

The Lincoln National Life Insurance Company

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

CERTIFIES THAT Group Policy No. GL 000860050048 has been issued to
Riverside Community College District
(The Group Policyholder)

The Issue Date of the Policy is March 1, 2004.


The insurance is effective only if the Employee is eligible for insurance and becomes and remains insured as provided in the Group Policy.

Certificate of Insurance for Class 2

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions, then you may contact the insurance company at the above address or phone them at 1-800-423-2765. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, Los Angeles, CA 90013, or by telephone at 1-800-927-4357. Please have your policy number available.

AD&D Insurance is subject to certain limitations. Please read these carefully.

You are entitled to the benefits described in this Certificate if you are eligible for insurance under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms.


President

CERTIFICATE OF GROUP LIFE INSURANCE

**Riverside Community College District
000860050048**

SCHEDULE OF INSURANCE

CLASS 2

All Other Full-Time Employees

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates of Coverages" section)

MINIMUM HOURS: 20 hours per week

LIFE AND AD&D INSURANCE

Amount of Personal
Life Insurance

\$50,000

AD&D Insurance
Principal Sum

\$50,000

Personal Life and AD&D Insurance will terminate when you retire.

The following chart applies to the Extension of Death Benefit provision when benefits end upon attainment of the Social Security Normal Retirement Age:

<u>Year of Birth</u>	<u>Normal Retirement Age</u>
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

If any evidence of insurability is required, it will be provided at your own expense.

TABLE OF CONTENTS

Amount of Insurance.....	3
Definitions.....	3
Eligibility	4
Effective Dates of Coverages.....	4
Termination of Coverage	5
Death Benefit	6
Beneficiary	6
Assignments	7
Extension of Death Benefit.....	8
Accelerated Death Benefit	9
Conversion Privilege.....	11
Accidental Death and Dismemberment Insurance	12
Safe Driver Benefit	18
Claims Procedures for Life or Accidental Death and Dismemberment Benefits	19
Notice.....	22
Prior Insurance Credit Provision.....	24

AMOUNT OF INSURANCE

The amount of your insurance is determined by the Schedule of Insurance in the Policy. The initial amount of coverage is the amount which applies to your class on the day your coverage takes effect. You may become eligible for increases in the amount of insurance in accord with the Schedule of Insurance. Any such increase will take effect on the latest of:

- (1) the first of the Insurance Month which coincides with or follows the date on which you become eligible for the increase; provided you are Actively at Work on that day;
- (2) the day you resume Active Work, if you are not Actively at Work on the day the increase would otherwise take effect; or
- (3) the day any required evidence of insurability is approved by the Company.

Any decrease will take effect on the first day of the Insurance Month which coincides with or follows the day of the change, whether or not you are Actively at Work.

DEFINITIONS

ACTIVE WORK or **ACTIVELY AT WORK** means an employee's full-time performance of all customary duties of his or her occupation at:

- (1) the EMPLOYER'S place of business; or
- (2) any other business location where the employee is required to travel.

Unless disabled on the prior workday or on the day of absence, an employee will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) an excused or emergency leave of absence (except a medical leave).

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

DAY or **DATE** means at 12:01 A.M., Standard Time, at the Group Policyholder's place of business; when used with regard to eligibility dates and effective dates. It means 12:00 midnight, Standard Time, at the same place; when used with regard to termination dates.

EMPLOYER means the Group Policyholder or the Participating Employer named on the Face Page.

FULL-TIME EMPLOYEE means an employee of the EMPLOYER:

- (1) whose employment with the EMPLOYER is the employee's principal occupation;
- (2) who is not a temporary or seasonal employee; and
- (3) who is regularly scheduled to work at such occupation at least the number of hours as shown in the Schedule of Insurance.

INSURANCE MONTH means:

- (1) that period of time beginning on the Issue Date of the Policy and extending for one month; and
- (2) each subsequent month beginning on the same day after that.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

POLICY means the Group Insurance Policy issued by the Company to the Group Policyholder. A copy of the Policy may be examined upon request at the Group Insurance Service Office of the Group Policyholder.

ELIGIBILITY

If you are a Full-Time Employee and a member of an employee class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

- (1) the Policy's date of issue; or
- (2) the day you complete the Waiting Period.

WAITING PERIOD. (See Schedule of Insurance).

EFFECTIVE DATES OF COVERAGES

Your insurance is effective on the latest of:

- (1) the day you become eligible for the coverage;
- (2) the day you resume Active Work, if you are not Actively at Work on the day you become eligible;
- (3) the day you make written application for coverage; and sign:
 - (a) a payroll deduction order, if you pay any part of the premium; or
 - (b) an order to pay premiums from your Section 125 Plan account, if Employer contributions are paid through a Section 125 Plan; or
- (4) the day the Company approves your coverage, if evidence of insurability is required.

