

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. GL 000010094366 has been issued to
Cortina Systems, Inc.
(The Group Policyholder)

The Issue Date of the Policy is October 1, 2007.

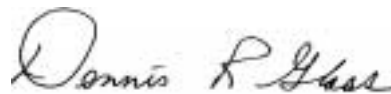
The insurance is effective only if the Employee is eligible for insurance and becomes and remains insured as provided in the Group Policy.

Certificate of Insurance for Class 1

The Employee is entitled to benefits described in this Certificate if the Employee is eligible for insurance under the provisions of the Policy and according to the records of the Employer.

This Certificate replaces any other certificate previously issued for the benefits described inside. As a Certificate of insurance, this does not constitute a contract of insurance, it summarizes the provisions of the Policy and is subject to the terms of the Policy.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE. If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in its sale, or if you have additional questions; then you may contact the insurance company at the above address or phone them at 1-800-423-2765. If unable to obtain satisfaction from the company or agent, you may contact the state regulatory agency at California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, Los Angeles, CA 90013, or phone them at 1-800-927-4357. Please have your policy number available.



President

CERTIFICATE OF GROUP LONG TERM DISABILITY INSURANCE

SCHEDULE OF BENEFITS

ELIGIBLE CLASS means: Class 1 All Full-Time Employees

MINIMUM HOURS PER WEEK: 30

LONG-TERM DISABILITY BENEFITS

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates" section)

BENEFIT PERCENTAGE: 60%

MAXIMUM MONTHLY BENEFIT: \$9,000

MINIMUM MONTHLY BENEFIT: \$100 or 10% of the Insured Employee's Monthly Benefit, whichever is greater

Long-Term Disability Benefits for PRE-EXISTING CONDITIONS will be subject to the Pre-Existing Condition Exclusion on the Exclusion page.

ELIMINATION PERIOD: 180 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 360 calendar day period.

MAXIMUM BENEFIT PERIOD: (For Sickness, Injury or Pre-Existing Condition): The Insured Employee's Social Security Normal Retirement Age, or the Maximum Benefit Period shown below (whichever is later).

| <u>Age at Disability</u> | <u>Maximum Benefit Period</u> |
|--------------------------|-------------------------------|
| Less than Age 60 | To Age 65 |
| 60 | 60 months |
| 61 | 48 months |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 and Over | 12 months |

OWN OCCUPATION PERIOD means a period beginning at the end of the Elimination Period and ending 24 months later for Insured Employees.

TABLE OF CONTENTS

| | |
|--|----|
| Definitions..... | 3 |
| General Provisions | 8 |
| Claims Procedures | 9 |
| Eligibility | 12 |
| Effective Dates..... | 12 |
| Individual Termination | 14 |
| Conversion Privilege..... | 15 |
| Total Disability Monthly Benefit | 16 |
| Partial Disability Monthly Benefit | 17 |
| Other Income Benefits | 19 |
| Recurrent Disability | 21 |
| Exclusions | 22 |
| Specified Injuries or Sicknesses Limitation..... | 23 |
| Voluntary Vocational Rehabilitation Benefit Provision | 24 |
| Reasonable Accommodation Benefit..... | 25 |
| Prior Insurance Credit Upon Transfer of Insurance Carriers | 26 |
| Family Income Benefit..... | 27 |
| Notice | 28 |

DEFINITIONS

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

ACTIVE WORK or **ACTIVELY-AT-WORK** means an Employee's full-time performance of all main duties of such Employee's occupation at:

1. the Employer's usual place of business; or
2. any other business location to which the Employer requires the Employee to travel.

Unless Disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except a medical leave) of 30 days or less.

BASIC MONTHLY EARNINGS or **PREDISABILITY INCOME** means the Insured Employee's average monthly base salary or hourly pay from the Employer before taxes on the Determination Date. The "Determination Date" is the last day worked just prior to the date the Disability begins.

It also includes:

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

It does **not** include bonuses, overtime pay, or any other extra compensation. It does not include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Monthly Earnings permitted by the Policy; whichever is less. (Maximum Covered Monthly Earnings equals the Maximum Monthly Benefit divided by the Benefit Percentage shown in the Schedule of Benefits.) Exception: For purposes of determining the amount of the Partial Disability Monthly Benefit, Basic Monthly Earnings will not exceed the amount shown in the Employer's financial records.

