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 000010120236 has been issued to
United Transportation Union
(The Group Policyholder)

The Issue Date of the Policy is March 1, 2010.

Certificate of Insurance for Class 2

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. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.

President

CERTIFICATE OF GROUP INSURANCE
PROVIDING
WEEKLY DISABILITY INCOME INSURANCE

United Transportation Union
000010120236

SCHEDULE OF INSURANCE

CLASS 2

All Full-Time Bus Craft Members residing in California

WAITING PERIOD: 30 days of continuous Active Work (For date insurance begins, refer to "Effective Dates" section)

OPEN ENROLLMENT PERIOD: February 1 - February 28

MINIMUM HOURS: 20 hours per week

WEEKLY DISABILITY INCOME INSURANCE

MAXIMUM WEEKLY BENEFIT: $200

MINIMUM WEEKLY BENEFIT: 10% of your Weekly Total Disability Benefit

MAXIMUM BENEFIT PERIOD: 52 weeks

DAY BENEFITS BEGIN: 31st consecutive day of Disability due to accidental Injury; and
31st consecutive day of Disability due to Sickness.

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

Weekly Disability Income Insurance will terminate when you retire.

The Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

CONTRIBUTIONS: You are required to contribute to the cost of the Weekly Disability Income Insurance.

TABLE OF CONTENTS

DEFINITIONS

As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.

ACTIVE WORK or ACTIVELY AT WORK means your performance of all Main Duties of your Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires you to travel.

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

This includes a Military Leave or an approved Family or Medical Leave that is not due to your own health condition.

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

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

DISABILITY or DISABLED means Total Disability or Partial Disability.

DEFINITIONS
(Continued)

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:

(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

EMPLOYEE or FULL-TIME EMPLOYEE means a person:

(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance per week;
(4) who is a member of an Eligible Class which is eligible for coverage 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.

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

EVIDENCE OF INSURABILITY means a statement of proof of your medical history. The Company uses this to determine your acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

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 Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:

(1) may consist of consecutive or intermittent work days; or
(2) may 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, you may elect the more favorable leave (but not both). If you are on an FMLA leave due to your own health condition on the date Policy coverage takes effect, you are not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Benefit, means the average number of hours you were regularly scheduled to work, at your Own Occupation, during the week just prior to:

(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while you are continuing coverage during a leave of absence.

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

INJURY means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:

(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before your Effective Date under the Policy.

The term "Injury" shall not include any:

(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

INSURANCE MONTH or **POLICY MONTH** means that period of time:

(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

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

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:

(1) are normally required to perform your Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:

(1) the Employer is subject to the Act; or
(2) you have requested such a job accommodation.

An Employer's failure to modify or omit other job tasks does **not** render you unable to perform the Main Duties of the job.

Main Duties include those job tasks:

(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.

Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing your Disability. Such treatment must be rendered:

(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

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

OPEN ENROLLMENT PERIOD means a designated timeframe for eligible employees to elect coverage who did not enroll during their initial eligibility period or for employees with existing coverage under the Policy to elect additional benefit amounts. Evidence of insurability is not required during this period provided certain conditions are met as described in the Schedule of Benefits. Participation in an Open Enrollment Period does not change the Policy provisions related to Waiting Periods or Pre-Existing Condition Limitations. Employees who have been previously declined for coverage or increased coverage may resubmit satisfactory evidence of insurability to apply for initial coverage or increased coverage during this Open Enrollment Period.

OWN OCCUPATION or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which you were employed with the Employer prior to Disability; and
(2) which was your main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, you:
(1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and
(2) are engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means you are working at your Own Occupation or any other occupation; however, because of a Partial Disability:
(1) your hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) you are working in a lower-paid occupation.

During Partial Disability Employment, your current earnings:
(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

PERSON means an Employee of the Employer:
(1) who is a member of an Employee class which is eligible for coverage under the Policy; and
(2) who has completed an enrollment form.

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

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

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for your disabling condition.

Physician does **not** include you or your relatives. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of like degree.

POLICY means the group insurance Policy issued by the Company to the Group Policyholder.

PREDISABILITY INCOME--See Basic Weekly Earnings definition.

