The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. CI-0000001403 has been issued to:
McLane Company, Inc.
(The Group Policyholder)

Certificate of Insurance for Class 1 Plan 1

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

Ellen Cooper
PRESIDENT

READ YOUR CERTIFICATE CAREFULLY

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

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

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

CERTIFICATE OF GROUP CRITICAL ILLNESS INSURANCE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- **hospitalization**
- **physician services**
- **hospice**
- **other approved items and services**

BEFORE YOU BUY THIS INSURANCE

- **Check the coverage in all health insurance policies you already have.**
- **For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.**
- **For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.**

Notice: The Insurance Policy under which this certificate is issued is not a policy of Workers' Compensation Insurance. You should consult your Employer to determine whether your Employer is a subscriber to the Workers' Compensation system.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't you may lose your right to appeal.

The Lincoln National Life Insurance Company
To get information or file a complaint with your insurance company or HMO:

Call: Client Services at 1-800-423-2765
Email: gpcomplaints@lfg.com
Mail: Group Insurance Service Office
8801 Indian Hills Drive
Omaha, NE 68114-4066

Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091
Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

The Lincoln National Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a:
Client Services al 1-800-423-2765
Correo electrónico: gpcomplaints@lfg.com
Dirección postal:
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, NE 68114-4066

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico:
ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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McLane Company, Inc.
CI-0000001403

SCHEDULE OF BENEFITS

Plan 1 – Critical Illness
Class 1 - All Full-Time Salaried and Hourly Employees

Group Policy Effective Date: January 1, 2021

Reissued Policy Effective Date: June 1, 2023

Group Policy Number: CI-0000001403

Participating Organizations:

Claims Services, Inc. (Effective Date January 1, 2021)
Consumer Value Products, Inc. (Effective Date January 1, 2021)
Empire Distributors of Colorado, Inc. (Effective Date January 1, 2021)
Empire Distributors of North Carolina, Inc. (Effective Date January 1, 2021)
Empire Distributors of Tennessee, Inc. (Effective Date January 1, 2021)
Empire Distributors, Inc. (Effective Date January 1, 2021)
Intrepid JSB, Inc. (Effective Date January 1, 2021)
Kahn Ventures, Inc. (Effective Date January 1, 2021)
Kinexo, Inc. (Effective Date January 1, 2021)
M & C Products, Inc. (Effective Date January 1, 2021)
MFS Fleet, Inc. (Effective Date January 1, 2021)
McLane Beverage Distribution, Inc. (Effective Date January 1, 2021)
McLane Beverage Holding, Inc. (Effective Date January 1, 2021)
McLane Eastern, Inc. (Effective Date January 1, 2021)
McLane Express, Inc. (Effective Date January 1, 2021)
McLane Foodservice Distribution, Inc. (Effective Date January 1, 2021)
McLane Foodservice, Inc. (Effective Date January 1, 2021)
McLane Mid-Atlantic, Inc. (Effective Date January 1, 2021)
McLane Midwest, Inc. (Effective Date January 1, 2021)
McLane Minnesota, Inc. (Effective Date January 1, 2021)
McLane New Jersey, Inc. (Effective Date January 1, 2021)
McLane Ohio, Inc. (Effective Date January 1, 2021)
McLane Southern, Inc. (Effective Date January 1, 2021)
McLane Suneast, Inc. (Effective Date January 1, 2021)
McLane Western, Inc. (Effective Date January 1, 2021)
Transco, Inc. (Effective Date January 1, 2021)

Eligible Class: Class 1 - All Full-Time Salaried and Hourly Employees

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

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

Eligibility Waiting Period: (For Date insurance begins, refer to "Effective Dates" section.)
None

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

Guarantee Issue Amount:
$30,000 for You

SCHEDULE OF BENEFITS
(Continued)

Plan 1 – Critical Illness
Class 1 - All Full-Time Salaried and Hourly Employees

$15,000 for Your Insured Dependent Spouse

Minimum Full-Time Hours: 30 hours per week

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

Continuation Rights Included:
Family or Medical Leave
Military Leave
Disability: 12 Insurance Months
Other Leave of Absence: three Insurance Months
Lay Off: three Insurance Months
Temporary Reduction in Hours: six Insurance Months
Labor Dispute: six Months
Refer to the Continuation Rights provision for more information.

