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

CERTIFIES THAT Group Policy No. 000010230844 has been issued to

Health Plan of San Mateo
(The Group Policyholder)

The issue date of the Policy is August 1, 2017.

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 1

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.

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, https://www.insurance.ca.gov/01-consumers/ or phone them at 1-800-927-4357. Please have your policy number available.

The Policy contains an Accelerated Death Benefit provision. Receipt of an Accelerated Death Benefit will reduce benefits specified in the Policy. Accelerated Death Benefits may be taxable. As with all tax matters, the Insured Person should consult a professional tax advisor before applying for this benefit. Please read the Limitations section of the Accelerated Death Benefit included in the Policy.

Dennis R Glass
PRESIDENT

CERTIFICATE OF GROUP LIFE INSURANCE

Health Plan of San Mateo
000010230844
SCHEDULE OF INSURANCE

ELIGIBLE CLASS

Class 1 All Full-Time Employees

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

Year of Birth	Normal Retirement Age
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.

Health Plan of San Mateo
000010230844
SCHEDULE OF INSURANCE
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: 30 hours per week

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

Basic Annual Earnings means your annual base salary or annualized hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the loss.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records or the amount for which premium has been paid; whichever is less.

LIFE AND AD&D INSURANCE

	Benefit Amount
Personal Life Insurance	Two times Basic Annual Earnings, rounded to the next higher $1,000; subject to a minimum of $10,000 and a maximum of $400,000.
AD&D Insurance Principal Sum	Two times Basic Annual Earnings, rounded to the next higher $1,000; subject to a minimum of $10,000 and a maximum of $400,000.

Personal Life and AD&D Insurance will be reduced as follows:
- At age 70, benefits will reduce by 25% of the original amount;
- At age 75, benefits will reduce an additional 25% of the original amount.

Benefits will terminate when you retire.

If you first enroll for Personal Life and AD&D Insurance at age 70 or older, the above age reductions will apply to:
- Any Guarantee Issue Amount available without evidence of insurability; and
- The maximum amount of insurance for which you are eligible.

TABLE OF CONTENTS

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 day 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 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 Minimum Hours 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 first day of the Insurance Month coinciding with or next following 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.

EXCEPTIONS. 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.

If your coverage terminates due to a lay-off, the Company will waive any Waiting Period or evidence of insurability requirement upon your return; provided:

(1) you return within 12 months after the date the lay-off begins;
(2) you apply or are reenrolled within 31 days after resuming Active Work; and
(3) the reinstated amount of insurance does not exceed the amount which terminated.

Reinstatement will take effect on the date you return to Active Work.

If your coverage terminates because your employment ends, the Company will waive any Waiting Period or evidence of insurability requirement upon your return; provided:

(1) you are rehired within 12 months after employment terminated;
(2) you apply or are reenrolled within 31 days after resuming Active Work; and
(3) the reinstated amount of insurance does not exceed the amount which terminated.

Reinstatement will take effect on the date you return to Active Work.

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.)

Ceasing Active Work terminates your eligibility. However, it may be possible to continue all or part of your insurance during a temporary lay off, leave of absence or military leave; or while you are unable to work due to sickness or injury. The conditions concerning such a continuance may be found in the Policy. See your Employer for this information.

If your eligibility ends because you cease Active Work due to a labor dispute, and your Employer's premium contributions are required by a collective bargaining agreement; then arrangements may be made with the Employer to continue insurance (except for any Weekly Disability Income Insurance) for up to six months, subject to:

(1) the conditions shown in the Policy; and
(2) payment of the required premium by at least 75% of the Insured Persons eligible to continue. (See your Employer for further information.)

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

BENEFIT FOR TOTAL DISABILITY PRIOR TO AGE 60**.** Your life insurance will be continued, **without payment of premiums**, if:

(1) you become Totally Disabled while insured under the Policy 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:

(1) the day you are approved for this Extension of Death Benefit; or
(2) the day the Policy terminates (whichever occurs first).

Upon receipt of satisfactory proof, the Company will refund up to 12 months' premium paid for your life insurance, from the 1st day of Total Disability.

DEFINITIONS.

"Total Disability" or "Totally Disabled," as used in this provision, means:

(1) during the first 24 consecutive months, you are unable to perform with reasonable continuity the Substantial and Material Duties of your Own Job due to sickness or bodily injury; and
(2) after 24 consecutive months, you are, due to sickness or bodily injury, unable to engage with reasonable continuity in any other job in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, or physical and mental capacity.

