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. CI-0001728843 has been issued to:
The Heritage Group
(The Group Policyholder)

Certificate of Insurance for Class 1 Plan 1

This Certificate, and any amendments which may be attached to it, contain the main provisions of the Policy. You are entitled to the benefits described in this Certificate only if You are eligible, become and remain insured under the provisions of the Policy. If You have enrolled for Dependents Insurance, Your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required Premium has been paid to keep the insurance in effect. This Certificate replaces any other certificates for the benefits described inside. If a change affecting this insurance is made, an amendment or a new certificate will be issued to describe the change.

Ellen Cooper
PRESIDENT

READ YOUR CERTIFICATE CAREFULLY

Insurance benefits may be subject to certain requirements, reductions, limitations, and exclusions.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

CERTIFICATE OF GROUP CRITICAL ILLNESS INSURANCE

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The Heritage Group
CI-0001728843

SCHEDULE OF BENEFITS

Plan 1 – Critical Illness - Buy-Up Plan
Class 1 - All Full-Time Benefit Eligible Employees, including Benefit Eligible Seasonal Employees, in active employment in the United States with the Employer, who have elected the Critical Illness buy-up option

Group Policy Effective Date: January 1, 2026

Group Policy Number: CI-0001728843

Participating Organizations:

Asphalt Materials, Inc. (Effective Date January 1, 2026)
Avenew Roads, Inc (Effective Date January 1, 2026)
Bituminous Materials and Supply, L/P (Effective Date January 1, 2026)
Emulsicoat, Inc (Effective Date January 1, 2026)
Envita Solutions, LLC (Effective Date January 1, 2026)
Heritage Aggregates, LLC (Effective Date January 1, 2026)
Laketon Refining Corporation (Effective Date January 1, 2026)
Milestone Contractors L.P. (Effective Date January 1, 2026)
Monument Chemical Bayport, LLC (Effective Date January 1, 2026)
Monument Chemical Houston, LLC (Effective Date January 1, 2026)
Monument Chemical Kentucky, LLC (Effective Date January 1, 2026)
Monument Chemicals, Inc (Effective Date January 1, 2026)
Real Estate Recovery Capital, LLC (Effective Date January 1, 2026)
Street Intelligence, Inc (Effective Date January 1, 2026)
U.S. Aggregates, Inc (Effective Date January 1, 2026)

Eligible Class: Class 1 - All Full-Time Benefit Eligible Employees, including Benefit Eligible Seasonal Employees, in active employment in the United States with the Employer, who have elected the Critical Illness buy-up option

Contributions: You are required to contribute to the cost for Your Critical Illness Insurance and to the cost for Dependents Critical Illness Insurance.

Insurance Month Period: A period beginning on the first Day of any calendar month and ending on the last Day of the same calendar month.

Eligibility Waiting Period: (For Date insurance begins, refer to "Effective Dates" section.)

(1) None if You were hired on or before the Policy Issue Date.
(2) None if You were hired after the Group Policy Effective Date.

Open Enrollment Period: 31 Days (See Your Employer for the Dates of the Enrollment Period)

Guarantee Issue Amount:

$10,000 for You
$10,000 for Your Insured Dependent Spouse or Life Partner

Minimum Full-Time Hours: 20 hours per week

Dependent Child Age: to 26 years
Refer to the Eligibility and Effective Dates for Dependents Critical Illness Insurance provision for more information.

SCHEDULE OF BENEFITS
(Continued)

Plan 1 – Critical Illness - Buy-Up Plan
Class 1 - All Full-Time Benefit Eligible Employees, including Benefit Eligible Seasonal Employees, in active employment in the United States with the Employer, who have elected the Critical Illness buy-up option

Continuation Rights Included:
Family or Medical Leave
Military Leave
Disability: six Insurance Months
Other Leave of Absence: six Insurance Months
Lay Off: six Insurance Months
Temporary Reduction in Hours: six Insurance Months
Refer to the Continuation Rights provision for more information.

Portability:
Request Period: 31 Days
Maximum Duration: Later of Age 70 or 12 months
Refer to the Portability provision for more information.

Pre-existing Condition Exclusion: Not Applicable

Time Limit between Occurrences of Different Covered Conditions: 3 Months
Refer to the Limitations and Exclusions provision for more information.

Time Limit between Recurrences of the Same Covered Condition: 6 Months
Refer to the Limitations and Exclusions provision for more information.

The Heritage Group
CI-0001728843

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Critical Illness - Buy-Up Plan
Class 1 - All Full-Time Benefit Eligible Employees, including Benefit Eligible Seasonal Employees, in active employment in the United States with the Employer, who have elected the Critical Illness buy-up option

CRITICAL ILLNESS INSURANCE

		Critical Illness Principal Sum
Class 1	Option 1	$10,000

DEPENDENTS CRITICAL ILLNESS INSURANCE
(For Class 1)

Dependent	Dependents Critical Illness Principal Sum	
Spouse or Life Partner	Option 1	$10,000
Dependent Child	50% of Your Critical Illness Principal Sum.	

The Heritage Group
CI-0001728843

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Critical Illness - Buy-Up Plan
Class 1 - All Full-Time Benefit Eligible Employees, including Benefit Eligible Seasonal Employees, in active employment in the United States with the Employer, who have elected the Critical Illness buy-up option

BENEFITS.

We will pay a Critical Illness benefit if You or an Insured Dependent sustains a Covered Condition shown below while covered under this Certificate. If You or an Insured Dependent sustains two or more Covered Conditions simultaneously, We will pay the highest applicable benefit. Refer to the definition of each Covered Condition for more information. Diagnostic criteria include diagnoses provided via Telemedicine.

Covered Conditions	Percentage of Principal Sum or Benefit Amount
Heart Attack	100%
Sudden Cardiac Arrest	100%
Arterial/Vascular Disease	50%
Mitral or Aortic Valve Disease	25%
Stroke	100%
End Stage Renal Failure	100%
Major Organ Failure	100%
Invasive Cancer	100%
Non-invasive Cancer/Cancer in Situ	25%
Skin Cancer	$1,000, payable once in Your lifetime and once in an Insured Dependent's lifetime

Child Covered Conditions	Percentage of Dependent Child Principal Sum
Cerebral Palsy	100%
Cleft Lip/Cleft Palate	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Critical Illness - Buy-Up Plan
Class 1 - All Full-Time Benefit Eligible Employees, including Benefit Eligible Seasonal Employees, in active employment in the United States with the Employer, who have elected the Critical Illness buy-up option

Type 1 Diabetes	100%

ELIGIBILITY AND EFFECTIVE DATES
For
Your Critical Illness Insurance

ELIGIBLE CLASSES. The classes eligible for insurance are shown in the Schedule of Benefits. We have the right to review and terminate eligible classes that cease to be insured by the Policy.

ELIGIBILITY. You become eligible for insurance provided by the Policy on the latest of:
(1) the Group Policy's Effective Date; or
(2) the Date Your organization becomes a Participating Organization.

ENROLLMENT. You may enroll for Critical Illness Insurance:
(1) within 31 Days of the Date You are first eligible; or
(2) within 31 Days following a qualifying Change In Family Status.

Open Enrollment Period. You may also enroll, re-enroll, or change benefit options for Critical Illness Insurance during the Group Policyholder's Open Enrollment Period.

EFFECTIVE DATES. Critical Illness Insurance becomes effective on the latest of:
(1) the first Day of the Insurance Month following the Date You become eligible for insurance;
(2) the Date You resume Active Work, if not Actively at Work on the Day You become eligible; or
(3) the Date You enroll for Critical Illness Insurance, and if You contribute to the cost of the Critical Illness Insurance, You sign a payroll deduction order and pay the required Premium to Us.

Effective Date of Increases. Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:
(1) the first Day of the Insurance Month coinciding with or next following the Date on which You become eligible for the increase, if Actively at Work on that Day;
(2) the first Day of the Insurance Month coinciding with or next following the Date of a qualifying Change in Family Status, if Actively at Work on that Day; or
(3) the Day You resume Active Work, if not Actively at Work on the Day the increase would otherwise take effect.

Effective Date of Decreases. Any decrease in insurance or benefits will take effect on the Date of the change, whether or not You are Actively at Work.

Effective Date for Change in Eligible Class. You may become a member of a different Eligible Class. Except as stated in the Effective Date provision for increases or decreases, insurance under the different Eligible Class will be effective on the first Day of the Insurance Month coinciding with or next following the Date of the change.

