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. HI-0001215065 has been issued to:
The IMA Financial Group, Inc.
(The Group Policyholder)

Certificate of Group Insurance for Plan 1/Class 1

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

Ellen Cooper
PRESIDENT

READ YOUR CERTIFICATE CAREFULLY

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

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

CERTIFICATE OF GROUP HOSPITAL INDEMNITY INSURANCE

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

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The IMA Financial Group, Inc.
HI-0001215065

SCHEDULE OF BENEFITS

Plan 1 - Low Plan
Class 1 - All Full-Time and Regular Part-Time Employees

Group Policy Effective Date: January 1, 2025

Reissued Policy Effective Date: January 1, 2025
Group Policy Number: HI-0001215065

Eligible Class: Class 1 - All Full-Time and Regular Part-Time Employees

Contributions: You are required to contribute to the cost for Your Hospital Indemnity Insurance and to the cost for Dependents Hospital Indemnity 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: None (For Date insurance begins, refer to "Effective Dates" section.)

Open Enrollment Period: 32 Days (See Your Employer for the Dates of the Enrollment Period)

Minimum Full-Time Hours: 20 hours per week

Minimum Part-Time Hours: 20 hours per week

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

Prior Insurance Credit: Included
Refer to the Prior Insurance Credit provision for more information.

Continuation Rights Included:
Family or Medical Leave
Military Leave
Disability: 12 Insurance Months
Other Leave of Absence: three Insurance Months
Temporary Reduction in Hours: six Insurance Months
Refer to the Continuation Rights section 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

The IMA Financial Group, Inc.
HI-0001215065

SCHEDULE OF BENEFITS
(Continued)

For
Plan 1 - Low Plan
Class 1 - All Full-Time and Regular Part-Time Employees

HOSPITAL INDEMNITY INSURANCE

The Hospital Indemnity benefits You or an Insured Dependent may receive are shown in this Schedule of Benefits. Multiple benefits may be payable for a single Covered Event. Refer to the detailed description of each Benefit for more information.

Occupational Insurance. Benefits may be payable under this certificate for losses caused or contributed to by Injuries that arise out of, or in the course of, any employment for wage or profit if You or Your Insured Dependent receives benefits under any Workers' Compensation act or similar law.

BASIC INSURANCE

Type of Benefit and Benefit Amount

Admission Benefits	
Hospital Admission	$500 per Day
Maximum per Calendar Year	one Day
Hospital ICU Admission	$500 per Day
Maximum per Calendar Year	one Day
Confinement Benefits	
Hospital Confinement	$100 per Day
Maximum per Calendar Year	30 Days
Hospital ICU Confinement	$200 per Day
Maximum per Calendar Year	30 Days
Newborn Care	$50 per Day
Maximum per Calendar Year	two Days per Childbirth
Enhancement Benefits	
Hospital NICU Admission Increase	25%
Hospital NICU Confinement Increase	25%

ELIGIBILITY AND EFFECTIVE DATES
For
Your Hospital Indemnity 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 later of:
(1) the Group Policy's Effective Date; or
(2) the Date the Eligibility Waiting Period shown in the Schedule of Benefits is completed.

Prior Service Credit Toward Eligibility Waiting Period. Prior service in an Eligible Class will apply toward the Eligibility Waiting Period upon Your return:
(1) from an approved Family or Medical Leave within:
  (a) the period required by federal law; or
  (b) any longer period required by a similar state law;
(2) from a Military Leave within the period required by federal USERRA law;
(3) from any other approved leave of absence within 12 months after the leave begins;
(4) within 12 months following a lay off;
(5) within 12 months following termination of employment for any other reason; or
(6) to an eligible class following a reduction in hours.

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

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

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

For purposes of this section, You are deemed Actively at Work if:
(1) You are not totally disabled or confined to a hospital or health care facility on the Date Your insurance would otherwise become effective; and
(2) You were Actively at Work on the Day prior to the Date Your insurance would otherwise become effective.

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.

REINSTATEMENT RIGHTS. If Your insurance terminates due to one of the following breaks in service, You will be entitled to Reinstate the insurance upon resuming Active Work with the Group Policyholder within the required timeframe. Reinstatement is available upon Your return:

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

To Reinstate insurance, You must enroll for insurance or be re-enrolled within 31 Days after resuming Active Work in an eligible class. The Reinstated amount of insurance may not exceed the amount that terminated. The Group Policyholder must resume the required Premium payments for insurance to be Reinstated. Reinstatement will take effect on the Date You return to Active Work.

ELIGIBILITY AND EFFECTIVE DATES
For
Dependents Hospital Indemnity Insurance

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

(1) the Date You become eligible for Hospital Indemnity 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 Hospital Indemnity Insurance:

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

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

EFFECTIVE DATES. Your Dependents Hospital Indemnity Insurance will become effective on the later of:

(1) the first Day of the Insurance Month coinciding with or next following the Date You become eligible for Dependents Hospital Indemnity Insurance; or
(2) the Date You enroll for Dependents Hospital Indemnity Insurance, and if You contribute to the cost of Dependents Hospital Indemnity Insurance, You sign a payroll deduction order and the additional Premium is paid 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) 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 Hospital Indemnity Insurance is provided to a Child based on a court order which requires You to provide Hospital Indemnity benefits for the Child, the insurance will become effective on the Date stated in the court order; subject to payment of any additional Premium.