"Own Job" means the occupation, trade or profession:

(1) in which you were employed with the Group Policyholder or Employer immediately prior to becoming Totally Disabled; and
(2) which was your main source of earned income immediately prior to becoming Totally Disabled.

"Substantial and Material Duties" means the important tasks, functions and operations that:

(1) are generally required by employers from those engaged in the your own job; and
(2) cannot be reasonably omitted or modified.

In determining what Substantial and Material Duties are necessary to pursue your Own Job, the Company will first look at the specific duties required by the Employer. If you are unable to perform one or more of these duties with reasonable continuity, the Company will then determine whether those duties are customarily required of other employees engaged in your Own Job. If any specific, material duties required of you by the Employer differ from the material duties customarily required of other employees engaged in your Own Job, then the Company will not consider those duties in determining what Substantial and Material Duties are necessary to pursue your Own Job.

Notice of Claim. Written notice of claim must be given within 20 days after Total Disability 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.

The Company's Group Insurance Service Office is at the following address:

The Lincoln National Life Insurance Company
Client Services
P.O. Box 2616
Omaha, NE 68103
Toll Free: (800) 423-2765
ClientServices@LFG.com

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 Total Disability.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of Total Disability; 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 Total Disability.

*** 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.

AMOUNT CONTINUED. The life insurance continued by this section:

(1) will be the amount of Personal Life Insurance in effect on the day your Total Disability begins; and
(2) will be subject to the reductions and terminations in effect under the Policy on that day.

If you receive an Accelerated Death Benefit, the amount will be reduced in accord with that provision. Any Accidental Death and Dismemberment Benefit will not be continued.

ADDITIONAL PROOF. At any time during this continuation, the Company may require you to submit further proof of your continued Total Disability. Proof other than Examinations will be at your expense. After the first two years of Total Disability, the Company will not request proof more than once a year.

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.

EXAMINATIONS. At any time during this continuation, the Company may require you to be examined by a Physician of the Company's choice, as often as reasonably necessary. Any such exam will be at the Company's expense. After the first two years of Total Disability, the Company will not request an exam more than once a year.

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

(1) the day you cease to be Totally Disabled;
(2) the day you fail to take a required medical examination;
(3) the 45th 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).

RIGHTS AFTER TERMINATION. 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 below.

CONVERSION POLICIES. If you have exercised the Conversion Privilege and the benefits payable under the Policy and the conversion policy combined would exceed:

(1) your original amount of life insurance prior to the conversion; or
(2) any greater amount for which you later become insured under the Policy;

then benefits will be payable under the terms of the Policy, provided the conversion policy is first surrendered to the Company. No claim may be made under the conversion policy, except for refund of premium less any dividends and policy loans.

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	½ 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	½ Principal Sum
Hemiplegia (Paralysis of Arm and Leg of Same Side)	Principal Sum	½ 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.

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.

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.

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.

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.

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 Benefits 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.

The Company's Group Insurance Service Office is at the following address:

The Lincoln National Life Insurance Company
Client Services
P.O. Box 2616
Omaha, NE 68103
Toll-free phone number: (800) 423-2765
www.LincolnFinancial.com

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; and
(3) 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.

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.

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.

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent.

Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

  For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

  - Life Insurance

    80% of death benefits but not to exceed $300,000

    80% of cash surrender or withdrawal values but not to exceed $100,000

  - Annuities and Structured Settlement Annuities

    80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

  The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

  The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, 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
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- 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 certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

AMENDMENT TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO: 000010230844

ISSUED TO: Health Plan of San Mateo

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 unchanged.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Officer of the Company

Lincoln Financial Group

Lincoln Financial Group® Privacy Practices Notice

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

Information We May Collect And Use

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

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

How We Use Your Personal Information

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

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers), regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or 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.**

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 required to complete privacy training annually.

Your Rights Regarding Your Personal Information

Access: 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 electronically or 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 request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. 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. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. 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.

Accounting of Disclosures: If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions;
- Included in a limited data set; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than six years from the date of your request.

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

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

If you would like to act upon your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial Group, Attn: Corporate Privacy Office, 7C-01, 1300 S. Clinton St., Fort Wayne, IN 46802. The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice. For general account service requests or inquiries, please call 1-877-ASK-LINC.

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

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