The Lincoln National Life Insurance Company

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

CERTIFIES THAT Group Policy No. 00040400356500000 has been issued to
Travel Nurse across America, LLC
(The Group Policyholder)

The Issue Date of the Policy is January 1, 2018.

Certificate of Insurance for Preferred Plan – Class 1

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

President

READ YOUR CERTIFICATE CAREFULLY

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

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

CERTIFICATE OF GROUP ACCIDENT INSURANCE

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Travel Nurse across America, LLC
00040400356500000

SCHEDULE OF BENEFITS

For Preferred Plan – Class 1

ELIGIBLE CLASS means: All Full-Time and Regular Part-Time Employees with Bi-Weekly Payroll Deductions

MINIMUM HOURS PER WEEK: 20

ANNUAL/OPEN ENROLLMENT PERIOD: November 1 – December 15

Coverage elected during this period will become effective on the later of:
(1) January 1 following the enrollment period, if Actively at Work on that day; or
(2) the day you resume Active Work, if not Actively at Work on the day the elected coverage or increase would otherwise take effect.

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

None

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

EMERGENCY CARE BENEFITS

Type of Benefit	Preferred Benefit Amount
Ambulance Transportation	$250
Air Ambulance Transportation	$1,200
Emergency Care Treatment	$170
Initial Physician Office Visit	$100
Major Diagnostic Exam	$200

TREATMENT CARE BENEFITS

Type of Benefit	Preferred Benefit Amount
Hospital Admission	$1,300
Hospital Confinement	$250
Intensive Care Unit (ICU) Confinement	$600
Alternate Care and Rehabilitative Facility Confinement	$130
Follow-up Care	$80
Transportation	$450
Lodging	$130
Family Care	$25

SPECIFIC INJURIES OR TREATMENTS

Type of Injury/Treatment	**Preferred Benefit Amount**	
Fractures	Non-Surg	Surg
Ankle	$1,000	$2,000
Arm (shoulder to elbow)	$1,000	$2,000
Arm (elbow to wrist)	$1,000	$2,000
Bones of Face (except those listed below)	$600	$1,200
Coccyx	$600	$1,200
Collarbone	$1,000	$2,000
Elbow	$1,000	$2,000
Finger	$250	$500
Foot (except toes)	$1,000	$2,000
Hand (except fingers)	$1,000	$2,000
Hip	$3,400	$6,800
Kneecap	$1,000	$2,000
Leg (hip to knee)	$1,800	$3,600
Leg (knee to ankle)	$1,800	$3,600
Lower Jaw	$1,000	$2,000
Nose	$600	$1,200
Pelvis	$1,800	$3,600
Rib	$600	$1,200
Shoulder Blade	$1,000	$2,000
Skull (depressed)	$3,000	$6,000
Skull (non-depressed)	$1,800	$3,600
Sternum	$1,000	$2,000
Toe	$250	$500
Upper Jaw	$1,000	$2,000
Vertebrae	$600	$1,200
Vertebral Column	$1,800	$3,600
Wrist	$1,000	$2,000
Chip Fracture	25% of the fracture benefit	

SPECIFIC INJURIES (CONTINUED)

Type of Injury/Treatment	**Preferred Benefit Amount**	
Dislocations	Non-Surg	Surg
Ankle	$1,000	$2,000
Collarbone (sternoclavicular)	$1,000	$2,000
Collarbone (acromio and separation)	$800	$1,600
Elbow	$800	$1,600
Finger	$300	$600
Foot (except toes)	$1,000	$2,000
Hand (except fingers)	$800	$1,600
Hip	$3,000	$6,000
Knee (not kneecap)	$1,800	$3,600
Lower Jaw	$800	$1,600
Shoulder Blade	$800	$1,600
Toe	$300	$600
Wrist	$800	$1,600
Partial Dislocations	25% of the dislocation benefit	
Transfusions: Blood, Plasma, Platelets	$400	
Burns		
2nd Degree		
<9%	$250	
10-18%	$500	
19-36%	$1,000	
37% +	$2,000	
3rd Degree		
<9%	$2,000	
10-18%	$4,000	
19-36%	$8,000	
37% +	$16,000	
Skin Grafts (due to burns)	25% of the burn benefit	

SPECIFIC INJURIES (CONTINUED)

Type of Injury/Treatment	**Preferred Benefit Amount**
Coma	$10,000
Concussion	$200
Dental Injury - Emergency Dental Work for the following:	
Crown	$200
Extraction	$75
Eye Injury	
Surgical repair	$400
Removal of foreign body	$200
Joint Replacement	
Hip	$3,000
Knee	$2,500
Shoulder	$2,500
Lacerations	
No Sutures Required	$100
Sutures Required	
up to 5 cm	$200
5.1-15.5 cm	$400
15.6 cm+	$800
Knee Cartilage	$750
Ligaments/Tendons/Rotator Cuff	$750
Ruptured Disc	$825
Surgery - Abdominal or Thoracic	$2,600
Surgery - Arthroscopic	$350

