

1989

Ward Perkins v. Lincoln National Life Insurance Company and Great-West Life Insurance Company : Brief of Appellee

Utah Court of Appeals

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Jathan W. Janove; Robert K. Heineman; Fabian and Clendenin; Attorneys for Defendant/Appellee.

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UTAH COURT OF APPEALS

80

UTAH

DOCKET

1

DOCKET NO.

890732-CA

IN THE COURT OF APPEALS
OF THE STATE OF UTAH

WARD PERKINS, Personal
Representative of the Estate
of NORMA PERKINS,

Plaintiff/Appellee,

v.

LINCOLN NATIONAL LIFE
INSURANCE COMPANY,

Defendant/Appellee,

and

GREAT-WEST LIFE ASSURANCE
COMPANY,

Defendant/Appellant.

Case No. 890732-CA

BRIEF OF APPELLEE LINCOLN

APPEAL FROM THE SUMMARY JUDGMENT OF
THE SIXTH JUDICIAL DISTRICT COURT OF KANE COUNTY
THE HONORABLE DON V. TIBBS

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Argument Priority 16

FILED

JUL 16 1990

Ms. Clerk of the Court

LIST OF PARTIES

In addition to the parties and attorneys shown on the cover page, third-party defendant Southwest Health Management Company, Inc., although served with process, has not yet appeared in this action, and to date no default has been entered against it.

TABLE OF CONTENTS

	<u>Page</u>
LIST OF PARTIES.....	i
TABLE OF AUTHORITIES.....	iii
JURISDICTION.....	1
ISSUES PRESENTED.....	2
STANDARD OF REVIEW.....	2
STATEMENT OF THE CASE.....	3
STATEMENT OF FACTS.....	3
SUMMARY OF ARGUMENT.....	4
ARGUMENT.....	5
POINT ONE	
THE COURT DID NOT ERR IN GRANTING SUMMARY JUDGMENT TO LINCOLN <u>SUA SPONTE</u>	5
POINT TWO	
GREAT-WEST DID NOT RAISE THE ISSUE OF THE TIMELINESS OF LINCOLN'S RULE 56(F) AFFIDAVIT IN THE PROCEEDINGS BELOW AND MAY NOT DO SO HERE.....	6
POINT THREE	
GREAT-WEST FAILED TO MEET ITS BURDEN OF SHOWING THE ABSENCE OF ANY GENUINE ISSUE OF MATERIAL FACT.....	8
CONCLUSION.....	11
APPENDIX 1	
Affidavit of Jathan W. Janove	
APPENDIX 2	
Lincoln Policy	

TABLE OF AUTHORITIES

<u>Case Law:</u>	<u>Page</u>
<u>Bergen v. Travelers Ins. Co.</u> , 776 P.2d 659, 662 (Utah Ct. App. 1989).....	2
<u>Busch Corp. v. State Farm Fire & Cas. Co.</u> , 743 P.2d 1217, 1219 (Utah 1987).....	7
<u>Christensen v. Farmers Ins. Exchange</u> , 443 P.2d 385, 389 (Utah 1968).....	9
<u>Cool Fuel, Inc. v. Connett</u> , 685 F.2d 309, 311 (9th Cir. 1982).....	6
<u>James v. Preston</u> , 746 P.2d 799 (Utah Ct. App. 1987).....	7
<u>Olwell v. Clark</u> , 658 P.2d 585 (Utah 1982).....	9
<u>Salt Lake City Corp. v. James Constructors, Inc.</u> , 761 P.2d 42, 46 (Utah Ct. App. 1988).....	7
<u>Utah County v. Brown</u> , 672 P.2d 83, 85 (Utah 1983).....	7
<u>Rules of Procedure:</u>	
Utah R. Civ. P. 56.....	4, 6, 7, 9, 10, 12
<u>Statutory Provisions:</u>	
Utah Code Ann. §78-2a-3-(2)(j) (Supp. 1989).....	2
ERISA, 29 U.S.C. §1001 <u>et seq.</u>	2
<u>Miscellaneous Authorities:</u>	
10A Wright & Miller, <u>Federal Practice and Procedure:</u> <u>Civil 2d.</u> , §2720 at 29-30, n. 20 (1983).....	6

Miscellaneous Authorities:

10A Wright & Miller, <u>Federal Practice and Procedure:</u> <u>Civil 2d.</u> , §2727 at 138-41 (1983).....	9
10A Wright & Miller, <u>Federal Practice and Procedure:</u> <u>Civil 2d.</u> , §2728 at 187-8 (1983).....	7
Advisory Committee Note to Rule 56 Amendments 31 F.R.D. 647, 648 (1962).....	10

IN THE COURT OF APPEALS
OF THE STATE OF UTAH

WARD PERKINS, Personal
Representative of the Estate
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Plaintiff/Appellee,

v.

LINCOLN NATIONAL LIFE
INSURANCE COMPANY,

Defendant/Appellee,

and

GREAT-WEST LIFE ASSURANCE
COMPANY,

Defendant/Appellant.

Case No. 890732-CA

BRIEF OF APPELLEE
LINCOLN NATIONAL LIFE INSURANCE COMPANY

JURISDICTION

Defendant Great-West Life Assurance Company filed a Notice of Appeal (record at 211) on July 3, 1989 from the Memorandum Decision entitled Court Order signed May 30, 1989, and filed June 2, 1989 (record at 189-92). On August 16, 1989 Great-West filed a Second Notice of Appeal (record at 240) from the Judgment signed June 23, 1989 and filed July 19, 1989 (record at 228-30). After these appeals were stayed by order of this court, Great-West obtained a Rule

54(b) certification on June 26, 1990. This court has jurisdiction over this appeal under Utah Code Ann. §78-2a-3(2)(j) (Supp. 1989).

ISSUES PRESENTED

Lincoln will address only those issues that affect its interests.^{1/}

1. Did the district court err in granting summary judgment to Lincoln sua sponte?
2. Did Great-West properly object to the timeliness of the rule 56(f) affidavit filed by Lincoln so as to preserve this issue for appeal?
3. Did Great-West meet its burden of showing the absence of any genuine issue of material fact?

STANDARD OF REVIEW

This is an appeal from summary judgment. Evidence is viewed in the light most favorable to the losing party. The court is free to reappraise the trial court's legal conclusions. If there is a dispute as to a genuine issue of material fact the summary judgment must be reversed. Bergen v. Travelers Ins. Co., 776 P.2d 659, 662 (Utah Ct. App. 1989).

^{1/} This action may be preempted by the Employee Retirement Income Security Act, 29 U.S.C. §1001 et seq. at §1144(a). As this issue was not addressed by the court below, Lincoln does not address it here.

STATEMENT OF THE CASE

This is a suit by Ward Perkins ("Perkins") as personal representative of the estate of Norma Perkins ("Mrs. Perkins") to recover life insurance proceeds from either Lincoln National Life Insurance Company ("Lincoln") or Great-West Life Assurance Company ("Great-West"). Prior to July 1, 1986 medical and life insurance was provided by Lincoln. As of July 1, 1986 coverage was provided by Great-West. Great-West counterclaimed for refund of medical benefits paid to Perkins in the amount of \$8,703.40. Great-West also crossclaimed against Lincoln for indemnity for the \$8,703.40 it paid to Mrs. Perkins "by mistake."

Perkins moved for summary judgment on his life insurance claim against Great-West. Great-West cross-moved for summary judgment on its counterclaim or in the alternative for summary judgment on its crossclaim against Lincoln. The court granted Perkins' motion for summary judgment against Great-West, denied both of Great-West's summary judgment motions, and sua sponte dismissed Great-West's crossclaim against Lincoln. Great-West has appealed.

STATEMENT OF FACTS

In addition to the facts stated in the appellant's brief, Lincoln would point the court's attention to the following additional relevant facts:

1. At all times prior to Dr. Roberts' recommendation of medical retirement on August 25, 1986, it was the intention of Norma Perkins to return to work. Affidavit of Ward Perkins, ¶3, record at 48.

2. The hospital considered Mrs. Perkins a full time active employee. Affidavit of Mark P. Toohey, record at 34.

3. Mrs. Perkins' physician expected her to return to work. Affidavit of Howard L. Roberts, Jr., record at 36.

SUMMARY OF ARGUMENT

The court below did not commit error in granting summary judgment to Lincoln sua sponte by dismissing Great-West's crossclaim. The court's ruling that Great-West was responsible for medical payments necessarily relieved Lincoln of any obligation to reimburse Great-West for amounts it claims were paid by mistake.

Great-West did not argue that Lincoln's Rule 56(f) affidavit was untimely in the proceedings below. This issue may not be raised for the first time on appeal. Lincoln's Rule 56(f) affidavit must be deemed timely. The denial of Great-West's summary judgment motion against Lincoln on Great-West's cross-claim was within the sound discretion of the trial court and should not be disturbed on appeal.

Great-West failed to meet its burden of showing the absence of any genuine issue of material fact. Great-West

sought recovery of approximately \$8,700.00 from Lincoln. Great-West did not show that any amounts would have been payable under Lincoln's policy.^{2/} Factual issues preclude granting summary judgment for Great-West.

ARGUMENT

POINT ONE

THE COURT DID NOT ERR IN GRANTING SUMMARY JUDGMENT TO LINCOLN SUA SPONTE.

Dismissal of Great-West's crossclaim against Lincoln was a proper and necessary corollary to the court's ruling on Perkins' motion for summary judgment. The court concluded as a matter of law that Mrs. Perkins was covered under Great-West's policy. All amounts Great-West paid for medical claims were therefore proper, and not paid by mistake. Lincoln has no duty to reimburse Great-West for claims that Great-West was obligated to pay.

The court was well within its authority to sua sponte dismiss Great-West's crossclaim with prejudice.

[T]he overwhelming weight of authority supports the conclusion that if one party moves for summary judgment and, at the hearing, it is made to appear from all the records, files, affidavits and documents presented that there is no genuine dispute respecting a material fact essential to the

^{2/} Lincoln's policy was attached as Exhibit B to Great-West's memorandum in support of Great-West Life Assurance Company's motion for summary judgment. These exhibits are contained in a separate manila envelope. A copy of Lincoln's policy is attached to this brief as Appendix 2 for the court's convenience.

proof of movant's case and that the case cannot be proved if a trial should be held, the court may sua sponte grant summary judgment to the non-moving party.

Cool Fuel, Inc. v. Connett, 685 F.2d 309, 311 (9th Cir. 1982).

See also, 6 Moore's Federal Practice, §56.12 (1988) and cases cited therein; 10A Wright & Miller, Federal Practice and Procedure: Civil 2d., §2720 at 29-30, n. 20 (1983) and cases cited therein. If this court should reverse the judgment entered by Judge Tibbs, Great-West is only entitled to a remand as discussed in Point Three, infra. Great-West is not entitled to summary judgment against Lincoln.

POINT TWO

GREAT-WEST DID NOT RAISE THE ISSUE OF THE TIMELINESS OF LINCOLN'S RULE 56(F) AFFIDAVIT IN THE PROCEEDINGS BELOW AND MAY NOT DO SO HERE.

Great-West asserts that it should have been granted summary judgment on its crossclaim against Lincoln since "Lincoln did not oppose the motion as required by Utah Rule of Civil Procedure 56, but merely filed an untimely Rule 56(f) affidavit of counsel." Brief of appellant at 3. Great-West asserts that Lincoln was dilatory in conducting discovery. This objection must fail.

Great-West did not raise any issue of timeliness below. There is no motion to strike the affidavit of Jathan W. Janove. Ms. Cassell discussed the Rule 56(f) affidavit at oral argument. She objected that Mr. Janove was not competent to testify and that the affidavit was "unnecessary." Transcript of proceedings

at 26-7. Mr. Janove's response detailed the purpose of Rule 56(f) and set forth a number of factual issues for which Lincoln required additional time to conduct discovery. Transcript of proceedings at 35-8.

