insured Employee does not receive a written decision by the 105<sup>th</sup> day after the Company receives the first proof of claim; then there is a right to an immediate review, as if the claim was denied.

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

**REVIEW PROCEDURE.** 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; then the notice will also describe:

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

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; then an extension of up to 45 more days will be permitted. In that event, the Company will send the Insured Employee a written delay notice, by the 30<sup>th</sup> day after receiving the request for review. The notice will explain:

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

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

## **CLAIMS PROCEDURES** **(continued)**

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

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

1. reduce future benefits until full reimbursement is made; and
2. recover such overpayments from the Insured Employee or his or her estate.

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 or any other reason.

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

## **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 this Policy, if any class ceases to be covered by this Policy.

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

1. the Policy's effective date; or
2. the date the Employee satisfies the Waiting Period.

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 a Family or Medical Leave within the leave period required by federal or state law (whichever is greater).

## **EFFECTIVE DATES**

**EFFECTIVE DATE.** Except as stated in Delayed Effective Date for Coverage, coverage for an Employee becomes effective at 12:01 a.m. on the latest of:

1. the first day of the Insurance Month following the date the Employee becomes eligible for coverage;
2. 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 premiums; or
  - (b) an order to pay premiums from the Employee's Flexible Benefits Plan account, if premiums are paid through such an account; or
3. the date determined by the Company, after the Company approves the Employee's evidence of Insurability, if required.

Evidence of insurability satisfactory to the Company must be submitted if:

1. written application for coverage (or an increased amount of coverage) is made more than 31 days after the Employee becomes eligible for such coverage;
2. coverage is elected after the Employee has requested:
  - (a) to terminate the insurance;
  - (b) to stop payroll deductions for the insurance; or
  - (c) to stop premium payments through a Flexible Benefits Plan account;
3. coverage is elected after the Employee has caused insurance to lapse by failing to pay the required premium when due; or
4. optional, supplemental or voluntary coverage is elected in excess of any Guaranteed Acceptance amounts shown in each Employer's Participation Agreement.

**DELAYED EFFECTIVE DATE.** An Employee's Effective Date of any initial, increased or additional coverage will be delayed; if such Employee is not Actively-at-Work on the date that coverage would otherwise be effective. Coverage will take effect on the Employee's second consecutive day of Active Work.

**EFFECTIVE DATE FOR COVERAGE IN ELIGIBLE CLASS.** An Insured Employee may become a member of a different Eligible Class. Except as stated in the Delayed Effective Date provision, coverage under the different Eligible Class will be effective:

1. immediately, if the different Eligible Class involves any reduction in coverage; or
2. the first day of the month after the Insured Employee has been Actively-at-Work for at least 15 days, as a member of different Eligible Class; if the different Eligible Class involves enhancement of any coverage.

**REINSTATEMENT AFTER FAMILY OR MEDICAL LEAVE.** A new Waiting Period and evidence of insurability will be waived for an Employee, upon return from an approved Family or Medical Leave; provided:

1. the Employee returns within the leave period required by federal or state law (whichever is greater);
2. the Employee applies for insurance or is enrolled under this Policy within 31 days after resuming Active Work; and
3. the reinstated amount of insurance does not exceed the amount which terminated.

If the above conditions are met, the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and 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, however.

## INDIVIDUAL TERMINATION

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

1. the date this Policy terminates or the Insured Employee's Employer ceases to be a Participating Employer; 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 end of the period for which the last required Employee contribution has been paid; or
5. the date on which the Insured Employee's employment with the Employer terminates.

Ceasing Active Work is deemed termination of employment; but insurance may be continued as follows.

