

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 000400002000-02608 has been issued to
The Commerce Trust Company as Trustee for
The Lincoln National Life Insurance Company Voluntary Insurance Trust

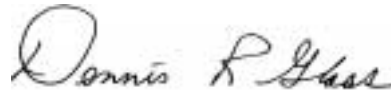
The Issue Date is January 1, 2010 for the Participating Employer.

Participating Employer: The Pantheos Group, LLC

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.



President

CERTIFICATE OF GROUP WEEKLY INCOME INSURANCE

The Pantheos Group, LLC
000400002000-02608

SCHEDULE OF INSURANCE

CLASS 1

All Full-Time Employees

WAITING PERIOD (For date insurance begins, refer to "Effective Dates of Coverages" section)

- (a) None for employees who were hired on or before the Policy Issue Date.
- (b) 30 days of continuous Active Work for employees who were hired after the Policy Issue Date.

MINIMUM HOURS: 30 hours per week

WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 60%

MAXIMUM WEEKLY BENEFIT: Any \$50 increment, subject to a \$100 minimum and a \$1,000 maximum, as elected on the enrollment form

MAXIMUM BENEFIT PERIOD: 13 weeks

DAY BENEFITS BEGIN: 1st day of Total Disability due to Accidental Injury; and
8th consecutive day of Total Disability due to Sickness.

The Minimum Weekly Disability Benefit is 15% of your Maximum Benefit, or \$50 per month (\$12.50 per week), whichever is greater.

The Maximum Weekly Disability Benefit will not exceed the Benefit Percentage times your Basic Weekly Earnings, rounded to the next lower \$50. **Basic Weekly Earnings** means your average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The "**Determination Date**" is the last day worked just prior to the date the Disability begins.

It also includes:

1. paid commissions averaged over the 12 months just prior to the Determination Date; or over the actual period of employment with the Employer just prior to that date, if shorter.

It does **not** include 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, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by the Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.)

The Maximum Benefit Period for Weekly Disability Income Insurance Benefits will be reduced by 50% when you attain age 70. Weekly Disability Income Insurance will terminate when you retire.

SCHEDULE OF INSURANCE (CONTINUED)

Evidence of Insurability must be submitted to and approved by the Company when:

1. Weekly Disability Income Insurance amounts exceed the guarantee issue amount of \$500 at initial enrollment;
2. any increment increase after the initial enrollment exceeds the amount of Weekly Disability Income Insurance by more than 1 increment level(s) over a 12-month period based on the month of the policy anniversary;
3. an increased amount of Weekly Disability Income Insurance coverage is requested and any amount of coverage has been previously withdrawn or declined or is pending underwriting review; or
4. initial coverage is elected more than 31 days after first becoming eligible.

Refer to the Evidence of Insurability section for any additional requirements.

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

TABLE OF CONTENTS

Amount of Insurance.....	3
Definitions.....	3
Eligibility	4
Effective Dates of Coverages.....	4
Termination of Coverage	4
Weekly Disability Income Insurance	5
Claims Procedures for Weekly Disability Income Benefits.....	7
Prior Insurance Credit Provision.....	10
Amendment.....	11
Notice.....	12

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 classification on the day your coverage becomes effective. You may become eligible for increases in the amount of insurance in accordance with the Schedule of Insurance. Any such increase will be effective on:

- (1) the first of the Insurance Month which coincides with or follows the date on which you become eligible for the increase; provided you are Actively at Work on that day;
- (2) the day you resume Active Work, if not Actively at Work on the day the increase otherwise would have been effective; or
- (3) the day determined by the Company after 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 the full-time performance of all customary duties of an employee's occupation at the EMPLOYER'S place of business (or other business location to which the EMPLOYER requires the employee to travel.)

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

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

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

FULL-TIME EMPLOYEE means an employee of the EMPLOYER:

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

INSURANCE MONTH means:

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

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.

YOU or YOUR means a FULL-TIME EMPLOYEE who is covered by Personal Insurance.

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, or
 - (b) an order to pay premiums from your Flexible Benefit Plan account, if Employer contributions are paid through a Flexible Benefit Plan; or
- (4) the day determined by the Company, after the Company approves your coverage, if evidence of insurability is required.