REINSTATEMENT RIGHTS. If Your insurance terminates due to one of the following breaks in service, You will be entitled to Reinstate the insurance upon resuming Active Work with the Group Policyholder within the required timeframe. Reinstatement is available upon Your return:
(1) from an approved Family or Medical Leave within:
  (a) the period required by federal law; or
  (b) any longer period required by a similar state law;
(2) from a Military Leave within the period required by federal USERRA law;
(3) from any other approved leave of absence within six months after the leave begins;
(4) within six months following a lay off; or
(5) within six months following termination of employment for any other reason.

To Reinstate insurance, You must enroll for insurance or be re-enrolled within 31 Days after resuming Active Work in an eligible class. The Group Policyholder must resume the required Premium payments for insurance to be Reinstated. Reinstatement will take effect on the Date You return to Active Work.

ELIGIBILITY AND EFFECTIVE DATES
For
Dependents Critical Illness Insurance

ELIGIBILITY. You must be insured for Critical Illness Insurance to insure Your Dependents. You become eligible for Dependents Critical Illness Insurance on the latest of:

(1) the Date You become eligible for Critical Illness Insurance;
(2) the Group Policy Effective Date; or
(3) the Date You first acquire a Dependent.

ENROLLMENT. Dependents to be insured by the Policy must be enrolled in the same plan of benefits as You. You may enroll for Dependents Critical Illness Insurance:

(1) when You are first eligible for Dependents Critical Illness Insurance; or
(2) within 31 Days following a qualifying Change in Family Status.

Open Enrollment Period. You may also enroll, re-enroll, or change benefit options for Dependents Critical Illness Insurance during the Group Policyholder's Open Enrollment Period.

EFFECTIVE DATES. Your Dependents Critical Illness Insurance will become effective on the later of:

(1) the first Day of the Insurance Month following the Date You become eligible for Dependents Critical Illness Insurance; or
(2) the Date You enroll for Dependents Critical Illness Insurance, and if You contribute to the cost of the Dependents Critical Illness Insurance, You sign a payroll deduction order and pay the additional Premium to Us.

New Dependents. If additional Premium is required to add a new Dependent, insurance for the new Dependent will become effective on the Date the Dependent is acquired, provided:

(1) You complete a written application; and
(2) a payroll deduction order election is made, and the additional Premium is paid to Us;

within 31 Days of the Date the Dependent is acquired.

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

EXCEPTIONS.

Court Ordered Insurance. If Dependents Critical Illness Insurance is provided to a Child based on a court order which requires You to provide Critical Illness benefits for the Child, the insurance will become effective on the Date stated in the court order, subject to payment of any additional Premium.

Disabled Children. Your Child may be insured after the maximum Dependent Child Age shown in the Schedule of Benefits if he or she is continuously unable to earn a living because of a physical or mental disability, and is chiefly dependent upon You for support and maintenance. The Child must be insured by the Policy on the Day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to Us:

(1) within 120 Days of the Day insurance would otherwise end due to age; and
(2) thereafter, when We request (but not more than once every two years).

Newborn Children. If You acquire a newborn Dependent child, the child will be insured automatically for the first 31 Days following birth. If You have no other Children enrolled for Dependents Insurance under this Certificate, and You do not elect to enroll the newborn child and pay any additional Premium within 31 Days following birth, the newborn child's insurance will terminate.

ELIGIBILITY AND EFFECTIVE DATES
For
Dependents Critical Illness Insurance
(Continued)

Newly Adopted Children. If You adopt a child, the child will be insured automatically for the first 31 Days following the earliest of:

(1) the Date of birth, if the adoption petition is filed within 31 Days of the child's birth;
(2) the Date of placement, if the adoption petition is filed more than 31 Days from the child's birth;
(3) the Date of entry of an order granting You custody of the child; or
(4) the effective Date of adoption.

If You have no other Children enrolled for Dependents Insurance under this Certificate, and You do not elect to enroll the adopted child and pay any additional Premium within 31 Days after his or her insurance begins, the adopted child's insurance will terminate.

REINSTATEMENT OF DEPENDENTS INSURANCE. If You Reinstate Your Critical Illness Insurance under the Reinstatement Rights of the Eligibility and Effective Dates for Your Critical Illness Insurance, You may also Reinstate Dependents Critical Illness Insurance at the same time. The Reinstated amount of insurance may not exceed the amount that terminated.

PRIOR INSURANCE CREDIT
For Group Critical Illness Insurance

This Prior Insurance Credit provision prevents loss of Critical Illness Insurance that could otherwise occur solely because of a transfer of insurance carriers. The following Prior Insurance Credit will apply when the Policy replaces a Prior Plan.

NOT ACTIVELY AT WORK ON THE REPLACEMENT DATE. Subject to Premium payments, the Policy will provide insurance if You were:

(1) insured by the Prior Plan on its termination Date; and
(2) not Actively at Work due to a Covered Event, as shown on the Schedule of Benefits, on the Replacement Date.

Amount. The amount of insurance will be that provided by the Prior Plan, had it remained in force. We will pay:

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

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS. The Certificate covers only Covered Conditions or losses that occur while insurance is in force. Benefits are not payable for any Covered Condition or loss caused or contributed to by:

(1) suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
(2) committing or attempting to commit a felony;
(3) war or any act of war, declared or undeclared;
(4) participation in a riot, insurrection or rebellion of any kind; or
(5) a Covered Condition sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

Benefits are also not payable while You or Your Insured Dependent are incarcerated in any type of penal or detention facility.

A benefit for Heart Attack or Sudden Cardiac Arrest is not payable if the Heart Attack or Sudden Cardiac Arrest occurs during a medical procedure.

TIME LIMIT BETWEEN OCCURRENCES OF DIFFERENT COVERED CONDITIONS. We will not pay a benefit if You or Your Insured Dependent sustains a Covered Condition shown in the Schedule of Benefits within 3 Months of a different Covered Condition.

Exception for Skin Cancer. This limitation does not apply to Skin Cancer. The benefit for Skin Cancer is payable once in Your or Your Insured Dependent's lifetime.

Exception for Invasive Cancer. If You or Your Insured Dependent sustains Invasive Cancer within 3 Months of a payable Non-invasive Cancer, We will pay the difference between the benefits for Non-invasive and Invasive Cancer as shown in the Schedule of Benefits.

Exception for Heart Attack or Sudden Cardiac Arrest. If You or Your Insured Dependent sustains a Heart Attack or Sudden Cardiac Arrest within 3 Months of a payable Arterial/Vascular Disease, We will pay the difference between the benefits for Arterial/Vascular Disease and Heart Attack or Sudden Cardiac Arrest as shown in the Schedule of Benefits.

If You or Your Insured Dependent sustains a Heart Attack or Sudden Cardiac Arrest within 3 Months of a payable Mitral or Aortic Valve Disease, We will pay the difference between the benefits for Mitral or Aortic Valve Disease and Heart Attack or Sudden Cardiac Arrest as shown in the Schedule of Benefits.

TIME LIMIT BETWEEN RECURRENCES OF THE SAME COVERED CONDITION. We will not pay a benefit if You or Your Insured Dependent sustains the same Covered Condition, as shown in the Schedule of Benefits, more than once within a period of 6 Months or less.

We will pay a benefit for the same Covered Condition more than once, if:

(1) You or Your Insured Dependent sustains the same Covered Condition more than 6 Months apart; and
(2) You or Your Insured Dependent received no Treatment for that Covered Condition during the period shown in item (1) above.

Note: Any Invasive Cancer after the first Invasive Cancer is considered recurrence of the same Covered Condition for the purposes of this section, regardless of whether the Invasive Cancers are related. Any Non-invasive Cancer/Cancer in Situ after the first Non-invasive Cancer/Cancer in Situ is considered a recurrence of the same Covered Condition for the purposes of this provision, regardless of whether the Non-invasive Cancers/Cancers in Situ are related.

Exception for Skin Cancer. This limitation does not apply to Skin Cancer. The benefit for Skin Cancer is payable once in Your or Your Insured Dependent's lifetime.

CLAIM PROCEDURES
For Critical Illness Insurance

FILING A CLAIM.

Notice of Claim. A claimant must provide Us notice of a claim at Our Group Insurance Service Office within 20 Days after a claim is incurred. The notice should include:

(1) the Group Policyholder's name and Group Policy Number (shown on the Schedule of Benefits);
(2) Your name, address and Certificate number, if available; and
(3) the claimant's name and relationship to You.

Claim Forms. When We receive notice of a claim, We will send forms for filing the required proof. We will include instructions for completing and submitting the forms. If We do not send the forms within 15 Days, the claimant may send Us written proof of a claim in a letter. The letter should state the nature, Date and cause of the claim.

