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. 00040500430600000 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 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 Critical Illness insurance coverage. There is no coverage for hospital, medical-surgical or major medical expenses.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS CERTIFICATE CONTAINS A PRE-EXISTING CONDITION EXCLUSION.

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

CERTIFICATE OF GROUP CRITICAL ILLNESS INSURANCE

TABLE OF CONTENTS

Travel Nurse across America, LLC
00040500430600000

SCHEDULE OF BENEFITS

For 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;
(2) the day you resume Active Work, if not Actively at Work on the day the elected coverage or increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

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

None

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

SCHEDULE OF BENEFITS
(Continued)

PERSONAL CRITICAL ILLNESS INSURANCE

Class 1 (Option as elected by you)	Personal Critical Illness Principal Sum
Option 1	$10,000
Option 2	$20,000
Option 3	$30,000

DEPENDENT CRITICAL ILLNESS INSURANCE
(For Class 1)

Dependent Spouse (Option as elected by you)	Dependent Critical Illness Principal Sum
Option 1	$5,000
Option 2	$10,000
Option 3	$15,000
Dependent Child	25% of your Personal Critical Illness Principal Sum.

HEART CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	**Percentage of Principal Sum**
Heart Attack	100%
Placement on United Network for Organ Sharing (UNOS) List for Heart Transplant*	100%
Stroke	100%
Arteriosclerosis	10%, subject to a lifetime maximum of 2 payments
Aneurysm due to Arteriosclerosis	10%, subject to a lifetime maximum of 2 payments

CANCER CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
Cancer	100%
Cancer in Situ	25%
Benign Brain Tumor	25%
Placement on the Be the Match Registry for Bone Marrow Transplant*	25%

ORGAN CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
End Stage Renal Failure	100%
Placement on United Network for Organ Sharing (UNOS) List for Major Organ Transplant (excluding Heart)*	100%
Acute Respiratory Distress Syndrome	25%

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

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

Event/Illness	Percentage of Principal Sum
ALS/Lou Gehrig's Disease	100%
Advanced Alzheimer's Disease	100%
Advanced Multiple Sclerosis	25%
Advanced Parkinson's Disease	100%
Loss of Sight	25%
Loss of Hearing	25%
Loss of Speech	25%

WELLNESS CATEGORY (Available for Insured Persons and Dependents)

Critical Illness Assessment Benefit

Critical Illness Assessment Period:	January 1st through December 31st
Critical Illness Assessment Benefit:	$50 for each Critical Illness Assessment Test performed, subject to a maximum of 1 Critical Illness Assessment Test per person per Critical Illness Assessment Period
Child Care Expense Benefit	$25 per Child per day

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

*A benefit for this Event may also be payable if you or your Insured Dependent:
(1) is determined to be too ill for a transplant, but otherwise meet the criteria for placement on the network/registry; or
(2) receives a transplant prior to placement on the network/registry.

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

(1) Critical Illness Insurance amounts exceed the guarantee issue amount of $30,000 for Insured Persons or $15,000 for Insured Dependent Spouses at initial enrollment;
(2) the amount of Critical Illness Insurance increases after the initial enrollment; or
(3) initial coverage is elected more than 31 days after first becoming eligible.

DEFINITIONS

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.

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

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

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

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

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

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

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

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

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

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

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 Critical Illness Insurance.

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

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

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

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

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

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

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

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

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

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

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.

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

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.

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

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

EVENT/ILLNESS means a Critical Illness event or illness:
(1) shown in the Schedule of Benefits; and
(2) for which the Insured Person or Insured Dependent is covered under the Policy.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Group Policyholder's 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.

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.

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

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

HOSPITAL means a general hospital which:

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

It does not include a place that:

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

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

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 DEPENDENT SPOUSE means the Insured Person's spouse or domestic partner for whom coverage is in effect.

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

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

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

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

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

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

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

PAYROLL PERIOD means that period of time established by the Group Policyholder 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 CRITICAL ILLNESS INSURANCE means the insurance provided by the Policy for Insured Persons.

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

PREMIUM means the amount charged for insurance coverage.

REGULAR PART-TIME EMPLOYEE means a person:

(1) whose employment is for wage or salary;
(2) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of 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.

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

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.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) an Insured Person or Insured Dependent incurs a claim during the first two years of coverage; and
(2) the Company discovers that the Insured Person or Insured Dependent made a Material Misrepresentation on his or her application.

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

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

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

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

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

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE

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

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed. (For Waiting Period, see Schedule of Benefits).

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

(1) a former employee is rehired within six 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 Critical Illness 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 Critical Illness Insurance becomes effective on the latest of:

(1) the first day of the Insurance Month following the date you become eligible for the insurance;
(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);
(3) if you contribute to the cost of the Personal Critical Illness Insurance, the first day of the Insurance Month following the date you make written application for insurance and pay the required premium to the Company; or
(4) the first day of the Insurance Month following the date the Company approves your Evidence of Insurability, if required. (See Schedule of Benefits).