Case law is well settled that issues not presented before the trial court may not be raised on appeal. See, e.g., Busch Corp. v. State Farm Fire & Cas. Co., 743 P.2d 1217, 1219 (Utah 1987); Utah County v. Brown, 672 P.2d 83, 85 (Utah 1983); James v. Preston, 746 P.2d 799 (Utah Ct. App. 1987). By failing to timely object to the timeliness of this affidavit, Great-West has waived its right to challenge this defect. Salt Lake City Corp. v. James Constructors, Inc., 761 P.2d 42, 46 (Utah Ct. App. 1988). Great-West's timeliness arguments must be deemed waived, and the affidavit of Jathan W. Janove must be considered timely.

Even if Great-West's timeliness argument is not deemed waived, the trial court's denial of summary judgment for Great-West on its crossclaim should not be disturbed on appeal. Granting a summary judgment motion is within the sound discretion of the court. "[I]n most situations in which the moving party seems to have discharged his burden of demonstrating that no genuine issue of fact exists, the court has discretion to deny a Rule 56 motion." 10A Wright & Miller, Federal Practice and Procedure: Civil 2d., §2728 at 187-8 (1983)(footnote omitted).

Great-West has not and cannot show an abuse of discretion by the court in denying its motion for summary judgment. The

affidavit of Jathan W. Janove competently sets forth a number of factual areas where discovery is required before Lincoln can adequately oppose a motion for summary judgment. At the time of Great-West's motion for summary judgment against Lincoln on its crossclaim, no discovery had yet been taken by Lincoln or Great-West. Affidavit of Jathan W. Janove ¶3, record at 112.^{3/} No discovery deadline had yet been set. It was within the trial court's discretion to deny Great-West's summary judgment motion to allow further development of the factual record.

POINT THREE

GREAT-WEST FAILED TO MEET ITS BURDEN OF SHOWING THE ABSENCE OF ANY GENUINE ISSUE OF MATERIAL FACT.

Great-West has appealed the grant of summary judgment to Perkins. Lincoln supports the court's decision below and adopts the arguments of Perkins in seeking affirmance. If this court reverses and determines it was error to conclude as a matter of law that Mrs. Perkins was covered under the policy issued by Great-West, then the case should be remanded for further proceedings. Even if this court holds as a matter of law that Perkins was not covered by Great-West's policy, it would be improper to order the entry of summary judgment for Great-West on its crossclaim against Lincoln.

^{3/} A copy of the affidavit is attached as Appendix 1.

As summary judgment was granted for Lincoln, this court may review the denial of summary judgment against Lincoln and direct the district court to enter judgment if appropriate. Christensen v. Farmers Ins. Exchange, 443 P.2d 385, 389 (Utah 1968). Even if this court determines as a matter of law that Mrs. Perkins was not covered by the policy issued by Great-West, Great-West is not entitled to summary judgment against Lincoln on its crossclaim.

The party moving for summary judgment has the burden of showing that there is no genuine issue as to any material fact. Great-West has not met this burden. As Great-West did not meet its burden, it was technically unnecessary for Lincoln oppose to the summary judgment motion. See 10A Wright & Miller, Federal Practice and Procedure: Civil 2d., §2727 at 138-41 (1983) (no need to oppose when matters presented fail to foreclose the possibility of a factual dispute).

The Supreme Court of Utah has clearly stated that opposition to summary judgment motions is not required in all cases. In Olwell v. Clark, 658 P.2d 585 (Utah 1982) the Supreme Court noted that summary judgment is proper only if "(a) the pleadings and affidavits, if any, show no issue as to any material fact, and (b) the party is entitled to judgment as a matter of law." Id. at 586. As there are genuine issues of material fact in this case, denial of Great-West's motion for summary judgment on its crossclaim against Lincoln was proper. As noted in the Advisory Committee's Note to the 1963 amendments to Rule 56, "[w]here the

evidentiary matter in support of the motion does not establish the absence of a genuine issue, summary judgment must be denied even if no opposing evidentiary matter is presented." 31 F.R.D. 647, 648 (1962).

Lincoln declined to rely solely on Great-West's failure to meet its burden and filed a Rule 56(f) affidavit instead. Paragraph 4(c) of the affidavit of Jathan W. Janove provides as follows:

(c) Great-West's motion raises the issue of whether, assuming Lincoln was the insurance carrier at the time of the medical claims, Lincoln would be responsible for the \$8,703.40 that Great-West asserts it paid. Neither Ms. Perkins nor Mr. Perkins ever submitted any claims for medical expenses to Lincoln. These claims would need to be analyzed according to the terms of Lincoln's health policy for considerations of timeliness of claims, eligibility of claims and whether the amounts involved meet Lincoln's guidelines for reasonable and customary charges. Discovery needs to be done as to the precise nature, amount and circumstances of each of these claims for reimbursement that form the \$8,703.40 that Great-West asserts Lincoln owes it.

Record at 113-4, Appendix 1 to this brief. Lincoln's policy was before the court as Exhibit B to Great-West's memorandum in support (record at 90-104 plus separate envelope containing exhibits).

To obtain judgment on its crossclaim in the amount \$8,703.40, Great-West must prove the following: (a) Mrs. Perkins was not covered by Great-West's policy; (b) Mrs. Perkins was covered under the terms of Lincoln's policy; (c) Mrs. Perkins complied with the 20 day notice requirement of Lincoln's policy (Appendix 2 at 43); (d) Mrs. Perkins complied with the 90 day

proof of claim requirement (Appendix 2 at 43); (e) charges were necessary for the care and treatment of Mrs. Perkins (§3B.1, Appendix 2 at 29); (f) charges were reasonable and customary for services rendered (§3B.4, Appendix 2 at 29), and (g) charges were for benefits provided by the policy (§3B.6, Appendix 2 at 29).

Obvious questions are raised as to compliance with notice and proof of claim requirements as set forth at page 43 of the policy, Appendix 2 to this brief. It would appear that any claim against Lincoln would be barred as untimely. Great-West has not set forth by affidavit or otherwise that there has been compliance with notice and proof requirements, or that the claims submitted are necessary, reasonable and customary, and compensable under Lincoln's policy. These are material issues of fact precluding summary judgment to Great-West.

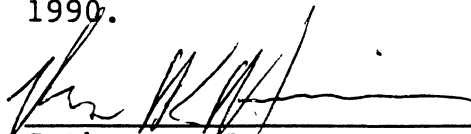
CONCLUSION

The dismissal of Great-West's crossclaim against Lincoln should be affirmed. The court below properly interpreted Great-West's policy and determined that Mrs. Perkins was covered under the policy as a matter of law. As Great-West was responsible for medical payments, its crossclaim for recovery from Lincoln of amounts allegedly paid by mistake was in fact moot and properly dismissed with prejudice. The decision below should be affirmed.

If this court determines that the court below erred in its grant of summary judgment, this matter should be remanded for further proceedings. Even if this court determines as a matter of law that Mrs. Perkins was not covered under Great-West's policy, Great-West is still not entitled to summary judgment on its crossclaim against Lincoln. Great-West did not meet its burden of showing the absence of any genuine issue of material fact with respect to its crossclaim against Lincoln. Obvious questions exist as to timeliness of notice and proof of claim. Further questions exist as to what amounts if any would be payable under Lincoln's policy if notice and proof of claim were properly made.

Lincoln properly opposed Great-West's summary judgment motion with a Rule 56(f) affidavit. As Great-West did not challenge the timeliness of this affidavit in the below, it may not raise such an objection here. Even if a proper objection could be raised, Lincoln was under no obligation to oppose the summary judgment motion as Great-West failed to meet its burden of showing the absence of any issue of material fact. The court below did not abuse its discretion in denying Great-West's summary judgment motion against Lincoln. This court should not second guess the trial court in the exercise of its discretion. The most relief Great-West is entitled to, if any, is a remand for further proceedings.

DATED this 16th day of July, 1990.



Jathan W. Janove
Robert K. Heineman
Fabian & Clendenin, a
Professional Corporation
Attorneys for Defendant/
Appellee Lincoln

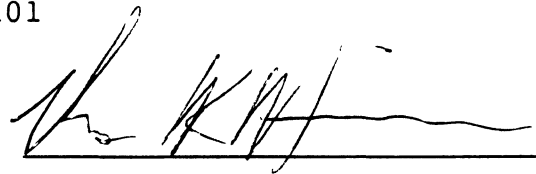
CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of July, 1990, I personally caused to be mailed, postage prepaid, four (4) copies of the foregoing Brief of Appellee Lincoln to the following:

Michael W. Park
110 North Main, Suite H
P. O. Box 765
Cedar City, UT 84720

and caused four (4) copies of the foregoing Brief of Appellee to be hand delivered to the following:

Clark W. Sessions
Cynthia K. Cassell
Campbell, Maack & Sessions
170 South Main Street, #400
Salt Lake City, UT 84101



RKH:062390B

APPENDIX 1

ORIGINAL	FLED IN <input type="checkbox"/>
Sixth Dist. Ct.	MAILED TO <input checked="" type="checkbox"/>
Fed Ex	
(COURT, AGENCY, ETC.)	
This 3rd day of April	1989
By MGD	

Jathan W. Janove
 FABIAN & CLENDENIN,
 a Professional Corporation
 Attorneys for Defendants
 Twelfth Floor
 215 South State Street
 P.O. Box 510210
 Salt Lake City, Utah 84151
 Telephone: (801) 531-8900

IN THE SIXTH JUDICIAL DISTRICT COURT IN AND FOR
 KANE COUNTY, STATE OF UTAH

WARD PERKINS, PERSONAL
 REPRESENTATIVE OF THE ESTATE OF
 NORMA PERKINS,

Plaintiff,

v.

LINCOLN NATIONAL LIFE INSURANCE
 COMPANY and GREAT-WEST LIFE
 ASSURANCE COMPANY,

Defendants.

GREAT-WEST LIFE ASSURANCE COMPANY,

Third-Party Plaintiff,

v.

SOUTHWEST HEALTH MANAGEMENT
 COMPANY, INC., a California
 Corporation, and LINCOLN NATIONAL
 LIFE INSURANCE COMPANY, an Indiana
 Corporation,

Third-Party Defendants.

AFFIDAVIT OF
 JATHAN W. JANOVE

Civil No. 2280

STATE OF UTAH)
 : ss.
COUNTY OF SALT LAKE)

Jathan W. Janove, after having been first duly sworn,
deposes and states as follows:

1. I am a member of Fabian & Clendenin, P.C., attorneys for defendant Lincoln National Life Insurance Company ("Lincoln").

2. This affidavit is submitted pursuant to Rule 56(f) of the Utah Rules of Civil Procedure in response to the motion of defendant and third-party plaintiff Great-West Life Assurance Company ("Great-West") for summary judgment against Lincoln on Great-West's crossclaim.

3. Neither Lincoln nor Great-West have yet commenced discovery in this matter. No depositions have been taken of any party or potential witness.

4. Great-West's motion for summary judgment raises the following factual issues which would require Lincoln to engage in discovery before it could properly respond:

(a) Great-West's motion raises the issue whether the decedent Norma Perkins was a "permanent, full-time full-pay," employee at the time Great-West began insuring the employee health plan for employees of Southwest Health Management Company, Inc. ("Southwest").

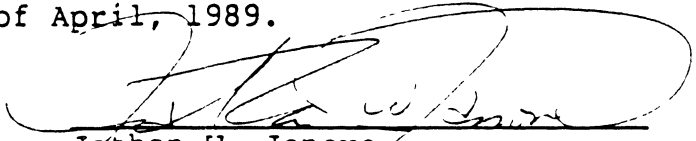
Discovery would need to be done including possible depositions of Ms. Perkins' employers, co-workers, husband or doctors as to her precise employment status and medical condition on this date.

(b) Great-West's motion raises the issue of whether Ms. Perkins was totally disabled as defined in the Lincoln policy. Discovery substantially similar to that described above would need to be done by Lincoln to determine if Ms. Perkins' disability or other medical problems constituted "total disability" under the policy at the time Great-West's insurance became effective.

