Lincoln National Corporation Employees’
Critical Illness Insurance Plan

*Summary Plan Description*

*January 1, 2016*

This document provides summary information about the terms and provisions of an employer-sponsored plan. If there are any conflicts between this information and the actual terms and provisions of the official plan documents, the plan documents control. Lincoln National Corporation reserves the right to amend or terminate any employer-sponsored plan at any time.
Introducing the Critical Illness Insurance Plan

The Lincoln National Corporation Employees’ Critical Illness Insurance Plan (the “Plan”), which is part of the Lincoln National Corporation Employees’ Life, Health and Accident Plan, is a stand-alone voluntary benefit that provides a lump sum cash payment if you are diagnosed with a covered critical illness, which may be used at your discretion and is not affected if you receive benefits from any other insurance.

In addition, the benefits and services provided by the Lincoln CareCompass Program SM include personalized help and guidance throughout the treatment process if you are diagnosed with a covered critical illness. See “Summary of Benefits” on page 3 for a description of the benefits of the Lincoln CareCompass Program SM.

Lincoln National Corporation and participating employers are referred to as the “Company.”

Your Benefits Information Source

In addition to the information found in this Summary Plan Description (“SPD”), HRDirect contains summary information about this Plan, as well as the other Lincoln health and welfare plans. To access HRDirect click on the HRDirect link from the One home page at http://one.lfg.com.

Please note that HRDirect is accessible while you are logged in to the internal Lincoln Financial Group network at work or through a virtual private network (VPN) connection at home. You can also access HRDirect via the HRDirect.lfg.com link from your home computer utilizing your internet browser or you can use your mobile device. Instructions on how to connect through your home or mobile devices are available on the HRDirect Home Page under Quick Links.

If you cannot find the information you need in this SPD or on HRDirect, contact the HR Service Center at 866-922-6543. Representatives are available Monday through Friday from 9 a.m. to 6 p.m. ET.

Coverage Year

The coverage year is January 1 through December 31.

Eligibility

You are eligible if you are a:

- Regular full-time employee working at least 35 hours per week; or
- Regular part-time employee working 20-34 hours per week.

Dependent eligibility for Spouse, Domestic Partner or Child

Eligible dependents include:

Spouse - A Spouse is someone to whom you are legally married pursuant to any state law. An individual from whom you are legally separated or divorced is not included in the term “Spouse”.

Domestic Partner - A Domestic Partner is an adult of either gender not related to you by blood or legal marriage, who shares a significant emotional and financial relationship with you, similar to that of a Spouse, and resides as your Domestic Partner at your home address for at least the last twelve (12) consecutive months. You and your Domestic Partner will need to satisfy all of the domestic partnership requirements, as well as provide documented verification supporting your eligibility for a Domestic Partner relationship. A Domestic Partner is not a legal Spouse, common-law Spouse or a child.

Child – Your child or your Spouse’s or approved Domestic Partner’s child who is:

- under the age of 26; or
• an unmarried incapacitated child who on his or her 26th birthday is:
  o (i) covered under the Plan (except in the case of a Participant hired on or after January 1, 2014); and
  o (ii) is primarily dependent upon you for support and who is incapable of sustaining employment because of physical or mental disability or is mentally incompetent.

For purposes of this section, a child is your natural child; a step-child; a legally adopted child; a child whose legal residence is with you and for whom you and/or your Spouse or approved Domestic Partner is required by court order to cover for health benefits; or an eligible foster child placed with you, your Spouse or approved Domestic Partner by an authorized placement agency or by court order, judgment or decree; or a child for whom you have legal guardianship and relies on you for over one-half of his or her financial support. For coverage purposes, your dependent child will be eligible until the end of the month in which the dependent child turns age 26.

An incapacitated child can remain covered under the Plan beyond his or her 26th birthday if he or she remains disabled and medical proof of the disability is provided within 31 days after the child’s 26th birthday and you periodically provide proof of continuance of the child’s incapacity as requested.

When Your Participation Begins

If you want Plan coverage for yourself and any eligible dependents, you must enroll via the HRDirect Benefits Portal. You can access the HRDirect Benefits Portal from the One home page at http://one.lfg.com. You must enroll in the Plan during the 31-day period beginning on the first day of your employment. If you enroll during this 31-day period, coverage for you and any eligible dependents you enroll in the Plan is effective on the first day of the month coincident with or next following your election. If you elect to decline coverage when first eligible and would like to elect coverage during a future annual enrollment period, you will be required to submit an evidence of insurability form (“EOI”) you will receive from Group Protection. This form must be completed and submitted prior to the stated deadline.