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

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

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

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

REINSTATEMENT OF DEPENDENTS INSURANCE. If You reinstate Your Hospital Indemnity Insurance under the Reinstatement Rights of the Eligibility and Effective Dates for Your Hospital Indemnity Insurance, You may also reinstate Dependents Hospital Indemnity Insurance at the same time.

PRIOR INSURANCE CREDIT
For Group Hospital Indemnity Insurance

PRIOR INSURANCE CREDIT. The Prior Insurance Credit provision prevents loss of Hospital Indemnity Insurance that could otherwise occur solely because of a transfer of insurance carriers. The following Prior Insurance Credit will apply and provide continuity of coverage 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 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.

HOSPITAL INDEMNITY INSURANCE BENEFITS

ADMISSION BENEFITS. Unless otherwise noted, the following Hospital Indemnity Admission benefits are paid in addition to all other benefits payable under this Certificate. The Schedule of Benefits shows all benefit amounts and the number of Days for which the following benefits may be payable.

Hospital Admission. We will pay a Hospital Admission benefit for the initial Day that You or Your Insured Dependent are Admitted to a Hospital for treatment as a result of a Covered Event. In the event of an Accidental Injury, the Admission must occur within 180 Days of the Accident. If You or Your Insured Dependent are Admitted to a Hospital within 90 Days after being discharged from a preceding stay for the same or related cause, the second Admission will be considered part of the first Admission and this benefit will not be payable again.

If both the Hospital Admission benefit and the Hospital ICU Admission benefit become payable on the same Day, only the Hospital ICU Admission benefit will be paid. If the amount of the benefits is the same, only one will be paid.

This benefit will not be paid:

(1) if You or Your Insured Dependent are treated solely in an Intensive Care Unit, an Observation Unit, Emergency Room, or on an Outpatient basis; or
(2) for a newborn Child's routine post-natal care.

Hospital Intensive Care Unit (ICU) Admission. We will pay a Hospital ICU Admission benefit for the initial Day that You or Your Insured Dependent are Admitted to an ICU for treatment as a result of a Covered Event. Your Insured newborn Child is also eligible for this benefit if it is Admitted to an ICU or NICU for care or treatment:

(1) as a result of premature birth, as determined by a Physician; or
(2) due to a Covered Event.

In the event of an Accidental Injury, the Admission must occur within 90 Days of the Accident. If You or Your Insured Dependent are Admitted to an ICU within 90 Days after being discharged from a preceding stay for the same or related cause, the second Admission will be considered part of the first Admission and this benefit will not be payable again.

If both the Hospital Admission benefit and the Hospital ICU Admission benefit become payable on the same Day, only the Hospital ICU Admission benefit will be paid. If the amount of the benefits is the same, only one will be paid.

This benefit will not be paid if You or Your Insured Dependent are treated solely in an Observation Unit, Emergency Room, or on an Outpatient basis.

HOSPITAL INDEMNITY INSURANCE BENEFITS

CONFINEMENT BENEFITS. Unless otherwise noted, the following Hospital Indemnity Confinement benefits are paid in addition to all other benefits payable under this Certificate. The Schedule of Benefits shows all benefit amounts and the maximum number of Days for which the benefits are payable.

Hospital Confinement. We will pay a Hospital Confinement benefit for each Day You or Your Insured Dependent are Confined in a Hospital as a result of a Covered Event. This benefit is payable beginning on the 2nd Day of Confinement. It is not payable on the same Day that an Admission benefit is payable. In the event of an Accidental Injury, the initial Hospital Confinement must begin within 180 Days of the Covered Event. The Hospital Confinement period ends on the Day of discharge from the Hospital. We will pay for only one Confinement at a time, even if the Confinement is caused by more than one Covered Event.

If both the Hospital Confinement benefit and the Hospital ICU Confinement benefit become payable on the same Day, only the Hospital ICU Confinement benefit will be paid. If the amount of the benefits is the same, only one will be paid.

This benefit is not payable for a newborn Child's routine post-natal care.

Hospital Intensive Care Unit (ICU) Confinement. We will pay an ICU Confinement benefit for each Day or partial Day You or Your Insured Dependent are Confined in an ICU as a result of a Covered Event. Your Insured newborn Child is also eligible for this benefit if it is Admitted to an ICU or NICU for care or treatment:

(1) as a result of premature birth, as determined by a Physician; or
(2) due to a Covered Event.

This benefit is payable beginning on the 2nd Day of Confinement. It is not payable on the same Day that an Admission benefit is payable. In the event of an Accidental Injury, the ICU Confinement must begin within 90 Days of a Covered Event. The ICU Confinement period ends on the Day of discharge from the ICU. We will pay for only one ICU Confinement at a time, even if the Confinement is caused by more than one Covered Event.

If You or Your Insured Dependent continues to be Hospital Confined after being discharged from the ICU or exhausting the ICU Confinement benefit, You or Your Insured Dependent may be eligible for the Hospital Confinement benefit.

If both the Hospital Confinement benefit and the Hospital ICU Confinement benefit become payable on the same Day, only the Hospital ICU Confinement benefit will be paid. If the amount of the benefits is the same, only one will be paid.