TRANSITIONAL CARE BENEFITS

Type of Benefit	**Preferred Benefit Amount**
Medical Appliance Assistance	
Crutches	$50
Wheelchair - expected use less than 1 year	$50
Wheelchair - expected use 1 year or longer	$700
Walker - expected use less than 1 year	$50
Walker - expected use 1 year or longer	$100
Other Medical Appliance used for mobility	$50
Prosthesis	$1,000
Reasonable Modifications	$5,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

Type of Benefit	**Preferred Benefit Amount**
Loss	
Loss of Life	
Insured Person	$100,000
Insured Dependent Spouse	$50,000
Insured Dependent Child	$25,000
Loss of Hand, Foot, Arm, Leg, Eye, or Hearing in One Ear	$14,000
Any Loss of finger, thumb or toe	$600
Common Carrier Accident	2x benefit amt
Common Disaster	2x benefit amt
Transportation of Remains	$8,000
Seat Belt/Air Bag/Helmet	10% of AD&D
Catastrophic Loss	$80,000
Loss of Sight in Both Eyes	
Loss of Hearing in Both Ears	
Loss of Speech	
Loss of Both Arms and Both Legs	
Loss of Both Arms	
Loss of Both Legs	
Loss of Arm and Leg	

DEFINITIONS

ACCIDENT or **ACCIDENTAL** refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

ACTIVE WORK or ACTIVELY AT WORK means an Employee's performance of all customary duties of his or her 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, an Employee will be considered Actively at Work on the following days:

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

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/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 45 days, during which the Group Policyholder allows eligible Employees to purchase or make changes to their Personal or Dependent Accident Insurance.

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

CHANGE IN FAMILY STATUS means a marriage, divorce, birth, adoption, death or change of employment or eligibility status or other event which qualifies under the requirements of Section 125 of the Internal Revenue Code of 1986, as amended. Change in Family Status also means the involuntary loss of comparable coverage under a spouse's benefit plan.

CHIP FRACTURE means a fracture in which a piece of the bone is broken off.

CHILD CARE CENTER means any facility which:

(1) is licensed as such by the state;
(2) provides non-medical care and supervision for children in a group setting; and
(3) is not operated by the Insured Person or a member of the Insured Person's immediate family.

COMA means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Physician.

COMMON CARRIER means any land, air or water conveyance operated under a license to transport passengers for hire.

COMMON CARRIER ACCIDENT means a Covered Accident while the Insured Person or Insured Dependent is a fare-paying passenger on a Common Carrier.

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

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 ACCIDENT means an Accident that:
(1) occurs while the Insured Person's or Insured Dependent's coverage under the Policy is in effect;
(2) results in an Injury; and
(3) is not otherwise excluded under the terms of the Policy.

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

DENTIST means a licensed doctor of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

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

DISLOCATION means a completely separated joint. A Partial Dislocation means that the joint is misaligned, but not completely dislocated, as diagnosed by a Physician.

ELIGIBILITY WAITING PERIOD means the period of time a Person must be in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for insurance under the Policy.

EMERGENCY CARE FACILITY means an emergency room or urgent care facility recognized by the laws of the state where located.

EMPLOYEE means a Full-Time Employee or Regular Part-Time Employee of the Group Policyholder.

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

FRACTURE means a broken bone that can be determined by a diagnostic exam.

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

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

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

HOSPITAL 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.

HOSPITAL CONFINEMENT means being a registered bed patient in a Hospital upon a Physician's recommendation. Such confinement must be medically necessary to diagnose or treat a covered Injury.

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

INSURANCE MONTH means that period of time:
(1) beginning at 12:01 a.m. on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month;
at the Group Policyholder’s primary place of business.

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

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

INJURY OR INJURIES means bodily injury solely due to an Accident. It includes all complications of and all injuries received from the same Covered Accident.

INTENSIVE CARE UNIT (ICU) means a designated part of a Hospital that:

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

LOSS, as used in the Dismemberment and Catastrophic Loss benefits, means severance or loss of function:

(1) of the hand through or above the wrist joint;
(2) of the foot through or above the ankle joint;
(3) of the arm above the elbow;
(4) of the leg above the knee;
(5) of sight in an eye, total and permanent loss of sight;
(6) of hearing, deafness in an ear that cannot be corrected to any functional degree by any procedure, aid or device;
(7) of speech, the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device;
(8) of a finger or a thumb; or
(9) of a toe.

Loss of function means the total and irrevocable loss of use.

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

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 leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

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

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

OCCUPATIONAL THERAPIST means a person other than the Insured Person who:
(1) is licensed by the state to practice occupational therapy;
(2) performs services within the scope of his/her license; and
(3) practices according to the Code of Ethics of the American Occupational Therapy Association.

OUTPATIENT TREATMENT means medical services that an Insured Person or Insured Dependent receives when not confined as an Inpatient in a Hospital.

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

PERSON means a Full-Time Employee or Regular Part-Time Employee of the Group Policyholder:
(1) who is a member of a class that is eligible for insurance under the Policy; and
(2) who has completed an enrollment form.

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

PHYSICAL THERAPIST means a person other than the Insured Person who:
(1) is licensed by the state to practice physical therapy;
(2) performs services within the scope of his/her license; and
(3) practices according to the Code of Ethics of the American Physical Therapy Association.