*If you do not enroll during this 31-day period, you will not have critical illness coverage and will not be permitted to enroll in the Plan until the next annual enrollment period.*

If you elect or increase coverage after this 31-day period, you will be required to submit EOI. Your coverage will be effective on the first day of the month coincident with or next following the date your EOI form is approved by Group Protection. If you do not provide EOI prior to the stated deadline, your application for coverage will be denied.

If both you and your Spouse or Domestic Partner (or former spouse) are employed by the Company and are both participating in the Plan, only one participant may cover eligible dependent children.

When Your Participation Ends

Your participation in the Plan automatically terminates on the earliest of:

• the date this Plan terminates (but without prejudice to any claim incurred prior to termination);
• the date that you are no longer eligible for insurance;
• the date you cease to be a member of the eligible class;
• the last day of the month in which you request termination;
• the last day of the last month for which premium payment is made on your behalf;
• the end of the period for which the last required premium has been paid;
• with respect to any particular insurance benefit, the date the portion of this policy providing that type of benefit terminates;
• with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category;
• the date you cease to be covered under at least one category other than the Wellness Category;

Lincoln National Corporation Employees’ Critical Illness Insurance Plan SPD,
Effective January 1, 2016
• the date your employment with the Company terminates; or
• the date you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard (if you send proof of military service, the Company will refund any unearned premium); unless insurance is continued.

**Portability**

If coverage under the Plan would end for any reason other than nonpayment of premiums, you have the option to continue coverage for you and your eligible dependents (if applicable). To continue your coverage, you must:
(1) notify the Company within 31 days after the date the insurance would otherwise end; and
(2) pay the applicable premium to the Company.

Portability is not available when insurance premiums terminate solely because you or your eligible dependents are no longer eligible for insurance.

Insurance continued under this section ends on the earliest of:
(1) the last day of the period for which the insured person paid premiums; or
(2) the date the Company receives a written request from the insured person to terminate the insurance; or
(3) the date the insured person attains age 90 or dies.

**Contributions**

This is a voluntary benefit and you pay the entire cost on an after-tax basis.

**Summary of Benefits**

With critical illness insurance, if you are diagnosed with a covered critical illness as described below on or after your coverage effective date, you get a lump-sum cash benefit to use however you wish – even if you receive benefits from other insurance.¹

At the core of the critical illness insurance is the *Lincoln CareCompass℠* program. These benefits and services provide personalized help and guidance throughout the treatment process if you’re diagnosed with a covered critical illness.

- Each year, you can use a cash benefit toward one of 24 covered health assessment tests.² An expert advocate guides you through the healthcare maze. Your health advocate can help at any time, not just during an illness.
- You can get referrals to community resources and support groups, and you have access to confidential assistance for a variety of issues throughout your critical illness.
- You’ll be provided help arranging travel and lodging for out-of-town care.³
- You can receive a benefit of $25 per day per child for up to 30 days of child-care expenses if you are hospitalized due to a covered critical illness.

¹ In California and New Jersey, applicants must have major medical insurance to be eligible for critical illness coverage.
² In California, 25 tests.
³ Travel must be 100 or more miles from home.
## Base Coverage