Newborn Care. We will pay a Newborn Care benefit for each Day Your Insured Dependent newborn Child is Confined to a Hospital for routine post-natal care following their birth. No other Hospital Admission and Hospital Confinement benefits are payable for a newborn Child that receives only routine post-natal care.

HOSPITAL INDEMNITY INSURANCE BENEFITS

ENHANCEMENT BENEFITS. Unless otherwise noted, the following Hospital Indemnity Enhancement benefits are paid in addition to all other benefits payable under this Certificate. The Schedule of Benefits shows all benefit amounts and maximums.

Hospital Neonatal Intensive Care Unit (NICU) Admission Increase. We will pay a Hospital NICU Admission Increase benefit when Your Insured Dependent newborn Child is admitted to the ICU or NICU for care or treatment:

(1) as a result of premature birth, as determined by a Physician; or
(2) due to a Covered Event.

If the Hospital ICU Admission benefit is payable for Your newborn Child's ICU or NICU Admission, the Hospital NICU Admission Increase benefit will increase the amount that becomes due by the percentage shown in the Schedule of Benefits.

Hospital Neonatal Intensive Care Unit (NICU) Confinement Increase. We will pay a Hospital NICU Confinement Increase benefit when Your Insured Dependent newborn Child is Confined in the ICU or NICU for care or treatment:

(1) as a result of premature birth, as determined by a Physician; or
(2) due to a Covered Event.

If the Hospital ICU Confinement benefit is payable for Your newborn Child's ICU or NICU Confinement, the NICU Confinement Increase benefit will increase the amount that becomes due by the percentage shown in the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS AND LIMITATIONS. The Policy insures only sicknesses and injuries that occur while it is in force. No benefits will be paid for a sickness or injury that occurs prior to the Effective Date of the insurance. This Certificate is subject to all Exclusions and Limitations in this section, unless stated otherwise in a specific provision.

General Exclusions. Benefits are not payable for any loss caused or contributed to by:

(1) suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
(2) voluntary intake or use by any means of any drugs, poison, gas, or fumes, except when:
    (a) prescribed or administered by a Physician; and
    (b) taken in accordance with the Physician's instructions;
(3) committing or attempting to commit a felony;
(4) war or any act of war, declared or undeclared;
(5) participation in a riot, insurrection, or rebellion of any kind;
(6) military duty, including the Reserves or National Guard;
(7) travel or flight in or on any Aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight, or as a passenger, pilot, or crew member in the Group Policyholder's Aircraft while flying for Group Policyholder business provided:
    (a) the Aircraft has a valid U.S. airworthiness certificate (or foreign equivalent); and
    (b) the pilot has a valid pilot's certificate with a non-student rating which authorizes flight of the Aircraft;
(8) driving a vehicle while intoxicated, as defined by the jurisdiction where the Accident occurred;
(9) cosmetic or elective Surgery, unless the treatment is the result of a Covered Event;
(10) treatment for dental care or dental procedures, unless the treatment is the result of a Covered Event;
(11) treatment of a mental illness;
(12) treatment of alcoholism, drug addiction, chemical dependency, or complications thereof;
(13) treatment through experimental procedures;
(14) travel outside the United States and its possessions for the sole purpose of receiving medical care or treatment;
(15) participating in, practicing for, or officiating any semi-professional or professional sport;
(16) riding in or driving in any motor driven vehicle for race, stunt show, or speed test;
(17) being incarcerated in any type of penal or detention facility;
(18) scuba diving;
(19) mountaineering or spelunking;
(20) bungee cord jumping, hang gliding, sail gliding, parasailing, parakiting, kitesurfing, base jumping, or any similar activities;
(21) skydiving, parachuting, jumping, or falling from any Aircraft for recreational purposes; or
(22) a loss sustained while residing outside the United States.

CLAIM PROCEDURES
For Hospital Indemnity 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 proof of claim. We will include instructions for completing and submitting the forms. If We do not send the forms within 15 Days, the claimant may send Us written proof of a claim in a letter. The letter should state the nature, Date and cause of the claim.

Proof of Claim. Proof of a claim must be provided 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 the Dates the services were 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. All benefits payable under this Certificate, including any benefits for Insured Dependents, will be paid to You, while living, unless:

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

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

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

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

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

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

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

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

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

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

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

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

If reasonably possible, We will send notice within 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, ERRORS RELATED TO COVERAGE. We have the right to correct any benefit payments that are made in error. The claimant, claimant's Beneficiary, or claimant's estate has the responsibility to return any overpayments to Us. We have the responsibility to make additional payments, if any underpayments have been made.

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 five years after the Date written proof of claim is required.

OUR DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder, We have the authority to:

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

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

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

The claimant has the right to:

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

BENEFICIARY

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

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

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

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

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

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

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

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

If a person who would otherwise receive payment dies:

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

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

CHANGING THE BENEFICIARY. Only You may change a Beneficiary. Beneficiaries may be named or changed at any time. A new Beneficiary may be named by submitting a Beneficiary designation change to the Group Policyholder or to Us 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 and delivered to the Group Policyholder or to Us.