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

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

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:
(1) the Insured Person's spouse, domestic partner, siblings, parents, children and grandparents; and
(2) his or her spouse's or domestic partner's relatives of like degree.

POLICY means the Group Accident Insurance policy issued by the Company to the Group Policyholder.

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

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

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

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:
(1) the Policy and any amendments to it; and
(2) the Group Policyholder's application.

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

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person or Insured Dependent, after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of insurance.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person or Insured Dependent were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If any Insured Person's or Insured Dependent's age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

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

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

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

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

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE

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

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

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

(1) a former employee is rehired within 6 months after his or her employment ends; or
(2) an employee returns from an approved Family or Medical Leave within:
    (a) the leave period required by federal law; or
    (b) any longer period required by a similar state law; or
(3) an employee returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Accident Insurance only:

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

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

(1) the first day of the Insurance Month following the day you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible. You will be deemed Actively at Work on any regular non-working day, if you:
    (a) are not totally disabled or Hospital confined on that day; and
    (b) were Actively at Work on the regular working day before that day; or
(3) if you contribute to the cost of the Personal Accident Insurance, the first day of the Insurance Month following the date you make written application for insurance and pays the required premium to the Company.

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 following the date on which you become eligible for the increase, if Actively at Work on that day; or
(2) the day you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect.

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

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL ACCIDENT INSURANCE (Continued)

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**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

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

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

TERMINATION OF PERSONAL ACCIDENT INSURANCE

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

(1) the date the Policy terminates(but without prejudice to any claim incurred prior to termination).;
(2) the date your Class is no longer eligible for insurance;
(3) the date you cease to be a member of the Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
(8) 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, the Company will refund any unearned premium).;

unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work results in termination of your eligibility for insurance, but insurance may be continued as follows.

Disability. If you are disabled due to illness or Injury, then insurance may be continued until the earlier of:

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

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

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

(1) the end of the leave period approved by the Group Policyholder;
(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.

Lay Off or Other Leave. When you cease work due to a temporary layoff, or due to an approved leave of absence (other than an approved Family or Medical Leave or Military Leave); insurance may be continued for three Insurance Months after the lay off or leave begins. The required premiums 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 Insured Persons in similar situations. Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

TERMINATION OF PERSONAL ACCIDENT INSURANCE (Continued)

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

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

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

Insurance continued under this section ends on the earliest of:

(1) the last day of the period for which you paid premiums; or
(2) the date the Company receives a written request from you to terminate the insurance.

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

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE

DEPENDENT means your:

(1) legal spouse, who is not legally separated from you;
(2) unmarried child less than 26 years of age;
(3) unmarried child, who is at least 19 years of age but less than 26 years of age, if attending an accredited educational institution for the minimum number of hours required to maintain full-time student status there; or
(4) unmarried child age 26 years or older, who is:
    (a) continuously unable to earn a living because of a physical or mental disability; and
    (b) chiefly dependent upon you for support and maintenance.

    The child must be covered by the Group Policyholder's Accident plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:

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

"Child" includes:

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

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

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

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

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

You must be insured for Personal Accident Insurance to insure your Dependents. Dependents to be insured by the Policy must be enrolled in the same plan of benefits as you.

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Accident Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE (Continued)

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

(1) the first day of the Insurance Month following the date you become eligible for Dependent Accident Insurance; or

(2) the first day of the Insurance Month following the date you make written application for Dependent Accident Insurance and pay the required Dependent premium to the Company.

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Accident benefits for the child, the insurance will become effective on the date stated in the court order; subject to payment of any additional premium.

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

(1) you complete a written application; and

(2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

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

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

TERMINATION OF DEPENDENT ACCIDENT INSURANCE

TERMINATION. Accident Insurance on a Dependent will cease on the date he or she ceases to be an eligible Dependent, as defined in the Policy.

Dependent Accident Insurance will cease for all your Insured Dependents on the earliest of:

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

SURVIVING DEPENDENTS. If Personal Accident Insurance terminates due to your death, Dependent Accident 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.

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

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for a Covered Accident that occurred while the Insured Dependent was insured under the Policy.

EMERGENCY CARE BENEFITS

The Company will pay one or more of the following emergency care benefits if you or your Insured Dependent meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

AMBULANCE TRANSPORTATION. The Company will pay an Ambulance Transportation benefit if a licensed ambulance company transports you or your Insured Dependent by ground transportation to or from a Hospital or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident. The ambulance transportation must be within 90 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

AIR AMBULANCE TRANSPORTATION. The Company will pay an Air Ambulance Transportation benefit if a licensed ambulance company transports you or your Insured Dependent by air ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident. The air ambulance transportation must be within 48 hours of the Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit may be paid in addition to the Ambulance Transportation benefit.

EMERGENCY CARE TREATMENT. The Company will pay an Emergency Care Treatment benefit if you or your Insured Dependent is examined or treated in an Emergency Care Facility as a result of a Covered Accident. The emergency care treatment must be received within 72 hours of a Covered Accident. This benefit will be paid once per person per Covered Accident.