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

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

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

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Critical Illness Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period. (See Schedule of Benefits).

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

REINSTATEMENT RIGHTS. If your insurance terminates due to one of the following breaks in service, 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;
(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 CRITICAL ILLNESS 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) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category;
(9) the date you cease to be covered under at least one category other than the Wellness Category;
(10) the date your employment with the Group Policyholder terminates; or
(11) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium).;

unless insurance is continued as provided below.

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

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

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

The required premium payments must be received from the Group Policyholder, 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.

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.

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

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

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

Insurance continued under this section ends on the earliest of:

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

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

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE

DEPENDENT means your:

(1) legal spouse, who is not legally separated from you;
(2) 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 Critical Illness plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company upon request. The premium will continue at the Dependent rate.

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

"Child" includes:

(1) your natural child, 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 for whom you are required by court order to provide Critical Illness insurance;
(4) a grandchild who resides in your household; and who is chiefly dependent on you for support;
(5) a child of a domestic partner; and
(6) a foster child for whom you have assumed full parental responsibility and control.

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

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

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

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

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

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

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

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

(1) the first day of the Insurance Month following the date you become eligible for Dependent Critical Illness Insurance; or
(2) the first day of the Insurance Month following the date you make written application for Dependent Critical Illness Insurance and pay the required Dependent premium to the Company; or
(3) the first day of the Insurance Month following the date the Company approves any Evidence of Insurability, if required. (See Schedule of Benefits).

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

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

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

(1) you complete a written application; and
(2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

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

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

TERMINATION OF DEPENDENT CRITICAL ILLNESS INSURANCE

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

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

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

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

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

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

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

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

CRITICAL ILLNESS BENEFITS

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

Benefit amounts payable are shown in the Schedule of Benefits.

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

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

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

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

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

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

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

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

"**Child Care Expense**" means an expense for the care of a Child, charged by a licensed care provider who:
(1) is not a member of your immediate family; and
(2) is not living in your home.

"**Child,**" as used in the Child Care Expense Benefit, means your naturally born child, legally adopted child, stepchild, foster child, or child for whom you are the legal guardian, if the child is:
(1) less than age 16 and living with you; or
(2) age 16 years or older, who is:
    (a) unmarried;
    (b) living with you; and
    (c) incapable of independent living due to a mental or physical condition.

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

Proof. You must submit to the Company satisfactory proof that a Child Care Expense has been incurred for a Child (as defined in this provision) and paid by you or your Insured Dependent Spouse. Satisfactory proof is a signed receipt from the Child care provider showing:
(1) Child name;
(2) Child age;
(3) dates of care;
(4) total charges for care;
(5) total payments for care; and
(6) provider name, address, telephone number, and Federal Employer Identification Number/Taxpayer Identification Number.

Duration. The Child Care Expense Benefit will be payable for up to a maximum of 30 days from the date you or your Insured Dependent Spouse were confined as an Inpatient in a Hospital. This Benefit will cease on the earliest of:
(1) the date you or your Insured Dependent Spouse is released from Inpatient treatment;
(2) the date your or your Insured Dependent Spouse's Child(ren) no longer meet(s) the definition of Child in this provision; or
(3) the date the maximum duration ends.

EXCLUSIONS

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

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

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

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

(1) resulting, directly or indirectly, from or in any degree caused by a Pre-Existing Condition; and
(2) diagnosed in the first 12 months following your or your Insured Dependent's Effective Date.

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

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

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

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

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable under the Policy will be paid to the named Beneficiary who survives you. If 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 CRITICAL ILLNESS INSURANCE

NOTICE AND PROOF OF CLAIM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Such reimbursement is required whether the overpayment is due to:

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

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

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

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

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

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

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

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

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.

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

SUMMARY PLAN DESCRIPTION

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

The name of the Plan is: Group Critical Illness Insurance for Employees of Travel Nurse across America, LLC

The name, address and ZIP code of the Sponsor of the Plan is: Travel Nurse across America, LLC, 5020 Northsore Drive, Suite 2, North Little Rock, AR 72118.

Employer Identification Number (EIN): 20-1068277 IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: Travel Nurse across America, LLC, 5020 Northsore Drive, Suite 2, North Little Rock, AR 72118, (501) 663-5288.

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

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

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

Type of Funding Arrangement: The Lincoln National Life Insurance Company

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits, any Benefit Waiting Period, and Exclusions, including any Pre-Existing Condition Exclusion. The Certificate also contains the Schedule of Benefits which includes the Categories of Benefits, Critical Illness Principal Sum, Benefit Amounts, Eligibility Waiting Period, and any age reduction information. If your Booklet, Certificate or Schedule of Benefits has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

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

Employees become eligible on the first day of the Insurance Month following the date of active full-time employment.

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

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

The name and section of relevant Collective Bargaining Agreements: None

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

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

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

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

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

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

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

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