Evidence of insurability is required if:

- (1) you apply for coverage more than 31 days after you become eligible; or
- (2) you make written application to re-enroll for coverage after you have requested:
 - (a) to cancel your coverage;
 - (b) to stop payroll deductions for the coverage; or
 - (c) to stop premium payments from your Section 125 Plan account.

Any increased or additional coverage 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 day on which you become eligible for the increase, if Actively at Work on that day;
- (2) the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
- (3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the first day of the Insurance Month coinciding with or next following the day of the change, whether or not you are Actively at Work.

EXCEPTION. If your coverage terminates due to an approved leave of absence or a military leave, any Waiting Period or evidence of insurability requirement will be waived upon your return; provided:

- (1) you return within six months after the leave begins;
- (2) you apply or are enrolled within 31 days after resuming Active Work; and
- (3) the reinstated amount of insurance does not exceed the amount which terminated.

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

- (1) the day the Policy terminates;
- (2) the last day of the Insurance Month in which you request termination;
- (3) the last day of the period for which the premium for your insurance has been paid;
- (4) the day you cease to be a member of an employee class shown in the Schedule of Insurance;
- (5) with respect to any particular insurance benefit, the day the part of the Policy providing that benefit terminates;
- (6) the day your employment with the Employer terminates; or
- (7) the day you enter the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

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

Disability. If you are absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

- (1) until the Day Benefits Begin; and
- (2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

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

- (1) the end of the leave period approved by the Employer;
- (2) the end of the 12-week leave period required by federal law, or any more favorable period required by a similar state law;
- (3) the date you notify the Employer that you will not return; or
- (4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

Military Leave. If you go on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Lay Off or Other Leave. If you cease work due to a temporary lay off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

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

DEATH BENEFIT

Upon receipt of satisfactory proof of your death, the Company will pay a death benefit equal to the amount of Personal Life Insurance in effect on the date of your death. The benefit will be paid in accord with the Beneficiary section. Arrangements may be made to have this death benefit paid in installments.

BENEFICIARY

Your Beneficiary is the person or persons named on your enrollment card. The Beneficiary may be changed in accord with the terms of the Policy. If you have not named a Beneficiary, or if no named Beneficiary is living when you die; then the death benefit will be paid to your:

- (1) surviving spouse; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving brothers and sisters in equal shares; or, if none
- (5) estate, or in accord with the Facility of Payment section of the Policy.

ASSIGNMENTS

Personal Life Insurance and Accidental Death Insurance may be assigned. The assignments allowed under the Policy are absolute assignments and funeral assignments as described below.

No assignment will be binding on the Company unless and until:

- (1) it is made on a form furnished by the Company;
- (2) the original is completed and filed with the Company at its Group Insurance Service Office;
and
- (3) it is approved by the Company.

The Company and the Employer do not assume responsibility for the validity or effect of an assignment.

ABSOLUTE ASSIGNMENTS. You may make an irrevocable assignment of your Personal Life Insurance and Accidental Death Insurance as a gift (with no consideration), providing you have the legal capacity and the mental capacity to do so. It may be made to a trust or to one or more of your relatives, their estates, or to a trustee of a trust under which one of the relatives is a beneficiary.

The term "relatives" includes, but is not limited to, your spouse, parents, grandparents, aunts, uncles, siblings, children, adopted children, stepchildren, and grandchildren.

In some states, community property is an established form of ownership that must be considered in making an assignment. If you make an absolute assignment to two or more assignees, such assignees will be joint owners with the right of survivorship between them. You should consult with your own legal advisor before making an assignment.

Once the assignment has been recorded by the Company, you can no longer change the beneficiary and cannot apply for conversion. Only the assignee can change the beneficiary designation if the previous designation is revocable. An assignment will have no effect on a prior irrevocable beneficiary designation. Only the assignee can apply for conversion but only when the Conversion Privilege provision would have been available to you in the absence of the assignment under the Policy.

An absolute assignment cannot be used as a collateral assignment.

FUNERAL ASSIGNMENTS. Upon your death, the beneficiary may assign the Personal Life Insurance benefit and Accidental Death Insurance benefit to a funeral home for payment of burial expenses. After payment has been made for the burial expenses to the assigned funeral home, the remaining death benefit is then paid in accord with the Beneficiary and Settlement Options sections of the Policy.