INITIAL PHYSICIAN OFFICE VISIT. The Company will pay an Initial Physician Office Visit benefit if you or your Insured Dependent is examined or treated by a Physician or Medical Health Professional in an office of practice as a result of a Covered Accident. The examination or treatment must be administered within 60 days of a Covered Accident. This benefit will be paid once per person per Covered Accident. This benefit will not be payable if you or your Insured Dependent receives payment for the Emergency Care Treatment benefit, as described above.

MAJOR DIAGNOSTIC EXAM. The Company will pay a Major Diagnostic Exam benefit if you or an Insured Dependent undergoes one of the following major diagnostic exams as a result of a Covered Accident:

(1) a computed tomography (CT or CAT) scan;
(2) a magnetic resonance imaging (MRI);
(3) a positron emission tomography (PET) scan;
(4) an electroencephalography (EEG);
(5) a spectroscopy (SPECT);
(6) a joint imaging scan;
(7) a diffusion tensor imaging (DTI) scan; or
(8) a magneticresonsance angiogram (MRA) scan.

A major diagnostic exam must be prescribed by a Physician and performed within 60 days of the Covered Accident. This benefit will be paid once per person per Covered Accident.

TREATMENT CARE BENEFITS

The Company will pay one or more of the following treatment care benefits if you or your Insured Dependent meet the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

HOSPITAL ADMISSION. The Company will pay a Hospital Admission benefit if you or your Insured Dependent is admitted to a Hospital as a result of a Covered Accident. The admission must occur within 180 days of a Covered Accident. The Company will not pay this benefit for emergency room treatment, Outpatient Treatment, or a stay of less than 20 hours in an Observation Unit. This benefit is payable once per person per Covered Accident.

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

INTENSIVE CARE UNIT (ICU) CONFINEMENT. The Company will pay an ICU Confinement benefit for each day or partial day you or your Insured Dependent is confined in an ICU as the result of a Covered Accident. The confinement must begin within 30 days of a Covered Accident. The ICU confinement period begins on the day of admission to the ICU and ends on the day of discharge from the ICU. This benefit will be paid for up to 15 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one ICU Confinement at a time, even if it is caused by more than one Covered Accident. In the event this ICU Confinement benefit and the Hospital Confinement benefit are payable on the same day, only the ICU benefit will be paid. If you or your Insured Dependent exhausts the ICU benefit but is still confined, you or your Insured Dependent may be eligible for the Hospital Confinement benefit.

ALTERNATE CARE AND REHABILITATIVE FACILITY CONFINEMENT. The Company will pay an Alternate Care and Rehabilitative Facility Confinement benefit for each day you or your Insured Dependent is confined on an Inpatient basis in an Alternate Care or Rehabilitative Facility as a result of a Covered Accident. The confinement must begin within 180 days of a Covered Accident. This benefit is payable for up to 90 days per person per Covered Accident, which may be used over a two-year period from the date of the Covered Accident. The Company will pay for only one Alternate Care or Rehabilitative Facility Confinement at a time, even if it is caused by more than one Covered Accident. The Alternate Care and Rehabilitative Facility Confinement benefit will not be paid on any day when the Hospital or ICU Confinement benefit is paid.

FOLLOW-UP CARE. The Company will pay a Follow-Up Care benefit for each occurrence of follow-up care for Physician treatment, physical therapy, occupational therapy, or home health care that result from Injuries sustained by you or your Insured Dependent. Follow-up care must be received within 365 days of a Covered Accident. Follow-up care must be provided by a Physician, Medical Health Professional, Physical Therapist, Occupational Therapist or a Home Health Care Agency. This benefit is payable for up to 6 times per person per Covered Accident. This benefit is not payable while you or your Insured Dependent is confined in a Hospital, ICU, or an Alternate Care or Rehabilitative Facility.

TRANSPORTATION. The Company will pay a Transportation benefit when you or your Insured Dependent must travel more than 100 miles one way for treatment at a Hospital or other specialized freestanding treatment facility. The treatment must be prescribed by a Physician and not available locally. This benefit is payable up to three times per person per Covered Accident. This benefit is not payable when transportation is provided by ambulance or air ambulance.

LODGING. The Company will pay a Lodging benefit for each day a Companion accompanies you or your Insured Dependent who is Hospital confined more than 100 miles from your or your Insured Dependent's principal place of residence due to a Covered Accident. The Companion must stay in a hotel, motel or Hospital-sponsored hospitality suite. This benefit is payable for up to 30 days, within 365 days of the Covered Accident.

FAMILY CARE. The Company will pay the Family Care Benefit if:

(1) you or your Insured Dependent is confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as a result of a Covered Accident; and
(2) you have a child or children attending a Child Care Center.

This benefit is payable for each child attending a Child Care Center on any given day you or your Insured Dependent is confined. The child attending a Child Care Center does not need to be insured under the Policy for this benefit to be payable but must meet the definition of Child in the Eligibility and Effective Dates for Dependent Accident Insurance provision. This benefit is payable for up to 30 days, within 365 days of the Covered Accident. The Company will pay only one Family Care benefit per child.