1. If an Insured Employee is absent due to Disability; then insurance may be continued during:
  - (a) the Elimination Period; and
  - (b) the period for which premium is waived.
2. If an Insured Employee goes on an approved Family or Medical Leave; then insurance may be continued, until the earliest of:
  - (a) the end of the leave period approved by the Employer;
  - (b) the end of the leave period required by federal or state law (whichever is greater);
  - (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;  
provided the Company receives the required premium from the Employer.
3. When an Insured Employee goes on a temporary lay-off, or an approved leave of absence which is not subject to the federal Family and Medical Leave Act (or any similar state law); then insurance may be continued:
  - (a) until the end of the calendar month following the month in which the lay-off or leave began;
  - (b) provided the Company receives the required premium from the Employer.

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.

Termination of the Policy during a Disability shall have no affect on the benefits payable to the Insured Employee for that Disability.

## **PORTABILITY**

**ELIGIBILITY.** The Policy provides portability provision, when an Insured Employee's insurance under the Policy terminates because his or her employment with the Employer ends; provided:

- (1) the Insured Employee is not Disabled, retired or on leave of absence; and
- (2) the Insured Employee was insured under the Employer's group long term disability plan for at least 12 months in a row, just prior to the date employment ended.

The 12 months may be a combination of coverage under the Policy, and under any prior group long term disability plan the Policy replaces.

**APPLICATION.** To continue insurance, written application and the first premium payment must be made within 31 days of the date insurance would otherwise end.

**AMOUNT OF COVERAGE.** The amount of continued insurance may not exceed the amount in force when employment ends. A former Employee may decrease the amount of continued insurance:

- (1) at any time during the continuation period;
- (2) by completing a request form supplied by the Company.

The decrease will take effect on the first day of the Insurance Month after the Company receives the request.

**PAYMENT OF PREMIUM.** Timely payment of premium must be made directly to the Company, throughout the period of continued insurance. The required premium will equal:

- (1) the group rate in effect when employment ends; plus
- (2) a direct billing fee based upon the premium frequency chosen.

The premium frequency may be changed by sending the Company advance written request on forms supplied by the Company. Such request may be sent at any time while continued insurance is in force; but not during a Grace Period.

**TERMINATION OF COVERAGE.** Continued insurance will end on the earliest of:

- (1) the date insurance has been continued for 12 months;
- (2) the date the Policy terminates; but without prejudice to any claim incurred prior to termination;
- (3) the end of the period for which premium has been paid;
- (4) the date the Insured Employee retires;
- (5) the date the Insured Employee enters the armed services of any state or country on active duty (If the Insured Employee sends proof of military service, the Company will refund any unearned premium); or
- (6) the date the Insured Employee is covered under any other group long term disability plan.

Continued insurance will not end when the Employer ceases to be a Participating Employer, however.

## **TOTAL DISABILITY MONTHLY BENEFIT**

The Company will pay a Total Disability Monthly Benefit to an Insured Employee after the completion of the Elimination Period if such Insured Employee:

1. is Totally Disabled;
2. requires the regular attendance of a Physician; and
3. submits proof of continued Total Disability, at the Insured Employee's expense, 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;
2. the date the Insured Employee dies; or
3. the date the Maximum Benefit Period ends.

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 as shown in the Schedule of Benefits or 15% of the Insured Employee's Monthly Benefit, whichever is greater. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit and Maximum Benefit Period are shown in the Schedule of Benefits.



## **PARTIAL DISABILITY MONTHLY BENEFIT**

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

1. is Disabled;
2. is engaged in Partial Disability Employment;
3. is earning at least 20% of Predisability Income when Partial Disability Employment begins;
4. requires regular attendance of a Physician; and
5. submits proof of Partial Disability, at his or her own expense, to the Company upon request.

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

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

1. the date the Insured Employee ceases to be Partially Disabled or dies;
2. the date the Maximum Benefit Period ends;
3. the date the Insured Employee earns more than 99% of Predisability Income, until Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability; or
4. the date the Insured Employee earns more than 85% of Predisability Income, after Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability.

The Company has the option to average earnings over three consecutive months, in the event that the Insured Employee earns less than 85% of Predisability Income in the succeeding months.