(c) Great-West's motion raises the issue of whether, assuming Lincoln was the insurance carrier at the time of the medical claims, Lincoln would be responsible for the \$8,703.40 that Great-West asserts it paid. Neither Ms. Perkins nor Mr. Perkins ever submitted any claims for medical expenses to Lincoln. These claims would need to be analyzed according to the terms of Lincoln's health policy for considerations of timeliness of claims, eligibility of claims and whether the amounts involved meet Lincoln's guidelines for reasonable and customary charges. Discovery needs to be

done as to the precise nature, amount and circumstances of each of these claims for reimbursement that form the \$8,703.40 that Great-West asserts Lincoln owes it.

DATED this 3d day of April, 1989.


Jathan W. Janove

SUBSCRIBED AND SWORN to before me this _____ day of April, 1989.




NOTARY PUBLIC

Residing at 1618 - 12 Sandy, UT

1618-12

CERTIFICATE OF SERVICE

I hereby certify that on this 3d day of April, 1989, I caused to be hand delivered a true and correct copy of the foregoing AFFIDAVIT OF JATHAN W. JANOVE to:

Cynthia K. Cassell, Esq.
SESSIONS & MOORE
Attorneys for Defendant and
Third-Party Plaintiff Great-
West Life Assurance Co.
400 First Federal Plaza
505 East 200 South
Salt Lake City, Utah 84102

and to mailed by U. S. mail, postage prepaid, to:

Michael W. Park, Esq.
Attorney for Plaintiff
110 North Main Street, Suite H
P. O. Box 765
Cedar City, Utah 84720

JWJ:033189A



APPENDIX 2

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY
GROUP INSURANCE AMENDMENT

Attached to and made a part of:

Group Insurance Policy No. 39,373 dated July 1, 1983

Policyholder GUADALUPE GENERAL HOSPITAL
Santa Rosa, New Mexico

Effective date of this Amendment February 1, 1985

FOR VALUE RECEIVED, IT IS HEREBY AGREED BETWEEN THE POLICYHOLDER AND LINCOLN NATIONAL THAT:

- A. Group Insurance Policy No. 39,373, bearing as Date of Issue, July 1, 1983, will no longer apply; Group Insurance Policy No. 39,373, bearing as Date of Issue, February 1, 1985, is substituted therefor.
- B. If an employee is not actively working for the Employer on the effective date of any increase in benefits, the increased benefits, if any, will not become effective with respect to such employee until the next following day on which the employee is actively working for the Employer.
- C. If a dependent of an employee is confined in a hospital or skilled nursing facility on the effective date of any increase in benefits, the increased benefits, if any, will not become effective with respect to such dependent until the day following the dependent's final discharge from the hospital or skilled nursing facility.

THIS POLICY SUPERSEDES ANY POLICY PREVIOUSLY ISSUED.

* * * * *

The payment of premiums due for insurance extended hereunder on and after the effective date of this Amendment will be deemed to constitute written acceptance of this Group Insurance Amendment by the Policyholder. Such payment of premiums is the only method by which this Group Insurance Amendment may be accepted by the Policyholder. If this Amendment is unacceptable to the Policyholder and the Policyholder desired to continue insurance under the Policy without this Amendment being placed in effect, written notice thereof must be given to Lincoln National at its home office in Fort Wayne, Indiana, within 31 days from the date the Policyholder receives this form.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Examined by

KR

Signed: F. W. LINKER

Assistant Secretary

Group Policy Number 39,373



POLICYHOLDER

SOUTHWEST HEALTH MANAGEMENT CO., INC.
Coulton, California

EMPLOYER (The POLICYHOLDER shown above, unless otherwise indicated here)

Subsidiaries and Affiliates whose employees are to be insured under the Policy.

NONE

DATE OF ISSUE: 12:01 A.M., February 1, 1985. The INITIAL PREMIUM is due on the DATE OF ISSUE and RENEWAL PREMIUMS are due monthly on the 1st day of each month.

POLICY ANNIVERSARIES occur annually on July 1, beginning July 1, 1985.

This policy is delivered in California, and is governed by its laws. If any part(s) of this policy is contrary to such laws, that part(s) is hereby amended to conform to such laws.

SUBJECT TO THE TERMS AND CONDITIONS CONTAINED IN THIS POLICY, The Lincoln National Life Insurance Company, on approval by its Home Office of the application of Policyholder and on payment of premiums when due, agrees that on and after the Date of Issue it will provide group insurance with respect to each Insured Individual.

This policy, and the application made by Policyholder (a copy of which is attached), form the entire contract between the parties.

The Lincoln National Life Insurance Company has caused this policy to be executed this 7th day of February, 1985.

Signed: F. W. LINKER

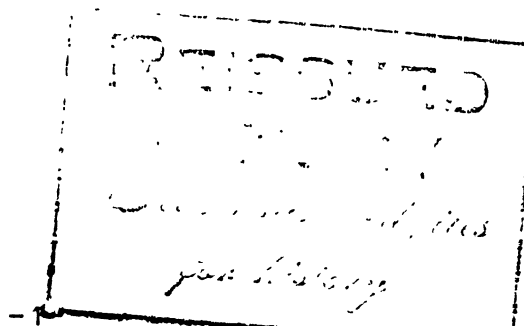
Assistant Secretary

Signed: IAN M. ROLLAND

President

Group Insurance Policy--Term Insurance--Contributory--Nonparticipating

Examined by KR



INDEX

SECTION 1	Definitions
SECTION 2	Schedule of Benefits and Description of Benefits
SECTION 3	Benefit Exclusions and Limitations. READ CAREFULLY, IT APPLIES TO ALL BENEFITS
SECTION 4	Coordination of Benefits
SECTION 5	Extension of Certain Benefits Upon End of Insurance While Totally Disabled
SECTION 6	Conversion
SECTION 7	General Information
SECTION 8	Policyholder
SECTION 9	Lincoln National
SECTION 10	Records

SECTION 1 - DEFINITIONS

"Actively at work," "active work" and "actively working" mean the active expenditure of time and energy in the service of the Employer. Except that, an individual will be considered actively at work on each day of a regular paid vacation or on a regular non-working day on which he or she is not disabled provided he or she was actively at work on the last preceding regular working day.

Basic Medical Insurance - benefits in this policy other than Life Insurance, Accidental Death, Weekly Income, and Major Medical.

Beneficiary - a person or entity named, on a form and in a manner approved by Lincoln National, to receive benefits for loss of life.

Benefit Period - the period of time (shown on the Schedule of Benefits) during which covered charges are incurred for which benefits may be paid.

Calendar Month - any one of the twelve months of the calendar.

Contributory - the employee pays a part of the cost of the insurance.

Cosmetic - surgery or other treatment to make a person better looking.

Covered Charges - charges covered under this policy.

Deductible - a set amount of covered charges which must be paid by the insured individual.

Dependent - see the last definition in this section.

Doctor - a person licensed to treat illness by the state in which the treatment is rendered.

Earnings - money paid to the employee by his or her Employer as base pay. This does not include:

1. Overtime, bonus, incentive, commission, and other non-base pay; or
2. Professional fees, retainers, and directors' fees.

Employed on a part-time basis - working less than 32 hours per week.

Employee - a person who is:

1. Actively working for the Employer; and
2. Receiving earnings.

Employer - the Employer(s) shown on the Face Page of this policy.

Evidence of Insurability - satisfactory proof, as determined by Lincoln National, that a person is acceptable for insurance.

Grace Period - a 31-day period which begins on the day following the due date of any premium due other than the first premium. During this period the premium due must be paid in order to prevent this policy from ending.

Hospital - a facility which:

1. Is licensed (if required) as a hospital; and
2. Is open at all times; and
3. Is operated mainly to diagnose and treat illnesses on an inpatient basis; and
4. Has a staff of one or more doctors on call at all times; and
5. Has 24-hour nursing services by Registered Nurses; and
6. Is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home or like place; and
7. Has organized facilities for major surgery.

Illness - means:

1. A disorder or disease of the body or mind; or
2. An accidental bodily injury; or
3. Pregnancy.

All illnesses due to the same cause, or to a related cause, will be deemed to be one illness. The donation of an organ or of tissue by an insured individual for transplanting into another person is considered to be an illness of the insured individual making the donation.

Individual - an employee or one of his or her dependents.

Insured Individual - an individual insured under this policy.

Lincoln National - The Lincoln National Life Insurance Company.

Medicare - medical benefits provided by Title XVIII of the Federal Social Security Act.

Month - a period starting at 12:01 a.m. on any day in a given Calendar Month, and ending at 12:01 a.m. on that same-numbered day in the next Calendar Month. If that next Calendar Month does not have a same-numbered day, the month will end at 11:59 p.m. of the last day of that Calendar Month. (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; 12:01 a.m. of May 31 through 11:59 p.m. of June 30.)

Necessary to the Care or Treatment of Illness--recommended by a doctor and commonly recognized in the doctor's profession as proper care or treatment of the patient's illness. Also, in the case of hospital or skilled nursing facility confinement, the length of confinement and the services and the supplies furnished by the hospital or skilled nursing

facility will be 'necessary' only if it is determined by Lincoln National that they are related to the care or treatment of the illness. The care or treatment, services, or supplies must not be:

1. For the scholastic education or vocational training of the patient; or
2. Experimental in nature.

Noncontributory - the employee pays no part of the cost of the insurance.

Officer of Lincoln National - the President, a Vice President, the Secretary or an Assistant Secretary of Lincoln National.

Policy - means this policy.

Policy Anniversary - the date shown as such on the Face Page of this Policy.

Policyholder - the legal entity named as the Policyholder on the Face Page of this policy.

Premium - money paid to Lincoln National by the Policyholder to pay for this insurance.

Pre-existing Illness - an illness for which medical advice or treatment was received prior to the individual's effective date of insurance.

Reasonable and Customary Charges - charges which Lincoln National determines do not exceed the amount usually charged by most providers in the same geographic area for services, treatment or materials, taking into account the nature of the illness involved.

Room and Board Charges - charges made by a hospital or skilled nursing facility for the room, meals, and routine nursing services for insured individuals confined as bed patients.

Schedule of Benefits - that part of Section 2 of this policy outlining the benefits.

Skilled Nursing Facility - a facility considered as such under Medicare.

Special Charges - charges made by a hospital or skilled nursing facility for other than for room and board.

Speech Therapist - someone who:

1. Has a master's degree in speech pathology; and
2. Has completed an internship; and
3. Is licensed by the state in which he or she performs his or her services, if that state requires licensing.

Total Disability - for purposes of this policy, an insured individual shall be deemed to have a total disability under the following circumstances:

1. If an EMPLOYEE is claiming waiver of premium for Life Insurance benefits, then total disability is defined as the EMPLOYEE's inability to work, because of an illness, in his or her normal job, or in any job for which he or she is or could be trained;
2. If an EMPLOYEE is claiming benefits other than for item 1. above, then total disability is defined as the EMPLOYEE'S inability to work, because of an illness, in his or her normal job;
3. If a DEPENDENT is claiming benefits under any coverage provided in this policy, then total disability is defined as the inability of the dependent to do the substantial and material duties of a person in similar circumstances who is in good health;

"One continuous period of total disability" means a period of time during which an individual is totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When an EMPLOYEE has successive periods of total disability which are due to the same or related causes, and which are not separated by two or more continuous weeks of active work with the Employer on a full-time basis; or
2. When a DEPENDENT has successive periods of total disability which are due to the same or related causes, and which are not separated by a period of three or more months during which the DEPENDENT is free from total disability which stems from those same or similar causes.

Totally disabled - having a total disability as defined above.

Waiting Period - the length of time an employee must continuously work for the Employer before he or she is eligible for insurance.