SPECIFIC INJURIES OR TREATMENTS

The Company will pay one or more of the following specific injuries or treatments benefits if you or your Insured Dependent meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

FRACTURE. The Company will pay a Fracture benefit when you or an Insured Dependent sustains a Fracture or Chip Fracture as a result of a Covered Accident. The Fracture or Chip Fracture must be diagnosed by a Physician within 90 days of a Covered Accident.

DISLOCATION. The Company will pay a Dislocation benefit when you or an Insured Dependent sustains a Dislocation or Partial Dislocation as a result of a Covered Accident. The Dislocation or Partial Dislocation must be diagnosed by a Physician within 90 days of a Covered Accident.

BLOOD, PLASMA, PLATELETS. The Company will pay a benefit for your or your Insured Dependent's:

(1) transfusion;
(2) administration;
(3) cross-matching; or
(4) typing and processing;

of blood, plasma, or platelets administered as a result of a Covered Accident, provided this is done within 90 days of such Covered Accident. This benefit is payable once per person per Covered Accident.

BURNS. The Company will pay a Burn benefit when you or your Insured Dependent sustains a 2nd or 3rd degree burn as a result of a Covered Accident. The 2nd or 3rd degree burn must be treated by a Physician within 72 hours of a Covered Accident. If the burns meet more than one of the Burn Benefit classifications shown in the Schedule of Benefits, the Company will pay the single highest benefit amount. This benefit is payable once per person per Covered Accident.

SKIN GRAFT. The Company will pay a Skin Graft benefit when grafting of the skin is necessary for a burn that was payable under the Burn Benefit. This benefit is payable once per person per Covered Accident.

COMA. The Company will pay a Coma benefit if you or your Insured Dependent has been in a Coma for 15 or more days as a result of a Covered Accident. This benefit is payable once per person per Covered Accident.

CONCUSSION. The Company will pay a Concussion benefit if you or your Insured Dependent sustains a concussion as a result of a Covered Accident. The concussion must be diagnosed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

DENTAL INJURY. The Company will pay a Dental Injury benefit if your or your Insured Dependent's natural teeth are damaged and:

(1) extracted; or
(2) repaired by placement of a crown;

by a Dentist as a result of a Covered Accident. Initial treatment must be received within 7 days of a Covered Accident. This benefit is payable for up to one crown and one extraction per person per Covered Accident, regardless of the number of teeth involved.

EYE INJURY. The Company will pay an Eye Injury benefit if you or your Insured Dependent injures an eye (or eyes) in a Covered Accident and:

(1) surgical repair is performed by a Physician within 90 days of a Covered Accident; or
(2) a Physician removes an embedded foreign body from your or your Insured Dependent's eye, with or without anesthesia, within 90 days of a Covered Accident.

This benefit is payable once for each eye per person per Covered Accident.

JOINT REPLACEMENT. The Company will pay a Joint Replacement benefit when you or your Insured Dependent sustains an Injury requiring a hip, knee, or shoulder joint replacement as a result of a Covered Accident. The joint replacement must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable for each required replacement per person per Covered Accident.

LACERATION. The Company will pay a Laceration benefit when you or your Insured Dependent sustains a laceration as a result of a Covered Accident. The laceration must be treated by a Physician or Medical Health Professional within 72 hours of a Covered Accident. This benefit is payable:

(1) once for lacerations not requiring sutures, regardless of the number; and
(2) once for the total length of all lacerations requiring sutures;

per person as a result of any one Covered Accident.

KNEE CARTILAGE. The Company will pay a Knee Cartilage benefit when you or your Insured Dependent sustains an Injury requiring the surgical repair or removal of torn knee cartilage as a result of a Covered Accident. The surgical repair or removal must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

TENDON/LIGAMENT/ROTATOR CUFF. The Company will pay the Tendon/Ligament/Rotator Cuff benefit when you or your Insured Dependent requires surgical repair of:

(1) tendons;
(2) ligaments; or
(3) the muscles or tendons that make up the rotator cuff;

as a result of a Covered Accident. The surgical repair must be performed by a Physician within 90 days of a Covered Accident. This benefit is payable once per person per Covered Accident.

RUPTURED DISC. The Company will pay the Ruptured Disc benefit when you or your Insured Dependent sustains an Injury requiring surgical repair of a ruptured intervertebral disc as a result of a Covered Accident. The ruptured disc must be surgically repaired by a Physician within 90 days of a Covered Accident. This benefit is payable once per disc per person per Covered Accident.

SURGERY (ABDOMINAL OR THORACIC). The Company will pay the Surgery (Abdominal or Thoracic) benefit when you or your Insured Dependent undergoes abdominal or thoracic surgery as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

SURGERY (ARTHROSCOPIC). The Company will pay a Surgery (Arthroscopic) benefit when you or your Insured Dependent undergoes arthroscopic surgery, with no repair, as a result of a Covered Accident. The surgery must be performed by a Physician within 72 hours of a Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSITIONAL CARE BENEFITS

The Company will pay one or more of the following transitional care benefits if you or your Insured Dependent meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

MEDICAL APPLIANCE ASSISTANCE. The Company will pay a benefit for Medical Appliances that are required by you or your Insured Dependent as a result of Injuries sustained in a Covered Accident. The Medical Appliance must be recommended by a Physician or Medical Health Professional and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the Physician or Medical Health Professional must recommend the Medical Appliance within two years of the Covered Accident. This benefit is payable once for any one Medical Appliance per person per Covered Accident.