## **DEFINITIONS**

**PARTIAL DISABILITY** or **PARTIALLY DISABLED** means that, as a result of a Sickness or Injury, the Insured Employee is:

1. unable to perform one or more of the material and substantial duties of his or her regular occupation; or
2. unable to perform such duties on a full time basis.

**PARTIAL DISABILITY EMPLOYMENT** means the Insured Employee continues or resumes working at his or her own or any other occupation; but because of a Partial Disability:

1. the Insured Employee's hours are reduced; or
2. one or more main duties of the job are eliminated or reassigned.

After the Insured Employee has received Partial Disability Monthly Benefits for 24 months for the same period of Disability, his or her current earnings may not exceed 85% of Predisability Income. This reduction in earnings must be due to the injury or sickness causing the Partial Disability.

Residual Disability

**PARTIAL DISABILITY MONTHLY BENEFIT**  
**(Continued)**

**BENEFIT AMOUNT.** The Partial 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 Partial Disability Employment.

Thus, the amount of the Partial 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 Partial 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 Partial Disability Employment.

The Partial Disability Monthly Benefit will never be less than the Minimum Monthly Benefit, or 15% of the Insured Employee's monthly benefit, whichever is greater. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

Progressive Calculation

## **OTHER INCOME BENEFITS**

OTHER INCOME BENEFITS mean those benefits shown below:

1. Any temporary or permanent benefits or awards for which the Insured Employee is eligible under:
  - (a) Workers' or Workmen's Compensation Law;
  - (b) occupational disease law; or
  - (c) any other act or law of like intent.
2. Any disability income benefits for which the Insured Employee is eligible under any compulsory benefit act or law.
3. Any disability income benefits for which the Insured Employee is eligible under:
  - (a) any other group plan, sick leave or formal salary continuance plan of the Employer;
  - (b) any governmental retirement system as a result of the Insured Employee's job with the Employer.
4. Any Disability Benefits or Retirement Benefits the Insured Employee receives under a Retirement Plan, as a result of his or her employment with the Employer.
5. Benefits under the Social Security Act, or any similar plan or act as follows:
  - (a) Disability benefits for which:
    - i. the Insured Employee is eligible; and
    - ii. the Insured Employee's spouse, child or children are eligible because of the Insured Employee's Disability.
6. Earnings the Insured Employee earns or receives from any form of employment.

These Other Income Benefits, except Retirement Benefits, are benefits resulting from the same Disability for which a Monthly Benefit is payable under the Policy.

**COST-OF-LIVING FREEZE.** After the first deduction for each of the Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

**LUMP SUM PAYMENTS.** Other Income Benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the time the Company expects the Insured Employee to live, based on the most current C.S.O. Table of Mortality.

## **RECURRENT DISABILITY**

A Recurrent Disability will be treated as a new period of Disability and a new Elimination Period must be completed before further Monthly Benefits are payable if the Insured Employee returns to such Insured Employee's regular occupation on a full-time basis for six months or more.

"Recurrent Disability" means a Disability which is related or due to the same cause(s) as a prior Disability for which a Monthly Benefit was payable.

A Recurrent Disability will be treated as part of the prior Disability if an Insured Employee returns to such Insured Employee's regular occupation on a full-time basis for less than six months.

To qualify for a Monthly Benefit, the Insured Employee must earn less than 80% of Predisability Income.

Monthly Benefit payments will be subject to the terms of the Policy for the prior Disability.

If an Insured Employee becomes eligible for coverage under any other group long term disability policy, this Recurrent Disability Provision will cease to apply to that Insured Employee.

## EXCLUSIONS

GENERAL EXCLUSIONS. The Policy will not cover any Total or Partial Disability due to:

1. war, declared or undeclared or any act of war;
2. intentionally self-inflicted injuries while sane;
3. active participation in a riot;
4. the Insured Employee's committing of or the attempting to commit a felony or any type of assault or battery.