Dependent - means:

1. An employee's spouse (if not legally separated from the Employee),
or
2. For Life Insurance Benefits, an employee's unmarried child (including a stepchild or legally adopted child) from live birth until the date the child attains age 21.
3. For Medical Insurance Benefits, an employee's unmarried child (including a stepchild or legally adopted child)
 - a. from live birth for other than routine nursery charges; and
 - b. from the 10th day of life for all covered charges,

until the date the child attains age 21. Except that, the term dependent includes an employee's unmarried child who has attained age 21 while:

c. the child is:

- 1) mentally or physically unable to earn his or her own living and proof of incapacity is furnished to Lincoln National within 31 days of the date his or her insurance would have ended due to age; and
- 2) actually dependent on the employee for a majority of his or her support; and
- 3) insured on the date just prior to the day his or her insurance would have ended due to age.

d. the child:

- 1) is enrolled in an accredited school as a full-time student as defined in the rules of such school; and
- 2) has not attained age 25.

To remain insured under c. or d. above, due proof that the employee's child continues to qualify as a dependent must be furnished to Lincoln National as it reasonably asks. Except that, in the case of c. above, Lincoln National will not ask for such proof more than once each twelve months in a row after two years from the date the child attains age 21.

4. A child who:

- a. is insured under the policy as an employee; or
 - b. who has benefits due under any extension of such insurance
- is not a dependent.

If a husband and wife are both insured under the policy as employees, their dependent children may be insured dependents of both the husband and the wife.

SECTION 2 - BENEFITS

A. SCHEDULE OF BENEFITS

EMPLOYEE

LIFE INSURANCE BENEFITS

The Amount of Insurance is equal to 100% of annual earnings rounded to the next higher \$5,000, unless already an even \$5,000. The maximum amount is \$70,000.

On becoming age 70, an employee's Amount of Insurance is equal to 50% of annual earnings rounded to the next higher \$2,500, unless already an even \$2,500. The maximum amount is \$35,000.

ACCIDENTAL DEATH BENEFITS

The Full Amount of Insurance is equal to the Amount of Insurance provided under Life Insurance Benefits.

DEPENDENT

DEPENDENT LIFE INSURANCE BENEFITS

Amount
of Insurance

The Amount of Insurance is equal to \$ 2,000

Except that, such amount will be \$100 for dependent children from live birth to six months of age and \$1,000 for dependent children six months of age or more.

EMPLOYEE AND DEPENDENT

ADDITIONAL ACCIDENT BENEFITS

Maximum Benefit for each Accidental Bodily Injury \$ 500

HOME HEALTH CARE BENEFITS

Benefit Percentage 80%

Maximum Payment for a Single Visit \$ 40

Maximum Number of Visits 100

Each visit by a representative of a home health care agency shall be considered as one home health care visit: each four hours of home

health care service by a representative shall be considered as one home health care visit.

MAJOR MEDICAL BENEFITS

Maximum Benefit (Lifetime Aggregate) \$ 1,000,000

Except that, the Maximum Benefit (Lifetime Aggregate)
for charges for mental illness(es), substance abuse,
or alcoholism is \$ 50,000

COST CONTAINMENT FEATURES

The Major Medical Benefits in this policy have been designed to encourage the insured individual to seek quality health care at a lower cost. Major Medical benefits are reimbursed, at a higher level, for charges for certain services performed while the insured individual is not confined as a bed patient in a hospital. Charges for certain hospital confinements will be reimbursed at a lower level. Second surgical opinions are encouraged with all surgeries and are required for certain elective procedures in order to obtain the full benefits provided by this policy. Out-patient surgery works in the same way. It is encouraged, when possible, and required for certain procedures. The specific cost containment features under Major Medical benefits are as follows.

PRE-ADMISSION TESTING

The Benefit Percentage is 100% and there is no deductible for charges for Pre-Admission Testing.

"Pre-Admission Testing" means X-ray and lab exams made in contemplation of and within seven days of a scheduled surgery which is performed within the 48 hours following the individual's admission to the hospital.

SECOND SURGICAL OPINIONS

The Benefit Percentage is 100% and there is no deductible for charges for a second surgical opinion consultation.

EXCEPT THAT, if a second surgical opinion is not obtained for the following "elective" procedures, the Benefit Percentage will NEVER be more than 50% for all charges incurred in connection with the surgery:

hysterectomy; total knee or hip joint replacement; cholecystectomy; inguinal herniorrhaphy; herniated intervertebral disc removal; tonsillectomy and adenoidectomy; prostatectomy; cataract removal; hemorrhoidectomy; surgery of the breast; D&C; and coronary artery bypass.

These procedures will be considered "elective" when they are scheduled at the patient's convenience without endangering the patient's life or without causing a serious impairment to the patient's normal bodily functions.

"Second surgical opinion" means an evaluation of the need for surgery by a second doctor (or a third doctor if the opinions of the doctor recommending surgery and the second doctor are

in conflict), including the doctor's exam of the patient and diagnostic testing.

GENERIC DRUGS

The Benefit Percentage is 100% and the deductible DOES apply for generic drugs dispensed while the individual is not a bed patient in a hospital subject to all of the following:

1. The generic name of the drug must appear on the receipt from the pharmacy.
2. The following statement must be included on the receipt from the pharmacy: "This prescription is filled with a lower priced generically equivalent drug." This statement must be signed by the pharmacist.
3. It does not apply to any drug for which there is no lower priced generically equivalent drug available.
4. It only applies to generically equivalent drugs which meet all FDA bioavailability standards.

HOME HEALTH CARE AND HOSPICE CARE

This policy includes benefits for Home Health Care (this is a separate benefit and is not part of Major Medical) and Hospice Care. See the descriptions of these benefits for details of the coverage.

OUT-PATIENT SURGERY

See the description of Out-Patient Surgery Benefits for details of this coverage. Read this carefully. If certain procedures are performed as an in-patient instead of an out-patient, the Benefit Percentage will NEVER be more than 50% for all charges incurred in connection with the surgery.

OTHER MAJOR MEDICAL BENEFIT PROVISIONS

Deductible

Hospital Charges -

An amount equal to the first day's room and board charge but in no event more than the prevailing semi-private room charge of the hospital during any one continuous period of hospital confinement. EXCEPT THAT, there is no deductible for hospital charges if:

1. The individual has obtained pre-admission testing; or
2. The hospital confinement is due to an accidental bodily injury; or
3. The hospital confinement was not scheduled prior to the day of admission.

All Other Charges a cash deductible of \$200 plus any amount paid as Basic Medical Insurance

A maximum of two times the individual cash deductible, no more than \$200 of which may be satisfied by only one person, will be applied to the covered charges incurred by a family unit during any benefit period.

If a single accident causes injuries to two or more insured individuals who are members of a family unit, a single deductible will apply to all such members of that family unit for whom a benefit period is not in effect for covered charges incurred during that calendar year and resulting from all such injuries. In no event will a lesser amount be paid than would be payable if this single deductible did not apply.

Benefit Percentage 80%

After \$2,000 of eligible charges payable at 50% or 80% are incurred by an insured individual, or \$4,000 of eligible charges payable at 50% or 80% are incurred by the insured members of a family unit, during a calendar year, Major Medical Benefits pays 100% of eligible charges (other than those for (i) mental illness, substance abuse and alcoholism, and (ii) dental conditions) subsequently incurred within the calendar year, provided such charges are not required to satisfy a deductible.

Maximum Covered Charge for Room and Board

Hospital Semi-Private Rate

Skilled Nursing Facility Semi-Private Rate

For treatment of mental illness, substance abuse or alcoholism, charges are limited to a maximum of 40 days of hospital confinement in any one calendar year.

Benefit Period

A Benefit Period for an insured individual begins when the individual has incurred in a calendar year covered charges which exceed the deductible amount. Included will be covered charges incurred in October, November and December of the preceding calendar year for which no benefits were paid because such charges were applicable to the deductible amount.

A Benefit Period for an insured individual ends on the earliest of the following:

1. the last day of the calendar year in which it was established; or
2. the day coverage provided under this policy ends; or
3. the day the maximum benefit is paid.

REPLACEMENT OF ORGANS OR TISSUE

A. The following procedures are payable on the same basis as any other illness:

1. cornea transplants
2. artery or vein transplants
3. kidney transplants
4. joint replacements

5. heart valve replacements
6. implantable prosthetic lenses in connection with cataracts
7. prosthetic by-pass or replacement vessels
8. bone marrow transplants

B. The following procedures are payable on the same basis as an illness up to the lifetime maximum of the policy or \$100,000 whichever is less. This maximum applies for each type of procedure and to all charges incurred as a result of the transplant(s):

1. heart transplants
2. heart and lung transplants
3. liver transplants

C. No other replacement of tissue or organs are covered by the policy.

MEDICAL BENEFITS FOR THE AGED

Medical benefits paid under this policy will be reduced by the amount of any benefits or compensation to which the insured individual is entitled under Medicare. The reduction will apply whether or not the insured individual has received or made application for such Medicare benefits. An insured individual is deemed entitled to all Medicare benefits for which he or she is or has been eligible.

PRE-EXISTING ILLNESS LIMITATION

Persons Whose Most Recent Date of Coverage Is On Or After February 1, 1985:

Payment for charges incurred in connection with an illness starting prior to the insured individual's effective date of coverage is limited to a maximum of \$1,000 unless the charges are incurred:

1. after a period of three months in a row ending after the effective date of coverage during which the person has received no treatment with respect to the illness; or
2. after a period of twelve months in a row following February 1, 1985, during which the person is continuously insured under this policy.

There is no pre-existing limitation for persons not listed above.

ELIGIBLE INDIVIDUALS

The individuals eligible for insurance under this policy are as follows:

1. employees who have completed the waiting period and who are actively working at least 32 hours per week in the employ of the Employer (herein called employees within the eligible classes), and
2. dependents of those employees who are meeting the requirements of 1. above.

No benefits are paid for retired employees and their dependents.

WAITING PERIOD

The waiting period is the period of time between the date of employment and the first day of the Calendar Month next following two months of employment.

CLASSIFICATION CHANGE DATE

A change in an employee's benefits caused by a change in his or her classification will be effective immediately on the date such change in classification becomes effective.

OCCUPATIONAL AND NON-OCCUPATIONAL BENEFITS

Life Insurance Benefits and Accidental Death Benefits are issued on an occupational and non-occupational basis.

CONTRIBUTIONS TOWARD PREMIUM BY EMPLOYEE

Insurance for employees is non-contributory.

Insurance for the dependents of an employee is contributory.

Insurance becomes effective as provided in Section 7.

B. DESCRIPTION OF BENEFITS

LIFE INSURANCE BENEFITS

1. Life Insurance Benefits

The Amount of Insurance will be paid for death of an insured employee from any cause.

2. Extension of Life Insurance Benefits

Life Insurance Benefits will be paid if:

- a. an insured employee becomes totally disabled prior to age sixty; and
- b. he or she remains totally disabled until death; and
- c. he or she dies prior to age sixty; and
- d. he or she dies within one year after the last date for which Life Insurance premium for him or her was paid.

3. Waiver of Premium Benefit

Life Insurance Benefits will be continued without premium payment for one year from the date proof satisfactory to Lincoln National has been received if:

- a. an insured employee becomes totally disabled prior to age sixty; and
- b. he or she remains totally disabled for at least nine months; and
- c. such proof of total disability is furnished to Lincoln National after he or she has been totally disabled for nine months; and
- d. such proof is submitted to Lincoln National no later than twelve months after the end of premium payments for the employee.

Life Insurance Benefits will be continued without premiums for further periods of one year if:

- a. the employee remains totally disabled; and
- b. proof of such total disability is furnished to Lincoln National during the three-month period prior to each anniversary of the date of the original proof.

All insurance under this Waiver of Premium Benefit will end on the earliest of:

- a. the date the insured employee is no longer totally disabled;
- b. the end of the last year for which proof was received by Lincoln National; or
- c. the date the employee attains age sixty-five.

4. Payment

Payment of Life Insurance Benefits will normally be made in one lump sum. However, the insured employee, prior to his or her death, may choose to have his or her Life Insurance Benefits paid

in any other way approved by Lincoln National. If the employee, prior to his or her death, has not made an election for payment other than in a lump sum, the beneficiary may elect the benefits to be paid in any other way approved by Lincoln National.

5. Reduction Due to Conversion

An employee who has converted any part of his or her Life Insurance Benefits under this policy because he or she ceased being an employee and who again becomes an insured employee at a later date will have his or her Amount of Insurance reduced by the amount of the converted benefit in force until he or she submits evidence of insurability to Lincoln National.