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

DEFINITIONS
(continued)

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

DISABLED or **DISABILITY** means Totally Disabled and/or Partially Disabled.

ELIGIBILITY WAITING PERIOD means the period of time that:

1. begins with an Employee's most recent date of employment with the Employer; and
2. ends on the day prior to the day such Employee is eligible for coverage under the Policy.

ELIMINATION PERIOD means the number of days of Disability during which no benefit is payable. The Elimination Period is shown in the Schedule of Benefits. It applies as follows.

1. The Elimination Period:
 - (a) begins on the first day of Disability; and
 - (b) is satisfied when the required number of days is accumulated within a period which does not exceed two times the Elimination Period.

During a period of Disability, the Insured Employee may return to full-time work, at his or her own or any other occupation, for an accumulated number of days not to exceed the Elimination Period.

2. Only days of Disability due to the same or a related Sickness or Injury will count towards the Elimination Period. Days on which the Insured Employee returns to full-time work will not count towards the Elimination Period.

EMPLOYEE means a person:

1. whose employment with the Employer is:
 - (a) on a regular full-time basis;
 - (b) the person's principal occupation; and
 - (c) for regular wage or salary;
2. who is regularly scheduled to work at such occupation at least the minimum number of hours shown in the Schedule of Benefits; and
3. who is a member of an Eligible Class which is eligible for coverage under the Policy;
4. who is not a temporary or seasonal employee; and
5. who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Policyholder and includes any division, subsidiary or affiliated company named in the Application.

EVIDENCE OF INSURABILITY means a statement of proof of an Employee's medical history. The Company uses this to determine his or her acceptance for insurance, or for an increased amount of insurance. Such proof will be provided at the Employee's own expense, for an Employee who declines or fails to enroll within 31 days of first becoming eligible..

DEFINITIONS
(continued)

FAMILY OR MEDICAL LEAVE means a leave of absence which is approved in writing by the Employer; and which is subject to:

1. the federal Family and Medical Leave Act of 1993, and any amendments to it; or
2. any similar state law requiring the Employer to grant family or medical leaves.

INSURED EMPLOYEE means an Employee for whom Policy coverage is in effect.

INJURY means bodily injury which is caused by and results directly from an accident, independently of all other causes. For purposes of determining benefits under the Policy, a Disability will be considered due to an Injury only if:

1. the Disability begins within 90 days after the Injury; or
2. the Injury occurred while the Employee was insured under the Policy.

The term "Injury" shall **not** include any:

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

DEFINITIONS (continued)

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job duties which:

1. are normally required to perform the Insured Person's regular occupation; and
2. cannot reasonably be modified or omitted.

It includes those main duties as performed in the usual and customary way in the general workforce; **not** as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services which are consistent with the symptoms or diagnosis causing the Insured Employee's Disability. Such treatment must be rendered:

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

MONTHLY BENEFIT means the amount payable monthly by the Company to the Insured Employee who is Totally or Partially Disabled.

OWN OCCUPATION PERIOD means a period as shown in the Schedule of Benefits.

PARTIALLY DISABLED or **PARTIAL DISABILITY** shall be as defined in the Partial Disability Monthly Benefit sections.

PARTIAL DISABILITY EMPLOYMENT means the Insured Employee is working at his or her own or any other occupation; but because of a Partial Disability:

1. the Insured Employee's hours or production is reduced;
2. one or more main duties of the job are reassigned; or
3. the Insured Employee is working in a lower-paid occupation.

His or her current earnings must be at least 20% of Predisability Income, and may not exceed the percentage specified in the Partial Disability Benefit section.

PHYSICIAN means:

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

The medical doctor or other medical practitioner must be acting within the scope of his or her license; and must be qualified to provide medically appropriate treatment for the Insured Employee's disabling condition.

Physician does **not** include the Insured Employee or a relative of the Insured Employee receiving treatment. (Relatives include the Insured Employee's spouse, siblings, parents, children and grandparents; and his or her spouse's relatives of like degree.)