Proof of Claim. Proof of a claim must be provided within 90 Days after the Date of the loss. We will review proof of a claim when it is complete. It must include:

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

Within 15 Days after receiving the first proof of claim, We may send a written acknowledgment requesting any missing information or additional items needed to support the claim. This may include:

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

Additional Proof by Exam or Autopsy. While a claim is pending, We may have the claimant examined:

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

In case of death, We may also have an autopsy done, where it is not forbidden by law.

Any such exam or autopsy will be at Our expense.

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

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

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

PAYMENT OF CLAIMS.

Time of Payment. Benefits payable under this Certificate will be paid:

(1) immediately after We confirm liability; and
(2) in no event more than 30 Days after We receive acceptable proof of claim.

Interest on Late Claims. If payment is delayed, interest will accrue on the unresolved portion of the claim at the rate required by Indiana law. Interest will accrue until the claim is settled. Interest will accrue as explained in the Clean Claim and Defective Claim sections.

Clean Claim. Under a clean claim, interest will accrue from:

(1) the 46th Day after We receive the first proof of claim in writing; or
(2) the 31st Day after We receive the first proof of claim by electronic means.

A claim is considered "clean" when the first proof of claim is complete, no part of the claim is contested, and no other defect prevents prompt payment. A claim will also be considered "clean" when We fail to promptly

request more information or to resolve it, within 45 Days after receiving a written claim or 30 Days after receiving an electronic claim.

Defective Claim. Under a defective claim, interest will accrue from:
(1) the 46th Day after We receive enough proof to confirm liability, if the claim is filed in writing and We request more information within 45 Days; or
(2) the 31st Day after We receive enough proof to confirm liability, if the claim is filed by electronic means and We request more information within 30 Days.

A claim is considered "defective" when the first proof of claim is incomplete, any part of the claim is contested, or some other defect prevents prompt payment.

To Whom Payable. Benefits payable under this Certificate, including any benefits for Insured Dependents, will be paid to You, while living, unless:
(1) an overpayment has been made and We are entitled to reduce future benefits; or
(2) state or federal law requires that benefits be paid to an Insured Dependent Child's custodial parent or custodian.

If any benefits remain to be paid after Your death, such benefits will be paid in accord with the Beneficiary provision, and the Facility of Payment and Payment Options provided below. Benefits payable after an Insured Dependent's death will be paid to:
(1) You, if You survive that Dependent; or
(2) Your Beneficiary or according with the Facility of Payment section, if You do not survive that Dependent.

Facility of Payment. If any benefit under this Certificate becomes payable to Your estate, a minor, or any person who We consider not competent to give a valid release, We may make payment to any one or more of the following:
(1) a person who has assumed the care and support of You or Your Beneficiary;
(2) a person who has incurred expense as a result of Your last illness or death;
(3) the personal representative of Your estate; or
(4) any person related by blood or marriage to You.

No payment made under this section may exceed $1,000. Any payment made in good faith under this section will fully discharge Us to the extent of the payment. Any remaining amount will be paid as shown in the Beneficiary section.

Payment Options. Benefits will be paid in a lump sum by check. However, You or Your Beneficiary may instruct Us to pay the benefit by direct deposit electronic funds transfer. Any election must comply with Our practices at the time it is made.

NOTICE OF OUR CLAIM DECISION. We will send the claimant a written notice of Our claim decision. If We deny any part of the claim, the written notice will explain:
(1) the reason for the denial;
(2) how the claimant may request a review of Our decision; and
(3) whether more information is needed to support the claim.

Time Limits for Our Decision. Notice of Our decision will be sent within 15 Days after resolving the claim. If We need more than 15 Days to process a claim, an extension will be permitted.

We will send the claimant a written delay notice explaining the special circumstances which require the delay, and when a decision can be expected:
(1) by the 15th Day after We receive the first proof of claim; and
(2) every 30 Days after that, until the claim is resolved.

If reasonably possible, We will send notice within 45 Days after receiving the first proof of a claim.

In any event, We must send written notice of Our decision within 180 Days after receiving the first proof of a claim. If We fail to do so, there is a right to an immediate review, as if the claim was denied.

Exception: If We need more information from the claimant to process a claim, it must be supplied within 45 Days after We request it. The resulting delay will not count toward the above time limits for claim processing.

OUR INTERNAL REVIEW OF CLAIM DECISION. If a claim is denied, the claimant may submit a grievance.

Second Review Request (Grievance). To begin a review, the claimant must send Us:
(1) a written or oral request; and
(2) any written comments or other items to support the claim.

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

The grievance should be sent to Our Group Insurance Service Office at the following address:

The Lincoln National Life Insurance Company
Client Services
PO Box 2616
Omaha, NE 68103-2616
Toll Free: (800) 423-2765
client.services@lfg.com

We will provide acknowledgement of the request to the claimant within five (5) business days after receipt of such request.

Time Limits for Claimant to Request a Second Review (Grievance). The claimant may request a claim review within 180 Days after receiving a claim denial notice.

Notice of Our Grievance Decision. We will review the claim and send the claimant a written notice of Our decision within five (5) business days after resolving it. The notice will explain the reasons for Our decision. If We uphold the denial of all or part of the claim, We 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.

Time Limits for Our Grievance Decision. Notice of Our decision will be sent within:
(1) 20 Days after We receive the request for review; or
(2) 30 Days, if a special case requires more time, as more fully explained below.

If We need more time to process an appeal in a special case, We will send the claimant a written delay notice by the 20th 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 We need more information from the claimant to process a grievance, it must be supplied within 45 Days after We request it. The resulting delay will not count towards the above time limits for grievance processing.

Appeal of Grievance Decision. The claimant may appeal the grievance decision by submitting a request to the same address as shown above for a grievance. To begin an appeal, the claimant must send Us:

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

We will provide acknowledgement of the request to the claimant within five (5) business days after receipt of such request.

Time Limits for Claimant to Appeal. The claimant may request an appeal within 180 Days after receiving a notice of grievance decision.

Notice of Appeal Decision. We will review the claim and send the claimant a written notice of Our decision within five (5) business days after resolving it. The notice will explain the reasons for Our decision. If We uphold the denial of all or part of the claim, We will also describe:

(1) the right to access relevant claim information; and
(2) the right to request a state insurance department review, or to bring legal action.

Time Limits for Our Appeal Decision. Notice of Our decision will be sent within:

(1) 20 Days after We receive the request for appeal; or
(2) 30 Days, if a special case requires more time, as more fully explained below.

If We need more time to process an appeal in a special case, We will send the claimant a written delay notice by the 20th Day after receiving the request for appeal. 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 We need more information from the claimant to process an appeal, it must be supplied within 45 Days after We request it. The resulting delay will not count towards the above time limits for appeal processing.

EXTERNAL GRIEVANCE REVIEW PROCEDURES. A claimant may request an external review of a grievance decision made by Us for the following types of determinations only:

(1) an adverse determination of appropriateness;
(2) an adverse determination of medical necessity; or
(3) a determination that a proposed service is experimental or investigational.

Time Limit for Claimant to Request External Review. The claimant may file a written request with Us for an external review of a grievance decision as described in this section not more than 120 Days after the claimant is notified of Our grievance decision.

Notice of External Grievance Review Decision. An independent review organization certified by the Indiana Office of the Commissioner of Insurance will review the grievance and make a determination to uphold or reverse Our appeal resolution based on information gathered from the claimant or the claimant's designee, Us, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate. The independent review organization will apply standards of decision making that are based on objective clinical evidence and the terms of the Policy.

The independent review organization will provide to the claimant all information reasonably necessary to enable the claimant to understand the:

(1) effect of the determination on the claimant; and
(2) manner in which We may be expected to respond to the determination.

The independent review organization's determination under this section is binding on Us.

Time Limits for External Grievance Review Decision. The independent review organization will make its determination within fifteen (15) business Days after the request for external review is filed. The independent review organization will notify Us and the claimant within seventy-two (72) hours after making the determination.

Expedited External Grievance Review. A claimant may request an expedited external review of a grievance decision as described in this section for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the claimant's:

(1) life or health; or
(2) ability to reach and maintain maximum function.

Time Limits for Expedited External Grievance Review Decision. The independent review organization will notify Us and the claimant of its decision within seventy-two (72) hours after the request for expedited external grievance review is filed.

Reconsideration of a Grievance Decision Based on New Information. If at any time during an external review, a claimant submits information to Us that is relevant to Our resolution of the claimant's appeal of a grievance decision and that was not considered by Us:

(1) We may reconsider the resolution based on the new information; and
(2) if We choose to reconsider, the independent review organization will cease the external review process until the reconsideration is completed.

If We reconsider the resolution of an appeal of a grievance decision due to the submission of new information, We will notify the claimant of Our decision:

(1) within seventy-two (72) hours after the information is submitted, for an expedited external review; or
(2) within fifteen (15) days after the information is submitted, for all other external reviews.