6. Assignability

An absolute assignment by an insured employee of all the incidents of ownership of his or her Life Insurance will be permitted, but only if Lincoln National is given actual notice of it. Any such assignment will only take effect for Lincoln National on the date it is received at the Home Office of Lincoln National. Collateral assignments, by whatever name called, will not be permitted.

7. Limit On Amount of Insurance

The total amount of Life Insurance Benefits paid will never exceed the Amount of Insurance shown on the Schedule of Benefits. In no event will payment ever be made under more than one of the following:

- a. Life Insurance Benefits;
- b. Extension of Life Insurance Benefits;
- c. Waiver of Premium Benefit; or
- d. Any benefits resulting from the Conversion Section of this policy.

THE AMOUNT OF INSURANCE IS SHOWN ON THE SCHEDULE OF BENEFITS.

ACCIDENTAL DEATH BENEFITS
(Including DISMEMBERMENT AND LOSS OF SIGHT BENEFITS)

1. Accidental Death Benefits

Benefits will be paid if an insured individual incurs any of the losses listed in the Table of Losses (Item 3. below), if and only if:

- a. The loss: i) results from an accidental bodily injury which occurred while the individual was insured; and ii) was independent of all other causes; AND
- b. The accidental bodily injury is evidenced by a visible bruise or wound (except in the case of: i) internal injuries shown by autopsy; or ii) drowning); AND
- c. The loss occurs no more than 90 days after the injury.

2. Exclusions

No Accidental Death Benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

- a. self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane; or
- b. insurrection, riot, or war; or
- c. the committing of, or the attempting to commit, an assault or felony; or
- d. disease or disorder of the body or mind; or
- e. medical or surgical treatment or diagnosis or preventive care; or
- f. ptomaines or bacterial infection (except only in pyogenic infection occurring at the same time as, and as a result of, a visible accidental wound); or
- g. the voluntary or involuntary: i) taking of drugs (except drugs taken as prescribed by a doctor) or poison; or ii) inhaling of gas.

3. Table of Losses

<u>In the Event of Loss of:</u>	<u>The Amount Payable will be:</u>
Life	The Full Amount of Insurance
Both Hands or Both Feet	The Full Amount of Insurance
Sight of Both Eyes	The Full Amount of Insurance
One Hand and One Foot	The Full Amount of Insurance
One Hand and Sight of One Eye	The Full Amount of Insurance
One Foot and Sight of One Eye	The Full Amount of Insurance
One Hand	One-Half The Full Amount of Insurance
One Foot	One-Half The Full Amount of Insurance
Sight of One Eye	One-Half The Full Amount of Insurance

With respect to hands or feet, "loss" means permanent severance at or above the wrist or ankle joint. With respect to eyesight, "loss" means the entire and permanent loss of sight.

NOTE: IN ANY EVENT, THE FULL AMOUNT OF INSURANCE WILL BE PAID ONLY ONCE FOR ANY ONE ACCIDENT, NO MATTER HOW MANY OF THE ABOVE-LISTED LOSSES OCCUR AS THE RESULT OF THAT ACCIDENT.

THE FULL AMOUNT OF INSURANCE IS SHOWN ON THE SCHEDULE OF BENEFITS.

DEPENDENT LIFE INSURANCE BENEFITS

1. The Amount of Insurance will be paid for the death of an insured dependent from any cause. The benefits will be paid in a lump sum.
2. Extension of Dependent Life Insurance Benefits

Dependent Life Insurance Benefits will be paid if an insured employee becomes totally disabled and his or her insured dependent dies:
 - a. while the employee remains disabled; and
 - b. prior to the employee's 65th birthday; and
 - c. within one year after the last date for which Dependent Life Insurance premium for his or her dependent was paid.
3. The total amount of Dependent Life Insurance Benefits paid will never exceed the Amount of Insurance shown on the Schedule of Benefits. In no event will payment ever be made under more than one of the following:
 - a. Dependent Life Insurance Benefits;
 - b. Extension of Dependent Life Insurance Benefits; or
 - c. Any benefits resulting from the Conversion Section of this policy.

THE AMOUNT OF INSURANCE IS SHOWN ON THE SCHEDULE OF BENEFITS.

ADDITIONAL ACCIDENT BENEFITS

Benefits will be paid if an insured individual has charges as a result of an accidental bodily injury which occurs while the individual is insured. Benefits will be paid for:

1. Medical, dental or surgical treatment or supplies;
2. Confinement in a hospital or skilled nursing facility;
3. X-ray or lab exams;
4. Services of a Registered Nurse (R.N.) for private duty nursing, and/or;
5. Services of a Licensed Practical Nurse (L.P.N.) for private duty nursing while confined as a bed patient in a hospital.

Charges must be incurred within three months of the date of the injury. Benefits will be paid equal to that portion of the expenses incurred which is in excess of the total amount payable under all other benefits of this policy except Major Medical Benefits. The total paid will be the amount charged, but not more than the Maximum Benefit.

THE MAXIMUM BENEFIT IS SHOWN ON THE SCHEDULE OF BENEFITS.

HOME HEALTH CARE BENEFITS

Benefits will be paid, based on the benefit percentage, if an insured individual has covered charges for Home Health Care. The amount paid will be the fee charged, but not more than the Maximum Amount for a single visit. Benefits will not be paid for more than the maximum number of visits in any one calendar year.

Covered charges are those which meet all three of the following requirements:

1. They are medically necessary for the care of an insured individual who is totally disabled and who would otherwise have been confined as a bed patient in a hospital or skilled nursing facility, PROVIDED:
 - a. the insured individual is under the direct care of a doctor;
 - b. the plan of treatment for the Home Health Care is established in writing by the attending doctor prior to the start of such treatment;
 - c. the plan of treatment for Home Health Care is certified by the attending doctor at least once each month, and
 - d. the insured individual is examined by the attending doctor once each 60 days.

2. They are for services provided by a home health agency.

A "home health agency" means an agency which meets the following requirements:

- a. its primary services are those listed in 3. below;
- b. it is federally certified as a home health agency; and
- c. it is licensed, if licensing is required.

3. They are for one or more of the following, unless the charge is a covered charge under Major Medical Benefits:

- a. part-time or intermittent nursing care by a Licensed Practical Nurse (L.P.N.);
- b. part-time or intermittent Home Health Aide services;
- c. occupational therapy performed by a licensed therapist;
- d. social work performed by a licensed social worker;
- e. nutrition services performed by a licensed nutritionist;
- f. special meals.

Exclusions

No Home Health Care Benefits will be paid for:

1. General housekeeping services; or
2. Services for custodial care.

THE BENEFIT PERCENTAGE, THE MAXIMUM AMOUNT FOR A SINGLE VISIT AND THE MAXIMUM NUMBER OF VISITS ARE ALL SHOWN ON THE SCHEDULE OF BENEFITS.

MAJOR MEDICAL BENEFITS

Benefits will be paid if an insured individual has covered charges during his or her Benefit Period.

Benefit Period

A Benefit Period begins and ends as shown on the Schedule of Benefits.

Determination of Benefits

Benefits to be paid will be determined by multiplying the benefit percentage times the amount of covered charges in a Benefit Period which exceed the Deductible.

Maximum Benefit

Payment will never be more than the Maximum Benefit for all of an insured individual's illnesses, even though the person may not have been continuously insured.

The Maximum Benefit will be renewed when an insured individual submits evidence of insurability to Lincoln National at his or her own expense. This renewed Maximum Benefit will apply to all charges made after the date such increase is effective.

COVERED CHARGES

1. Room and Board and routine nursing for confinement in a hospital as shown on the Schedule of Benefits.
2. Room and Board and routine nursing for confinement in a skilled nursing facility as shown on the Schedule of Benefits.
3. Intensive Nursing Care for each day of confinement in a hospital as follows:
 - a. for those hospitals which make a separate charge for Intensive Nursing Care, the hospital's specific charge for Intensive Nursing Care is covered;
 - b. for those hospitals which make a combined charge for Room and Board and Intensive Nursing Care, that part of the combined charge which is in excess of the hospital's prevailing semi-private Room and Board rate will be the covered charge for Intensive Nursing Care.
4. Medical services and supplies furnished by the hospital.
5. Anesthetics and their administration.
6. Medical treatment given by or in the presence of a doctor if such treatment is within the scope of his or her license.
7. Services of a Registered Nurse (R.N.) for private duty nursing services.
8. Services of a Licensed Practical Nurse (L.P.N.) for private duty nursing services in a hospital.
9. Services of a licensed physiotherapist.

10. Charges by a doctor or speech therapist for speech therapy due to an illness (other than a functional nervous disorder), or due to surgery on account of an illness. If the speech therapy is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.
11. X-ray exams (other than dental), lab tests and other diagnostic services.
12. X-ray and radiation therapy.
13. Charges for the repair of natural teeth (including their replacement) which are a result of and within 24 months of an accidental bodily injury which occurs while the person is insured.
14. Transportation within the United States and Canada of the insured individual by professional ambulance service, railroad, or scheduled airline to, but not returning from a hospital or sanitarium. These charges will be covered if the insured individual's illness cannot be adequately treated in the locale where the illness occurs.
15. Medical supplies as follows:
 - a. drugs which require a written prescription of a doctor and which must be dispensed by a licensed pharmacist or doctor;
 - b. blood and other fluids to be injected into the circulatory system;
 - c. artificial limbs and eyes for loss of natural limbs and eyes which occurred while insured;
 - d. lens, each eye (contact or frames) immediately following and because of cataract surgery only;
 - e. casts, splints, trusses, braces, crutches and surgical dressings;
 - f. purchase or rental of hospital-type equipment for kidney dialysis for the personal and exclusive use of the patient. The total purchase price to be eligible will be on a monthly pro-rata basis during the first 24 months of ownership but only so long as a dialysis treatment continues to be medically required. Lincoln National also will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also reasonable and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient. No benefits are paid for an insured individual on or after the day such individual is entitled to benefits under Medicare.
 - g. rental of hospital-type medical equipment for other than kidney dialysis, including wheelchair, hospital bed, equipment for the treatment of respiratory paralysis, and equipment for the use of oxygen.

MAJOR MEDICAL LIMITATIONS

The maximum payment for care of mental illness, nervous conditions of any type or cause, substance abuse or alcoholism, by a doctor will not be more than \$20.00 for each visit with a maximum of \$2,000 in any one calendar year.

(A "visit" occurs each time the doctor provides care to the patient.)

THE DEDUCTIBLE, BENEFIT PERCENTAGE, AND MAXIMUM BENEFIT ARE ALL SHOWN ON THE SCHEDULE OF BENEFITS.

CHANGE IN INSURANCE CLASSIFICATION NOT AS A RESULT OF AMENDMENT OF POLICY

If the insured individual's insurance classification changes and results in an increase in the Maximum Benefit, such increase will not apply to any illness which exists on the date of such change. The increase will not apply to those illnesses until a three-month period has elapsed during which the insured individual has not received any treatment for the existing illness.

5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the patient.
9. It is licensed, if licensing is required.

"Patient's immediate family" means the patient's spouse and children who are insured under this policy.

OUT PATIENT SURGERY

The following surgical procedures may be performed while the patient is confined in a hospital as a bed patient or in a hospital or elsewhere as an out-patient. If performed as an out-patient, the Benefit Percentage is 100%. If performed as an in-patient, the Benefit Percentage is 50%. In addition, there is no deductible when performed as an out-patient.

EXCEPT THAT, benefits for the listed procedures will be paid the same as for any other surgery if performed as an in-patient in a hospital; and IF:

1. The attending doctor certifies that the individual's medical condition requires hospitalization; AND
2. Another doctor, other than the attending doctor, certifies that the individual's medical condition requires hospitalization; OR
3. The surgical procedure is performed while the individual is confined as a bed patient in a hospital, and such confinement is not related to the surgery.