EXTENSION OF DEATH BENEFIT IF YOU BECOME TOTALLY DISABLED

Your life insurance will be continued, **without payment of premiums**, if:

- (1) you become Totally Disabled while insured and before reaching age 60;
- (2) you remain Totally Disabled for at least 6 months in a row; and
- (3) you submit satisfactory proof within the 7th through 12th months of disability; or:
 - (a) as soon as reasonably possible after that; but
 - (b) not later than the 24th month of disability, unless you were legally incapacitated.

PREMIUM PAYMENT. Premium payments must continue until you are approved for this benefit, or the Policy terminates, if earlier. Upon receipt of satisfactory proof, the Company will refund up to 12 months' premium paid for your life insurance, from your 1st day of Total Disability.

DEFINITION. For this benefit, Total Disability or Totally Disabled means you:

- (1) are unable, due to sickness or injury, to engage in any employment or occupation for which you are or become qualified by reason of education, training, or experience; and
- (2) are not engaging in any gainful employment or occupation.

AMOUNT CONTINUED. The amount of Personal Life Insurance and any Dependent Life Insurance continued will be subject to the reductions and terminations in effect under the Policy on the day your Total Disability begins. Any Accidental Death and Dismemberment Benefit will not be continued.

ADDITIONAL PROOF. From time to time, you must submit proof that your Total Disability is continuing. Proof will be at your expense; unless the Company requests to have you examined by a Physician of its choice. If you die after submitting proof, further proof must be submitted to the Company showing that you remained continuously and Totally Disabled until death. If you die within 12 months after Total Disability begins, but before submitting proof; then your death benefit will still be paid under the terms of the Policy. But the Company must first receive satisfactory proof of your continuous Total Disability, from your last day of Active Work until your date of death.

TERMINATION. Any life insurance continued under this section will terminate automatically on:

- (1) the day you cease to be Totally Disabled;
- (2) the day you fail to take a required medical examination;
- (3) the 60th day after the Company mails a request for additional proof, if it is not given;
- (4) the effective date of your individual conversion policy, with respect to any amount of life insurance converted in accord with the Conversion Privilege section; or
- (5) the day you reach Social Security Normal Retirement Age (SSNRA), as shown in the Schedule of Insurance (whichever occurs first).

If your Total Disability ends, and you **do not return** to a class eligible for Policy coverage; then you may exercise the Conversion Privilege. If your Total Disability ends, and you **do return** to an eligible class; then your Policy coverage will resume when premium payments are resumed, and any conversion policy is surrendered as provided in the Policy.

ACCELERATED DEATH BENEFIT

BENEFIT. The Accelerated Death Benefit is an advance payment of part of your Personal Life Insurance. It may be paid to you, in a lump sum, once during your lifetime.

To qualify, you must:

- (1) have satisfied the Active Work requirement under the Policy;
- (2) have been insured under the Policy for at least 12 months; and
- (3) have at least \$2,000 of Personal Life Insurance under the Policy on the day before the Accelerated Death Benefit is paid.

Receiving the Accelerated Death Benefit will reduce the Remaining Life Insurance and the Death Benefit payable at death, as shown on the next page.

"Claimant," as used in this section, means the Terminal Insured Person for whom the Accelerated Death Benefit is requested.

"Terminal" means you have a medical condition which is expected to result in death within 12 months, despite appropriate medical treatment.

APPLYING FOR THE BENEFIT. To withdraw the Accelerated Death Benefit, you (or your legal representative) must send the Company:

- (1) written election of the Accelerated Death Benefit, on forms supplied by the Company; and
- (2) satisfactory proof that the Claimant is Terminal, including a Physician's written statement.

The Company reserves the right to decide whether such proof is satisfactory.

Before paying an Accelerated Death Benefit, the Company must also receive the written consent of any irrevocable beneficiary, assignee or bankruptcy court with an interest in the benefit. (See Limitations 3, 4, and 5.)

NOTE: THIS IS NOT A LONG-TERM CARE POLICY. RECEIVING THIS ACCELERATED DEATH BENEFIT WILL REDUCE THE BENEFIT PAYABLE AT DEATH. ANY AMOUNT WITHDRAWN MAY BE TAXABLE INCOME, SO YOU SHOULD CONSULT A TAX ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

AMOUNT OF THE BENEFIT. You may elect to withdraw an Accelerated Death Benefit in any \$1,000 increment; subject to:

- (1) a minimum of \$1,000 or 10% of the Claimant's amount of Life Insurance (whichever is greater); and
- (2) a maximum of \$250,000 or 75% of the Claimant's amount of Life Insurance (whichever is less).