If Our reconsideration of Our grievance decision is adverse to the claimant, he or she may request that the independent review organization resume the external review.

If We choose not to reconsider Our resolution based on new information submitted to Us, We will forward the submitted information to the independent review organization not more than two (2) business Days after We receive it.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews, We 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, We must be repaid within 60 Days. If You do not repay an overpayment, We have the right to:

(1) reduce future benefits payable to You, Your Beneficiary, or Your estate under this Certificate or any other group insurance policy We issue until full reimbursement is made; and
(2) recover overpayments from You, Your Beneficiary, or Your estate.

Repayment is required whether the overpayment is due to fraud, Our error in processing a claim, or any other reason.

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

OUR DISCRETIONARY AUTHORITY. (This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq). Except for the functions that the Policy clearly reserves to the Group Policyholder, We have the authority to:

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

Our authority includes (but is not limited to) the right to:

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

Any decision We make, in the exercise of Our authority, shall be conclusive and binding; subject to the claimant's right to:

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

BENEFICIARY

PAYMENTS TO BENEFICIARY. Any amount payable after Your death will be paid to the named Beneficiary who survives You.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown in Your Beneficiary designation for this insurance. If the Policy replaces a group policy providing similar insurance, Your Beneficiary named under the prior policy will be the Beneficiary under Our Policy, until changed.

Multiple Beneficiaries. You may name one or more Beneficiaries, and control the order and share of payment made to each named Beneficiary. If more than one Beneficiary is named and You do not designate the order or share of payment, benefits will be paid equally to Your Beneficiaries. If a named Beneficiary dies and You do not otherwise designate how that Beneficiary's share will be paid, then:

(1) that share will be divided and paid equally to Your surviving Beneficiaries; and
(2) the entire benefit will be paid to a single Beneficiary, if only one survives.

No Beneficiary Named or Surviving. If You have not named a Beneficiary, or if no named Beneficiaries survive You, payment will be made to Your:

(1) Spouse or Life Partner; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving sibling or siblings in equal shares; or, if none
(5) estate.

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

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

If a person who would otherwise receive payment dies:

(1) within 15 Days of Your death; and
(2) before We receive satisfactory proof of Your death;

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

CHANGING THE BENEFICIARY. Only You may change the Beneficiary. You may name or change the Beneficiary at any time. A new Beneficiary may be named by submitting a Beneficiary designation change to the Group Policyholder prior to Your death. Subject to any action We take before receiving notice, any change to Your Beneficiary will be effective:

(1) the Date it was completed; or
(2) for written notice, the Date it was signed.

TERMINATION
For
Your Critical Illness Insurance

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

(1) the Date the Policy terminates or the Participating Organization's participation terminates (but without prejudice to any claim incurred prior to termination.);
(2) the Date Your Class is no longer eligible for insurance;
(3) the Date You cease to be a member of the Eligible Class;
(4) the last Day of the Insurance Month in which You request termination;
(5) the last Day of the last Insurance Month for which Premium payment is made on Your behalf;
(6) the end of the period for which the last required Premium has been paid;
(7) with respect to any particular insurance benefit, the Date that benefit terminates;
(8) the Date Your employment with the Group Policyholder terminates; or
(9) the Date You enter armed services of any state or country on active duty, except for duty of 30 Days or less for training in the Reserves or National Guard. (If You send proof of military service, We will refund any unearned Premium.);

unless insurance is continued as provided in the Continuation Rights or Portability provisions.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for a Covered Condition that occurred while You were insured under the Policy.

REISSUE FOLLOWING POLICY TERMINATION. If We terminate the Policy for reasons other than fraud or nonpayment of Premium and issue a new policy to the Group Policyholder within one year after the effective Date of termination of the Policy, We will accept for coverage under the new policy an individual who:

(1) was covered under the old Policy; and
(2) has continued to meet the requirements for membership in the group that applied to the old Policy.

However, We may not exclude or limit the coverage to an individual or individual's dependents due to Evidence of Insurability.

TERMINATION
For
Dependents Critical Illness Insurance

DATE OF TERMINATION. Critical Illness Insurance on a Dependent will cease on:

(1) the Date he or she ceases to be an eligible Spouse or Life Partner; or
(2) the last Day of the Insurance Month following the Date he or she ceases to be an eligible Dependent Child.

Dependents Critical Illness Insurance will cease for all Your Insured Dependents on the earliest of:

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

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

CONTINUATION RIGHTS
For
You and Your Dependents

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

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

(1) the end of the leave period approved by the Group Policyholder;
(2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
(3) the Date You notify the Group Policyholder that You will not return; or
(4) the Date You begin employment with another employer.

The required Premium payments must be received from the Group Policyholder throughout the period of continued insurance.

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

Disability. If You are disabled as a result of a Covered Condition as shown in the Schedule of Benefits, then insurance may be continued until the earlier of:

(1) six Insurance Months after the disability begins; or
(2) the Date You are no longer disabled.

The required Premium payments must be received from the Group Policyholder, throughout the period of continued insurance.

Other Leave of Absence. When You cease work due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave), insurance may be continued for six Insurance Months. The required Premiums must be received from the Group Policyholder throughout the period of continued insurance.

Lay Off. When You cease work due to a temporary layoff, insurance may be continued for six Insurance Months following the month in which the layoff begins. The required Premiums must be received from the Group Policyholder throughout the period of continued insurance.

Temporary Reduction in Hours. When Your hours are temporarily reduced resulting in Your loss of eligibility, insurance may be continued for six Insurance Months after the temporary reduction in hours begins, provided You work at least 30 hours in a two week period. The required Premium payments must be received from the Group Policyholder throughout the period of continued insurance.

Conditions. In administering the above continuations, the Group Policyholder must not act so as to discriminate unfairly among Employees in similar situations. Insurance may not be continued when You cease Active Work due to a labor dispute, strike, work slowdown or lockout.

CONTINUATION RIGHTS FOR SURVIVING DEPENDENTS. If Critical Insurance terminates due to Your death, Dependents Critical Insurance may be continued:

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

PORTABILITY
For
You and Your Dependents

PORTABILITY FOR YOU. If Your Critical Illness Insurance ends, You may be eligible for Portability. Portability allows continuation of Your Critical Illness Insurance and Dependents Critical Illness Insurance under this Certificate. Portability follows any Continuation Rights. To continue insurance, You must:

(1) notify Us within 31 Days of the Date the insurance would otherwise end;
(2) pay the applicable Premium to Us; and
(3) have been insured under this Certificate just prior to the Date Your insurance under the Policy replaces.

Maximum Duration. Subject to Termination of Portability, the maximum period You may continue Your Critical Illness Insurance and Dependents Critical Illness Insurance under this provision is the later of:

(1) the Date You reach age 70; or
(2) the Date the insurance has been continued for 12 months.

Limitations on Portability. Portability is not available when insurance terminates solely because of:

(1) Your Spouse, Life Partner, or Child ceasing to be an eligible Dependent;
(2) Your organization ceasing to be a Participating Organization;
(3) nonpayment of Premiums; or
(4) Policy termination.

Payment of Premium. We will send You a billing statement on or before each Premium due Date. You must pay Premium directly to Us on or before each due Date, throughout the period of continued insurance. The required Premium will equal:

(1) the group rate; plus
(2) a direct billing fee based on the Premium frequency You choose.

You may request to change:

(1) Premium frequency if You notify Us in advance; and
(2) billing frequency at any time the insurance is in force, except during a Grace Period.

Termination of Your Portability. Insurance continued under this section ends on the earliest of:

(1) the Date We receive a written request from You to terminate the insurance;
(2) the last Day of the period for which You paid Premiums;
(3) the Date You die;
(4) the Date the Maximum Duration ends; or
(5) the Date You return to an eligible class under the Policy.

DEPENDENTS PORTABILITY. If You die, divorce, or dissolve Your Life Partnership, Your Insured Spouse or Life Partner may be eligible for Dependents Portability. Dependents Portability allows Your Insured Spouse or Life Partner to continue his or her insurance under this Certificate. To continue his or her insurance, Your Insured Spouse or Life Partner must:

(1) notify Us within 31 Days of the Date the insurance would otherwise end;
(2) pay the applicable Premium to Us; and
(3) have been insured under this Certificate just prior to the Date You died, divorced, or dissolved Your Life Partnership.

Your Insured Spouse or Life Partner may also continue Your Dependent Child's Critical Illness insurance, provided:

(1) the Dependent Child was insured at the time of Your death, divorce, or dissolution of Your Life Partnership; and
(2) You are not continuing Dependents Critical Illness Insurance for Your Child.