OUT PATIENT SURGICAL PROCEDURES

ENDOSCOPIC PROCEDURES

Bronchoscopy
Colonoscopy
Esophagoscopy
Esophagastroduodenoscopy

GENERAL SURGERY

Herniorrhaphy and Umbilical Hernia - under age 5
Hemorrhoidectomy - external
Simple Mastectomy - male
Colon Polypectomy (Non-laparotomy)
Skin and Subcutaneous Lesions, Benign and Malignant less than 2 cm.
Biopsies - muscle, lymph node, breast, skin and subcutaneous, cervical and vaginal, endoscopic biopsies
Cysts of the skin and subcutaneous tissue

GENITO URINARY/GYNECOLOGICAL

Vasectomy
Circumcision and Meatotomy
Sterilization by Mini-Laparotomy or Laparoscopy
Bartholin Marsupialization
Colposcopy
Hysterosalpingography
Amniocentesis
D & C for Diagnosis or Treatment

ORTHOPEDIC SURGERY

Simple Fractures - closed reduction
Excision Ganglion
Open Reduction Digital Fracture
Nerve Repair Fingers
Palmar Fasciotomy
Amputation - digits
K-Wire and Hardware Removal
Arthroscopy for Diagnosis or Treatment
Exostosis Excision
Uncomplicated Extensor Tendon Repair
Morton's Neuroma
Trigger Finger
Carpal Tunnel Release

EYES, EARS, NOSE AND THROAT

Tonsillectomy and Adenoidectomy
Myringotomy with Tube Insertion
Extraocular Muscle Surgery

NON-GOVERNMENTAL CHARITABLE RESEARCH HOSPITAL BENEFITS

Notwithstanding any terms of the policy to the contrary, it is hereby understood and agreed that payment will be made for hospital, medical or surgical services rendered by a nongovernmental charitable research hospital which makes no charge for its services in the absence of insurance. Payment will be made in accordance with all of the other terms, conditions and limitations of the policy.

For the purposes of this Policy, a charitable research hospital means a hospital that meets all of the following criteria:

1. is internationally recognized as devoting itself primarily to medical research;
2. expends not less than 10 percent of its operating budget in each fiscal year exclusively on medical research activities which are not directly related to the provision of services to patients;
3. derives not less than one-third of its gross revenues in each fiscal year from contributions, donations, grants, gifts, or other gratuitous forms from individuals, groups, persons, or entities unrelated to the hospital. Contributions, donations, grants, gifts, or other gratuitous sources of revenue received as compensation for medical services provided patients shall not be considered for purposes of this subdivision;
4. accepts patients without regard to the patient's ability to pay for medical services;
5. not less than two-thirds of the patients admitted have a primary diagnosis or suspected disease or condition directly related to the specific area or areas in which the hospital conducts research. Patients admitted because of an emergency life-threatening condition who could not be safely transported to another hospital shall not be considered as patients for purposes of this section.

SECTION 3 - BENEFIT EXCLUSIONS AND LIMITATIONS

A. THE FOLLOWING EXCLUSIONS AND LIMITATIONS APPLY TO ALL BENEFITS OTHER THAN LIFE INSURANCE:

No benefits are provided for:

1. Any accidental bodily injury which arises out of or in the course of any employment with any employer or for which the individual is entitled to benefits under any worker's compensation law or occupational disease law, or receives any settlement from a worker's compensation carrier, unless it is shown in the Schedule of Benefits that the coverage provided by a benefit is issued on both an occupational and non-occupational basis.
2. Any illness for which the individual is entitled to benefits under any worker's compensation or occupational disease law, or receives any settlement from a worker's compensation carrier, unless it is shown in the Schedule of Benefits that the coverage provided by a benefit is issued on both an occupational and non-occupational basis.
3. Losses which are due to war or any act of war, whether declared or undeclared.
4. Charges incurred or disability claimed while an insured individual is not under the direct care of a doctor.

B. IN ADDITION, FOR MEDICAL INSURANCE THE FOLLOWING CHARGES ARE NOT COVERED:

1. Charges which are not necessary to the care or treatment of an illness.
2. Charges which would not have been made if no insurance existed.
3. Charges which the insured individual is not legally obliged to pay.
4. Charges which are in excess of the reasonable and customary charges for services and materials.
5. Charges for treatment by a doctor which is not within the scope of his or her license.
6. Charges for which benefits are not provided in this policy.
7. Charges for dental services or supplies for treatment of the teeth, gums or alveolar processes if Dental Benefits are not included in this policy. Except that, Lincoln National will pay for:
 - a. hospital charges if the insured individual is a bed patient; or
 - b. any dental charges covered under Major Medical and/or Additional Accident Benefits.
8. Charges for the purchase of hearing aids, if Hearing Aid Benefits are not included in this policy.

9. Charges for eye glasses or contact lenses or the fitting of them, if Vision Benefits are not included in this policy. Except that, Lincoln National will pay for charges covered under Major Medical Benefits for cataract surgery.
10. Charges for confinement in a Skilled Nursing Facility, unless such confinement:
 - a. starts within 14 days after the insured individual has been confined for at least three days in a hospital for which room and board charges were paid; and
 - b. is for treatment of the illness causing the hospital confinement; and
 - c. is one during which a doctor visits the insured individual at least once every 30 days; and
 - d. is not routine custodial-type care.
11. Charges for any treatment for cosmetic purposes or for cosmetic surgery. Except that, Lincoln National will pay for cosmetic treatment or surgery:
 - a. due solely to an accidental bodily injury which occurred while the individual was insured under this policy; or
 - b. due solely to surgical removal of all or a part of the breast tissue as a result of an illness; or
 - c. due solely to a birth defect of an individual who was insured under this policy on the date of his or her birth.
12. Charges for services of a person who usually lives in the same household as the insured individual, or who is a member of his or her immediate family or the family of his or her spouse.
13. Charges for services or supplies furnished by an agency of the United States Government or a foreign government agency, unless excluding them is prohibited by law.
14. Charges due to a pre-existing illness, except as shown in the Schedule of Benefits.
15. Charges for diagnosis or treatment of temporomandibular joint dysfunction, by any name called. EXCEPT, this limitation does not apply to such charges which result in payments

not exceeding a total of \$1,000.00 in an individual's lifetime, subject to the deductible and benefit percentage shown on the Schedule of Benefits.

16. Charges due to tissue transplants, organ transplants or replacement of tissue or organs, whether natural or artificial replacement materials or devices are used; and all charges due to complications arising from such procedures or treatment unless such charges are specifically provided for on the Schedule of Benefits.

C. CHARGE FOR SERVICE OR PURCHASE

The charge for service or purchase will be deemed to have been incurred on the date the service is performed or the date the purchase occurs.

D. RETURN OF OVER PAYMENT

Payment made for charges must be returned to Lincoln National if:

1. it is found that such charges were paid in error, or
2. a third party is determined to be liable for such charges.

If an individual insured under the policy has:

- a. medical or dental charges; or
- b. loss of earnings;

as a result of the negligence or intentional act of a third party, and makes a claim to Lincoln National for benefits under the policy for such charges or such lost earnings, the insured individual (or legal representative of a minor or incompetent) must agree in writing to repay Lincoln National from any amount of money received by the insured individual from the third party, or its insurer. The repayment will be to the extent of the benefits paid by Lincoln National, but will not exceed the amount of the payment received by the individual from the third party, or its insurer. However, the reasonable expenses, such as lawyers' fees and court costs, incurred in effecting the third party payment reimbursed to Lincoln National may be deducted from the repayment to Lincoln National.

The repayment agreement will be binding upon the insured individual (or legal representative of a minor or incompetent) whether:

- a. the payment received from the third party, or its insurer, is the result of:
 - 1) a legal judgment; or
 - 2) an arbitration award; or
 - 3) a compromise settlement; or
 - 4) any other arrangement; or
- b. the third party, or its insurer, has admitted liability for the payment; or
- c. the medical or dental charges or loss of earnings are itemized in the third party payment.

SECTION 4 - COORDINATION OF BENEFITS (COB)

COB may limit benefits when an individual is entitled to benefits from more than one source. It does this by relating an individual's total benefits from various sources to his or her total expenses. The COB provision is widely used in the insurance industry. Its purpose is to keep the cost of insurance down by limiting benefits to no more than 100% of his or her eligible expenses. Therefore, the benefits payable under this policy may be reduced, as appropriate under the rules set out below, so that from all sources, an insured individual should not be paid for more than 100% of his or her eligible expenses.

COB takes into consideration benefits from many sources, but COB does not apply to individual policies. (Except that, Lincoln National does coordinate with individual no-fault auto insurance policies, by whatever name called.)

Following is a list of the sources (plans) with which this policy coordinates:

1. Group insurance.
2. Other arrangements, whether insured or uninsured, covering individuals in a group.
3. Plans designed to pay a fixed-dollar benefit per day while the insured individual is hospital-confined, but which, at the time of claim, allow the individual to elect an alternate benefit.
4. Plans designed to pay a fixed-dollar benefit per day while the insured individual is hospital-confined. COB will only be applied to that portion of the daily benefit which exceeds \$30.00 per day.
5. Blue Cross and Blue Shield plans on a group basis.
6. Plans of other hospital or medical service organizations on a group basis.
7. Group practice plans.
8. Group pre-payment plans.
9. Coverage under Federal Government plans or programs.
10. Coverage required or provided by law.
11. Student insurance. (Except that, COB will not apply to accident-only coverage for grammar or high school students for which the parent pays the entire premium and which is sponsored by or provided through a school.)
12. Group auto insurance.
13. Individual no-fault auto insurance, by whatever name called.

Any plan(s) which do not have a COB provision, or one like it, pay first. For plan(s) having a COB provision, or one like it, these rules apply to determine which benefit plan pays first and the order in which the other plans follow:

1. The plan(s) which cover the patient as an employee/member will be considered before the plan(s) which cover the patient as a dependent.
2. For dependent children, the father's coverage will be considered before the mother's coverage. Except that, when the natural parents of a dependent child are divorced or otherwise separated, then these rules apply:
 - a. When the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be considered before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - b. When the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be considered before the benefits of a plan which covers that child as a dependent of his or her step-parent; and the benefits of a plan which covers that child as a dependent of the parent without custody will be considered last.
 - c. Except that, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, a. and b. above will not apply; instead, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be considered before the benefits of any other plan which covers the child as a dependent child.
3. In case the above rules still produce a conflict (such as when two plans cover the patient as an employee/member), the plan which has covered the patient the longest will be considered first.

COB only applies to medical and dental coverages. It does not apply to Life Insurance Benefits, Accidental Death Benefits or Weekly Income Benefits.

In determining total expenses, each item of expense will be considered by Lincoln National under this COB provision if it is payable in whole or in part by at least one of the sources whose benefits are being coordinated.

Benefits will be coordinated on a calendar year basis. This is called the "Claim Determination Period".

In order to make this COB provision work:

1. The insured individual, if requested, is required to furnish Lincoln National complete information concerning all sources and all benefits paid or payable from those sources.

2. As permitted by law, Lincoln National may, without the insured individual's consent:
- a. Obtain information from all plans which might be involved.
 - b. Release to such other plans any information it has.
 - c. Reimburse such other plans, to the extent necessary, if Lincoln National determines that benefits have been paid by another plan which should have been paid by Lincoln National. Such reimbursement will count as a valid payment under this plan.
 - d. Obtain reimbursement from any such other plan(s), and/or from the insured individual, if Lincoln National has paid benefits which should have been paid by any such other plan(s). Such reimbursement is a valid payment under the other plan(s).
 - e. Obtain repayment of whatever amount is appropriate for the proper working of this provision, if payment from all sources exceeds 100% of total expenses, and if Lincoln National determines that the 100% of eligible expenses was exceeded as a result of Lincoln National's payment.