To determine the Accelerated Death Benefit, the Company will use the lesser of A or B below:

- A. the Claimant's amount of Life Insurance which is in force on the day before the Accelerated Death Benefit is paid; or
- B. the Claimant's amount of Life Insurance which would be in force 12 months after that date; if the coverage is scheduled to reduce, due to age, within 12 months after the Accelerated Death Benefit is paid.

ADMINISTRATIVE CHARGE: NONE

WITHDRAWAL FEE: NONE

EFFECT ON AMOUNT OF LIFE INSURANCE. "Remaining Life Insurance" means the amount of Life Insurance which remains in force on the Claimant's life after an Accelerated Death Benefit is paid. The Remaining Life Insurance will equal:

- (1) the Claimant's amount of Life Insurance which was used to determine the Accelerated Death Benefit (A or B above); minus
- (2) any percentage by which the Claimant's coverage is scheduled to reduce, due to age; if the reduction occurs more than 12 months after the Accelerated Death Benefit is paid, and while he or she is still living; minus
- (3) the amount of the Accelerated Death Benefit withdrawn.

PREMIUM: There is no additional charge for this benefit. Continuation of the Remaining Life Insurance will be subject to timely payment of the premium for the reduced amount; unless you qualify for waiver of premium under the Policy's Extension of Death Benefit provision, if included.

CONDITIONS. If the Claimant exercises the Conversion Privilege after an Accelerated Death Benefit is paid, the amount of the conversion policy will not exceed the amount of his or her Remaining Life Insurance. If the Claimant has Accidental Death and Dismemberment benefits under the Policy, the Principal Sum will not be affected by the payment of an Accelerated Death Benefit.

EFFECT ON DEATH BENEFIT. When the Claimant dies after an Accelerated Death Benefit is paid, the amount of Remaining Life Insurance in force on the date of death will be paid as a Death Benefit. Your Death Benefit will be paid in accord with the Beneficiary section of the Policy. If the Claimant dies after application for an Accelerated Death Benefit has been made, but before the Company has made payment; then the request will be void and no Accelerated Death Benefit will be paid. The amount of Life Insurance in force on the date of death will be paid in accord with Policy provisions.

EFFECT ON TAXES AND GOVERNMENT BENEFITS. Any Accelerated Death Benefit amount withdrawn may be taxable income to you. Receipt of the Accelerated Death Benefit may also affect the Claimant's eligibility for Medicaid, Supplemental Security Income and other government benefits. The Claimant should consult his or her own tax and legal advisor before applying for an Accelerated Death Benefit. The Company is not responsible for any tax owed or government benefit denied, as a result of the Accelerated Death Benefit payment.

LIMITATIONS. No Accelerated Death Benefit will be paid:

- (1) if any required premium is due and unpaid;
- (2) on any conversion policy purchased in accord with the Conversion Privilege;
- (3) without the written approval of the bankruptcy court, if you have filed for bankruptcy;
- (4) without the written consent of the beneficiary, if you have named an irrevocable beneficiary;
- (5) without the written consent of the assignee, if you have assigned your rights under the Policy;
- (6) if any part of the Life Insurance must be paid to your child, spouse or former spouse; pursuant to a legal separation agreement, divorce decree, child support order or other court order;
- (7) if the Claimant is Terminal due to a suicide attempt, while sane or insane; or due to an intentionally self-inflicted injury;
- (8) if a government agency requires you or the Claimant to use the Accelerated Death Benefit to apply for, receive or continue a government benefit or entitlement; or
- (9) if an Accelerated Death Benefit has been previously paid for the Claimant under the Policy.

CONVERSION PRIVILEGE

If your insurance or insurance on a Dependent terminates for any reason except:

- (1) termination or amendment of the Policy; or
- (2) your request for:
 - (a) termination of insurance; or
 - (b) cancellation of your payroll deduction,

an individual life policy, known as a conversion policy, may be purchased without evidence of insurability.

To purchase a conversion policy, application and payment of the first premium must be made within 31 days after the life insurance is terminated.

The conversion policy will:

- (1) be in an amount not to exceed the amount of life insurance which was terminated;
- (2) be on any form (except term) then issued by the Company at the age and amount for which application is made;
- (3) be issued at the person's age at nearest birthday;
- (4) be issued without disability or other supplemental benefits; and
- (5) require premiums based on the class of risk to which the person then belongs.

A conversion policy also may be purchased if:

- (1) all or part of your insurance or insurance on a Dependent terminates due to amendment or termination of the Policy; and
- (2) you have been covered continuously under the Policy for at least 5 years or you are Totally Disabled (as defined by the Policy).

The amount of the conversion policy may not exceed the lesser of:

- (1) \$3,000 (not applicable if you are Totally Disabled); or
- (2) the amount of life insurance which terminates, less the amount of any group life insurance for which the person becomes eligible within 31 days after the termination.