REGULAR CARE OF A PHYSICIAN means you:
(1) personally visit a Physician, as often as medically required according to standard medical practice to effectively manage and treat your disabling condition; and
(2) receive Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION--See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by you (Payments representing Employee contributions are deemed to be received over your expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
    (a) early or normal retirement; or
    (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall not include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which you are eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:

(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of your Predisability Income for a specified period after you become Disabled.

It does **not** include compensation the Employer pays you for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL DISABILITY or **TOTALLY DISABLED** means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

WEEKLY BENEFIT means the amount payable weekly by the Company to you while you are Totally Disabled or Partially Disabled.

WORKERS' COMPENSATION OR SIMILAR COVERAGE means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):

(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:
(1) the Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached to the Policy);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

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

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

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) you incur a claim during the first two years of coverage; and
(2) the Company discovers that you made a Material Misrepresentation on your application.

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

MISSTATEMENTS OF FACTS. If relevant facts about any Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If your age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

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

CURRENCY. In administering the Policy:
(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefits must be paid in U.S. dollars.

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

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

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

ELIGIBILITY. A Person becomes eligible for coverage provided by the Policy on the later of:
(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) you are a former Employee and are rehired within one year after your employment ends;
(2) you return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law; or
(3) you return from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATE. Your initial amount of Personal Insurance 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 you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible;
(3) the date you make written application for coverage and sign a payroll deduction order, if you pay any part of the Policy premiums; or
(4) the date the Company approves your Evidence of Insurability, if required.

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 day of the change, whether or not you are Actively at Work.

Evidence of Insurability. Evidence of Insurability satisfactory to the Company must be submitted (at your expense) when:
(1) you make written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) you make written application for coverage after you have requested:
  (a) to cancel insurance; or
  (b) to stop payroll deductions for the insurance.

Effective Date for Change in Eligible Class. You may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

ELIGIBILITY AND EFFECTIVE DATES
(Continued)

REINSTATEMENT RIGHTS. If your coverage terminates due to one of the following breaks in service, you will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

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

To reinstate coverage, you must apply for coverage 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. Reinstatement will take effect on the date you return to Active Work.

If the above conditions are met, and the Policy includes a Pre-Existing Condition Exclusion, then:

(1) the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and
(2) a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance.

A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance.

INDIVIDUAL TERMINATIONS

TERMINATION OF COVERAGE. Your coverage will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates or the Employer's participation ends (but without prejudice to any claim incurred prior to termination);
(2) the date your class is no longer eligible for insurance;
(3) the date you cease to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the day the portion of the Policy providing that benefit terminates;
(8) the date your employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date 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.)

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of your coverage during a Disability will have no effect on benefits payable for that period of Disability.

CLAIMS PROCEDURES
FOR WEEKLY DISABILITY INCOME BENEFITS

NOTICE AND PROOF OF CLAIM -- Notice of Claim. Written notice of a Disability claim must be given:
(1) within 20 days after the Injury or Sickness causing Disability begins; or
(2) as soon as reasonably possible after that.*
The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address, and 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, you may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send you additional claim forms.

Proof of Claim. The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at your own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by you and your Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of your Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

***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 you lack legal capacity.

EXAMINATION. The Company may have you examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

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

The Company may determine that (in its opinion) you have:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.
In that event, benefits may be denied or suspended, until the required exam is completed.

CLAIMS PROCEDURES
(Continued)

TIME OF PAYMENT OF CLAIMS. Weekly Disability Income Benefits payable under the Policy will be paid:

(1) immediately after the Company receives complete proof of claim and confirms liability; and
(2) in any event, within two months after the Company receives complete proof of claim.

Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit.

Any balance, which remains unpaid at the end of the period of liability, will be paid:

(1) immediately after the Company receives complete proof of claim and confirms liability; and
(2) in any event, within two months after the Company receives complete proof of claim.

TO WHOM PAYABLE. All Weekly Disability Income Benefits are payable to you, while living. After your death, such benefits will be payable to your estate.

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

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

This notice will be sent within 15 days after the Company resolves the claim; and, in any event, within two months after the Company receives complete proof of claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send you 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:

(1) what additional information is needed to determine liability; and
(2) when a decision can be expected.