SECTION 5
EXTENSION OF CERTAIN BENEFITS UPON END OF INSURANCE
WHILE TOTALLY DISABLED

If an insured individual is totally disabled on the day his or her insurance ends, the insurance under Home Health Care Benefits and Major Medical Benefits, will be extended solely for the illness causing that total disability. Such benefits will be extended only until the earlier of:

1. The end of that total disability; or
2. 12 months from the date his or her insurance ends.

SECTION 6 - CONVERSION

A. LIFE INSURANCE CONVERSION

1. If an employee's group term life insurance ends due to the end of his or her employment or the end of his or her membership in the eligible classes, he or she may convert such insurance to an individual policy of life insurance. If a dependent spouse or child's group term life insurance ends for reasons other than the ending of this policy, he or she may convert such insurance to an individual policy of life insurance. Evidence of Insurability will not be required.

The form of the life policy may be any then offered by Lincoln National, except term insurance, at the individual's then attained age and for the amount for which he or she applies. At the individual's option, the amount of such policy will be equal to or less than the amount of his or her group term life insurance under this policy.

The premium for such policy will be at Lincoln National's rate then in effect for:

- a. the form and amount of the policy;
 - b. the class of risk to which the individual then belongs; and
 - c. the individual's attained age on the effective date of the policy.
2. If an individual's group term life insurance ends because this policy ends or is amended to end Life Insurance Benefits, he or she may convert such insurance to an individual policy of life insurance. The form and premium will be as in 1. above, but the amount of insurance may not exceed the lesser of:
 - a. the amount of the group term life insurance the individual has under this policy less the amount of any life insurance for which he or she is or becomes eligible under any Group policy which replaces, within 31 days, his or her insurance that just ended under this policy; or
 - b. \$2,000
 3. The individual policy of life insurance:
 - a. will only be issued if application is made and the first premium is paid to Lincoln National within 31 days after the date on which the insured individual's group term life insurance under this policy ends;
 - b. will take effect at the end of this 31 day application period; and
 - c. will be issued without Disability or other added benefits.
 4. If benefits are paid under the Waiver of Premium Benefit or Extension of Life Insurance Benefits provisions of this policy, any policy issued under this Section will be void. The individual policy must be returned to Lincoln National for a refund of premium, and no claims under it will be paid.
 5. If an insured individual dies during the 31-day application period, Lincoln National will pay the maximum amount of insurance which the individual might have converted. The death

claim will be paid under the group policy and not the individual policy. Any premiums paid for the individual policy will be refunded.

6. The total amount of Life Insurance Benefits paid will never exceed the Amount of Insurance shown on the Schedule of Benefits. In no event will payment ever be made under more than one of the following:
 - a. Life Insurance Benefits;
 - b. Extension of Life Insurance Benefits;
 - c. Waiver of Premium Benefit; or
 - d. Any benefits resulting from this Conversion Section of this policy.

B. MEDICAL INSURANCE CONVERSION

1. An individual whose medical insurance ends for reasons other than the end of this policy may convert to an individual medical policy then being issued by Lincoln National.

The provisions of the individual policy will not be the same as the provisions of this policy. It will usually not include all the benefits of this policy, nor the same level of benefits as this policy. Upon request, Lincoln National will furnish complete details of the benefits available.

2. The individual policy may insure the following individuals if they were insured under this policy on the date their insurance ends:
 - a. the employee and his or her dependents;
 - b. the spouse of a deceased employee and that spouse's dependents;
 - c. the dependents of a deceased employee if the employee is not survived by a spouse;
 - d. a dependent child whose insurance ends because of his or her age or marriage;
 - e. the former spouse of an employee, when the ending of the marriage ends the spouse's insurance under this policy. Also, dependents of this former spouse, if their insurance ends solely because of the end of the marriage.
3. The individual must apply and pay the first premium for the individual medical policy to Lincoln National within 31 days from the time his or her insurance ends under this policy.
4. The individual policy will take effect on the day after the individual's group insurance ends.
5. The premium for the individual policy will be Lincoln National's scheduled premium based on the age and sex of the applicant.
6. This Section does not extend an individual's medical insurance under this policy beyond the date such insurance would otherwise end.
7. An individual whose medical insurance ends because this policy ends will not be entitled to convert to an individual medical policy.

CONTINUANCE OF INSURANCE

DURING LABOR DISPUTE

Notwithstanding any language to the contrary in the policy, if all or any part of the premium hereunder is customarily paid by an Employer pursuant to the terms of a collective bargaining agreement, then, in the event of cessation of work by all or any part of the employees insured hereunder as a result of a labor dispute, insurance hereunder, upon timely continued payment of premium hereunder on the first day of every month of the calendar during the period of cessation of work, will continue in effect with respect to all employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution, and who assume and pay the contribution due from the Employer, for the period of cessation of work, under the following conditions:

- a. If the Policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the Employer, the employee's individual contribution will, except as provided in paragraph e. below, be the rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy.
- b. If the Policyholder is a trustee or the trustees of a fund established or maintained in whole or in part by the Employer, the employee's individual contribution will, except as provided in paragraph e. below, be the amount which he and his employer would have been required to contribute to the trust for such employee if
 - 1) the cessation of work had not occurred, and
 - 2) the agreement requiring the Employer to make contributions to the trust were in full force.
- c. The continuation of insurance is contingent upon the collection of individual contributions by the union or unions representing the employees for policies referred to in paragraph a. above, by the Policyholder or the Policyholder's agent with respect to policies referred to in paragraph b. above, and with respect to employees insured under a policy referred to in paragraph a. above who are not in a bargaining unit represented by a union, the Policyholder or the Policyholder's agent.
- d. The continuation of insurance on each employee is contingent upon timely payment of the premium with respect to such employee by the entity responsible for collecting his individual contributions.
- e. Each individual premium rate applicable to such an employee during the period of cessation of work will be increased by twenty percent (20%) of that rate otherwise actually being charged at the commencement of work stoppage, and this will have the effect of increasing the employee's contribution by a like percent.

- f. If a premium is unpaid at the date of cessation of work and such premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of such premium prior to the date the next premium becomes due under the terms of the policy.
- g. The entity responsible for premium collection, as indicated in paragraph c. above, will maintain a record which will show at all times the names of employees whose insurance is continued under this provision, and the date each employee became insured under this provision.

The entity responsible for premium collection will furnish periodically to the Lincoln National such information relative to terminations of insurance as the Lincoln National may require for the administration of the insurance hereunder.

Nothing herein will be deemed to require the continuation of any Weekly Income Benefits included in any group disability policy, nor of any other coverages beyond the time that less than seventy-five percent (75%) of the employees continue such coverage or as to any individual employee beyond the date that he takes full-time employment with another employer; nor shall anything herein be deemed to provide continuation of coverage more than six (6) months after the cessation of work.

SECTION 7 - GENERAL INFORMATION

A. INDIVIDUALS ELIGIBLE

The individuals eligible for insurance are shown on the Schedule of Benefits.

Each employee must fill out and sign an enrollment card approved by Lincoln National.

B. INSURANCE BENEFITS

Benefits for each insured individual will be determined from information in the Benefits Section of this policy.

Any change in the amount of an individual's insurance caused by a change in classification will be effective on the Classification Change Date shown on the Schedule of Benefits, EXCEPT THAT:

1. If the insured employee is not actively at work on a full-time basis on the date his or her insurance or his or her dependents' insurance would increase due to a change in classification, such increase will not be effective until the employee returns to active, full-time work; and
2. The amount of insurance for a dependent will not be increased while the dependent is confined in a hospital or skilled nursing facility. Such increase will only become effective on the day after his or her final discharge from the hospital or skilled nursing facility.

C. EFFECTIVE DATES OF INSURANCE

An individual's insurance will be effective as follows:

1. EMPLOYEES

If the Schedule of Benefits shows that employee insurance is non-contributory, an employee's insurance will be effective on the day he or she becomes eligible.

If the Schedule of Benefits shows that employee insurance is contributory, each employee who both applies for insurance on a form approved by Lincoln National, and agrees in writing to pay the required contributions, will become insured as follows:

- a. if the employee applies within 31 days of the date he or she first becomes eligible, he or she will be insured on the later of:
 - 1) the date he or she applies; or
 - 2) the date he or she becomes eligible.

- b. if the employee applies after:
 - 1) 31 days from the date he or she first becomes eligible; or
 - 2) he or she previously elected to end his or her insurance,

he or she must then furnish evidence of insurability, at his or her own expense, to Lincoln National before he or she may be considered for insurance. If Lincoln National approves insurance for that employee, he or she will become insured on the date of Lincoln National's approval.

2. DEPENDENTS

If the Schedule of Benefits shows that dependent insurance is non-contributory, a dependent's insurance will be effective on the date he or she becomes eligible. The employee must be insured in order for his or her dependents to be insured.

If the Schedule of Benefits shows that dependent insurance is contributory, the employee who both applies for dependent insurance on a form approved by Lincoln National and agrees in writing to pay the required contributions for dependents will become insured for his or her dependents as follows:

- a. if the employee applies within 31 days after the date he or she became eligible for dependents' insurance, his or her dependents will be insured on the later of:
 - 1) the date the employee applies for dependents' insurance; or
 - 2) the date the employee becomes insured.
- b. if the employee applies after:
 - 1) 31 days from the date he or she became eligible for dependents' insurance; or
 - 2) he or she previously elected to end the insurance for his or her dependents while continuing to have dependent(s) eligible;

his or her dependent(s) will not be considered for insurance until the employee furnishes to Lincoln National evidence of insurability, at his or her own expense, for each dependent he or she wants to enroll. Insurance for those dependents must be approved by Lincoln National, and will only become effective on the date of Lincoln National's approval.

A newly acquired dependent will be automatically insured if the employee is already insured for dependents' insurance. Except that, if an insured employee acquires his or her first newborn child while not insured for dependents' insurance that child may become insured without evidence of insurability. If the employee applies for dependent insurance prior to the child's birth, dependent insurance for that child will be effective on the date of that child's birth. If the employee applies for dependents' insurance within 31 days of the date of the child's birth, dependents' insurance for that child will be effective on the date the employee applies. If the employee applies after 31 days after the date of the child's birth, evidence of insurability will be required in order for that child to become insured.

3. EMPLOYEES AND DEPENDENTS

- a. if an individual is not eligible because:

- 1) the employee is not actively working for the Employer;
and/or

- 2) the dependent is confined in a hospital or skilled nursing facility,

the employee will not become insured until the day he or she returns to full-time active work;

the dependent will not become insured if the employee is not insured, or if the dependent is confined in a hospital or skilled nursing facility.

- b. once an individual is required to submit evidence of insurability in order to become insured under this policy, and does not submit it, that individual will continue to be subject to such requirement regardless of:

- 1) changes in this policy;
- 2) changes in employment;
- 3) changes in eligibility.

D. NOTICE AND PROOF OF CLAIM

1. NOTICE - 20 DAYS

- a. Written notice of claim must be given to Lincoln National within 20 days of the date of any:
 - 1) loss of weekly income; and/or
 - 2) expenses incurred.
- b. If notice is not given within 20 days, a claim will not be denied or reduced if notice was given as soon as was reasonably possible.
- c. When Lincoln National receives notice of claim, forms for filing proof of claim will be furnished to the insured individual. If these forms are not furnished to the insured individual within 15 days from the time notice is received by Lincoln National, the insured individual will have met the proof of loss requirements if written proof of loss is submitted within the time required.

2. PROOF - 90 DAYS

- a. Proof of claim for hospital confinement must be given to Lincoln National within 90 days after release from hospital.
- b. Proof of any other loss must be given to Lincoln National not later than 90 days after loss.
- c. If proof of any claim is not given within 90 days, the claim will not be denied or reduced if that proof was given as soon as was reasonably possible.
- d. "Proof" as required in this subsection means proof satisfactory to Lincoln National.

3. EXAMINATION

- a. Lincoln National, at its own expense, will have the right to have an insured individual examined, as often as it may require, whenever his or her illness is the basis of a claim.

- b. Lincoln National will have the right to require an autopsy, if not prohibited by law.

E. PAYMENT OF CLAIM

1. Benefits Paid for other than Loss of Life

All of these benefits will be paid to the employee, unless Lincoln National determines that he or she is unable to receive such payment because he or she is not legally able to give a binding receipt for it.