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

1. which is caused or contributed to by, or results from a Pre-Existing Condition; and
2. which begins in the first 24 months after the Insured Employee's Effective Date, unless such Insured Employee received no Treatment of the condition for 12 consecutive months after the Insured Employee's Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which the Insured Employee received treatment within 12 months prior to the Insured Employee's Effective Date.

"Treatment" means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

## **MENTAL ILLNESS LIMITATION**

Benefits for Total or Partial Disability due to Mental Illness will not exceed 24 months of Monthly Benefit payments unless the Insured Employee:

1. is in a Hospital or Institution at the end of the 24 month period. The Monthly Benefit will be paid during confinement. If the Insured Employee remains Totally or Partially Disabled when discharged, the Monthly Benefit will be paid for a recovery period of up to 90 days.

If the Insured Employee is again confined during the 90 day recovery period for at least 14 days in a row, benefits will be paid for the reconfinement and another recovery period of up to 90 more days.

2. continues to be Totally or Partially Disabled and becomes confined in a Hospital or Institution after the 24 month period and for at least 14 consecutive days. The Monthly Benefit will be payable during the confinement.

In any case, the Monthly Benefit will not be payable beyond the Maximum Benefit Period.

"Mental Illness" means mental, nervous or emotional diseases and disorders of any type.

## **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, the prior carrier's pre-existing condition exclusion will be applied as follows:
  - (a) If the Insured Employee satisfies the prior carrier's pre-existing condition exclusion, giving consideration towards continuous time insured under both policies, such Insured Employee will be paid according to the prior carrier's benefit schedule.
  - (b) 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 payable to the Insured Employee immediately prior to death. Any reductions for Other Income Benefits, or for earnings the Insured Employee received for 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 children; then payment will be made to:

1. the surviving children, in equal shares; or
2. a person named by the Company to receive payments 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



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

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

**DISCLAIMER**

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

**Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.**

**Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales or to induce you to purchase any kind of insurance policy.**

**The Wyoming Life and Health Insurance Guaranty Association  
P.O. Box 36009  
Denver, CO 80236-0009  
303-292-5022**

**State of Wyoming Department of Insurance  
106 East 6<sup>th</sup> Avenue  
Cheyenne, Wyoming 82002-0400  
800-438-5768**

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

## **COVERAGE**

Generally, individuals will be protected by the Wyoming Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

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

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

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contractholders, not individuals); or
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in cash surrender values for life insurance policies, \$300,000 for basic hospital, medical and surgical insurance or major medical insurance, \$300,000 for disability insurance, disability income insurance and long-term care insurance, \$100,000 for coverages not defined as disability insurance or disability income insurance or basic hospital medical and surgical insurance or major medical insurance or long term care insurance, including any net cash surrender and net cash withdrawal values, \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values, or \$300,000 in life insurance death benefits -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.



## LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

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.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. 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 our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends 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.
- **Information about your transactions:** We keep 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 history.
- **Information from outside our family of companies:** If you are 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 purchases group products from us, we may obtain information about you from your employer 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 have requested; provide customer service; and 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, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. 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.**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

## 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 trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group  
Attn: Enterprise Compliance and Ethics  
Corporate Privacy Office, 7C-01  
1300 S. Clinton St.  
Fort Wayne, IN 46802

**Please include all policy/contract/account numbers with your correspondence.**

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

First Penn-Pacific Life Insurance Company	Lincoln Life & Annuity Company of New York
Lincoln Financial Group Trust Company, LLC	Lincoln Retirement Services Company, LLC
Lincoln Financial Investment Services Corporation	Lincoln Variable Insurance Products Trust
Lincoln Investment Advisors Corporation	The Lincoln National Life Insurance Company

## *ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS*

### CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

### MAKING SURE MEDICAL INFORMATION IS ACCURATE

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 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 believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. 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. 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.

Questions about your personal medical information should be directed to:

Lincoln Financial Group  
Attn: Medical Underwriting  
P.O. Box 21008  
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company  
Lincoln Life & Annuity Company of New York  
The Lincoln National Life Insurance Company