TERMINATION
For
Your Hospital Indemnity Insurance

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

(1) the Date the Policy terminates;
(2) the Date Your Class is no longer eligible for insurance;
(3) the Date You cease to be a member of a class which is eligible for insurance;
(4) the Date You die;
(5) the last Day of the Insurance Month in which You request termination;
(6) the last Day of the last Insurance Month for which Premium payment is made on Your behalf;
(7) the end of the period for which the last required Premium has been paid;
(8) with respect to any particular insurance benefit, the Date that benefit terminates;
(9) the last Day of the Insurance Month coinciding with or next following the Date Your employment with the Group Policyholder terminates; or
(10) 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).

CONTINUATION OF YOUR INSURANCE. When Your insurance that is provided by this Certificate terminates, it may be continued only as provided in the Continuation Rights and Portability provisions.

EFFECT OF TERMINATION ON YOUR BENEFITS. Termination will have no effect on benefits payable for a claim incurred while You were insured under the Policy.

TERMINATION
For
Your Dependent Hospital Indemnity Insurance

DATE OF TERMINATION. Dependent Insurance will terminate as follows.

Termination for Spouse or Life Partner. Dependent Insurance for Your Spouse or Life Partner will cease on the earlier of:

(1) the Date he or she ceases to be an eligible Spouse or Life Partner; or
(2) the Date he or she enters the armed forces 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).

Termination for Child. Dependent Insurance for Your Child will cease on the earlier of:

(1) the last day of the Insurance Month following the Date he or she ceases to be an eligible Dependent Child; or
(2) the Date he or she enters the armed forces 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).

Termination for All Dependents. Dependent Insurance for all of Your Insured Dependents will cease on the earliest of:

(1) the Date Your Hospital Indemnity Insurance terminates;
(2) the Date Dependent Hospital Indemnity Insurance is discontinued;
(3) the Date You cease to be in a class eligible for Dependent Hospital Indemnity Insurance;
(4) the Date You request that Your Dependent Hospital Indemnity 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 Your Insured Dependents.

CONTINUATION OF DEPENDENTS INSURANCE. When Your Dependents Insurance that is provided by this Certificate terminates, it may be continued only as provided in the Continuation Rights, Portability and Dependents Portability provisions.

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

CONTINUATION RIGHTS
For
Your and Your Dependents Hospital Indemnity Insurance

YOUR CONTINUATION RIGHTS. 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 Event, 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.

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.

Portability Following Your Continuation Rights. When Your Continuation Rights end, You may be entitled to continue insurance as provided in the Portability provision.

PORTABILITY

PORTABILITY FOR YOU. If Your Hospital Indemnity Insurance ends, You may be eligible for Portability. Portability allows You to continue Your Hospital Indemnity Insurance and Dependents Hospital Indemnity Insurance under this Certificate. Portability follows any Continuation Rights. Portability is available when Your employment with the Group Policyholder terminates.

To continue insurance, You must notify Us of Your election and pay the applicable Premium within 31 Days of the Date the insurance would otherwise end.

Maximum Duration. Subject to Termination of Portability, the Maximum Duration You may continue the Hospital Indemnity Insurance provided by this Certificate is shown in the Schedule of Benefits.

Limitations on Portability. Portability is not available when insurance ends because of:
(1) Sickness or Injury;
(2) nonpayment of Premiums;
(3) Policy termination;
(4) entering armed services of any state or country on active duty; or
(5) Your Spouse, Life Partner, or Child ceasing to be an eligible Dependent.

Portability is not available to Your Spouse, Life Partner, or Child if You do not continue Your Insurance.

Premium. You are required to pay Us Premium to continue insurance under the Portability provision. 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 the Premium frequency if You notify Us in advance at any time the insurance is in force, except during a Grace Period.

Amount of Insurance. During the continuation period:
(1) continued insurance may not be increased; and
(2) additional dependents may not be enrolled for Dependent Insurance.

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

Any Dependent Insurance that You extend under Portability will terminate automatically on the earliest of:
(1) the day Your insurance extended under this provision terminates;
(2) the day Your Dependent ceases to be eligible under this Certificate; or
(3) the last Day of the period for which You paid Premiums for Dependents Insurance.

DEPENDENTS PORTABILITY

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

To continue their insurance, Your Spouse or Life Partner must notify Us of their election and pay the applicable Premium to Us within 31 Days of the Date the insurance would otherwise end.

Your Spouse or Life Partner may also continue Your Dependent Child's Hospital Indemnity insurance, provided:

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

Maximum Duration. Subject to Termination of Dependents Portability, the Maximum Duration Your Spouse or Life Partner may continue the Hospital Indemnity Insurance provided by this Certificate is shown in the Schedule of Benefits.

Premium. Your Spouse or Life Partner is required to pay Us Premium to continue insurance under the Dependents Portability provision. We will send Your Spouse or Life Partner a billing statement on or before each Premium due Date. Premiums must be paid 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.

Your Spouse or Life Partner may request to change the Premium frequency if You notify Us in advance at any time the insurance is in force, except during a Grace Period.

Amount of Insurance. During the continuation period:

(1) continued insurance may not be increased; and
(2) additional dependents may not be enrolled for Dependent Insurance.

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

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

We may terminate the Dependents Hospital Indemnity Insurance continued under this provision for any reason by providing 45 Days notice.