If Lincoln National determines that the employee is not legally able to receive such payment, Lincoln National may, at its option, pay the benefits to the employee's estate or to any or all of the following relatives of the employee:

- a. spouse;
- b. child(ren);
- c. parent(s);
- d. brother(s); or
- e. sister(s).

Any payment made under this option will completely discharge Lincoln National from further obligation for such payment.

Lincoln National reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to the insured individual and to any assignees. Such actions will be binding on the insured individual and on his or her assignees.

2. Benefits Paid for Loss of Life

Benefits for loss of life will be paid to the beneficiary named by the insured employee. The name of the beneficiary must be filed with Lincoln National on a form and in a manner approved by Lincoln National. The employee may change his or her beneficiary at any time if he or she files such change with Lincoln National on a form and in a manner approved by Lincoln National. Any payment made by Lincoln National before its receipt of notice of such change will fully discharge Lincoln National's obligation for such payment.

- a. If two or more beneficiaries are named, and if the employee did not state their respective interests, they will share equally. If any of such beneficiaries die before the employee does, his or her interest will pass to the surviving beneficiaries equally.
- b. If the employee fails to name a beneficiary for all or a part of his or her insurance, or if no named beneficiary survives the employee, payment will be made to the employee's estate or, at Lincoln National's option, to:
 - 1) the employee's spouse, if living; otherwise
 - 2) the employee's then living children, if any; otherwise
 - 3) the employee's surviving parent(s), equally.

Any payment made under this paragraph b. will completely discharge Lincoln National from further liability for the amount paid.

- c. The most recently named beneficiary under the Conversion Section of this policy will be used for any claims under the Extension of Life Insurance Benefits or Waiver of Premium Benefit provisions of this policy.

3. Benefits Paid for Loss of Life - Dependent

Benefits for loss of life of a dependent of an employee will be paid to the employee. If the employee dies before such dependent does, benefits will be paid to the beneficiary named by the employee.

F. CHOICE OF DOCTOR

The insured is free to be treated by any doctor he or she chooses.

G. WORKER'S COMPENSATION

This policy is not a worker's compensation policy. This policy does not satisfy any requirements for coverage by worker's compensation insurance.

H. LAWSUITS

No lawsuit may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such lawsuit may be brought after 3 years from the time written proof of loss is required to be given.

J. STATEMENTS

In the absence of fraud, all statements made by the insured individual and his or her dependents will be deemed representations and not warranties. No such representations will void the insurance or be used to deny a claim unless a copy of the instrument containing such representation is or has been furnished to the insured individual or to his or her beneficiary, if any.

K. END OF INDIVIDUAL'S INSURANCE

An individual's insurance will end automatically on the earliest of the following dates:

1. The date this policy ends;
2. The end of the last period for which any required contribution agreed to in writing has been made;
3. The date after which he or she is no longer eligible for insurance;
4. The date the employee's employment with the Employer ends. For the purposes of this policy, an employee's employment will end on the last day of the month in which employment ends. EXCEPT THAT: The policyholder may, at its option, continue insurance as shown below for individuals whose employment has ended, if it does so

without individual selection between employees and if it continues making premium payments for those individuals.

Insurance may be continued for all benefits for:

- a. up to two months if such employee is employed on a part-time basis; or
- b. up to two months if such employee is on an approved leave of absence; or
- c. up to two months if such employee is temporarily laid off; or
- d. longer than shown above if such employee is unable to work because of disability. Except that, life insurance may only be continued for 12 months for employees who become totally disabled prior to age sixty.

The Policyholder may, at its option, continue dependents' insurance for up to twelve months after the employee's death, if it does so without individual selection among employees and if it continues making premium payments for those individuals.

No benefits are payable for charges incurred after an individual's insurance ends, except as provided in Section 5 of this policy.

NOTE: See Section 6 - Conversions.

L. MISSTATEMENT OF AGE

For Life Insurance Benefits, if the age of any insured individual has been misstated, the premium may be adjusted. If the amount of insurance would be affected by such misstatement, it will be changed to the amount the insured individual would have had at his or her correct age, and the premium will be based on the corrected age and amount.

M. LIFE INSURANCE INCONTESTABILITY

1. Policyholder

The validity of the Life Insurance Benefits provision of this policy will not be contested, except for nonpayment of premium by the Policyholder, after this policy has been in force for at least two consecutive years from its Date of Issue.

2. Insured Individual

No statement made by an insured individual relating to his or her insurability for life insurance under this policy will be used in contesting the validity of the insurance with respect to which the statement was made, after such insurance has been in force, prior to the contest, for a period of two consecutive years during such insured individual's lifetime, nor unless it is contained in a written instrument signed by that individual.

SECTION 8 - POLICYHOLDER

A. EFFECT OF ACTIONS OF POLICYHOLDER

In all matters regarding this policy, the Policyholder acts for the Employer and for all Subsidiaries and Affiliates shown on the Face Page of this Policy. Each agreement made with the Policyholder will be binding on all such parties. Each notice given to the Policyholder will be deemed to have been given to all such parties.

B. RECORD OF EMPLOYEES INSURED

As required to administer this insurance, the Policyholder will furnish to Lincoln National information about individuals:

1. Who qualify to become insured;
2. Whose amounts of insurance change; and/or
3. Whose insurance ends.

If the Policyholder makes an error in furnishing such information, this policy will be administered as if the correct information had been furnished.

Lincoln National may check Employer's and/or Policyholder's records which, in the opinion of Lincoln National, relate to this insurance.

C. PAYMENT OF PREMIUMS

All premiums due for this policy, including any adjustments, are to be paid by the Policyholder on or before their due dates. The due date is stated on the Face Page of this policy. Premiums will only be considered paid when they are received at the Home Office of Lincoln National in Fort Wayne, Indiana (or, at Lincoln National's option, at a specified Lincoln National Depository Facility). The payment of any Renewal Premium will not keep this insurance in force beyond the day just before the next Renewal Premium due date, except as provided in D. below.

D. GRACE PERIOD

If the Policyholder does not pay in full any Renewal Premium on or before its due date, the Policyholder will have a grace period in which to pay that Renewal Premium. This policy will remain in force during the grace period. If the premium is not paid in full before the grace period ends, this policy will end on the last day of the grace period.

The grace period will end 31 days after the premium due date. If the Policyholder gives written notice to Lincoln National at its Home Office, before or during the grace period, that it desires to end this policy before the end of the grace period, this policy will end either on the date the notice is received by Lincoln National at its Home Office, or on the date stated in the notice, whichever is later.

ON THE DATE THIS POLICY ENDS, THE POLICYHOLDER MUST PAY LINCOLN NATIONAL ALL PREMIUMS THEN DUE, INCLUDING ANY PREMIUM DUE FOR THE GRACE PERIOD OR FOR ANY PART OF THE GRACE PERIOD.

E. PREMIUM ADJUSTMENT

No unearned premium will be returned to the Policyholder for any period prior to the most recent policy anniversary.

F. PREMIUM REFUNDS - EMPLOYEE PORTION

If any insurance under this policy is contributory, any premium refund in excess of an amount which equals the Policyholder's contribution to premium must be used for the sole benefit of the employees. The Policyholder, not Lincoln National, will be responsible for seeing that premium refunds are so used.

G. REPRESENTATIONS

In the absence of fraud, the Policyholder's statements are deemed representations, not warranties.

H. EMPLOYEE CERTIFICATE

The Policyholder will deliver to each insured employee a certificate issued by Lincoln National.

I. EMPLOYEE IDENTIFICATION CARDS

If Lincoln National furnishes identification cards for verification of coverage, the Policyholder will deliver them to each insured employee. When an employee's insurance ends, the Policyholder will collect all such cards from the employee. The Policyholder will be responsible for any benefits paid in error, if such payment is made because the Policyholder failed to collect a card from an employee whose insurance has ended or if the Policyholder failed to promptly notify Lincoln National that an employee's coverage has ended.

SECTION 9 - LINCOLN NATIONAL

A. COMPUTATION OF PREMIUMS

1. Premiums for this policy will be based on Lincoln National's rates, adjusted to reflect Lincoln National's underwriting risk. Lincoln National may change these premiums:

- a. on any Policy Anniversary; or
- b. on any premium due date (if Lincoln National notifies the Policyholder of the change at least 31 days before such premium due date); or
- c. whenever the terms of this policy are changed.

The premiums may not be changed as stated in b. above during the first 12 months after the Date of Issue.

Any changed premiums will apply to all future premiums as well as to the one then due.

2. If premiums are payable on a basis other than monthly, and if a change occurs during a premium pay period which affects premiums, a pro rata charge or credit will be made for such change on the next closest premium due date.
3. Premiums may also be figured by any other method upon which Lincoln National and the Policyholder have agreed.

B. NON-PARTICIPATING POLICY

This policy does not share in the profits of Lincoln National.

C. EXPERIENCE PREMIUM REFUNDS

1. At Lincoln National's sole discretion, an experience premium refund may be made. Both the amount of such refund, if any, and the method of calculating it, will also be at Lincoln National's sole discretion. In the process of calculating whether a refund is due, Lincoln National will combine the experience of this policy with the experience of any other group policies issued to this Policyholder by Lincoln National or its Affiliates. A refund calculation will be made at the end of each refunding period. A refunding period may only end on a policy anniversary. A refund may only be made if, at the end of a refunding period:

- a. the required number of employees is insured; and
- b. the required amount of premium has been accumulated; and
- c. this policy is in force; and
- d. all premiums have been paid.

2. Any premium refunded will, at the Policyholder's option:

- a. be paid in cash to the Policyholder; or
- b. either be held by Lincoln National in a Premium Stabilization Fund, or be used for future premium payments.

D. AMENDMENT AND ALTERATION OF CONTRACT

1. This policy may be amended or changed at any time by written agreement between the Policyholder and Lincoln National.
2. This policy may also be amended by Lincoln National when it determines that such amendment is required for consistent application of policy provisions due to new or amended legislation or due to new medical discoveries or procedures. The Policyholder will be notified of such amendment, in writing, at least 60 days prior to its effective date. Payment of premium beyond the effective date of the amendment constitutes the Policyholder's consent to the amendment.
3. Only an Officer of Lincoln National may change, amend, alter, or waive in any manner the provisions of this policy, and then only when in writing and signed by the Officer.
4. Lincoln National will not be bound by any promise made by any agent or person other than an Officer of Lincoln National.

E. END OF POLICY DUE TO LOW ENROLLMENT

Lincoln National may end this policy on any premium due date by giving written notice to the Policyholder at least 31 days in advance of that date, if:

1. On any two premium due dates in a row, the number of employees insured is less than 10 (if there were fewer than 25 employees insured on the Date of Issue or on the date this policy was last amended); or
2. On any two premium due dates in a row, the number of employees insured is less than 25 (if there were 25 or more employees insured on the Date of Issue or on the date this policy was last amended); or
3. The percentage of eligible employees insured is less than 100%.

F. EMPLOYEE'S CERTIFICATE

Lincoln National will issue to the Policyholder, for delivery to each insured employee, an individual certificate. It will describe:

1. The coverage provided; and
2. To whom benefits are to be paid; and
3. The limitations or requirements of this policy that may apply to insured individuals.

The certificate is not a part of this policy.

G. NON-WAIVER OF POLICY PROVISIONS

Failure of Lincoln National to insist on compliance with any of the provisions of this policy at any given time under any given set of

circumstances will not operate; with respect to any other time or as to any other occurrence, whether the circumstances are, or are not, the same, to:

1. waive or modify such provisions; or
2. in any way render it unenforceable.

SECTION 10 - RECORDS

1. Lincoln National will maintain a record which will show at all times:
 - a. the names of all employees insured; and
 - b. the beneficiary(ies), if any, named by each employee; and
 - c. the date on which each employee became insured; and
 - d. the effective date of any increase or decrease in the amount of each employee's insurance; and
 - e. such other information as may be required to administer this insurance.
2. Lincoln National will furnish the Policyholder with a copy of such record, as of the Date of Issue of this policy, and will report to the Policyholder all changes in such record.