Evidence of insurability is required if:

- (1) you apply for coverage in excess of the Guarantee Acceptance Amount (or in any amount when first applying at age 70 or older);
- (2) you apply for coverage (or an increased amount of coverage) more than 31 days after you become eligible;
- (3) 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 Flexible Benefit Plan account; or
- (4) you apply to reinstate coverage after it lapses, due to failure to pay premiums when due.

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

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

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

- (1) the day the Policy terminates or your Employer ceases to be a Participating Employer;
- (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 eligible employee class;
- (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 results in termination of insurance; but coverage may be continued if you are disabled due to illness or injury:

- (1) until you are no longer disabled;
- (2) provided premium payments are made on your behalf. Premium payments will be required until the day benefits begin but will be waived for any period for which benefits are payable. If coverage is to continue following a period during which premium payments are waived, premium payments must resume as they become due.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. If you become Totally Disabled while insured for this benefit, the Company will pay the Weekly Total Disability Benefit for each week the Total Disability continues:

- (1) beginning on the Day Benefits Begin; and
- (2) ending on the day the Maximum Benefit Period ends or you cease to be Totally Disabled (whichever occurs first).

The amount of the Weekly Total Disability Benefit equals:

- (1) the Benefit Percentage (as shown in the Schedule of Insurance) times your Basic Weekly Earnings; or
- (2) the Maximum Weekly Benefit (whichever is less).

In no event will the amount be less than \$12.50 per week, or 15% of the Insured Person's Maximum Weekly Benefit; whichever is more. The Day Benefits Begin, the Maximum Benefit Period, the Maximum Weekly Benefit and the definition of Basic Weekly Earnings are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay the Weekly Partial Disability Benefit if:

- (1) you become Partially Disabled within 30 days after Total Disability Benefits cease;
- (2) the Partial Disability is due to a Sickness or Injury which is the same as (or related to) the cause of the prior period of Total Disability for which benefits were payable; and
- (3) you earn less than 80% of Basic Weekly Earnings when Partial Disability employment begins.

Partial Disability Benefits will end on the earliest of:

- (1) the date the Maximum Benefit Period ends;
- (2) the date you cease to be Partially Disabled; or
- (3) the date your current earnings exceed 85% of Basic Weekly Earnings.

The amount of the Weekly Partial Disability Benefit equals the lesser of:

- (1) the Benefit Percentage (as shown in the Schedule of Insurance) times your Basic Weekly Earnings (limited to the Maximum Weekly Benefit); or
- (2) your Basic Weekly Earnings minus earnings received from any form of employment for that period of Disability.

In no event will the amount be less than \$12.50 per week, or 15% of the Insured Person's Maximum Weekly Benefit; whichever is more. The Maximum Weekly Benefit and the definition of Basic Weekly Earnings are shown in the Schedule of Insurance.

SUCCEEDING PERIODS OF DISABILITY. Two or more periods of Disability will be treated as one period of Disability, unless:

- (1) you return to Active Work on a full-time basis for at least two weeks in a row between periods of Disability; or
- (2) the succeeding period of Disability is due to a Sickness or Injury unrelated to the cause of the prior period of Disability for which benefits were payable.

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

- (1) which is the result of an intentional self-inflicted injury or self-destruction (while sane);
- (2) for which you have not furnished satisfactory proof of Disability to the Company (including your Employer's statement and your Physician's statement, as requested by the Company);
- (3) which is the result of a Sickness or Injury covered by Worker's Compensation;
- (4) which is the result of, or due to, a Sickness or Injury arising out of, or in the course of, any employment for wage or profit;
- (5) during which you receive payment under a salary continuance or retirement plan sponsored by the Employer.

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 12 months after your Effective Date.

DEFINITIONS. "Disability" means Total Disability or Partial Disability.

"Injury" means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Disability Income benefits, a Disability will be considered due to 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.

"Partial Disability" means that, due to Sickness or Injury, you are:

- (1) unable to perform one or more of the material and substantial duties of your regular occupation;
or
- (2) unable to perform such duties on a full-time basis.

"Pre-Existing Condition" means a Sickness or Injury for which you received treatment within 12 months prior to your Effective Date.

"Sickness" means illness, disease, pregnancy or its complications.