GENERAL PROVISIONS
For
Your and Your Dependents Hospital Indemnity Insurance

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 individual applications of an Insured or Insured Dependent; and
(4) the Certificate for each insured class and any amendments to it.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a designated Company officer 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:
(1) agreed upon by an underwriting officer;
(2) attached to the Policy by rider, endorsement, or amendment; and
(3) signed by a designated Company officer.

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

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

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

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

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

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

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

DEFINITIONS
For
Your and Your Dependents Hospital Indemnity Insurance

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

ACTIVE, 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.

ADMISSION or ADMITTED means You or Your Insured Dependent is accepted for Inpatient services in a Hospital or an Intensive Care Unit for a period of more than 20 hours.

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

AMBULATORY SURGICAL FACILITY means a licensed surgical center that operates exclusively for the purpose of providing surgical services and that has permanent facilities and equipment to perform surgical procedures on an Outpatient basis. An Ambulatory Surgical Facility may be a freestanding facility or distinct unit of a Hospital. An ambulatory Surgical Facility does not have Inpatient accommodations.

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

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

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

Change in Family Status **does not** include a change in employment or eligibility status due solely to a disability.

CHILD or **CHILDREN** means:

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

Stepchild includes Your Life Partner's child.

CHILDBIRTH means normal delivery of a Child or Children or the delivery of a Child or Children by elective cesarean section.

CIVIL UNION PARTNER means the person who is recognized as Your civil union partner under the laws of the state where You reside.

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.

COMPLICATIONS OF PREGNANCY means:

(1) conditions requiring Hospital Confinement based on diagnoses that are distinct from, but adversely affected or caused by, pregnancy including:
   (a) acute nephritis;
   (b) nephrosis;
   (c) preeclampsia and eclampsia;
   (d) cardiac decompensation;
   (e) puerperal infection; and
   (f) other similar medical and surgical conditions of comparable severity;
(2) missed abortion;
(3) non-elective cesarean section;
(4) termination of ectopic pregnancy; and
(5) spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include:

(1) elective cesarean section;
(2) false labor,
(3) occasional spotting,
(4) Physician prescribed rest during pregnancy,
(5) morning sickness,
(6) hyperemesis gravidarum; and
(7) other similar conditions associated with the management of a difficult pregnancy but not constituting a medically classifiable distinct complication of pregnancy.

CONFINED or CONFINEMENT means assigned to a bed as a resident Inpatient in a Hospital or Intensive Care Unit on the advice of a Physician for a period of no less than 20 consecutive hours.

COVERED EVENT means an Accident, Sickness, or Childbirth which:

(1) occurs on or after the Effective Date of Your or Your Dependent's insurance;
(2) occurs while the insurance is effective for You or Your Dependent; and
(3) which is not excluded under this Certificate.

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

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

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

DEPENDENTS HOSPITAL INDEMNITY INSURANCE means the insurance provided by the Policy for eligible Dependents.

DOMESTIC PARTNER means the person, regardless of sex or registration, who is recognized as Your domestic partner under the laws of the state where You reside.

ELIGIBILITY WAITING PERIOD means the period of time You must be in an eligible class with the Group Policyholder, before You become eligible to enroll for insurance under the Policy.

The period of service must be continuous, except as explained in the Eligibility section captioned Prior Service Credit Towards Waiting Period.

EMERGENCY ROOM means an area of a Hospital:
(1) that is dedicated to providing emergency care;
(2) that is staffed and equipped to handle trauma;
(3) that is supervised by Physicians;
(4) within which Physicians provide treatment and care; and
(5) that provides care 24 hours per day, 7 days per week.

EMPLOYEE means a person:
(1) whose employment with the Group Policyholder is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is 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.

Employee includes:
(1) full-time and regular part-time Employees of the Group Policyholder; and
(2) former Employees of the Group Policyholder who have elected Portability.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

FAMILY means You and all of Your Insured Dependents.

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

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

If 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.

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

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

HOSPITAL INDEMNITY INSURANCE means the insurance provided by the Policy for You.

INJURY or INJURIES means bodily harm solely due to an Accident. It includes all complications of and all Injuries sustained in the same Accident.

INPATIENT means a person who is Confined overnight as a registered resident bed patient in a Hospital where at least one day's room and board is charged. The Confinement must be on the advice of Physician.

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 Hospital Indemnity Insurance under this Certificate is in effect.

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

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

INTENSIVE CARE UNIT or ICU means a unit of a Hospital that:
(1) is restricted to patients who are critically Sick or Injured and who require intensive, comprehensive, monitoring and care;
(2) is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
(3) is permanently equipped with special lifesaving devices for the care of the critically sick or injured;
(4) is under close observation by specially trained nursing staff assigned exclusively to the unit on a 24-hour basis; and
(5) has a Physician assigned to it on a full-time basis.

Intensive Care Unit (ICU) includes a Neonatal Intensive Care Unit (NICU).

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

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

NEONATAL INTENSIVE CARE UNIT or NICU means a specialized unit of a Hospital that:
(1) is restricted to newborn infants who are premature or critically Sick or Injured, and who require intensive, comprehensive, monitoring and care;
(2) is separate and apart from the ICU or surgical recovery room, and from rooms, beds, and wards customarily used for patient confinement;
(3) is permanently equipped with special lifesaving devices for the care of the premature or critically Sick or Injured newborns;
(4) is under close observation by specially trained nursing staff assigned exclusively to the unit on a 24-hour basis; and
(5) has a Physician assigned to it on a full-time basis.