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

Pre-existing Condition Exclusion: Not Applicable

Time Limit between Occurrences of Different Covered Conditions: 6 Months
Refer to the Limitations and Exclusions provision for more information.

Time Limit between Recurrences of the Same Covered Condition: 12 Months
Refer to the Limitations and Exclusions provision for more information.

McLane Company, Inc.
CI-0000001403

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Critical Illness
Class 1 - All Full-Time Salaried and Hourly Employees

CRITICAL ILLNESS INSURANCE

		Critical Illness Principal Sum
Class 1	Option 1	$10,000
	Option 2	$20,000
	Option 3	$30,000

DEPENDENTS CRITICAL ILLNESS INSURANCE
(For Class 1)

Dependent	Dependents Critical Illness Principal Sum	
Spouse	Option 1	$5,000
	Option 2	$10,000
	Option 3	$15,000
Dependent Child	Option 1	$2,500
	Option 2	$5,000
	Option 3	$7,500

Dependent Critical Illness Insurance may not exceed 50% of Your Critical Illness Principal Sum in effect under this Certificate.

McLane Company, Inc.
CI-0000001403

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Critical Illness
Class 1 - All Full-Time Salaried and Hourly Employees

BENEFITS.

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

Covered Conditions	Percentage of Principal Sum or Benefit Amount
Heart Attack	100%
Arterial/Vascular Disease	25%
Stroke	100%
End Stage Renal Failure	100%
Major Organ Failure	100%
Invasive Cancer	100%
Non-invasive Cancer/Cancer in Situ	25%
Skin Cancer	$250, payable once in Your lifetime and once in an Insured Dependent's lifetime

Child Covered Conditions	Percentage of Dependent Child Principal Sum
Cerebral Palsy	100%
Cleft Lip/Cleft Palate	100%
Cystic Fibrosis	100%
Down Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Type 1 Diabetes	100%

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Critical Illness
Class 1 - All Full-Time Salaried and Hourly Employees

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to Us must be submitted when You initially enroll for Critical Illness Insurance or Dependents Critical Illness Insurance more than 31 days after becoming eligible.

ELIGIBILITY AND EFFECTIVE DATES
For
Your Critical Illness Insurance

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

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

ENROLLMENT. You may enroll for Critical Illness Insurance:
(1) within 31 Days of the Date You are first eligible; or
(2) within 60 Days following a qualifying Change In Family Status.

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

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

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

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

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

ELIGIBILITY AND EFFECTIVE DATES
For
Dependents Critical Illness Insurance

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

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

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

(1) when You are first eligible for Dependents Critical Illness Insurance; or
(2) within 60 Days following a qualifying Change in Family Status.

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

Refer to the Schedule of Benefits for Evidence of Insurability requirements.

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

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

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

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

within 31 Days of the Date the Dependent is acquired.

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

EXCEPTIONS.

Court Ordered Insurance. If Dependents Critical Illness Insurance is provided to a Child based on a court order which requires You to provide Critical Illness benefits for the Child, then the child will be automatically covered for the first 31 days following Our receipt or notice of the court order. If You have no other Children enrolled for Dependents Insurance under this Certificate, and You do not elect to enroll the Child and pay any additional Premium within 31 Days following Our receipt of notice of the court order, the Child's insurance will terminate.

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

(1) within 31 Days of the Day insurance would otherwise end due to age; and
(2) thereafter, when We request (but not more than once every two years).

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

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

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

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

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

PRIOR INSURANCE CREDIT
For Group Critical Illness Insurance

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

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

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

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

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

TIME LIMIT BETWEEN OCCURRENCES OF DIFFERENT COVERED CONDITIONS. We will not pay a benefit if You or Your Insured Dependent sustains a Covered Condition shown in the Schedule of Benefits within 6 Months of a different Covered Condition.

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

Exception for Invasive Cancer. If You or Your Insured Dependent sustains Invasive Cancer within 6 Months of a payable Non-invasive Cancer, We will pay the difference between the benefits for Non-invasive and Invasive Cancer as shown in the Schedule of Benefits.