The conversion policy will take effect on the later of:

- (1) its date of issue; or
- (2) 31 days after the date the insurance terminated.

If death occurs during the 31 day conversion period, the Company will pay the life insurance which could have been converted even if no one applied for the conversion policy.

When your insurance terminates, written notice of your right to convert will be given to you.

If written notice is not given to you at least 15 days before the end of the 31 day conversion period, an additional period in which to convert will be granted. Any such extension of the conversion period will expire on the earliest of:

- (1) 25 days after you are given the written notice; or
- (2) 60 days after the end of the 31 day conversion period, even if you are never given such notice.

No death benefit will be payable under the Policy after the 31 day conversion period has expired even though the right to convert may be extended.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

DEATH OR DISMEMBERMENT BENEFIT FOR AN INSURED PERSON. The Company will pay the benefit listed below, if:

- (1) you sustain an accidental bodily injury while insured under this provision; and
- (2) that injury directly causes one of the following losses within 365 days after the date of the accident.

The loss must result directly from the injury and from no other causes.

LOSS	BENEFIT FOR COMMON CARRIER ACCIDENT	BENEFIT FOR OTHER COVERED ACCIDENT
Loss of Life	2 Times Principal Sum	Principal Sum
Loss of One Member (Hand, Foot or Eye)	Principal Sum	1/2 Principal Sum
Loss of Two or More Members	2 Times Principal Sum	Principal Sum
Quadriplegia (Paralysis of Both Arms and Both Legs)	2 Times Principal Sum	Principal Sum
Paraplegia (Paralysis of Both Legs)	Principal Sum	1/2 Principal Sum
Hemiplegia (Paralysis of Arm and Leg of Same Side)	Principal Sum	1/2 Principal Sum

The Principal Sum for your class is shown in the Schedule of Insurance.

MAXIMUM PER PERSON. If you sustain more than one loss resulting from the same accident, the benefit:

- (1) will be the one largest amount listed;
- (2) will not exceed two times the Principal Sum for all of your combined losses resulting from a Common Carrier Accident; and
- (3) will not exceed the Principal Sum for all of your combined losses resulting from any other covered accident.

TO WHOM PAYABLE. Benefits for your loss of life will be paid in accord with the Beneficiary section. All other benefits will be paid to you.

LIMITATIONS. Benefits are not payable for any loss to which a contributing cause is:

- (1) intentional self-inflicted injury or self-destruction;
- (2) disease, bodily or mental infirmity, or medical or surgical treatment of these;
- (3) duty as a member of any military, naval or air force;
- (4) war or any act of war, declared or undeclared;
- (5) participation in the commission of a felony;
- (6) voluntary use of drugs; except when prescribed by a Physician;
- (7) voluntary inhalation of gas, including carbon monoxide;
- (8) travel or flight in any aircraft, including balloons and gliders; except as a fare paying passenger on a regularly scheduled flight; or
- (9) driving a vehicle while intoxicated.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

DEFINITIONS.

"Beneficiary" means the person(s) named on your enrollment form. You may change the Beneficiary by filing a written notice of the change with the Company at its Group Insurance Service Office.

"Common Carrier Accident" means a covered accidental bodily injury, which is sustained while riding as a fare paying passenger (not a pilot, operator or crew member) in or on, boarding or getting off from a Common Carrier

"Common Carrier" means any land, air or water conveyance operated under a license to transport passengers for hire.

"Intoxicated" shall be defined by the jurisdiction where the accident occurs. The exclusion will apply whether or not the driver is convicted.

"Loss of a Member" includes the following:

- (1) "Loss of Hand or Foot," means complete severance through or above the wrist or ankle joint. (In South Carolina, "Loss of Hand" can also mean the loss of four whole fingers from one hand.)
- (2) "Loss of an Eye," means total and irrevocable loss of sight in that eye.

"Paralysis" means complete and irreversible loss or use of an arm or leg (without severance).

REPATRIATION BENEFIT. The Company will pay a Repatriation Benefit, if:

- (1) you die as a result of a covered accident at least 150 miles from your principal place of residence; and
- (2) expense is incurred for the preparation and transportation of your body to a mortuary.

This benefit will be paid in addition to all other benefits payable under the Policy. This benefit will equal the expenses incurred for the preparation and transportation of your body to a mortuary subject to a maximum of \$5,000. This benefit will be paid:

- (1) when the benefit for accidental loss of life is paid; or
- (2) when the Company receives proof of expense incurred, if later.

PROOF. In order for this benefit to be payable, proof of payment for any expenses incurred for Repatriation must be provided to the Company.