PORTABILITY
For
You and Your Dependents
(Continued)

Maximum Duration. Subject to Termination of Dependents Portability, the maximum period Your Insured Spouse or Life Partner may continue his or her insurance under this provision is the later of:

(1) the Date he or she reaches age 70; or
(2) the Date the insurance has been continued for 12 months.

Insurance provided under this provision for a Dependent Child will cease on the Date he or she ceases to be an eligible Dependent Child.

Payment of Premium. We will send Your Insured Spouse or Life Partner a billing statement on or before each Premium due Date. He or she must pay Premium directly to Us on or before each due Date, throughout the period of continued insurance. The required Premium will equal:

(1) the group rate if You remained an Employee; plus
(2) a direct billing fee based on the Premium frequency Your Insured Spouse or Life Partner chooses.

Your Insured Spouse or Life Partner may change the Premium frequency by sending Us advance written notice on forms We supply. He or she may send a request to change billing frequency at any time the insurance is in force, except during a Grace Period.

Termination of Dependents Portability. Insurance continued under this section ends on the earliest of:

(1) the Date We receive a written request from Your Insured Spouse or Life Partner to terminate the insurance;
(2) the last Day of the period for which Your Insured Spouse or Life Partner paid Premiums;
(3) the Date Your Insured Spouse or Life Partner dies;
(4) the Date the Child ceases to be an eligible Dependent; or
(5) the Date the Maximum Duration ends.

We may terminate the Dependents Critical Illness Insurance continued under this provision for any reason by providing 31 Days notice.

GENERAL PROVISIONS
For
You and Your Dependents

ENTIRE CONTRACT. The entire contract with the Group Policyholder includes:
(1) the Policy and any amendments to it;
(2) the Group Policyholder's application, if any;
(3) any Participating Organization's Application or Participation Agreement;
(4) any individual applications of an Insured or Insured Dependent; and
(5) the Certificate for each insured class and any amendments to it.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in Our Group Insurance Service Office has the authority to:
(1) determine the insurability of a group or any individual within a group;
(2) make a contract in Our name;
(3) amend or waive any provision of the Policy; or
(4) extend the time for payment of any Premium.

No change in the Policy will be valid, unless it is made in writing, agreed upon by an underwriting officer, and signed by a Company officer as described above.

INCONTESTABILITY. Except for the non-payment of Premiums, We 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 You or Your Insured Dependent, after the insurance has been in force for two years during Your or Your Insured Dependent's lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) this Certificate’s eligibility requirements, exclusions and limitations; and
(2) other Certificate provisions unrelated to the validity of insurance.

In the absence of fraud, all statements made by You or Your Insured Dependents are representations and not warranties. No statement made by You or Your Insured Dependent will be used to contest the insurance provided by the Policy, unless:
(1) it is contained in a written statement signed by You or Your Insured Dependent; and
(2) a copy of the statement has been furnished to You or Your Insured Dependent.

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

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

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

MISSTATEMENT OF FACTS. If relevant facts about You or any Insured Dependent were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount of insurance is valid under the Policy.
If Your or Your Insured Dependent's age has been misstated, the correct age will be used to determine if insurance is in effect and adjust benefits, as appropriate.

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

DEFINITIONS
For
You and Your Dependents

ACTIVE, ACTIVE WORK, or ACTIVELY AT WORK means Your performance, for at least the Minimum Hours shown in the Schedule of Benefits, of all customary duties of Your occupation at:

(1) the Group Policyholder's place of business; or
(2) any other business location designated by the Group Policyholder.

Unless disabled on the prior workday or on the Day of absence, You will be considered Actively at Work on the following Days:

(1) a non-scheduled workday or holiday;
(2) a paid vacation Day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

ANEURYSM means an abnormal widening or ballooning of a portion of an artery due to weakness of the arterial wall. Aneurysm is diagnosed by a Physician based on arteriography or other appropriate imaging studies.

ARTERIAL/VASCULAR DISEASE means an Aneurysm or obstruction of an artery that is diagnosed as being of sufficient severity to require surgical/invasive intervention, such as:

(1) coronary artery bypass graft or other bypass;
(2) angio jet clot busting;
(3) laser/balloon angioplasty;
(4) atherectomy;
(5) stent implantation; or
(6) abdominal aortic aneurysm surgery.

Diagnosis must be made by a board-certified or board-eligible cardiologist, neurologist, or vascular surgeon. The surgical/invasive intervention requirement will be waived if:

(1) You or Your Insured Dependent are determined to be too ill for surgical/invasive intervention; and
(2) the Arterial/Vascular Disease would otherwise be diagnosed as of sufficient severity as to warrant surgical/invasive intervention.

CEREBRAL PALSY means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and/or behavior and/or by a seizure disorder. Cerebral Palsy diagnosis must be made during childhood by a Physician.

CERTIFICATE means the Group Critical Illness Certificate, which contains the main provisions of the Policy. The Certificate includes any amendments which may be attached to it.

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

(1) the formation or dissolution of a Life Partnership; or
(2) involuntary loss of comparable insurance under a Spouse or Life Partner's benefit plan.

CHILD or **CHILDREN** means:

(1) Your natural child, legally adopted child, stepchild, or a child subject to legal guardianship;
(2) a child placed with You for the purpose of adoption;
(3) a child for whom You are required by court order to provide insurance;
(4) Your grandchild; or
(5) a foster child for whom You have assumed full parental responsibility and control.

Stepchild includes Your Life Partner's child.

CIVIL UNION PARTNER means Your civil union partner to the extent recognized by the state in which You reside.

CLEFT LIP/CLEFT PALATE means orofacial cleft diagnosed during childhood by a Physician**.**

CLINICAL DIAGNOSIS means a clinical identification of Invasive Cancer, Non-invasive Cancer/Cancer in Situ, or Skin Cancer based on history, laboratory study and symptoms. We will accept a Clinical Diagnosis in lieu of a Pathological Diagnosis only if there is medical evidence to support such diagnosis, it is consistent with professional medical standards, and a qualified medical professional has recommended interventional treatment or palliative care.

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.

COVERED CONDITION means an event or illness:
(1) shown in the Schedule of Benefits or in the Schedule of Benefits of any Certificate Amendment; and
(2) for which You or Your Insured Dependent is covered under the Policy.

CRITICAL ILLNESS INSURANCE means the insurance provided by the Policy for You.

CYSTIC FIBROSIS means a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands. Diagnosis must be made during childhood by a Physician and based on genetic testing.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight. Day or Date is based on the time at the Group Policyholder's place of business.

DEPENDENT means Your Spouse, Life Partner, or Dependent Child.

DEPENDENT CHILD means Your Child who meets the age requirements shown in the Schedule of Benefits.

DEPENDENTS CRITICAL ILLNESS INSURANCE means the insurance provided by the Policy for eligible Dependents.

DOMESTIC PARTNER means Your domestic partner (whether same or opposite sex), regardless of registration.

DOWN SYNDROME means Down Syndrome diagnosed during childhood by a Physician and based on genetic testing.

EMPLOYEE (Full-Time) means a person:
(1) whose employment with the Group Policyholder or Participating Organization is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is Actively at Work;
(4) who is a member of an eligible class under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

It also includes a former Employee who has elected Portability.

END STAGE RENAL FAILURE means chronic and irreversible failure of the kidneys of such magnitude that permanent dialysis or transplant is required to sustain life, or would be required if You or Your Insured Dependent were healthy enough for such treatment.

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

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

The leave period may:

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

If You are entitled to a leave under both the federal FMLA law and a similar state law, the leave period that is more favorable to You will apply. If You are on an FMLA leave due to Your own health condition on the Group Policy Effective Date, You are not considered Actively at Work.

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

HEART ATTACK (MYOCARDIAL INFARCTION) means death of a portion of heart muscle due to inadequate circulation in coronary arteries. No benefits are payable for a heart attack in which no death of heart muscle occurs. Diagnosis is made by a board-certified or board-eligible cardiologist and based on findings from an electrocardiogram (EKG) and elevation of cardiac enzymes or cardiac imaging evidence of segmental wall motion abnormalities. In the event of death, either autopsy confirmation of a myocardial infarction or a death certificate indicating the primary cause of death as a myocardial infarction may be substituted for diagnostic criteria. A benefit for Heart Attack is not payable if the Heart Attack occurs during a medical procedure.

INSURANCE MONTH means that period of time shown on the Schedule of Benefits:

(1) beginning at 12:01 a.m.; and
(2) ending at 12:00 midnight;

at the Group Policyholder's primary place of business.

INSURED DEPENDENT means a Dependent for whom Critical Illness Insurance under this Certificate is in effect.

INSURED DEPENDENT CHILD means a Dependent Child for whom Critical Illness Insurance under this Certificate is in effect.