Exception for Heart Attack. If You or Your Insured Dependent sustains a Heart Attack within 6 Months of a payable Arterial/Vascular Disease, We will pay the difference between the benefits for Arterial/Vascular Disease and Heart Attack as shown in the Schedule of Benefits.

TIME LIMIT BETWEEN RECURRENCES OF THE SAME COVERED CONDITION. We will not pay a benefit if You or Your Insured Dependent sustains the same Covered Condition, as shown in the Schedule of Benefits, more than once within a period of 12 Months or less.

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

(1) You or Your Insured Dependent sustains the same Covered Condition more than 12 Months apart; and
(2) You or Your Insured Dependent received no Treatment for that Covered Condition during the period shown in item (1) above.

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

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

CLAIM PROCEDURES
For Critical Illness Insurance

FILING A CLAIM.

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

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

Claim Forms. When We receive notice of a claim, We will send forms for filing the required proof. We will include instructions for completing and submitting the forms. If We do not send the forms within 15 Days, the claimant may send Us written proof of a claim in a letter. We will deem the letter to comply with the requirements for providing proof of loss if it is received within the timeframes established in the Proof of Claim section. The letter should state the nature, Date and cause of the claim.

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

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

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

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

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

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

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

Any such exam or autopsy will be at Our expense.

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

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

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

PAYMENT OF CLAIMS.

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

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

To Whom Payable. Benefits payable under this Certificate, including any benefits for Insured Dependents, will be paid to You, while living, unless:

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

If any benefits remain to be paid after Your death, such benefits will be paid in accord with the Beneficiary provision, and the Facility of Payment and Payment Options provided below. Benefits payable after an Insured Dependent's death will be paid to:

(1) You, if You survive that Dependent; or
(2) Your Beneficiary or according with the Facility of Payment section, if You do not survive that Dependent.

Facility of Payment. If any benefit under this Certificate becomes payable to Your estate, a minor, or any person who We consider not competent to give a valid release, We may make payment to any one or more of the following:

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

No payment made under this section may exceed $1,000. Any remaining amount will be paid as shown in the Beneficiary section.

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

NOTICE OF OUR CLAIM DECISION. We will send the claimant a written notice of Our claim decision. If We deny any part of the claim, the written notice will explain:

(1) the reason for the denial;
(2) how the claimant may request a review of Our decision; and
(3) whether more information is needed to support the claim.

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

We will send the claimant a written delay notice explaining the special circumstances which require the delay, and when a decision can be expected:

(1) by the 15th Day after We receive the first proof of claim; and
(2) every 30 Days after that, until the claim is resolved.

If reasonably possible, We will send notice within 90 Days after receiving the first proof of a claim.

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

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

REVIEW OF OUR CLAIM DECISION. If a claim is denied, the claimant may request a review of Our decision.

Second Review Request (Appeal). To begin a review, the claimant must send Us:

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

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

Time Limits for Claimant to Request a Second Review (Appeal). The claimant may request a claim review within 60 Days after receiving a claim denial notice.

Notice of Our Review Decision. We will review the claim and send the claimant a written notice of Our decision. The notice will explain the reasons for Our decision. If We uphold the denial of all or part of the claim, We will also describe:

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

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

(1) 60 Days after We receive the request for review; or
(2) 120 Days, if a special case requires more time.

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

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

RIGHT OF RECOVERY. If benefits have been overpaid on any claim, We must be repaid within 60 Days. If You do not repay an overpayment, We have the right to:

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

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

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

PAYMENT TO THE TEXAS DEPARTMENT OF HUMAN SERVICES. All benefits paid on behalf of a Child under this Certificate must be paid to the Texas Department of Human Services whenever:

(1) the Texas Department of Human Services is paying benefits under the Human Resources Code chapters addressing financial and medical assistance service programs; and
(2) the parent who is covered by this Certificate:
    (a) has possession or access to the Child pursuant to a court order; or
    (b) is not entitled to access or possession of the Child and is required by the court to pay child support.

When the claim is first submitted to Our Group Insurance Service Office, written notice that all benefits must be paid directly to the Texas Department of Human Services must also be included.

Benefits will not be reduced or denied because they are covered by the Medical Assistance Act of 1967, as amended.