NURSE means a registered nurse (RN) or a licensed practical nurse (LPN).

OBSERVATION UNIT means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient Surgery or treatment in the Emergency Room by a Physician and which:
(1) is under the direct supervision of a Physician or registered Nurse;
(2) is staffed by Nurses assigned specifically to that unit; and
(3) provides care seven Days per week, 24 hours per Day.

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 Hospital Indemnity Insurance.

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

OUTPATIENT means medical treatment received without being Admitted or Confined to a Hospital.

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

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

PHYSICIAN means:

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

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

Physician does **not** include You or Your Relatives.

POLICY means the Group Hospital Indemnity Insurance policy issued by Us to the Group Policyholder.

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

PRIOR PLAN means a Group Policyholder-sponsored group or Group Policyholder-sponsored individual Hospital Indemnity 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.

QUARANTINE means Physician ordered separation, restriction of movement, and observation in a Hospital due to an identifiable exposure to a life-threatening contagious or infectious disease.

RELATIVE or RELATIVES means Your:

(1) Spouse or Life Partner, siblings, parents, Children and grandparents; and
(2) Spouse's or Life Partner's relatives of like degree.

REPLACEMENT DATE means the Effective Date of the group Hospital Indemnity Insurance Policy underwritten by Us.

SICKNESS means an illness, infection, or disease that requires treatment by a Physician. Routine pregnancy and Complications of Pregnancy will be treated the same as any other Sickness. Sickness also includes organ donation and Quarantine.

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

SURGERY or SURGICAL means medical procedures involving cutting of body tissue, debridement, or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, or endoscopic procedures that are performed in a Hospital, Ambulatory Surgical Facility, Physician’s office, Urgent Care Facility, or an Emergency Room. Surgery typically requires general anesthesia that is administered by a nurse anesthetist or a licensed anesthesiologist unless the type of procedure ordinarily requires the patient to be awake to assist in the procedure while the Surgery is being performed. Surgery includes elective or non-emergency cesarean sections.

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.

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.

SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by The Lincoln National Life Insurance Company of Omaha, NE 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: Hospital Indemnity Insurance for Employees of The IMA Financial Group, Inc.

The name, address and ZIP code of the Sponsor of the Plan is:
The IMA Financial Group, Inc.
430 E Douglas Avenue STE 400
WICHITA, KS 67202

Employer Identification Number (EIN): 480805634 IRS Plan Number: 504

The name, business address, ZIP code and business telephone number of the Plan Administrator is:
The IMA Financial Group, Inc.
430 E Douglas Avenue STE 400
WICHITA, KS 67202
(720) 388-1060

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: Hospital Indemnity Insurance

Type of Funding Arrangement: The Lincoln National Life Insurance Company

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

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

Employees become eligible on the first Day of the Insurance Month coinciding with or next following the Date of completion of active full-time or regular part-time employment.

Contributions: You are required to make contributions for Hospital Indemnity Insurance and Dependents Hospital Indemnity 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 Hospital Indemnity 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 Hospital Indemnity 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 Hospital Indemnity 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.

Lincoln Financial® Privacy Practices Notice

What Does Lincoln Financial Do with Your Personal Information?

The Lincoln Financial companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. 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.

Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this carefully to understand what we do.

Information We May Collect and Use

We collect personal information about you:

- to help us identify you as a consumer, our customer or our former customer;
- to process your requests and transactions;
- to offer investment, insurance, retirement and other financial services to you;
- to pay your claim;
- to 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 types of personal information we collect depend on your relationship and on the products or services you request and may include the following:

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

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

How We Share and Use Your Personal Information

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

- to process transactions you, your employer, or your group representative have requested;
- to provide customer service;
- to 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/or
- to inform you of products or services we offer that you may find useful.

Our service providers may or may not be affiliated with us. Affiliates are companies related by common ownership or control. Nonaffiliates are companies not related by common ownership or control. They include:

- Financial service providers: third party administrators; broker-dealers; insurance agents and brokers; registered representatives; reinsurers and other financial services companies with which we have joint marketing agreements. A joint marketing agreement is a formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include, but are not limited to, insurance providers and financial technology solutions.
- Non-financial companies and individuals: consultants; vendors; and companies that perform marketing services on our behalf.

Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law. We may execute agreements with our service providers that permit the service provider to process your personal information outside of the United States, when not prohibited by our contracts and permitted by applicable law.

When you apply for one of our products:

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

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

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

Federal law gives you the right to limit only:

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

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

Security of Information

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

Your Rights Regarding Your Personal Information

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). We will send you notification within 30 business days if we need additional time to respond to your request. If you request a copy of your information by mail, we may charge you a fee for copying and mailing costs.

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

If we make changes to your records 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 recipients 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 exercise your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial, Attn: Corporate Privacy Office, 1301 South Harrison St., Fort Wayne, IN 46802. **The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice.**

For general account service requests or inquiries unrelated to this Privacy Notice, please call 1-877-ASK-LINC.