POLICY means the Group Long Term Disability Insurance Policy issued by the Company to the Policyholder.

POLICYHOLDER means the person, individual, firm, trust or other organization as shown on the Face Page of this Certificate.

PREDISABILITY INCOME - See Basic Monthly Earnings.

DEFINITIONS
(continued)

REGULAR CARE OF A PHYSICIAN or **REGULAR ATTENDANCE OF A PHYSICIAN** means the Insured Employee:

1. personally visits a Physician, as often as medically required according to standard medical practice to effectively manage and treat his or her disabling condition; and
2. receives medically appropriate treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION or **OWN OCCUPATION** means the occupation, trade or profession:

1. in which the Insured Employee was employed with the Employer prior to Disability; and
2. which was his or her primary source of earned income prior to Disability.

It includes any work in the same occupation for pay or profit; whether such work is with the Employer, with some other firm or on a self-employed basis. It includes the main duties of that occupation as performed in the usual and customary way in the general workforce; **not** as performed for a certain firm or at a certain work site.

SICK LEAVE or **ANY SALARY CONTINUANCE PLAN** means a plan which:

1. is established and maintained by the Employer for the benefit of Insured Employees; and
2. continues payment of all or part of an Insured Employee's Predisability Income for a specified period after he or she becomes Disabled.

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

SICKNESS means illness, pregnancy or disease.

TOTAL COVERED PAYROLL means the total amount of Basic Monthly Earnings for all Employees insured under the Policy.

TOTAL DISABILITY or **TOTALLY DISABLED** shall be defined in the Total Disability Monthly Benefit section.

GENERAL PROVISIONS

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy as to any Insured Employee, after it has been in force for two years during his or her lifetime.

RESCISSION. The Company has the right to rescind any insurance for which evidence of insurability was required, if:

1. an Insured Employee incurs a claim during the first two years of coverage; and
2. the Company discovers that the Insured Employee made a material misrepresentation on his or her enrollment form.

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

MISSTATEMENTS OF FACTS. If relevant facts about any person were misstated:

1. a fair adjustment of the premium will be made; and
2. the true facts will decide if and in what amount insurance is valid under the Policy.

If an Insured Employee's age has been misstated; then any benefits shall be in the amount the paid premium would have purchased at the correct age.

POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Policyholder acts on its own behalf or as Agent of the Employee. Under no circumstances will the Policyholder be deemed the Agent of the Company.

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

CLAIMS PROCEDURES

NOTICE OF CLAIM. Written notice of claim must be given during the Elimination Period. The notice must be sent to the Company's Group Insurance Service Office. It should include:

1. the Insured Employee's name and address; and
2. the number of the Policy.

If this is not possible, written notice must be given as soon as it is reasonably possible.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms to the Insured Employee. If the Company does not send the forms within 15 days; then the Insured Employee may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send the Insured Employee additional Claim Forms.

PROOF OF CLAIM. The Company must be given written proof of claim within 90 days after the end of the Elimination Period. When it is not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason; if the proof is filed:

1. as soon as reasonably possible; and
2. in no event later than one year after it was required.

These time limits will not apply while an Insured Employee lacks legal capacity.

Proof of claim must be provided at the Insured Employee's own expense. It must show the date the Disability began, its cause and degree. Documentation must include:

1. completed statements by the Insured Employee and the Employer;
2. a completed statement by the attending Physician, which must describe any restrictions on the Insured Employee's performance of the duties of his or her regular occupation;
3. proof of any other income received;
4. proof of any benefits available from other income sources, which may affect Policy benefits;
5. a signed authorization for the Company to obtain more information; and
6. any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, regular care of a Physician, and any other income benefits affecting the claim must be given to the Company, upon request. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have the Insured Employee examined:

1. by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
2. as often as reasonably required.

The Company may deny or suspend benefits for an Insured Employee who fails to attend an exam or to cooperate with the examiner, without good cause. The Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Benefits will be payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. After that:

1. Any Long Term Disability benefits will be paid monthly, during any period for which the Company is liable. If benefits are due for less than a month; then they will be paid on a pro rata basis. The daily rate will equal 1/30 of the monthly benefit.
2. Any balance, which remains unpaid at the end of the period of liability, will be paid within 15 days after the Company receives complete proof of claim and confirms liability.