If you do not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from you to process a claim. If so, 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. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

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

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

Notice of Decision. The Company will review the claim and send you a written notice of its decision. The notice will state 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, 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.

This 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.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:
(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send you 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: The Company may need more information from you to process an appeal. If so, 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 plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:
(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) 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, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:
(1) reduce future benefits and suspend payment of the Minimum Weekly Benefit under the Policy, until full reimbursement is made;
(2) reduce benefits payable to you or your beneficiary under any group insurance policy issued by the Company, until full reimbursement is made; or
(3) recover such overpayments from you or your 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 five 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 manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:
(1) establish administrative procedures, determine eligibility and resolve claims questions;
(2) determine what information the Company reasonably requires to make such decisions; and
(3) resolve all matters when an internal claim review is requested.

Any decision the Company makes in the exercise of its authority shall be conclusive and binding; subject to your rights to request a state insurance department review or to bring legal action.
This provision does not apply to residents of California.

NOTICE: A person is guilty of insurance fraud, if he or she submits an application or files a claim containing a false or deceptive statement:
(1) with intent to defraud an insurance company; or
(2) knowing that he or she is aiding a fraud against an insurance company.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if you:

(1) become Totally Disabled while insured for this benefit;
(2) are under the Regular Care of a Physician; and
(3) at your own expense, submit proof of continued Total Disability and Physician's care to the Company upon request.

Duration. Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date you cease to be Totally Disabled or die;
(2) the date the Maximum Benefit Period ends; or
(3) the date you are able, but choose not to engage in Partial Disability Employment in your Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice; or
(2) the 45th day after the Company requests additional proof, if not given.

Amount. The amount of the Weekly Total Disability Benefit equals the Maximum Weekly Benefit.

The Day Benefits Begin, Maximum Benefit Period and Maximum Weekly Benefit are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay a Weekly Partial Disability Benefit, if you:

(1) become Partially Disabled while insured for this benefit;
(2) are engaged in Partial Disability Employment;
(3) are earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) are under the Regular Care of a Physician>; and
(5) at your own expense, submit proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

You are not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

Duration. Benefits start on the Day Benefits Begin, and will cease on the earliest of:

(1) the date you cease to be Partially Disabled or die;
(2) the date the Maximum Benefit Period ends;
(3) the date you earn more than 99% of Basic Weekly Earnings; or
(4) the date you are able, but choose not to work Full-Time or part-time in your Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice; or
(2) the 45th day after the Company requests additional proof, if not given.

Amount. The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:

(A) The Maximum Weekly Benefit; or
(B) Your Basic Weekly Earnings minus earnings you earned or received from any occupation or form of employment during that period of Disability.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit.

The Day Benefits Begin, Maximum Benefit Period, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

RULES CONCERNING EARNINGS AND OTHER BENEFITS. Your Earnings during Partial Disability Employment may affect the amount of the Weekly Benefit. Also, the Disability may entitle you to other benefits, awards or settlements that affect your eligibility for Policy benefits. If so, the following rules will apply.

"Earnings", as used in this provision, means pay you earn or receive from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:

(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Claiming Other Benefits. You must actively pursue a claim for the other benefits. For example, if Workers' Compensation benefits may be payable for the same period of Disability:

(1) you and your Employer must cooperate in filing a claim for those benefits; and
(2) the Company will require proof of the denial or duration of those benefits, to determine its liability under the Policy.

Refunding Overpayments. Upon receiving other benefits for the same period of Disability, you must refund any resulting overpayment of Weekly Benefits under the Policy. If you do not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:

(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

RECURRENT DISABILITY. "Recurrent Disability" means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if you:
  (a) have returned to your Own Occupation; and
  (b) have worked on a full-time basis, for two consecutive weeks or more.
  A new Day Benefits Begin and new Maximum Benefit Period will apply.
(2) A Recurrent Disability will be treated as part of the prior Disability, if you:
  (a) have returned to your Own Occupation; and
  (b) have worked on a full-time basis, for less than two consecutive weeks.
  The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, you must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability. This Recurrent Disability provision will cease to apply when you become eligible for coverage under any other group short-term disability policy.