*This information applies to the following Lincoln Financial companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company, Inc.
Lincoln Financial Investments Corporation (formerly 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
Lincoln Financial Insurance Agency Incorporated

Lincoln Financial Group® Privacy Notice for Protected Health Information

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

You have received this Notice because you have applied for, or currently have, insurance coverage or an annuity ("Coverage"), that contains benefit provisions subject to the federal privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act, as amended ("HIPAA"), such as a dental plan, vision plan, or a life or annuity product with a long-term care policy (including a long-term care rider). This is Coverage that has been or will be issued by or through one of the Lincoln Financial Group insurance companies* ("Company"). Some insurance coverage and annuities (e.g., disability plans) are not subject to this Notice. If you have questions as to whether this Notice applies to you, please contact us using the contact information below. This Notice sometimes refers to the Company by using the terms "us," "we," or "our." We value our relationship with you and are committed to protecting the confidentiality and security of information we collect about you, especially health information.

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

We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected Health Information; and to follow the terms of this Notice.

The Company reserves the right to change this Notice at any time. We can make any changes effective for Protected Health Information we already have about you, as well as any Protected Health Information we receive in the future. If the revised Notice contains material changes, we will send you the revised Notice, as well as post it on the Company internet sites.

Uses and Disclosures of your Protected Health Information

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

Authorization: Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Protected Health Information. For example, we will not share your information for marketing purposes (other than face-to-face communications or for promotional gifts of nominal value) or allow for the sale of your information without your authorization. An authorization to use or disclose any psychotherapy notes we may have will specifically state that it is an authorization for psychotherapy notes. You or your legal representative has the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage.

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

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

Health Care Operations: We may use and disclose your Protected Health Information for our insurance operations. Our insurance operations may include underwriting, enrollment, premium rating, and other activities related to the issuance, renewal or replacement of Coverage, or for reinsurance purposes. For example, when you apply for insurance, we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Protected Health Information to conduct or arrange for medical review, legal

services, contract for reinsurance, business planning and development, or auditing, including fraud and abuse detection and compliance programs. Protected Health Information may also be disclosed for business management and general administrative activities, including customer service, servicing our current and future customer relationships as permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction. Protected Health Information may also be disclosed for the health care operations of the entity that receives the information, as long as the entity has a relationship with you and the Protected Health Information pertains to such relationship. For group plans, Protected Health Information may be collected from or disclosed to (1) your Plan Sponsor for purposes of obtaining coverage or administering your Plan or (2) any other health plan maintained by your employer to facilitate claims payments under the plan. If we use or disclose Protected Health Information for underwriting purposes, the Protected Health Information used or disclosed for that purpose will not include information that constitutes genetic information except when permitted by law.

Business Associates: We may also disclose Protected Health Information to non-affiliated business associates of ours, but only if the business associate's receipt of Protected Health Information is necessary to provide a service to us and the business associate agrees to protect the Protected Health Information in accordance with, and use it, only as allowed by, HIPAA. Examples of business associates are: billing companies, data processing companies, auditors, claims processing companies and companies that provide general administrative services.

Uses and Disclosures to Family, Friends or Others Involved in Your Care: Unless you object or direct us otherwise, we may disclose your Protected Health Information to a designated member of your family, friend, or other individual that you may identify as involved in your care or involved in the payment for your care. Should you become incapacitated, deceased, or be in an emergency medical situation and not able to provide us with your approval, we may disclose Protected Health Information about you that is directly relevant to such person's involvement in your care or payment for such care.

Whistleblowers: We strive to comply with all applicable laws and encourage our workforce to speak up if they have concerns about our business practices. If a member of our workforce believes in good faith that we have engaged in unlawful or unprofessional conduct or that our services, care, or conditions could endanger someone, we allow that person to disclose Protected Health Information to (i) a health oversight agency or public health authority authorized to investigate the conduct or (ii) an attorney retained by the employee or business associate for purposes of determining legal options with respect to the aforementioned conduct.

Workforce Member Crime Victims: We may disclose Protected Health Information to a law enforcement official when our employee is the victim of a criminal act, provided the Protected Health Information is about the suspected perpetrator and the information is limited.

Where Required by Law, for Public Health or Similar Activities: We may also disclose Protected Health Information where required or permitted by law, for public health or similar activities, the protection of you or others, legal proceedings and other reasons as provided in the HIPAA regulations. Examples of disclosures that may be required or permitted by law include releasing Protected Health Information:

- To state or local health authorities, as required by law, of particular communicable diseases, injury, birth, death, and for other required public health investigations;
- To a governmental agency or regulator with health care oversight responsibilities. These oversight activities include audits, investigations, inspections, licensure or disciplinary actions and other activities necessary for the government to monitor the health care system, government programs such as Medicare and Medicaid and compliance with civil rights laws;
- To a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death or to a funeral director;
- To public health or other appropriate authorities, as required by law, or when there is reason to suspect abuse, neglect, or domestic violence;
- To the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- If required by law to do so by a court or administrative tribunal for law enforcement purposes as permitted by law, and to comply with a subpoena or discovery request. When a subpoena or discovery request is issued by someone other than a judge, we will make reasonable efforts to notify you of such requests or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- To law enforcement to identify or locate a suspect, fugitive, material witness or missing person; if an individual is the victim or suspected victim of a crime, but only under certain conditions; if the individual dies and we suspect that death resulted from criminal conduct;