Medical Appliance means an item that is intended by its manufacturer for use in directly substituting for a malfunctioning part of the body for assistance with mobility. Examples include crutches, wheel chairs and walkers.

PROSTHESIS. The Company will pay a benefit for functional prosthetic limbs that are required by you or an Insured Dependent as a result of Injuries sustained in a Covered Accident. The functional prosthetic limb must be prescribed by a Physician and received within 365 days of a Covered Accident. In the event of a Catastrophic Loss, the prosthetic limb must be prescribed by a Physician and received within two years of the Covered Accident. This benefit is payable once per limb per person per Covered Accident.

REASONABLE MODIFICATIONS. The Company will pay a benefit for required modifications made to you or your Insured Dependent's:

(1) principal place of residence; or
(2) vehicle;

provided you or your Insured Dependent suffers a Catastrophic Loss, as described in the Schedule of Benefits. Modifications must be made within two years from the date of the Covered Accident. This benefit is payable once per person per Covered Accident.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The Company will pay one or more of the following AD&D benefits if you or your Insured Dependent meets the terms and conditions for an applicable benefit as the result of Injuries sustained in a Covered Accident. Benefit amounts payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH OR DISMEMBERMENT. The Company will pay an Accidental Death or Dismemberment benefit when you or your Insured Dependent sustains an Injury that causes death or dismemberment as a result of a Covered Accident. The Injury must cause death or dismemberment within 365 days of the Covered Accident. The benefit amount payable is shown in the Schedule of Benefits for each type of Loss.

The Accidental Dismemberment Benefit will also be payable if a covered body part is surgically reattached.

If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

COMMON CARRIER ACCIDENT. The Company will pay the Common Carrier Accident benefit when you or your Insured Dependent sustains a Common Carrier Accident that results in your or your Insured Dependent's death or dismemberment within 90 days of the Covered Accident. This benefit is payable once per person per Covered Accident.

TRANSPORTATION OF REMAINS. The Company will pay a Transportation of Remains benefit if you or your Insured Dependent dies at least 100 miles from your or your Insured Dependent's principal place of residence as a result of a Covered Accident, and the bodily remains or ashes are returned:

(1) by a company that provides mortuary transport services; and
(2) to a mortuary or funeral home within 30 miles of the deceased's principal place of residence.

The Company will pay for only one Transportation of Remains benefit per person.

A benefit payable for the transportation of your remains will be paid in accord with the Beneficiary provision. A benefit payable for the transportation of your Insured Dependent's remains will be paid to you.

SEAT BELT/HELMET. If you or your Insured Dependent:

(1) was wearing a seat belt or helmet while operating or riding in or on a bicycle or motorized vehicle at the time of a Covered Accident; and
(2) suffers an AD&D loss;

the Accidental Death or Dismemberment benefit amount will be increased by the percentage stated in the Schedule of Benefits.

COMMON DISASTER. The Company will pay a Common Disaster benefit if both you and your Insured Dependent Spouse:

(1) is Injured in the same Covered Accident; and
(2) lose your lives as a direct result of such Injuries within 365 days of the Common Accident.

The Common Disaster benefit increases your Insured Dependent Spouse's benefit for Accidental loss of life to equal your Accidental Death Benefit.

CATASTROPHIC LOSS. The Company will pay the Catastrophic Loss benefit when you or your Insured Dependent sustains an Injury in a Covered Accident that results in a Catastrophic Loss within 365 days of the Covered Accident. The benefit amount is payable once per person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment Benefit will not be paid for the same or attached body part.

LIMITATIONS AND EXCLUSIONS

The Policy covers only Injuries that occur while insurance is in force. Benefits are not payable for any loss if the loss resulting, directly or indirectly, from or was in any degree caused by:

(1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
(2) intentional self-inflicted injury or self-destruction, or any attempt thereof; suicide or suicide attempt, whether sane or insane;
(3) deliberate use of drugs, poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, except when administered within the therapeutic levels and dosage prescribed by a licensed Physician;
(4) participation in, commission of or attempt to commit a felony;
(5) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
(6) duty as a member of any military, including Reserves or National Guard;
(7) 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 or pilot in the Group Policyholder's aircraft while flying on 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 to fly the aircraft;
(8) your or your Insured Dependent having a blood alcohol level of .08 grams of alcohol or more per 100 milliliters of blood;
(9) Injury arising out of or in the course of any employment for wage or profit;
(10) high risk sports or extreme sports such as, but not limited to, bungee jumping, parachuting, base jumping, or mountaineering;
(11) cosmetic or elective surgery;
(12) being incarcerated in any type of penal or detention facility;
(13) participating in or practicing for, or officiating any semi-professional or professional sport;
(14) riding in or driving in any motor driven vehicle for race, stunt show or speed test; or
(15) an Injury sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

BENEFICIARY

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

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

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

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

If the person who would otherwise receive payment dies:

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

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

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

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

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

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

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

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

NOTICE AND PROOF OF CLAIM

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

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

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

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

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

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

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

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

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

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

PHYSICAL EXAMS. While an Accident claim is pending, the Company may have the claimant examined:

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

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

TIME OF PAYMENT OF CLAIMS. Any Accident Benefits payable under this Certificate will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE

Accidental Death & Dismemberment. Benefits due to loss of your life will be paid in accord with the Beneficiary provision. All other benefits will be paid to you.