CLAIMS PROCEDURES (continued)

Interest on Late Claims. Any disability income benefits will accrue interest from the 31st day, if the Company fails to:

1. send a delay notice, within 30 days after receiving the initial proof of claim; or
2. make a disability income benefit payment or send a notice of its claim decision, within 30 days after receiving complete proof of claim and enough information to determine liability.

In that event, simple interest will accrue at the rate of 10% per year. But interest will not accrue while the Company is waiting for relevant information requested from the Insured Employee, the Employer, or a health care provider; or is investigating a report of possible fraud.

TO WHOM PAYABLE. All benefits are payable to the Insured Employee, while living. After his or her death, benefits will be payable as follows.

1. Any Survivor Benefit will be payable in accord with that section.
2. Any other benefits will be payable to the Insured Employee's estate.

If a benefit becomes payable to the Insured Employee's estate, a minor or any other person who is not legally competent to give a valid receipt; then up to \$2,000 may be paid to any relative of the Insured Employee that the Company finds entitled to payment. If payment is made in good faith to such a relative; then the Company will not have to pay that benefit again.

NOTICE OF CLAIM DECISION. The Company will send the Insured Employee a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

1. the reason for the denial under the terms of the Policy and any internal guidelines;
2. whether more information is needed to support the claim; and
3. how the Insured Employee may request a review of the decision by the Company, or by the state Department of Insurance. It will include the address and phone number of their consumer complaint unit.

This notice will be sent within 15 days after the Company receives complete proof of claim and enough information to determine liability. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. If the Company needs more than 15 days to process the claim, due to matters beyond its control; then an extension will be permitted. If needed, the Company will send the Insured Employee a written delay notice:

1. by the 15th day after receiving the first proof of claim; and
2. every 30 days after that, until the claim is resolved.

The notice will explain:

1. what additional information is needed to resolve the claim; and
2. when a decision can be expected.

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

Exception: If the Company needs more information from the Insured Employee to process the claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

CLAIMS PROCEDURES **(continued)**

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, the Insured Employee may request a claim review by sending the Company:

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

The Insured Employee may review certain non-privileged information relating to the request for review.

The Company will review the claim and send the Insured Employee a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

1. any further appeal procedures available under the Policy;
2. the right to access relevant claim information; and
3. the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

Exception: If the Company needs more information from the Insured Employee to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant must exhaust available administrative remedies. Under this Policy, the Insured Employee must first seek two administrative reviews of the adverse claim decision, in accord with this provision. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

1. reduce future benefits until full reimbursement is made; and
2. recover such overpayments from the Insured Employee or his or her estate.

Such reimbursement is required whether the overpayment is due to:

1. the Company's error in processing a claim;
2. the Insured Employee's receipt of Other Income Benefits;
3. fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until sixty days after the required written proof of claim has been given. No legal action may be brought more than three years after the date written proof of claim is required.

ELIGIBILITY

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

ELIGIBILITY DATE. An Employee becomes eligible for coverage provided by the Policy on the later of:

1. the Policy's effective date; or
2. the date the Employee satisfies the Waiting Period.

Prior service in an Eligible Class will apply toward the Waiting Period, when:

1. a former Employee is rehired within one year after his or her employment ends; or
2. an Employee returns from a Family or Medical Leave within the leave period required by federal or state law (whichever is greater).

EFFECTIVE DATES

EFFECTIVE DATE. Except as stated in the Delayed Effective Date provision, coverage for an Employee becomes effective at 12:01 a.m. on the latest of:

1. the date the Employee becomes eligible for coverage;
2. the date the Employee makes written application for coverage; and signs:
 - (a) a payroll deduction order, if the Employees pay any part of the Policy premiums; or
 - (b) an order to pay premiums from the Employee's Flexible Benefits Plan account, if premiums are paid through such an account; or
3. the date the Company approves the Employee's evidence of insurability, if required.