- For certain research purposes when the information has been completely deidentified or when such research is approved by an institutional review board with established rules to ensure privacy or by a privacy board with members who have appropriate professional competency with privacy rights;
- If you are a member of the military (including a foreign military) as deemed necessary by armed forces services;
- To federal officials for intelligence, counterintelligence, and other national security activities authorized by law or for the conduct of investigations or the provision of protective services to the President, foreign heads of state, or others;
- To worker's compensation agencies if necessary for your worker's compensation benefit determination;
- To avert a serious threat to someone's health or safety, including the disclosure of Protected Health Information to government or private disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations;
- To organizations that manage organ procurement or organ, eye or tissue transplant or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplant;
- To a correctional institution or law enforcement official if necessary (1) for the provision of health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety, security, and good order of the correctional institution.

State Law Restrictions: State laws may be more stringent and may prohibit certain uses and disclosures identified in this Notice. When state law is more protective of your privacy, we will follow that state law. For example, some state laws require additional protection for records related to mental health treatment, drug and alcohol treatment, and HIV-related information. If you have a question about how we comply with your state's laws, please contact us using the information below.

Required Disclosures

The following is a description of two specific disclosures of your Protected Health Information that we are required to make.

Government Audits. We are required to disclose your Protected Health Information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with HIPAA.

Disclosures to You. When you request, we are required to disclose to you the portion of your Protected Health Information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested by you, to provide you with an accounting of most disclosures of your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the Protected Health Information was not disclosed pursuant to your individual authorization. Please refer to the further description of your right to receive an accounting below. When permitted by applicable law, we may also contact you for case management or care coordination purposes to provide information about treatment alternatives or other health-related benefits or services that may be of interest to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights as a consumer under HIPAA concerning the Protected Health Information we have about you in our records. Any request to exercise your rights as described below should be made in writing and sent to **Lincoln Financial Group, Attn: Corporate Privacy Office - 1301 South Harrison Street, Fort Wayne IN 46802.** Also, should you wish to terminate a request for a restriction that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request to exercise the rights described below should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

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

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

Right to Inspect and Copy Your Protected Health Information: In most instances, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. Your request must be in writing and sent to the address provided above. We will deny inspection and copying of certain Protected Health Information, for example psychotherapy notes and Protected Health Information collected by us in connection with, or in reasonable anticipation of, any legal claim or legal proceeding. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. In those limited circumstances that we deny your request to inspect and obtain a copy of your Protected Health Information, you may have the right to request a review of our denial. Your request to review our denial should be submitted in writing and sent to the address provided above. If the information you request is maintained electronically and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on an alternative electronic form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

Right to Amend Your Protected Health Information: You have the right to request that we amend your Protected Health Information in our records if you believe it is inaccurate or incomplete. Your request must be in writing and sent to the address provided above. Your request must provide your reason(s) for seeking the amendment or correction. We will act on your request no later than 60 days after the receipt of the request, by requesting an extension, granting the amendment, in whole or in part, or denying the request, in whole or in part. We may request a single 30-day extension, to agree to accept the request, in whole or in part, or deny the request to amend PHI, in whole or in part. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as make reasonable efforts to notify others to whom we have disclosed the erroneous Protected Health Information. We may deny your request if you ask us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. If we deny your request, in whole or in part, the notice of denial will explain the basis for the denial. You have the right to file a statement of disagreement with us and any future disclosures of your Protected Health Information will include your statement.

If we are informed by another organization of an amendment to your Protected Health Information, we must amend the Protected Health Information in your record.

Right to Receive an Accounting of Disclosures of Your Protected Health Information: You have the right to request an accounting or list of disclosures we have made of your Protected Health Information in the past six (6) years. This list will not include disclosures:

- For treatment;
- For payment or health care operations;
- To law enforcement, for purposes of national security;
- To department of corrections personnel;
- Pursuant to your authorization;
- Incidental to a permitted disclosure;
- To certain persons involved in an individual's care or payment for that care;
- or directly to you.

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

Right to be Notified of a Breach: You have the right to be notified in the event that we (or our business associate) discover a breach of your unsecured Protected Health Information.

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

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us, by sending it to the address listed below. You may also file a complaint with the U.S. Department of Health and Human Services ("HHS") Office of Civil Rights. If you send your complaint to HHS by mail or fax, you should send it to the regional office of the HHS Office of Civil Rights covering the area where the potential violation occurred. You can find more information about how to file a complaint with HHS, including the addresses of the regional offices of the HHS Office of Civil Rights on the HHS website: http://www.hhs. gov/ocr/privacy/hipaa/complaints/index.html or complaints may be sent to HHS by email to: OCRComplaint@hhs.gov. The Company supports your right to protect the privacy of your Protected Health Information. No action will be taken against you for filing a complaint.

For Further Information: For further information regarding this Notice or the Company's privacy practices, please contact **Lincoln Financial Group, Attn: Corporate Privacy Office, 1301 South Harrison Street, Fort Wayne IN 46802, or call 1-877-275-5462.**

Effective Date: This Notice is effective November 9, 2021.

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

First Penn-Pacific Life Insurance Company

Lincoln Life & Annuity Company of New York

The Lincoln National Life Insurance Company