TO WHOM PAYABLE. Benefits for Repatriation will be paid in accord with the Beneficiary and/or Facility of Payment sections of the Policy.

Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

EDUCATION BENEFIT. The Company will pay an Education Benefit for each of your eligible Dependent Children, if you:

- (1) are injured in a covered accident while insured under the Policy;
- (2) die as a direct result of such injuries within 365 days after the accident; and
- (3) are survived by one or more Dependent Children who are eligible for the benefit.

To be eligible for the Education Benefit, your Dependent Child:

- (1) must be dependent on you for principal support;
- (2) must be enrolled as a Full-Time Student on the date of your death or within 365 days after that date; and
- (3) must incur expenses after the date of your death for tuition, fees, books, room and board, or any other costs payable directly to (or approved and certified by) that school.

This benefit will be paid in addition to all other benefits payable under the Policy. The benefit will equal the actual expense incurred after the date of your death up to 5% of your Principal Sum, subject to a maximum of \$5,000 for each eligible Dependent Child per year, for up to 4 consecutive years or until age 25. The benefit will be paid to your Dependent Child, if your child has reached the age of majority. Otherwise, benefits will be paid to your child's legal guardian. The first payment will be made:

- (1) when the benefit for accidental loss of life is paid; or
- (2) when the Company receives proof of payment for the expenses incurred and that your eligible Dependent Child meets the above requirements, if later.

Subsequent payments will be made when the Company receives:

- (1) verification that the eligible Dependent Child continues to be a Full-Time Student during each additional semester/year; and
- (2) proof of payment for the expenses incurred.

"Full-Time Student" means a Dependent Child who:

- (1) is attending a licensed or accredited college, university or vocational school (beyond the 12th grade);
- (2) is considered a full-time student based upon that school's standards; and
- (3) incurs expenses for tuition, fees, books, room and board, or other costs payable directly to (or approved or certified by) that school.

"Child" includes your naturally born child, legally adopted child, stepchild, and foster child.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

SPOUSE TRAINING BENEFIT. The Company will pay a Spouse Training Benefit to your surviving Spouse, if you:

- (1) are injured in a covered accident while insured under the Policy;
- (2) die as a direct result of such injuries within 365 days after the accident; and
- (3) are survived by a Spouse who is eligible for the benefit.

To be eligible for the Spouse Training Benefit, your Spouse:

- (1) must not be legally separated from you on the date of the accident;
- (2) must be enrolled as a student on the date of your death or within 365 days after that date in any school to retrain or refresh skills needed for employment; and
- (3) must incur expenses after the date of your death for tuition, fees, books, room and board or other costs payable directly to (or approved or certified by) that school.

This benefit will be paid in addition to all other benefits payable under the Policy. The benefit will equal the actual expense incurred after the date of your death up to 5% of your Principal Sum; subject to a maximum of \$5,000. The benefit will be paid for one year. Payment will be made:

- (1) when the benefit for accidental loss of life is paid; or
- (2) when the Company receives proof of expense incurred and that the Spouse meets the above requirements, if later.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

CHILD CARE BENEFIT. The Company will pay a Child Care Benefit for each of your eligible Dependent Children, if you:

- (1) are injured in a covered accident while insured under the Policy;
- (2) die as a direct result of such injuries within 365 days after the accident; and
- (3) are survived by one or more Dependent Children who are eligible for the benefit.

To be eligible for the Child Care Benefit, your Dependent Child must:

- (1) be dependent on you for principal support;
- (2) be under age 13 on the date of the accident; and
- (3) attend a licensed Child Care Center on a regular basis on the date of your death or within 365 days after that date.

The Child Care Benefit is paid in addition to all other Policy benefits. The benefit will equal the actual expense incurred after the date of your death, up to 5% of your Principal Sum; subject to a maximum of \$5,000 for each eligible Dependent Child per year. The benefit will be paid to the legal guardian of the eligible Dependent Child:

- (1) for up to 4 consecutive years; or
- (2) until your Dependent Child's 13th birthday (whichever occurs first).

The first payment will be made:

- (1) when the benefit for accidental loss of life is paid; or
- (2) when the Company receives proof of expense incurred and that an eligible Dependent Child meets the above requirements; if later.

Subsequent payments will be made quarterly on a reimbursement basis when the Company receives:

- (1) verification that your eligible Dependent Child continues to attend a licensed Child Care Center on a regular basis; and
- (2) satisfactory proof of payment for the child care expense incurred.

DEFINITIONS. "Child Care Center" means any facility (other than a family day care home) which:

- (1) is licensed as such by the state; and
- (2) provides non-medical care and supervision for children in a group setting; and
- (3) cares for children at least 6 but less than 24 hours per day.