INSURED SPOUSE OR LIFE PARTNER means Your Spouse or Life Partner for whom Critical Illness Insurance under this Certificate is in effect.

INVASIVE CANCER means leukemia, except for item (4) in the list below, or malignant cells/tumors characterized by uncontrolled growth with spread beyond the initial tissue. Diagnosis must be by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on Pathological Diagnosis. If a Pathological Diagnosis is medically inappropriate or life-threatening, a Clinical Diagnosis of Cancer will be accepted instead. The following are not considered Invasive Cancer for purposes of this definition:

(1) Non-Invasive Cancer/Cancer in Situ;
(2) basal cell carcinoma and squamous cell carcinoma of the skin (see Skin Cancer definition);

(3) melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm; and
(4) chronic lymphocytic leukemia of stage zero.

LIFE PARTNER means Your:
(1) Civil Union Partner; or
(2) Domestic Partner.

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

MAJOR ORGAN FAILURE means end-stage organ disease, as determined by a Physician appropriately specialized for the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If You or Your Insured Dependent are determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if You or Your Insured Dependent receives a Major Organ transplant prior to placement on the network.

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

MITRAL or AORTIC VALVE DISEASE means loss of function of the mitral or aortic valve that is diagnosed as being of sufficient severity to require surgical replacement/repair or cardiac catheterization. Diagnosis must be made by a board-certified or board-eligible cardiologist or cardio-vascular surgeon. The surgical replacement/repair or cardiac catheterization requirement will be waived if:
(1) You or Your Insured Dependent is determined to be too ill for surgical replacement/repair or cardiac catheterization; and
(2) the Mitral or Aortic Valve Disease would otherwise be diagnosed as of sufficient severity as to warrant surgical replacement/repair or cardiac catheterization.

MUSCULAR DYSTROPHY means Muscular Dystrophy diagnosed during childhood by a Physician and based on genetic testing.

NON-INVASIVE CANCER/CANCER IN SITU means malignant cells confined to the surface tissues without invasion of the basement membrane and with no spread to regional lymph nodes or other tissues. Melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm is considered Non-Invasive Cancer/Cancer in Situ for purposes of this definition. Diagnosis is made by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on Pathological Diagnosis. If a Pathological Diagnosis is medically inappropriate or life-threatening, a Clinical Diagnosis of Cancer will be accepted instead. The following are not considered Non-Invasive Cancer/Cancer in Situ for purposes of this definition:
(1) leukemia, except for chronic lymphocytic leukemia of stage zero; and
(2) basal cell and squamous cell carcinomas of the skin.

OPEN ENROLLMENT PERIOD means the calendar year period designated by the Group Policyholder, and approved by Us, during which You may be eligible to purchase or make changes to Your or Your Dependents Critical Illness Insurance.

PARTICIPATING ORGANIZATION means an organization that We have approved for participation in the insurance provided by the Policy.

PATHOLOGICAL DIAGNOSIS means identification of Invasive Cancer, Non-invasive Cancer/Cancer in Situ, or Skin Cancer based on a microscopic study of fixed tissue or preparations from the hemi (blood) system by a qualified medical professional acting within the scope of his or her license, whether or not certified by the American Board of Pathology.

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

PERSON means an Employee of the Group Policyholder:
(1) who is a member of a class that is eligible for insurance under the Policy; and
(2) who has enrolled for insurance.

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

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

Physician does **not** include You or Your relatives. Relatives include Your:
(1) Spouse or Life Partner, siblings, parents, Children and grandparents; and
(2) Spouse's or Life Partner's relatives of like degree.

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

PREMIUM means the amount charged for the insurance provided by the Policy.

PRINCIPAL SUM means the Critical Illness Insurance benefit amount for You or Your Insured Dependent.

PRIOR PLAN means a Group Policyholder-sponsored group or Group Policyholder-sponsored individual Critical Illness Insurance policy, which the Policy replaced within 1 Day of the prior plan's termination Date. It does not include any coverage under the Prior Plan that was continued under a portability or other coverage continuation provision.

REINSTATEMENT or TO REINSTATE means to enroll or re-enroll for Critical Illness Insurance without satisfying a new Eligibility Waiting Period.

REPLACEMENT DATE means the Effective Date of the group Critical Illness Insurance Policy underwritten by Us.

SKIN CANCER means basal cell and squamous cell carcinomas of the skin. Diagnosis is made by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and Pathological Diagnosis. If a Pathological Diagnosis is medically inappropriate or life-threatening, a Clinical Diagnosis of Cancer will be accepted instead.

SPINA BIFIDA means Spina Bifida diagnosed during childhood by a board-certified or board-eligible Physician**.**

SPOUSE means the person lawfully married to You, as recognized by any state, possession, or territory of the United States.

STROKE means neurological damage to the brain due to inadequate blood flow in any of the cranial vessels, due to either blockage or rupture of the vessel. Diagnosis of neurological damage must be made by a

neurologist and demonstrated by imaging (CT or MRI) and examination demonstrating new neurological deficits (motor, cognitive, or sensory), lasting more than 7 Days, that were caused by the Stroke. In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted. Transient Ischemic Attacks (TIA) are not considered Strokes.

SUDDEN CARDIAC ARREST means the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction, resulting in death.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A benefit for Sudden Cardiac Arrest is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction). A benefit for Sudden Cardiac Arrest is not payable if the Sudden Cardiac Arrest occurs during a medical procedure.

TELEMEDICINE means health care services delivered by use of interactive audio, video, or other electronic media. It does not include the delivery of health care services by use of the following:

(1) a telephone transmitter for transtelephonic monitoring.
(2) a telephone or any other means of communication for the consultation from one provider to another provider.

TREATED or TREATMENT means consultation, care and services provided or prescribed by a Physician. It includes diagnostic measures and the prescription, refill or taking of prescribed drugs or medicines for which symptoms exist.

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

WE, OUR, or US refer to The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

YOU, YOUR, and YOURS means the Person for whom Policy insurance is in effect.

NOTICE OF PROTECTION PROVIDED BY THE

INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after January 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

Annuities

- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

NOTICE TO POLICYHOLDERS REGARDING FILING COMPLAINTS WITH THE DEPARTMENT OF INSURANCE

Questions regarding your policy or coverage should be directed to:

The Lincoln National Life Insurance Company
1-800-423-2765

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone, or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by The Lincoln National Life Insurance Company of Omaha, Nebraska is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 to be distributed to participants in the Plan. This Summary Plan Description is only intended to provide an outline of the Plan's benefits. The Plan Document will govern if there is any discrepancy between the information contained in this Description and the Plan.

The name of the Plan is: Group Critical Illness Insurance for Employees of The Heritage Group

The name, address and ZIP code of the Sponsor of the Plan is:
The Heritage Group
6640 Intech Blvd. STE 200
INDIANAPOLIS, IN 46278.

Employer Identification Number (EIN): 351448549 IRS Plan Number: 601

The name, business address, ZIP code and business telephone number of the Plan Administrator is:
The Heritage Group
6640 Intech Blvd. STE 200
INDIANAPOLIS, IN 46278.
(800) 303-0408.

The Plan Administrator is responsible for the administration of the Plan and is the designated agent for the service of legal process for the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of contributions, maintenance of records of Plan participants, authorization and payment of Plan administrative expenses, selection of the insurance consultant, selection of the insurance carrier and assisting The Lincoln National Life Insurance Company. The Lincoln National Life Insurance Company has the sole discretionary authority to determine eligibility and to administer claims in accord with its interpretation of policy provisions, on the Plan Administrator's behalf.

Type of Administration. The Plan is administered directly by the Plan Administrator with benefits provided in accordance with provisions of the group insurance policy issued by The Lincoln National Life Insurance Company whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska.

Type of Plan. The benefits provided under the Plan are: Group Critical Illness Insurance

Type of Funding Arrangement: The Lincoln National Life Insurance Company

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits, Limitations, and Exclusions. The Certificate also contains the Schedule of Insurance which includes the Types of Benefits, Benefit Amounts, and Waiting Period information. If your Booklet, Certificate or Schedule of Insurance has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

Eligibility. Full-time employees working at least 20 hours per week.

Employees become eligible on the first Day of the Insurance Month following the Date of completion of 0 Days of active full-time employment.

Contributions. You are required to make contributions for Personal Critical Illness Insurance and Dependents Critical Illness Insurance.