### Critical Illness Base Coverage

<table>
<thead>
<tr>
<th>Benefit Descriptions</th>
<th>Benefit Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Principal Sum</strong></td>
<td><strong>Choice of $10,000 - $20,000</strong></td>
</tr>
<tr>
<td>Employee</td>
<td>Choice of $5,000 - $10,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>Choice of $5,000 - $10,000</td>
</tr>
<tr>
<td>Child</td>
<td>Choice of $5,000 - $10,000</td>
</tr>
<tr>
<td>Spouse and Child Principal Sum cannot exceed the Employee Principal Sum</td>
<td><strong>Choice of $10,000 - $20,000</strong></td>
</tr>
<tr>
<td><strong>Guarantee Issue</strong></td>
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<tr>
<td>Employee</td>
<td>Choice of $5,000 - $10,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>Choice of $5,000 - $10,000</td>
</tr>
<tr>
<td>Child</td>
<td>Choice of $5,000 - $10,000</td>
</tr>
<tr>
<td><strong>Lincoln CareCompass Program℠ Category</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Critical Illness Assessment Benefit</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Family Care Benefit (per insured dependent)</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td><strong>Heart Category</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Heart Attack, Heart Transplant, Stroke</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Arteriosclerosis, Aneurysm</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
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<tr>
<td><strong>Cancer Category</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Invasive Cancer</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Cancer in Situ, Benign Brain Tumor, Bone Marrow Transplant</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td><strong>Organ Category</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
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<tr>
<td>End Stage Renal Failure, Major Organ Transplant</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Acute Respiratory Distress Syndrome</td>
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</tr>
<tr>
<td><strong>Quality of Life Category</strong></td>
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</tr>
<tr>
<td>ALS/Lou Gehrig’s Disease, Advanced Alzheimer’s Disease, Advanced Parkinson’s Disease</td>
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<tr>
<td>Advanced Multiple Sclerosis, Loss of Sight, Hearing or Speech</td>
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</tr>
<tr>
<td><strong>Accident</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>Coma</td>
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<tr>
<td>Severe Burn</td>
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<tr>
<td>Paralysis</td>
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</tr>
<tr>
<td><strong>Lifetime Category Maximum (Category Recurrence)</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>200% (100% recurrence)</td>
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</tr>
<tr>
<td><strong>Additional Category Occurrence</strong></td>
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</tr>
<tr>
<td>100% payable benefit</td>
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<tr>
<td><strong>Benefit Waiting Period</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>None</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td><strong>Pre-existing Period</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>None</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td><strong>Benefit Reduction</strong></td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
<tr>
<td>None</td>
<td><strong>Choice of $5,000 - $10,000</strong></td>
</tr>
</tbody>
</table>

### Exclusions

A benefit will not be paid under the Plan when:

- A category maximum has been reached (for that category, coverage will automatically terminate). If *Lincoln CareCompass℠* is the only remaining category, coverage will be terminated.
- A new category occurrence happens within 90 days after another payable event in a different category.
- A category recurrence happens within 180 days after another payable event in the same category.
- An event was caused by self-inflicted injury, self-destructive, suicide or attempting any of these, whether sane or insane.
• An event occurs during the attempt or commission of a felony, whether charged or not.
• An event occurs during an act of war (which is not terrorism), participation in a riot, insurrection or rebellion of any kind.
• An event occurs while serving as a member of any armed forces or auxiliary unit.
• An event occurs after the insured had resided outside of the US, Mexico, or Canada for 12 or more months.
• An event occurs while the insured was incarcerated in any type of penal facility.

**Accident Exclusions:**

Additionally, a benefit will not be paid under the Plan when injury occurs due to:

• Bungee jumping, parachuting, base jumping, or mountaineering.
• Cosmetic or elective surgery.
• Being intoxicated.
• Having any sickness, illness (physical or mental), or infection independent of accident.
• Deliberate use of drugs, poison, gas or fumes, by ingestion, injection, inhalation, or absorption.
• Injury at work or in the course of employment.
• Participating in, practicing for, or officiating a semiprofessional or professional sport.
• Riding in or driving any motor-driven vehicle for race, stunt show, or speed test.
• Being incarcerated in any type of penal or detention facility.
• Injuries sustained while residing outside of the US, US Territories, Mexico, or Canada for 12 or more months.

**For assistance or additional information**

Contact Lincoln Financial Group at 800-680-4652 or log in to www.LincolnFinancial.com

**Filing a Claim**

In order to file a claim under the Plan, you or your personal representative should complete the Critical Illness claim form and your physician should complete the “Attending Physician’s Statement – Critical Illness” portion of the form. You can obtain a claim form from HRDirect, click on “Health and Life Benefits”; and then click on “Critical Illness” on the drop down menu. Click on the Critical Illness Claim form link or the Critical Illness Wellness Claim Form for any tests performed. You can also contact the HR Service Center at 866-922-6543 to request a claim form.

Forms must be completed in full and forwarded to:

Mailing Address: The Lincoln National Life Insurance Company
P.O. Box 2609Omaha, NE 68103-2609
Phone: 800-680-4652
Fax: 877-668-5331

**Appealing a Denied Claim**

If your Critical Illness claim is denied in whole or in part, you will receive a written notice of the denial from The Lincoln National Life Insurance Company (Group Protection) no later than 45 days after your claim was received. Any denial notice will explain the reason for the denial and will include a contact address for review of the claim.

You may request a review of any denied claim. The request must be submitted, in writing, within 180 days after the date the denial was made. The appeal should be sent to: Lincoln Financial Group, Attn: Appeals, 8801 Indian Hills Drive, Omaha, NE 68114. The Lincoln National Life Insurance Company is the claims and appeals fiduciary for the Plan. You should include the reason for requesting the review. You may also request all documents, records and other information related to the benefit determination, regardless of whether such material was relied upon in the decision process.