PAYMENT TO POSSESSORY OR MANAGING CONSERVATOR OF DEPENDENT CHILD. Benefits may be paid on behalf of a minor Dependent Child, to a person other than You, if an order issued by any court of competent jurisdiction names such person the possessory or managing conservator of the Child.

To be entitled to receive benefits, a possessory or managing conservator of a Child must submit to Us with the claim form, written notice that such person is the possessory or managing conservator of the Child on whose behalf the claim is made, and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised, or to claims You submit where You paid any portion of a medical bill that would be covered under the terms of the Policy.

BENEFICIARY

PAYMENTS TO BENEFICIARY. Any amount payable after Your death will be paid to the named Beneficiary (or the Beneficiary's assignee) who survives You.

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

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

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

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

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

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

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

If a person who would otherwise receive payment dies:

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

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

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

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

TERMINATION
For
Your Critical Illness Insurance

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

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

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

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

TERMINATION
For
Dependents Critical Illness Insurance

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

(1) the Date he or she ceases to be an eligible Spouse; or
(2) the Date he or she ceases to be an eligible Dependent Child.

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

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

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

CONTINUATION RIGHTS
For
You and Your Dependents

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

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

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

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

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

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

(1) 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.

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

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

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

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

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

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

PORTABILITY
For
You and Your Dependents

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

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

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

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

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

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

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

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

You may request to change:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS
For
You and Your Dependents

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

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

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

INCONTESTABILITY. Except for the non-payment of Premiums, We may not contest the validity of the Policy after it has been in force for two years from its Date of issue. In the absence of fraud, a statement made by You or Your Insured Dependent relating to Your or Your Insured Dependent's insurability may not be used to contest the validity of the insurance with respect to which the statement was made:
(1) after the insurance has been in force for two years during Your or Your Insured Dependent's lifetime; and
(2) unless the statement is contained in a written instrument signed by the person making the statement.

This clause does not preclude, at any time, the assertion of defenses based upon this Certificate's eligibility requirements.

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

RESCISSION. We have the right to rescind (cancel insurance back to its effective Date) any insurance for which Evidence of Insurability was required, if:
(1) You or Your Insured Dependent incur(s) a claim during the first two years of insurance; and
(2) We discover that You or Your Insured Dependent made an incomplete or untrue statement on an application that caused Us to issue insurance that We would have disapproved, had We known the truth.

We will refund all Premium paid for any rescinded insurance, less any benefits paid for Your or Your Insured Dependent's claims. We reserve the right to recover any claims paid in excess of such Premiums.

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

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

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:

(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

MISSTATEMENT OF AGE. If Your or Your Insured Dependent's age has been misstated, the correct age will be used to determine if insurance is in effect and adjust benefits, as appropriate.

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

DEFINITIONS
For
You and Your Dependents

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

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

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

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

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

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

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

Diagnosis must be made by a Physician. The surgical/invasive intervention requirement will be waived if:

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

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

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

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

CHILD or **CHILDREN** means:

(1) Your natural child, legally adopted child, or stepchild;
(2) a child placed with You for the pursuant of adoption, or for which You are a party in a suit to adopt the child;
(3) a child for whom You are required by court or administrative order to provide insurance or to provide medical support under an order issued under Texas Family Code or enforceable by a court in the State of Texas;
(4) Your grandchild; or
(5) a foster child for whom You have assumed full parental responsibility and control.

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

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

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

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

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

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

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

DEPENDENT means Your Spouse or Dependent Child.

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

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

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

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

It also includes a former Employee who has elected Portability.

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

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

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

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

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

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

INSURANCE MONTH means that period of time shown on the Schedule of Benefits:
(1) beginning at 12:01 a.m.; and
(2) ending at 12:00 midnight;
at the Group Policyholder's primary place of business.

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

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

INSURED SPOUSE means Your Spouse for whom Critical Illness Insurance under this Certificate is in effect.

INVASIVE CANCER means leukemia, except for item (4) in the list below, or malignant cells/tumors characterized by uncontrolled growth with spread beyond the initial tissue. Diagnosis must be by a Physician and based on Pathological Diagnosis. If a Pathological Diagnosis is medically inappropriate or life-threatening, or if a Clinical Diagnosis is consistent with professional medical standards, a Clinical Diagnosis of Cancer will be accepted instead. The following are not considered Invasive Cancer for purposes of this definition:
(1) Non-Invasive Cancer/Cancer in Situ;
(2) basal cell carcinoma and squamous cell carcinoma of the skin (see Skin Cancer definition);
(3) melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm; and
(4) chronic lymphocytic leukemia of stage zero.