The Plan's fiscal year ends on: December 31st of each year

The name and section of relevant Collective Bargaining Agreements: None

The name, title and address of each Plan Trustee: None

Loss of Benefits. The Plan Administrator may terminate the policy, or subject to The Lincoln National Life Insurance Company's approval, may modify, amend or change the provisions, terms and conditions of the policy. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured Person or any other person referred to in the policy will be required to terminate, modify, amend or change the policy. See your Plan Administrator to determine what, if any, arrangements may be made to continue your coverage beyond the date you cease active work.

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Group Insurance Service Office of The Lincoln National Life Insurance Company. To expedite the processing of your claim, instructions on the claim form should be followed carefully; be sure all questions are answered fully. In accordance with ERISA, The Lincoln National Life Insurance Company will send you or your beneficiary a written notice of its claim decision within:

- 90 days after receiving the first proof of a death or other Critical Illness claim (180 days under special circumstances); or 45 days after receiving the first proof of a disability claim, if applicable (105th day under special circumstances).

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial, how a review of the decision may be requested, and whether more information is needed to support the claim. You, or another person on your behalf, may request a review of the claim by making a written request to The Lincoln National Life Insurance Company within:

- 60 days after receiving a denial notice of a death or other Critical Illness claim; or 180 days after receiving a denial notice of a claim for disability income benefits, if applicable.

This written request for review should state the reasons why you feel the claim should not have been denied and should include any additional documentation to support your claim. You may also submit for consideration additional questions or comments you feel are appropriate, and you may review certain non-privileged information relating to the request for review. The Lincoln National Life Insurance Company will make a full and fair review of the claim and provide a final written decision to you or your beneficiary within:

- 60 days after receiving the request for a review of a death or other Critical Illness claim (120 days under special circumstances); or 45 days after receiving the request for review of a claim for disability income benefits, if applicable (90 days under special circumstances).

If more information is needed to resolve a claim, the information must be supplied within 45 days after requested. Any resulting delay will not count toward the above time limits for claims or appeals processing. Please refer to your certificate of insurance for more information about how to file a claim, how to appeal a denied claim, and for details regarding the claims procedures.

Statement of ERISA Rights

The following statement of ERISA rights is required by federal law and regulation. As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The administrator may make a reasonable charge for copies.

Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF THE CERTIFICATE FOR GROUP POLICY NO.: CI-0001728843
ISSUED TO: The Heritage Group

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

ACCIDENTAL INJURY BENEFIT

The Accidental Injury Benefit will apply if elected by the Group Policyholder and the required premium is paid.

ACCIDENTAL INJURY BENEFIT. We will pay an Accidental Injury Benefit if You or Your Insured Dependent sustains one of the following incidents as a result of an Accident:
(1) Severe Traumatic Brain Injury;
(2) Severe Burn; or
(3) Paralysis.
The benefit is payable once per Accident.

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

AMOUNT. The amount of the Accidental Injury Benefit equals Your or Your Insured Dependent's Critical Illness Principal Sum shown in the Schedule of Benefits of the Certificate.

DEFINITIONS. The following additional definitions apply to this Accidental Injury Benefit.

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

Aircraft means any device used for aerial navigation, including but not limited to airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

Alternate Care or Rehabilitative Facility means a facility that is licensed according to state and local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

Covered Accident means an Accident that:
(1) You or an Insured Dependent sustains; and
(2) is not otherwise excluded under the Certificate or this Certificate Amendment.

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

It does not include a place that:
(1) is specialized solely in dentistry, mental illness or substance abuse;
(2) is a rest home, home for the aged, convalescent home or nursing home; or
(3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

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

Inpatient means an overnight resident patient.

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

(1) by a Physician within 30 Days of a Covered Accident; and
(2) while this Certificate is in force for You or Your Insured Dependent.

Severe Burn means:

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

Diagnosis is made based on clinical examination findings conducted by a board-certified or board-eligible plastic surgeon or other Physician. The Severe Burn must be diagnosed:

(1) by a Physician within 30 Days of a Covered Accident; and
(2) while this Certificate is in force for You or Your Insured Dependent.

Severe Traumatic Brain Injury means a sudden impact to the head or a penetrating head Injury that:

(1) causes irreversible physical damage to the brain;
(2) prevents performance of the material functions and activities of a person of like age and gender who is in good health;
(3) is diagnosed by a Physician as 8 or less on the Glasgow Coma Scale (or as an equivalent score on any other officially recognized scale used to measure the severity of a brain injury).

The Severe Traumatic Brain Injury must be diagnosed:

(1) by a Physician within 30 Days of a Covered Accident; and
(2) while this Certificate is in force for You or Your Insured Dependent.

Sickness means:

(1) illness;
(2) pregnancy; or
(3) infection, except when the infection is due to an Accidental cut or wound.

Surgery or Surgical means a procedure performed by a Physician in a Hospital or an outpatient facility that:

(1) is intended to be curative, palliative, or exploratory; and
(2) requires an incision to the skin or tissue, or general anesthesia.

EXCLUSIONS. The Exclusions contained in the Certificate apply to this Certificate Amendment. In addition, benefits are not payable for any loss caused or contributed to by:

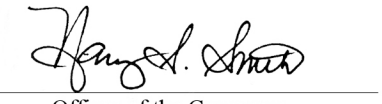
(1) disease, physical or mental infirmity, Sickness, or medical or Surgical treatment of these;
(2) voluntary intake or use by any means of any drugs, poison, gas, or fumes, except when:
    (a) prescribed or administered by a Physician; and
    (b) taken in accordance with the Physician's instructions;
(3) military duty, including Reserves or National Guard;
(4) travel or flight in or on any Aircraft, except:
    (a) as a fare-paying passenger on a regularly scheduled commercial flight; or
    (b) as a passenger, pilot, or crew member in the Group Policyholder's Aircraft while flying for the Group Policyholder's business provided:
        (i) the Aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
        (ii) the pilot has a valid pilot's certificate with a non-student rating authorizing him or her to fly the Aircraft;
(5) driving a vehicle while intoxicated, as defined by the jurisdiction where the Accident occurred;
(6) cosmetic or elective Surgery;
(7) participating in, practicing for, or officiating any semi-professional or professional sport;
(8) riding in or driving in any motor driven vehicle for race, stunt show or speed test;
(9) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months;

(10) bungee cord jumping, mountaineering, or base jumping;
(11) skydiving, parachuting, or jumping from any Aircraft for recreational purposes; or
(12) Injury arising out of, or in the course of, any employment for wage or profit.

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

This amendment takes effect on January 1, 2026, or on Your effective Date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF THE CERTIFICATE FOR GROUP POLICY NO.: CI-0001728843
ISSUED TO: The Heritage Group

The Certificate is amended by the addition of the following Occupational Disease Benefit.

OCCUPATIONAL DISEASE BENEFIT

The Occupational Disease Benefit will apply if elected by the Group Policyholder and the required premium is paid.

SCHEDULE OF BENEFITS

Covered Condition	Percentage of Principal Sum
Hepatitis	100%
HIV	100%
Invasive MRSA Infection	25%
Rabies	25%
Tetanus	25%
Tuberculosis	25%

OCCUPATIONAL DISEASE BENEFIT. We will pay an Occupational Disease Benefit if You test positive for an Occupational Disease shown in the Schedule of Benefits above while covered under this Occupational Disease Benefit Amendment. Infection acquired outside Your workplace is not considered Occupational Disease. The benefit does not affect any other benefits payable under the Certificate.

PROOF. We must receive proof of infection from the laboratory that performed the test. You are responsible for any expenses incurred for testing for infection. The testing:
(1) may not be self-administered; and
(2) must be provided by a licensed laboratory.

DEFINITIONS. The following additional definitions apply to this Occupational Disease Benefit.

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

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

Invasive MRSA Infection means infection with Methicillin-resistant Staphylococcus aureus (MRSA). Diagnosis of Invasive MRSA Infection must be made by a Physician. Treatment must occur in a hospital/clinical setting.

Occupational Disease means Hepatitis, HIV, MRSA Infection, Rabies, Tetanus, or Tuberculosis that occurs as a result of Your documented accidental exposure in Your workplace to one of those diseases. Diagnosis of infection must be confirmed by testing relevant to the disease, administered under the direction of and interpreted by a Physician. The accidental exposure must be documented by an appropriate accident report at the workplace. Infection acquired outside Your workplace is not considered Occupational Disease.

Rabies means viral disease of mammals transmitted through the bite of an animal infected with the rabies virus. Diagnosis must be made by a Physician.

Tetanus means infectious disease caused by contamination of wounds with the bacteria Clostridium tetani. Diagnosis of Tetanus must be made by a Physician.

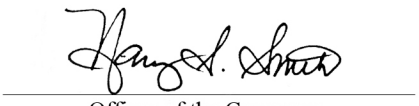
Tuberculosis means infection by the bacteria Mycobacterium tuberculosis. Diagnosis of Tuberculosis must be made by a Physician.