WEEKLY DISABILITY INCOME INSURANCE
(Continued)

EXCLUSIONS. Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which you are not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which you receive benefits under Workers' Compensation or similar coverage;
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
    (a) the Employer had enrolled you for such coverage; and
    (b) you and your Employer had cooperated in filing a claim under that plan;
(6) during which you receive payment under the Employer's Sick Leave or Salary Continuance Plan; or
(7) during which you receive Disability Benefits or Retirement Benefits under the Employer's Retirement Plan.

PRE-EXISTING CONDITION LIMITATION. The Policy will not cover any period of Disability:

(1) which is caused or contributed to by, or results from a Pre-Existing Condition; and
(2) which begins in the first 6 months after your Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which you received Treatment within 3 months prior to your Effective Date.

"Treatment" means consultation, care and services by a Physician. It includes diagnostic measures and the prescription, refill and taking of prescribed drugs or medicines.

Notice Concerning Coverage Limitations And Exclusions Under The Ohio Life And Health Insurance Guaranty Association Act

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. 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 by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty 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). You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

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.*

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor - Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page 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 guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, 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 association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, a HMO; a fraternal benefit society; a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- 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;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under 401, 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

ERISA INFORMATION

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.

The name of the Plan is: UTU Group VSTD Plan

The name, address and ZIP code of the Sponsor of the Plan is: United Transportation Union, 14600 Detroit Avenue, Cleveland, OH, 44107-4250.

Employer Identification Number (EIN): 34-1031303 Plan Number: 506

The name, business address, ZIP code and business telephone number of the Plan Administrator is: United Transportation Union, 14600 Detroit Avenue, Cleveland, OH, 44107-4250, (216) 228-9400.

Agent for service of legal process. For disputes arising under the short term disability coverage insured by The Lincoln National Life Insurance Company, legal process may be made upon The Lincoln National Life Insurance Company at 8801 Indian Hills Drive, Omaha, Nebraska. As to the Plan, legal process may be served on the Plan Administrator, the Trustees or on the General Counsel of the UTU, at the above address.

Discretionary Authority. The Lincoln National Life Insurance Company has the sole discretionary authority to determine eligibility and to administer claims in accordance with its interpretation of Policy provisions, on the Plan Administrator's behalf.

Type of Administration. The Plan is insurer administered 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: Weekly Disability Income Insurance benefits.

Type of Funding Arrangement: Benefits are provided under the Policy and the premiums are paid through a trust.

If your Booklet, Certificate or Schedule of Insurance is misplaced, you may obtain a copy from the Plan Administrator at no charge.

Eligibility. Full-time Bus Craft Members working at least 20 hours per week.

Employees become eligible on the first of the month coinciding with or next following completion of 30 days of active full-time employment.

Contributions. You are required to make contributions for coverage under the Plan.

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

The name, title and address of each Plan Trustee: Malcolm B. Futhey, Jr., Arthur Martin III, Kim N. Thompson, United Transportation Union, 14600 Detroit Avenue, Cleveland, Ohio 44107.

Loss of Benefits. The Plan Sponsor 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 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 a written notice of its claim decision within:

- 45 days after receiving the first proof of a claim for disability benefits (105 days under special circumstances).

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial under the terms of the Policy and any internal guidelines, how a review of the decision may be requested, whether more information is needed to support the claim and a statement of your right to bring legal action under ERISA following the final review of the claim on appeal. If the claim does not include the necessary information, The Lincoln National Life Insurance Company may either deny your claim or contact you to obtain the missing information. If you are contacted, you will be given 45 days to provide the necessary information. If, due to matters beyond its control, The Lincoln National Life Insurance Company needs more time to decide a claim, it may take up to two 30-day extensions. If an extension is taken, you will be notified of the circumstances and the date by which it expects to decide the claim. You may request a review of the claim by making a written request to The Lincoln National Life Insurance Company within:

- 180 days after receiving a denial notice of a claim for disability income benefits.

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 within:

- 45 days after receiving the request for review of a claim for disability income benefits (90 days under special circumstances). The written notice will state the reasons for the decision under the terms of the Policy and any internal guidelines. If the denial of all or part of the claim is upheld, the written notice will also describe any further appeal procedures available under the Policy, a statement that you have the right to access relevant claim information and a statement of your right to bring legal action under ERISA.

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 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 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, 6C-00
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 Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Variable Insurance Products Trust
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