Other Accident Benefits. Any other Accident Benefits will be paid to you; unless:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLAIM PROCEDURES FOR ACCIDENT INSURANCE
(Continued)

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

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

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

Such reimbursement is required whether the overpayment is due to:

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

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

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

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Disability Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

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

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

EXCLUSIONS FROM COVERAGE. However, persons holding such policies are NOT protected by the Guaranty Association if:

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

The Guaranty Association also does NOT provide coverage for:

* any policy or contract or portion of a policy which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;

* any policy of reinsurance (unless an assumption certificate was issued);

* interest rate yields that exceed an average rate;

* dividends, voting rights, and experience rating credits;

* credits given in connection with the administration of a policy by a group contract holder;

* employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

* unallocated annuity contracts (which give rights to group contractholders, not individuals);

* unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") whether the FPBC is yet liable or not;

* portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);

* portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

* obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;

* contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE. The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 00040400356500000
ISSUED TO: Travel Nurse across America, LLC
FOR: Preferred Plan-Class 1

The definitions of DEPENDENT and "Child" shown in the ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT ACCIDENT INSURANCE are amended to read:

DEPENDENT means an your:

(1) legal spouse, who is not legally separated from you;
(2) domestic partner;
(3) child less than 26 years of age; or
(4) child age 26 years or older, who is:
    (a) continuously unable to earn a living because of a physical or mental disability; and
    (b) chiefly dependent upon you for support and maintenance.

    The child must be covered by the Group Policyholder's Accident plan on the day before coverage would otherwise end due to his or her age. Proof of the total disability must be sent upon request. The premium will continue at the Dependent rate.

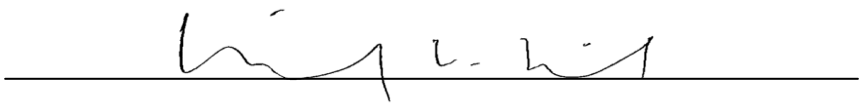
Dependent will also include a child that you are required to provide insurance under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under,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

"Child" includes:

(1) your natural child, legally adopted child, or stepchild;
(2) a child placed under your charge, care or control for whom you have filed a petition to adopt, from:
    (a) the moment of birth, if the petition of adoption and application for coverage is filed within 60 days after the birth of the minor; or
    (b) the date of the filing of a petition for adoption, if you apply for coverage within 60 days after the filing of the petition for adoption;
(3) a child of a domestic partner;
(4) a grandchild;
(5) a child for whom you are required by court order to provide Accident coverage; and
(6) a foster child for whom you have assumed full parental responsibility and control.

This amendment takes effect on January 1, 2018, 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

Lincoln Financial Group®

Lincoln Financial Group® Privacy Practices Notice

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

Information We May Collect And Use

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

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

How We Use Your Personal Information

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

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

Security of Information

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

Your Rights Regarding Your Personal Information

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

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

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

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

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

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

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

Questions about your personal information should be directed to:

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

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

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

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

Lincoln Financial Group℠

LINCOLN FINANCIAL GROUP® PRIVACY NOTICE FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You have received this Notice because you have applied for, or currently have, insurance coverage or an annuity ("Coverage"), that contains benefit provisions subject to the federal privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act, as amended ("HIPAA"). This is Coverage that has been, or will be issued with one of the Lincoln Financial Group insurance companies* ("Company"). This Notice refers to the Company by using the terms "us," "we," or "our." We value our relationship with you and are committed to protecting the confidentiality and security of information we collect about you, especially health information.

We collect, use and disclose information about you to evaluate and process any requests for coverage and claims for benefits you may make regarding your Coverage. This notice describes how we protect the protected health information we have about you which relates to your Coverage ("Protected Health Information"), and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This Notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required to provide you with this Notice in accordance with federal health privacy regulations that were issued as a result of HIPAA. We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected Health Information; and to follow the terms of this Notice.

We reserve the right to change the terms of this Notice. Any such changes will apply to all Protected Health Information we already have about you as well as any Protected Health Information we may receive in the future. If we make a material change to the terms of the Notice, we will promptly send the revised Notice to you should you still maintain coverage with us when the revised Notice becomes effective.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following describes when we may use and disclose your Protected Health Information with your written authorization and without your authorization:

Authorization: Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Protected Health Information. You or your legal representative has the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage.

Treatment: We may use and disclose your Protected Health Information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request Protected Health Information that we hold about you in order to make decisions about your care.

Payment of Claims: We may use and disclose your Protected Health Information to pay for benefits under your Coverage. For example, when you present a claim for benefits, we may obtain medical records from the doctor or health facility involved in your care to determine if you are eligible for benefits under the insurance policy and to reimburse you for services provided. Other payment-related uses and disclosures that are permitted and we may engage in include: making claim decisions, coordinating benefits with other insurers or payers, billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.