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

MAJOR ORGAN FAILURE means end-stage organ disease, as determined by a Physician appropriately specialized for the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If You or Your Insured Dependent are determined to be too ill for a transplant,

but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if You or Your Insured Dependent receives a Major Organ transplant prior to placement on the network.

MILITARY LEAVE means a leave of absence that:

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

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

NON-INVASIVE CANCER/CANCER IN SITU means malignant cells confined to the surface tissues without invasion of the basement membrane and with no spread to regional lymph nodes or other tissues. Melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm is considered Non-Invasive Cancer/Cancer in Situ for purposes of this definition. Diagnosis is made by a Physician and based on Pathological Diagnosis. If a Pathological Diagnosis is medically inappropriate or life-threatening, a Clinical Diagnosis of Cancer will be accepted instead. The following are not considered Non-Invasive Cancer/Cancer in Situ for purposes of this definition:

(1) leukemia, except for chronic lymphocytic leukemia of stage zero; and
(2) basal cell and squamous cell carcinomas of the skin.

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

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

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

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

PERSON means an Employee of the Group Policyholder:

(1) who is a member of a class that is eligible for insurance under the Policy; and
(2) who has enrolled for insurance.

PHYSICIAN means:

(1) a 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 medical doctor.

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

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

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

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

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

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

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

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

SPINA BIFIDA means Spina Bifida diagnosed during childhood by a Physician**.**

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

STROKE means neurological damage to the brain due to inadequate blood flow in any of the cranial vessels, due to either blockage or rupture of the vessel. Diagnosis of neurological damage must be made by a neurologist and demonstrated by imaging (CT or MRI) and examination demonstrating new neurological deficits (motor, cognitive, or sensory), lasting more than 7 Days, that were caused by the Stroke. In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted. Transient Ischemic Attacks (TIA) are not considered Strokes.

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

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

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

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

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

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

- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $200,000 for all other types of health insurance.

Life insurance:

- Up to $100,000 in net cash surrender or withdrawal value.
- Up to $300,000 in death benefits.

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

Other policy types: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

Individual aggregate limit: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

Parts of some policies might not be protected: For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 1717 West 6th Street Suite 230 Austin, TX 78703-4776 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 12030 Austin, TX 78711 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

SUMMARY PLAN DESCRIPTION

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

The name of the Plan is: Group Critical Illness Insurance for Employees of McLane Company, Inc.

The name, address and ZIP code of the Sponsor of the Plan is:
McLane Company, Inc.
4747 McLane Parkway
TEMPLE, TX 76504.

Employer Identification Number (EIN): 741478631 IRS Plan Number: 502

The name, business address, ZIP code and business telephone number of the Plan Administrator is:
McLane Company, Inc.
4747 McLane Parkway
TEMPLE, TX 76504.

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

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

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

Type of Funding Arrangement: The Lincoln National Life Insurance Company

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

Eligibility. Full-time employees working at least 30 hours per week.

Employees become eligible on the Date of completion of active full-time employment.

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

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

The name and section of relevant Collective Bargaining Agreements: None

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

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

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

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

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

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

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

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

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

Statement of ERISA Rights

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

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

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

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

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

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

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

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

CERTIFICATE AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF THE CERTIFICATE FOR GROUP POLICY NO.: CI-0000001403
ISSUED TO: McLane Company, Inc.

The Certificate is amended by the addition of the following Health Assessment Benefit provision.

HEALTH ASSESSMENT BENEFIT

The Health Assessment Benefit will apply if elected by the Group Policyholder and the required Premium is paid.

SCHEDULE OF BENEFITS

Health Assessment Benefit:	$50 per Health Assessment Test
Individual Maximum of Tests:	1 per person per Health Assessment Period

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HEALTH ASSESSMENT BENEFIT. We will pay the Health Assessment Benefit when You or Your Insured Dependent receives a Health Assessment Test during a Health Assessment Period.