"Total Disability" means your inability, due to Sickness or Injury, to perform the material and substantial duties of your regular occupation. A person engaging in any employment for wage or profit is not Totally Disabled.

"Treatment" means consultation, care or services provided by a Physician (including diagnostic measures and taking prescribed drugs or medicines).

ASSIGNMENT. Weekly Income Benefits may not be assigned.

**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;
- (2) by the Day Benefits Begin, if later; or
- (3) 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, address and Policy number.

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 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 within 90 days after the Day Benefits Begin; or 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 your attending Physician. This must describe any restrictions on your performance of the duties of your regular occupation.
- (3) Proof of any other income received, which may affect Policy benefits.
- (4) A signed authorization for the Company to obtain more information.
- (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, until such proof is received.

*** 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.

EXAM OR AUTOPSY. At anytime while a claim is pending, 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.

If you fail to cooperate with an examiner or fail to take an exam, without good cause; then the Company may deny or suspend 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. Disability income benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week; then 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 immediately after the Company receives complete proof of claim and confirms liability.

CLAIMS PROCEDURES (Continued)

TO WHOM PAYABLE. All disability income benefits are payable to you, while living. After your death, such benefits will be payable:

- (1) to your estate; or
- (2) in accord with the Facility of Payment section.

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; then 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:

- (1) within 15 days after the Company resolves the claim;
- (2) within 30 days after the Company receives acceptable proof of claim; and
- (3) within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. If the Company needs more than 15 days to process the claim, due to matters beyond its control; then an extension will be permitted. If needed, 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 your first proof of claim; then you have a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from you 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. 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 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.

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; then an extension of up to 45 more days will be permitted. In that event, 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: If the Company needs more information from you 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 PROCEDURES (Continued)

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 this Policy, you must first seek two administrative reviews of the adverse claim decision, in accord with this section. If you bring legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that you 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 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.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000400002000-02608
ISSUED TO: The Pantheos Group, LLC

Your Certificate is amended by adding the following provisions.

PRIOR INSURANCE CREDIT UPON TRANSFER OF DISABILITY INCOME INSURANCE CARRIERS

This provision prevents loss of disability income 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 disability income policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to premium payments, the Policy will provide disability income coverage if you:

- (1) were insured by the prior plan on its termination date; and
- (2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date.

AMOUNT OF COVERAGE. Until you satisfy the Policy's Active Work rule, your disability income coverage will not exceed that provided by the prior plan, had it remained in force. The Company will pay:

- (1) the benefit the prior plan would have paid; minus
- (2) any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a period of disability due to a Pre-Existing Condition if you:


- (1) were insured by the prior plan on its termination date; and
- (2) were Actively-At-Work and became insured under the Policy on its Effective Date.

The benefits will be determined as follows:

- A. The Company will apply the Policy's Pre-Existing Condition Limitation. If you qualify for benefits, you will be paid according to the Policy's benefit schedule.
- B. If you cannot satisfy the Policy's Pre-Existing Condition Limitation; then the prior plan's pre-existing condition limitation will be applied, as follows:
 - (1) If you satisfy the prior plan's pre-existing condition limitation, giving consideration towards continuous time insured under both policies; then benefits will be paid according to the prior plan's benefit schedule.
 - (2) If you cannot satisfy the Pre-Existing Condition Limitation of the Policy, or that of the prior plan; then no benefit will be paid.

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

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000400002000-02608

ISSUED TO: The Pantheos Group, LLC

FOR CERTIFICATES DELIVERED IN ILLINOIS

A. The following COMPLAINT NOTICE is added to your Certificate:

NOTICE: Should any complaint arise concerning this insurance, you may contact the Group Administration Department, The Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, NE 68114-4066 (phone 800-423-2765). If it is not resolved, you may also contact the Illinois Department of Insurance, Consumer Division or Public Service Section, Springfield, IL 62767.

B. Under the WEEKLY DISABILITY INCOME INSURANCE section, the Pre-Existing Condition Limitation is amended to read as follows:

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

- (1) which is caused by, or results from a Pre-Existing Condition; and
- (2) which begins in the first 12 months after your Effective Date.

This amendment applies only to Certificates delivered to Participating Employers in the state of Illinois. This amendment takes effect on your effective date of coverage under the Policy. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

**ILLINOIS
LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION LAW**

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of the Guaranty 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 policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) 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, as noted below.

**ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
DISCLAIMER**

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Guaranty Associations or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(312) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

**SUMMARY OF GENERAL PURPOSES
AND CURRENT LIMITATIONS OF COVERAGE**

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law")[215 ILCS 5/531.01, et seq.]. The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

- (A) Coverage:
The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:
- (1) life insurance, health insurance and annuity contracts;
 - (2) life, health or annuity certificates under direct group policies or contracts;
 - (3) unallocated annuity contracts; and
 - (4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected even if they live in another state.
- (B) Exclusions from Coverage:
- (1) The Guaranty Association does not provide coverage for:
 - (a) any policy or portion of a policy for which the individual has assumed the risk;
 - (b) any policy of reinsurance (unless an assumption certificate was issued);
 - (c) interest rate guarantees which exceed certain statutory limitations;
 - (d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or government lottery;
 - (e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
 - (f) any stop loss insurance.
 - (2) In addition, persons are not protected by the Guaranty Association if:
 - (a) the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
 - (b) their policy was issued by an organization which is not a member insurer of the Association.
- (C) Limits on Amount of Coverage:
- (1) The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the less of either:
 - (a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
 - (b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
 - (i) in the case of life insurance, \$300,000 in death benefits but not more than \$100,000 in net cash surrender or withdrawal values;
 - (ii) in the case of health insurance, \$300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
 - (iii) with respect to annuities, \$100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and \$100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is \$5,000,000 in benefits per contract holder, regardless of the number of contracts.
 - (2) However, in no event is the Guaranty Association liable for more than \$300,000 with respect to any one individual.

SUMMARY PLAN DESCRIPTION

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

The name of the Plan is: Weekly Disability Income Insurance for Employees of The Pantheos Group, LLC.

The name, address and ZIP code of the Sponsor of the Plan is: The Pantheos Group, LLC, 200 S. Frontage Road #212, Burr Ridge, IL, 60527.

Employer Identification Number (EIN): 20-5950091

IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: The Pantheos Group, LLC, 200 S. Frontage Road #212, Burr Ridge, IL, 60527, (630) 321-0133.

The Plan Administrator is responsible for the administration of the Plan and is the designated agent for the service of legal process for the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of contributions, maintenance of records of Plan participants, authorization and payment of Plan administrative expenses, selection of the insurance consultant, selection of the insurance carrier and assisting The Lincoln National Life Insurance Company. The Lincoln National Life Insurance Company has the sole discretionary authority to determine eligibility and to administer claims in accord with its interpretation of policy provisions, on the Plan Administrator's behalf (this does not apply to employers situated in California or to California residents).

Type of Administration. The Plan is administered directly by the Plan Administrator with benefits provided in accordance with provisions of the group insurance policy issued by The Lincoln National Life Insurance Company whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

Type of Plan. The benefits provided under the Plan are: Weekly Disability Income Insurance benefits.

Type of Funding Arrangement: The Lincoln National Life Insurance Company.

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits, any Pre-Existing Condition Limitation and Exclusions. The Certificate also contains the Schedule of Insurance which includes the Benefit Percentage, Maximum and Minimum Weekly Benefits, Maximum Benefit Period, Day Benefits Begin, Waiting Period and age reduction information. If your Booklet, Certificate or Schedule of Insurance has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

Eligibility. Full-time employees working at least 30 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.

Evidence of Insurability is required as outlined in the Certificate Schedule of Insurance.

Contributions. You are required to make contributions for Weekly Disability Income Insurance.

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

The name and section of relevant Collective Bargaining Agreements: None

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

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

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Group Insurance Service Office of The Lincoln National Life Insurance Company. To expedite the processing of your claim, instructions on the claim form should be followed carefully; be sure all questions are answered fully. In accordance with ERISA, The Lincoln National Life Insurance Company will send you 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, how a review of the decision may be requested, and whether more information is needed to support 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).

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

Statement of ERISA Rights

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

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

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

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

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

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

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

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



LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

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

INFORMATION WE MAY COLLECT AND USE

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

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

HOW WE USE YOUR PERSONAL INFORMATION

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

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

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

SECURITY OF INFORMATION

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

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Services Compliance-Privacy, 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