Health Care Operations: We may use and disclose your Protected Health Information for our insurance operations. Our insurance operations may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of Coverage, or for reinsurance purposes. For example, when you apply for insurance we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Protected Health Information to conduct or arrange for medical review, legal services, contract for reinsurance, business planning and development regarding the management and operation of our Coverage processes, or auditing, including fraud and abuse detection and compliance programs. Protected Health Information may also be disclosed for customer service, servicing our current and future customer relationships permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction. For group plans Protected Health Information may be disclosed to your Plan Sponsor for purposes of administering your Plan or other health plan maintained by your employer to facilitate claims payments under the plan.

Business Associates: We may also disclose Protected Health Information to non-affiliated business associates, but only if the receipt of Protected Health Information is necessary to provide a service to us and the business associate agrees to protect the Protected Health Information according to HIPAA rules. Examples of business associates are: billing companies, data processing companies, auditors, claims processing companies and companies that provide general administrative services.

Where Required by Law, for Public Health or Similar Activities: We may also disclose Protected Health Information where required by law, for public health or similar activities. Examples include:

- Releasing Protected Health Information to state or local health authorities, as required by law, of particular communicable diseases, injury, birth, death, and for other required public health investigations;
- Releasing Protected Health Information to a governmental agency or regulator with health care oversight responsibilities;
- Releasing Protected Health Information to a coroner, medical examiner or funeral director to assist in identifying a deceased individual or to determine the cause of death;
- Releasing Protected Health Information to public health or other appropriate authorities, as required by law, when there is reason to suspect abuse, neglect, or domestic violence;
- Releasing Protected Health Information to the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- Releasing Protected Health Information if required by law to do so by a court or administrative ordered subpoena or discovery request, or for law enforcement purposes as permitted by law. We will make efforts to notify you of such requests or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- Releasing Protected Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- Releasing Protected Health Information if you are a member of the military as required by armed forces services;
- Releasing Protected Health Information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Releasing Protected Health Information to worker's compensation agencies if necessary for your worker's compensation benefit determination;

- Releasing Protected Health Information to avert a serious threat to someone's health or safety, including the disclosure of Protected Health Information to government or privacy disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations.
- Uses and Disclosures to Family, Friends or Others Involved in Your Care: With your written approval, we may disclose your Protected Health Information to designated family, friend, personal representative, or other individual that you may identify as involved in your care or involved in the payment for your care. Should you become incapacitated or be in the face of an emergency medical situation and not able to provide us with your written approval, we may disclose Protected Health Information about you that is directly relevant to such person's involvement in your care or payment for such care.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights as a consumer under HIPAA concerning the Protected Health Information we have about you in our records. Any request to exercise your rights as described below should be made in writing and sent to **Lincoln Financial Group, Attn: Enterprise Compliance – Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802.** Also, should you wish to terminate a request that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

Right to Request Restrictions: You have the right to request that we restrict or limit our use or disclosure of your Protected Health Information that would otherwise be permitted for purposes related to treatment, payment or our health care operations, including disclosure to someone who may be involved in your care or payment for your care, like a family member, friend or personal representative. While we will consider your request, we are not required to agree to your restriction. If we do agree to the restriction, we will not use or disclose your Protected Health Information as requested but reserve the right to terminate the agreed to restriction if we deem appropriate. In your request to restrict use and disclosure, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications: You have the right to request that we communicate with you about Protected Health Information in a certain way or using a certain address or email address, if you make such a request in writing and send it to the address provided above. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Copy Your Protected Health Information: In most instances, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. Your request must be in writing and sent to the address provided above. We will deny inspection and copying of certain Protected Health Information, for example psychotherapy notes and Protected Health Information collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. In those limited circumstances that we deny your request to inspect and obtain a copy of your Protected Health Information, you have the right to request a review of our denial. Your request to review our denial should be submitted in writing and sent to the address provided above.

Right to Amend Your Protected Health Information: You have the right to request that we amend your Protected Health Information in our records if you believe it is inaccurate or incomplete. Your request must be in writing and sent to the address provided above. Your request must provide your reason(s) for seeking the amendment or correction. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as notify others with whom we have disclosed the erroneous Protected Health Information. We may deny your request if you ask us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. If we deny your request, we will provide you with an explanation for our denial and any further rights you may have regarding your request to amend.

Right to Receive an Accounting of Disclosures of Your Protected Health Information: You have the right to request an accounting or list of disclosures we have made of your Protected Health Information. This list will not include disclosures

- For treatment;
- For payment or health care operations;
- To law enforcement, for purposes of national security
- To department of corrections personnel;
- Pursuant to your authorization;
- or directly to you.

To request this list, you must submit your request in writing to the address provided above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. We reserve the right to charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice upon request, even if you received this Notice electronically.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit a written complaint to the address provided above. You can be assured that the Company will not retaliate against you for filing a complaint.

For Further Information: For further information regarding this Notice or the Company's privacy practices, please contact **Lincoln Financial Group, Attn: Enterprise Compliance – Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802, or call 1-877-275-5462.**

Effective Date: This Notice is effective June 1, 2011.

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

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

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 Accident 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 Accident 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 Accident 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.