The Health Assessment Test must be performed while Your and Your Dependents' insurance under this Certificate Amendment is in effect. The Health Assessment benefit is subject to the scheduled Individual and Overall Maximums.

DEFINITIONS. The following definitions are in addition to the Definitions found in the Certificate.

Health Assessment Period means an annual period beginning on Your effective Date of coverage under this Certificate Amendment.

Health Assessment Test means any of the following:

(1) stress test;
(2) abdominal, aortic, or carotid ultrasound;
(3) CT angiography;
(4) electrocardiogram (EKG/ECG)
(5) angiography
(6) mammography;
(7) breast ultrasound;
(8) pap smear;
(9) CA 15-3 (blood test for breast cancer);
(10) CA125 (blood test for ovarian cancer);
(11) PSA (blood test for prostate cancer);
(12) CEA (blood test for colon cancer);
(13) serum protein electrophoresis (blood test for myeloma)
(14) bone marrow testing;
(15) colonoscopy;
(16) flexible sigmoidoscopy;
(17) hemoccult stool analysis;
(18) double contrast barium enema;
(19) helical CT scan;
(20) dental Brush biopsy or other FDA approved screening for oral cancer;
(21) diabetes (A1C or fasting glucose);
(22) HIV screening;
(23) hepatitis screening;
(24) human papillomavirus screening; or
(25) blood chemistry profile.

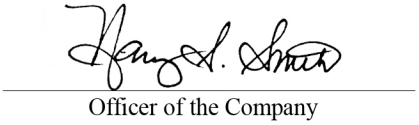
HIV means the Human Immunodeficiency Virus, whether HIV-1 or HIV-2.

PROOF. We must receive written proof of a Health Assessment Test, in accord with the Proof of Claim section under the Claims Procedures in the Certificate.

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

This amendment takes effect on June 1, 2023, or on Your effective Date of coverage under the Policy, whichever is later. In all other respects, the Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO AND MADE A PART OF THE CERTIFICATE FOR GROUP POLICY NO.: CI-0000001403
ISSUED TO: McLane Company, Inc.

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

SUPPLEMENTAL BENEFITS

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

SCHEDULE OF BENEFITS

Covered Condition	Percentage of Principal Sum
Advanced ALS/Lou Gehring's Disease	25%
Advanced Alzheimer's Disease	25%
Advanced Parkinson's Disease	25%
Advanced Multiple Sclerosis (MS)	25%
Benign Brain Tumor	100%
Loss of Speech	100%
Loss of Sight	100%
Loss of Hearing	100%

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

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

Advanced ALS/Lou Gehrig's Disease means amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) of the Middle Stage according to the Muscular Dystrophy Association. Definitive diagnosis must be made by a Physician according to diagnostic criteria for the specific illness. Other motor neuron diseases are not considered to be ALS. Initial diagnosis of ALS/Lou Gehrig's Disease must occur while You or Your Insured Dependent is covered under the Policy.

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

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

(1) neurological examination demonstrating functional impairments;

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

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

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

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

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

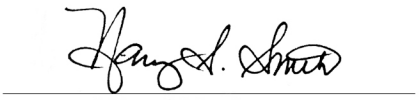
Loss of Sight means permanent loss of sight in both eyes such that corrected visual acuity is 20/200 or less, or the field of vision is less than 20 degrees, and which cannot be corrected by surgery or the use of a device. Diagnosis is made by a Physician based on the above criteria and noted to be of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

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

This amendment takes effect on June 1, 2023, 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

SUMMARY OF NONINSURANCE BENEFITS AND SERVICES

HEALTH ASSISTANCE SERVICES. The program provider delivers support services including answering healthcare questions, researching treatment options, coordinating benefits, resolving of billing and claims issues, and short-term counseling and support options to promote a healthy work/life balance for eligible program participants. **The health advocate services are NOT insurance.** Participants wishing to access these services or receive additional program details may contact the program provider by visiting www.HealthAdvocate.com/members or by dialing 866-799-2728.

Participants who are eligible for the provider's programs and services that are described in this section are the employees of the Group Policyholder and their dependents who **are enrolled** for the Critical Illness insurance provided by the Policy.

Health Assistance Services. The program provider can help participants resolve a variety of healthcare and insurance related issues.