The Lincoln National Life Insurance Company will ordinarily notify you of its final decision not later than 45 days after the appeal is received. If special circumstances require an extension of time of up to an additional 45 days, you will be notified of this extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.
The decision upon review will be final. If your claim is denied, you will be notified either in writing or electronically within the applicable day period specified above and you will be explained the specific reason(s) for denying your appeal, the Plan provisions that support the decision to deny your appeal, and a statement of your right to bring a civil action under ERISA section 502(a). Claimants will not be entitled to challenge the determination in judicial or administrative proceedings without first complying with the Plan’s claims and appeals procedures. Any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than one year following a final decision on the claim for benefits.

**Administration and Your ERISA Rights**

**Amendment and termination of the Plan**

The Plan Sponsor has the exclusive power to amend and to terminate the Plan pursuant to action taken by the Lincoln National Corporation Board of Directors or its designee. These powers can be used whenever it becomes necessary or it is desirable to do so. The consent of any employee, participant or adopting employer to use any of these powers is not required.

The Plan cannot be amended, however, to (i) return Plan assets to the adopting employers, except under limited circumstances provided by applicable federal law; or (ii) use Plan assets for other than Plan specified purposes; (iii) deprive a participant of a benefit he is entitled to under the terms of the Plan; or (iv) cause the Trust’s exempt status under the Internal Revenue Code to be lost.

No participant or beneficiary shall have any vested right to any benefit available under the Plan.

**Contributions and benefit payments**

Benefits under the Plan are provided through an insurance policy issued by The Lincoln National Life Insurance Company.

**Plan Sponsor**

The Plan Sponsor is Lincoln National Corporation. The address is:

Lincoln National Corporation  
Corporate Benefits  
150 N. Radnor Chester Rd.  
Radnor, PA 19087  
484-583-1400

**Plan Administrator**

The Lincoln National Corporation Benefits Committee is the Plan Administrator and a fiduciary of the Plan. The Plan Administrator has the exclusive right to construe and interpret the terms of the Plan and to determine eligibility for benefits, and may delegate its duties.

Any correspondence with the Plan Administrator should be directed to: Lincoln National Corporation Benefits Committee, Corporate Benefits, 150 N. Radnor Chester Rd., Radnor, PA 19087, 484-583-1400.

**Participating Employers**

Employees of the Plan Sponsor and the following employers may participate in the Plan:

California Fringe Benefit & Insurance and Marketing Corp.  
LFA Limited Liability Co.  
Lincoln Financial Advisors Corp.  
Lincoln Financial and Insurance Services Corp.

Lincoln National Corporation Employees’ Critical Illness Insurance Plan SPD,  
Effective January 1, 2016
Plan year
The plan year is January 1 through December 31, and Plan records are kept on a plan year basis.

Agent for Service of Legal Process
The designated Agent for Service of Legal Process is the Company’s Executive Vice President and General Counsel, who can be contacted at the following address:

Lincoln National Corporation
150 N. Radnor Chester Rd.
Radnor, PA 19087
484-583-1400

Service of Legal Process may also be made upon the Plan Administrator.

Identification Numbers
The Employer Identification Number that has been assigned to Lincoln National Corporation by the Internal Revenue Service is 35-1140070.

The Employer Identification Number that has been assigned to Lincoln National Corporation Benefits Committee by the Internal Revenue Service is 35-1620788.

The Plan Number which has been assigned to the Lincoln National Corporation Employees’ Critical Illness Insurance Plan is 512.

Legal Note
This SPD is an abbreviated description of the Plan and your rights and obligations under the Plan. The Plan document together with this SPD and any other certificates pertaining to this Plan together will control the operation of this Plan for the participants and for the Participating Employers.

Your rights and protection under ERISA
You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that you shall be entitled to:

Receive information about your Plan and benefits:
- Examine, without charge, at the Plan Administrator’s office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce your rights:

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why it 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 (you should first check with the Plan Administrator on your claim and also use the Plan’s appeal process, as applicable.) 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 questions:

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

Changes in your personal information:

It is your responsibility to update the Plan Administrator with any changes to your address or phone number. If you have changes to your personal information, you can contact the HR Service Center at 866-922-6543.

Lincoln National Corporation Employees’ Critical Illness Insurance Plan SPD, Effective January 1, 2016