EXCLUSIONS. The Exclusions contained in the Certificate apply to this Certificate Amendment. In addition, We will not pay an Occupational Disease Benefit if You test positive for HIV prior to the effective date of Your coverage under the Policy; or before the effective date of the Occupational Disease Benefit, if added later by amendment.

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

This amendment takes effect on January 1, 2026, or on Your effective Date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF THE CERTIFICATE FOR GROUP POLICY NO.: CI-0001728843
ISSUED TO: The Heritage Group

The Certificate is amended by the addition of the following Supplemental Benefits.

SUPPLEMENTAL BENEFITS

The Supplemental Benefits amendment will apply if elected by the Group Policyholder and the required premium is paid.

SCHEDULE OF BENEFITS

Covered Condition	Percentage of Principal Sum
Acquired Immune Deficiency Syndrome (AIDS)	100%
Advanced ALS/Lou Gehring's Disease	100%
Advanced Alzheimer's Disease	100%
Advanced Chronic Obstructive Pulmonary Disease (COPD)	100%
Advanced Parkinson's Disease	100%
Advanced Multiple Sclerosis (MS)	100%
Advanced Huntington's Disease	100%
Benign Brain Tumor	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

SUPPLEMENTAL BENEFITS. We will pay a Supplemental Benefit if You or Your Insured Dependent sustains a Covered Condition shown in the Schedule of Benefits above while insured under this Certificate Amendment.

DEFINITIONS. The following additional definitions apply to this Supplemental Benefits amendment.

Acquired Immune Deficiency Syndrome (AIDS) means Acquired Immune Deficiency Syndrome with a CD4 cell count below 200 cells/mm, diagnosed by a Physician.

Advanced ALS/Lou Gehrig's Disease means amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) of the Middle Stage according to the Muscular Dystrophy Association. Definitive diagnosis must be made by a board-certified or board-eligible neurologist according to diagnostic criteria for the specific illness. Other

motor neuron diseases are not considered to be ALS. Initial diagnosis of ALS/Lou Gehrig's Disease must occur while You or Your Insured Dependent is covered under the Policy.

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

Advanced Chronic Obstructive Pulmonary Disease (COPD) means Grade 4 Very Severe pulmonary disease as confirmed by a pulmonologist with spirometric evidence of severe airflow limitations defined by FEV1 < 30 percent of predicted.

Advanced Huntington's Disease means Huntington's Disease of the Middle Stage. Diagnosis must be made by a board-certified or board-eligible neurologist on the basis of neurological examination and cognitive testing. Initial diagnosis of Huntington's Disease must occur while You or Your Insured Dependent is covered under the Policy.

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

(1) neurological examination demonstrating functional impairments;
(2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and
(3) analysis of cerebrospinal fluid consistent with the diagnosis; and
(4) an Expanded Disability Status Scale (EDSS) score of 6 or above.

Initial diagnosis of Multiple Sclerosis must occur while You or Your Insured Dependent is covered under the Policy.

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

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

Loss of Hearing means permanent reduction in both ears to a point that You or Your Insured Dependent is unable to hear sounds at or below 70 decibels, which cannot be corrected by surgery or the use of a device. Diagnosis is made by a board-certified or board-eligible otolaryngologist as diagnosed by audiometric testing.

Loss of Sight means permanent loss of sight in both eyes such that corrected visual acuity is 20/200 or less, or the field of vision is less than 20 degrees, and which cannot be corrected by surgery or the use of a device. Diagnosis is made by a board-certified or board-eligible ophthalmologist or board-certified or board-eligible neuro-ophthalmologist based on the above criteria and noted to be of permanent duration.

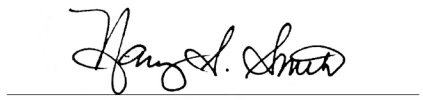
Loss of Speech means loss of the ability to speak to the extent that the individual is unintelligible to another person with normal hearing, for at least 12 months. Diagnosis is made by a board-certified or board-eligible otolaryngologist or board-certified or board-eligible neurologist.

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

CERTIFICATE AMENDMENT
(Continued)

This amendment takes effect on January 1, 2026, or on Your effective Date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

What Does Lincoln Financial Do with Your Personal Information?

The Lincoln Financial 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. 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.

We are committed to the responsible use of information and protecting individual privacy rights. As such, we look to leading data protection standards to guide our privacy program. These standards include collecting data through fair and lawful means, such as obtaining your consent when appropriate.

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, insurance, retirement, and other financial services to you;
- to pay your claim;
- 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 types 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; 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; payment details; 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, retirement information, and information related to Social Security benefits), 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 to enroll you in the plan.

When you are no longer our customer, we continue to share your information as described in this notice.

How We Share and Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They may use this information:

- to process transactions you, your employer, or your group representative have requested;
- to provide customer service;
- to evaluate or enhance our products and services;
- to gain customer insight; to provide education and training to our workforce and customers; and/or
- 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. Affiliates are companies related by common ownership or control. Nonaffiliates are companies not related by common ownership or control. They include:

- Financial service providers: third party administrators; broker-dealers; insurance agents and brokers; registered representatives; reinsurers and other financial services companies with which we have joint marketing agreements. A joint marketing agreement is a formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include, but are not limited to, insurance providers and financial technology solutions.
- Non-financial companies and individuals: 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. We may execute agreements with our service providers that permit the service provider to process your personal information outside of the United States, when not prohibited by our contracts and permitted by applicable law.

When you apply for one of our products:

- We may share information about your application with credit bureaus.
- We may provide information to group policy owners or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers).
- We may provide information to regulatory authorities, law enforcement officials, and to other nonaffiliated 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 with the acquiror as part of the sale.
- **We do not sell or release your information to outside marketers who may want to offer you their own products and services unless we receive your express consent; nor do we release information we receive about you from a consumer reporting agency.**

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information, the reasons Lincoln chooses to share, and whether you can limit this sharing.

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

Federal law gives you the right to limit only:

- sharing for our affiliates' everyday business purposes – information about your creditworthiness;
- sharing for our affiliates to market to you; and
- sharing for nonaffiliates to market to you.

State laws and individual companies may give you additional rights to limit sharing. California residents can review our California Privacy Notice located at https://www.lincolnfinancial.com/public/general/privacy/californiaprivacynotice.

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards, secure files, and buildings. Our employees are authorized to access your information only when they need it to perform their job responsibilities. 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

Lincoln complies with all applicable laws and regulations regarding the provision of personal information. The rights provided to you in this Privacy Notice will be administered in accordance with your state's specific laws and regulations.

Access to personal information: You must submit a written request to receive a copy of your personal information. You may see your personal information in person, or you may ask us to send you a copy of your personal information by mail or electronically. We will need to verify your identity before we process the request. Within 30 business days of receiving your request, we will, depending on the specific request you make, (1) inform you of the nature and substance of the recorded personal information we have about you; (2) permit you to obtain a copy of your personal information; and (3) provide the identity (if recorded) of persons to whom we disclosed your personal information within two years prior to the request (if this information is not recorded, we will provide you with the names of those insurance institutions, agents, insurance support organizations or other persons to whom such information is normally disclosed). We will send you notification within 30 business days if we need additional time to respond to your request. If you request a copy of your information by mail, we may charge you a fee for copying and mailing costs.

Changes to personal information: If you believe that your personal information is inaccurate or incomplete, you may ask us to correct, amend, or delete 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 from the date we receive your request.

If we make changes to your records because 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 your personal information within the past two years. We will also send the updated information to any insurance support organization that gave us the information, and any insurance support organization that systematically received personal information from us within the prior 7 years unless that support organization no longer maintains your personal information.

If we deny your request to correct, amend, or delete your information, we will provide you with the reasons for the denial. You may write to us and concisely describe what you believe our records should say and why you disagree with our denial of your request to correct, amend, or delete that information. We will file this communication from you with the disputed information, identify the disputed information if it is disclosed, and provide notice of the disagreement to the recipients and in the manner described in the paragraph above.

Basis for adverse underwriting decision: You may ask in writing for 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 additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

If you would like to exercise 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, Attn: Corporate Privacy Office, 1301 South Harrison 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 unrelated to this Privacy Notice, please call 1-877-ASK-LINC.

*This information applies to the following Lincoln Financial companies:

First Penn-Pacific Life Insurance Company
Lincoln Retirement Services Company, LLC
Lincoln Life & Annuity Company of New York
Financial Investments Corporation (formerly Lincoln Investment Advisors Corporation)
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company, Inc.
Lincoln Variable Insurance Products Trust Lincoln
The Lincoln National Life Insurance Company
Lincoln Financial Insurance Agency Incorporated

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