Personal Health Assistance. Personalized assistance is made available from registered nurses, supported by medical directors and benefits and claims specialists, as participants seek healthcare services and interact with providers and insurers. Coordination of care among physicians and medical institutions may also be provided.

Benefit Assistance. When necessary or appropriate, the program provider can:

1. help solve claims and related paperwork problems, and assist with coverage and benefits issues;
2. attempt to negotiate fees with healthcare providers and review questionable bills to catch incorrect charges;
3. furnish advice and assistance with filing a complaint or grievance with a health insurer;
4. guide participants through the coverage review process, and assist in identifying alternative coverage options; and
5. assist with prescription drug issues including formulary and benefit questions.

Physician Locator. The program provider assists with identifying physicians, hospitals, dentists and other healthcare providers for needed services.

Program Referrals. The program provider helps with identifying leading medical institutions and medical providers to assist when complex medical care is needed. Assistance with scheduling appointments with these providers is made available, as required.

Special Services. As necessary, the program provider locates resources and arranges for special services that typically fall outside the realm of traditional healthcare benefits. Participants are responsible for payment for any services that they use beyond those covered by their health insurance plan.

Billing Negotiations. A specialized negotiator works with participants' healthcare providers to help lower out-of-pocket costs on certain non-covered unpaid medical and dental bills.

Employee Assistance Program. The program provider makes available short-term professional counseling services to promote well-being and help reduce stress and anxiety.

Counseling Services. Licensed professional counselors provide support for participants experiencing issues with depression, family, marital, parenting, substance abuse, and more. In case of a crisis, help is available 24 hours a day, 7 days a week. Up to three in person or video conference counseling sessions are available, per issue.

Telephonic Support for Work/Life Balance. Program specialists locate and determine availability for eldercare, childcare, legal and financial wellness support services, and more.

SUMMARY OF NONINSURANCE BENEFITS AND SERVICES

Personal Concierge Services. Provides access to experts who can help participants handle a wide range of personal tasks such as travel arrangements, including travel research and bookings, making restaurant reservations, ticketing for sporting events, and party and event planning. Participants also have easy access to a comprehensive website and mobile application providing articles, tips, webinars, and other helpful tools.

SUMMARY OF NONINSURANCE BENEFITS AND SERVICES

NONINSURANCE BENEFITS AND SERVICES. You may be offered the following benefit and service programs in connection with the sale of the Policy. Acceptance or declination of the programs is optional to the Group Policyholder. These benefit and service programs **are <u>not</u> insurance. We do not provide any of these benefit and service programs directly to You. We make these programs available to You through a third party provider as shown below.**

Noninsurance benefit and service programs may end at any time, including when:

(1) the Policy terminates;
(2) Your insurance under the Policy terminates;
(3) the program provider terminates the program or any portion of the program; or
(4) We discontinue the use of a program or any portion of the program.

Noninsurance benefits and services will **no longer be available** to You when insurance terminates or a program is terminated or discontinued.

If a program is terminated, in whole or in part, by a provider while Your insurance remains in effect, We will attempt to find a suitable replacement. In the event We cannot find a suitable replacement or if We discontinue use of a program, We will give the Group Policyholder advance written notice of Our intent to do so. Notice will be provided to the Group Policyholder 30 Days in advance of any program termination or discontinuance.

This document is only a summary of the benefits and services We make available to You through a third party. Please review all program materials and details carefully. The third-party provider has sole discretion to determine Your eligibility for any available benefits and services.

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.

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

Information we may collect and use

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

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

How we use your personal information

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

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers), regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or release your information to outside marketers who may want to offer you their own products and services; nor do we release 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 perform their job responsibilities. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your rights regarding your personal information

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

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

Changes to personal information: If you believe that your personal information is inaccurate or incomplete, you may ask us to correct, amend, or delete the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days from the date we receive your request.

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

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

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

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

If you would like to act upon your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial Group, Attn: Corporate Privacy Office, 1301 South Harrison St., Fort Wayne, IN 46802. The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice. For general account service requests or inquiries, please call 1-877-ASK-LINC.

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

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

**This Notice is effective 14 calendar days after it is made available on Lincoln's website, www.LFG.com/privacy.