"Child" includes your naturally born child, legally adopted child, stepchild, and foster child.

"Expense Incurred" means the cost for the supervision and care of a Dependent Child, excluding any fees for extra activities, which are directly payable to a Child Care Center.

EXCLUSIONS. Benefits will not be paid:

- (1) when the Dependent Child's care is provided by (or at a facility operated by) the child's grandparent, parent, aunt, uncle or sibling; or
- (2) for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section of the Policy.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

COMA BENEFIT. The Company will pay a Coma Benefit, while you remain in a coma; provided:

- (1) the coma is caused by an Injury sustained while you are insured under the Policy;
- (2) the coma begins within 365 days after the date of the accident; and
- (3) you remain in a continuous coma for at least 31 days in a row.

The coma must result directly from the Injury and from no other causes.

This benefit will be paid in addition to all other benefits payable under the Policy. The Coma Benefit will equal a one-time payment of 5% of the Insured Person's Principal Sum; subject to a maximum of \$5,000.

PROOF. Proof of the coma must be provided to the Company. The Company retains the right to investigate and to determine whether the coma exists.

TO WHOM PAYABLE. Upon receipt of satisfactory proof, the Coma Benefit will be paid to you.

"Coma" means being in a state of complete mental unresponsiveness, with no evidence of appropriate responses to stimulation.

EXCLUSIONS. Benefits will not be paid:

- (1) when you remain in a coma for less than 31 days in a row; or
- (2) for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section of the Policy.

SAFE DRIVER BENEFIT

BENEFIT. If you die as a direct result of a covered auto accident, for which Accidental Death and Dismemberment Benefits are payable; then:

- (1) an additional Seat Belt Benefit will be payable, if you were wearing a properly fastened seat belt at the time of the accident; and
- (2) an additional Air Bag Benefit will be payable, if the auto was equipped with air bag(s).

The Seat Belt Benefit equals \$10,000 or 10% of the Principal Sum, whichever is less; and the Air Bag Benefit equals \$10,000 or 10% of the Principal Sum, whichever is less. The Seat Belt Benefit and the Air Bag Benefit will not be less than \$1,000. The Principal Sum is the amount payable because of the Insured Person's accidental death.

A copy of the police report must be submitted with the claim. The position of the seat belt or presence of an air bag must be certified by:

- (1) the official accident report; or
- (2) the coroner, traffic officer or other investigating officer.

Upon receipt of satisfactory written proof, the additional benefit will be paid in accord with the Beneficiary section.

DEFINITIONS. As used in this provision:

"Auto" means a 4-wheel passenger car, station wagon, jeep, pick-up truck or van-type car. It must be licensed for use on public highways. It includes a car owned or leased by the Employer.

"Intoxicated," "Impaired," or "Under the Influence of Drugs" shall be defined as by the jurisdiction where the accident occurs.

"Seat Belt" means a properly installed:

- (1) seat belt or lap and shoulder restraint; or
- (2) other restraint approved by the National Highway Traffic Safety Administration.

LIMITATIONS. Safe Driver Benefits will not be paid if:

- (1) the Accidental Death and Dismemberment Benefit is not paid under the Policy for your death; or
- (2) at the time of the accident, you or any other person who was driving the auto in which you were traveling:
 - (a) was driving without a valid drivers' license;
 - (b) was driving in excess of the legal speed limit; or
 - (c) was driving while intoxicated, impaired, or under the influence of drugs (except for drugs taken as prescribed by a Physician for the driver's use).

The above limitations will apply, whether or not the driver is convicted.

**CLAIMS PROCEDURES
FOR LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

NOTE: The Policy may include an Extension of Death Benefit, an Accelerated Death Benefit or a Living Benefit. If so, please refer to that section for special claim procedures.

NOTICE AND PROOF OF CLAIM

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

- (1) your name and address; and
- (2) the number of the Policy.

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

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of the loss; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. In addition to the information requested on the claim form, documentation must include:

- (1) A certified copy of the death certificate, for proof of death.
- (2) A copy of any police report, for proof of accidental death or dismemberment.
- (3) A signed authorization for the Company to obtain more information.
- (4) Any other items the Company may reasonably require in support of the claim.

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

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

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

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have you examined:

- (1) by a Physician of the Company's choice;
- (2) as often as reasonably required.

If you fail to cooperate with an examiner or fail to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

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

TO WHOM PAYABLE

Death. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment and Settlement Options sections of the Policy. If the Policy includes Dependent Life Insurance; then any benefits payable for an insured Dependent's death will be paid to:

- (1) you, if you survive that Dependent; or
- (2) your Beneficiary, or in accord with the Facility of Payment section; if you do not survive that Dependent.

Dismemberment. If the Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than your death benefit, will be paid to you.

CLAIMS PROCEDURES (Continued)

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

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) whether more information is needed to support the claim; and
- (3) how the claimant may request a review of the decision by the Company, or by the state Department of Insurance. It will include the address and phone number of their consumer complaint unit.

The Company will send this notice within 15 days after it receives complete proof of claim and enough information to determine liability. If reasonably possible, the Company will send it within:

- (1) 90 days after receiving the first proof of a death or dismemberment claim; or
- (2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

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

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

The notice will explain the special circumstances which require the delay, and when a decision can be expected. In any event, the Company must send written notice of its decision within:

- (1) 180 days after receiving the first proof of a death or dismemberment claim; or
- (2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

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

REVIEW PROCEDURE. The claimant may request a claim review, within:

- (1) 60 days after receiving a denial notice of a death or dismemberment claim; or
- (2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

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

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

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy, the notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

CLAIMS PROCEDURES (Continued)

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

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

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

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

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

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from you, or from your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

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

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

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

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

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

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

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

**CALIFORNIA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER**

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these type of insurance are members of the California Life and Health Insurance Guaranty Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guaranty Association may not provide coverage for the policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

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

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life & Health Insurance Guaranty Association P.O. Box 16860 Beverly Hills, CA 90209-3319	or	Consumer Communications Bureau California Department of Insurance 300 South Spring Street Los Angeles, CA 90013
--	----	--

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guaranty Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contractholders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the life insurance company would owe under a life policy or annuity contract up to
- \$100,000 in cash surrender values,
- \$100,000 in present value of annuities; or
- \$250,000 in life insurance death benefits.
- A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000860050048

ISSUED TO: Riverside Community College District

Your Certificate is amended by the addition of the following provisions.

**PRIOR INSURANCE CREDIT UPON TRANSFER OF
LIFE INSURANCE CARRIERS**

This provision prevents loss of life insurance coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group life insurance policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to payment of premiums, the Policy will provide life coverage if you:

- (1) were insured under the prior plan on its termination date;
- (2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date;
- (3) are not entitled to any extension of life insurance under the prior plan; and
- (4) are not Totally Disabled (as defined in the Extension of Death Benefit section of the Policy) on the date the Policy takes effect.

AMOUNT OF LIFE INSURANCE. Until you satisfy the Policy's Active Work rule, the amount of your group life insurance under the Policy will not exceed the amount for which you were insured under the prior plan on its termination date.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

SUMMARY PLAN DESCRIPTION

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

The name of the Plan is: Group Life and Accidental Death and Dismemberment Insurance for Employees of Riverside Community College District.

The name, address and ZIP code of the Sponsor of the Plan is: Riverside Community College District, 4800 Magnolia Avenue, Riverside, CA, 92506.

Employer Identification Number (EIN): 95-6000929

IRS Plan Number: 500

The name, business address, ZIP code and business telephone number of the Plan Administrator is: Riverside Community College District, 4800 Magnolia Avenue, Riverside, CA, 92506, (951) 328-3273.

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

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

Type of Plan. The benefits provided under the Plan are: Group Life and Accidental Death and Dismemberment Insurance benefits.

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. The Certificate also contains the Schedule of Insurance which includes the amount of Personal Life insurance, AD&D Principal Sum, Dependent Life amounts (if any), Waiting Period and age reduction information. If your Booklet, Certificate or Schedule of Insurance has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

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

Employees become eligible on the day of .

Contributions. You are not required to make contributions for Personal Life Insurance and AD&D Insurance.

The Plan's year ends on: August 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 dismemberment claim (180 days under special circumstances);
- 45 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy (105 days 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 The Lincoln National Life Insurance Company within:

- 60 days after receiving a denial notice of a death or dismemberment claim;
- 180 days after receiving a denial notice of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy.

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 dismemberment claim (120 days under special circumstances);
- 45 days after receiving the request for review of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy (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 work sites 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.



LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

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

INFORMATION WE MAY COLLECT AND USE

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

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

HOW WE USE YOUR PERSONAL INFORMATION

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

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

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

SECURITY OF INFORMATION

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

Questions about your personal information should be directed to:

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

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

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

First Penn-Pacific Life Insurance Company	Lincoln Life & Annuity Company of New York
Lincoln Financial Investment Services Corporation	Lincoln Variable Insurance Products Trust
Lincoln Investment Advisors Corporation	The Lincoln National Life Insurance Company

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply 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