Evidence of insurability satisfactory to the Company must be submitted (at the Employee's expense) if:

1. written application for coverage (or an increased amount of coverage) is made more than 31 days after the Employee becomes eligible for such coverage;
2. coverage is elected after the Employee has requested:
 - (a) to terminate the insurance;
 - (b) to stop payroll deductions for the insurance; or
 - (c) to stop premium payments through a Flexible Benefits Plan account;
3. coverage is elected after the Employee has caused insurance to lapse by failing to pay the required premium when due; or
4. optional, supplemental, voluntary or Buy-Up Benefit coverage is elected in excess of any guaranteed issue amounts shown in the Schedule of Benefits.

DELAYED EFFECTIVE DATE. An Employee's Effective Date of any initial, increased or additional coverage will be delayed; if such Employee is not Actively-at-Work on the date that coverage would otherwise be effective. Coverage will take effect on the Employee's second consecutive day of Active Work.

EFFECTIVE DATE FOR CHANGE IN ELIGIBLE CLASS. An Insured Employee may become a member of a different Eligible Class. Except as stated in the Delayed Effective Date provision, coverage under the different Eligible Class will be effective:

1. immediately, if the different Eligible Class involves any reduction in coverage; or
2. the first day of the month after the Insured Employee has been Actively-at-Work for at least 15 days, as a member of a different Eligible Class; if the different Eligible Class involves enhancement of any coverage.

REINSTATEMENT AFTER FAMILY OR MEDICAL LEAVE. A new Waiting Period and evidence of insurability will be waived for an Employee, upon return from an approved Family or Medical Leave, provided:

1. the Employee returns within the leave period required by federal or state law (whichever is greater);
2. the Employee applies for insurance or is enrolled under the Policy within 31 days after resuming Active Work; and
3. the reinstated amount of insurance does not exceed the amount which terminated.

If the above conditions are met, the months of leave will count towards any unmet Pre-Existing Condition Exclusion period; and a new Pre-Existing Condition Exclusion will not apply to the reinstated amount of insurance. A new Pre-Existing Condition Exclusion will apply to any increased amount of insurance, however.

INDIVIDUAL TERMINATION

INDIVIDUAL TERMINATION OF COVERAGE. An Insured Employee's coverage will terminate at 12:00 midnight on the earliest of:

1. the date the Policy or the Employer's participation terminates; but without prejudice to any claim incurred prior to termination;
2. the date the Insured Employee's Class is no longer eligible for insurance;
3. the date such Insured Employee ceases to be a member of an Eligible Class;
4. the end of the period for which the last required premium has been paid; or
5. the date on which the Insured Employee's employment with the Employer terminates; unless coverage is continued as provided below.

CONTINUATION. Ceasing Active Work is deemed termination of employment; but insurance may be continued as follows.

1. **Disability.** If an Insured Employee is absent due to Total Disability, or is engaged in Partial Disability Employment; then Long Term Disability insurance may be continued during:
 - (a) the Elimination Period; provided the Company receives the required premium from the Employer; and
 - (b) the period for which Long Term Disability benefits are payable, without payment of premium.
2. **Family or Medical Leave.** If an Insured Employee goes on an approved Family or Medical Leave, and is not entitled to continue insurance due to Disability, as provided above; then Long Term Disability insurance may be continued, until the earliest of:
 - (a) the end of the leave period approved by the Employer;
 - (b) the end of the leave period required by federal or state law (whichever is greater);
 - (c) the date the Insured Employee notifies the Employer that he or she will not return;
or
 - (d) the date the Insured Employee begins employment with another employer;
provided the Company receives the required premium from the Employer.
3. **Lay-off or Other Leave.** When an Insured Employee goes on a temporary lay-off, or an approved leave of absence which is not subject to the federal Family and Medical Leave Act (or any similar state law); then Long Term Disability insurance may be continued:
 - (a) until the end of the calendar month following the month in which the lay-off or leave began;
 - (b) provided the Company receives the required premium from the Employer.

The Employer must not act so as to discriminate unfairly among Employees in similar situations. Insurance may not be continued when an Insured Employee ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of an Insured Employee's coverage during a Disability will have no effect on benefits payable for that period of Disability.

CONVERSION PRIVILEGE

ELIGIBILITY. The Policy provides a conversion privilege, when an Insured Employee's insurance under the Policy ends because he or she:

1. resigns from employment with the Employer;
2. is terminated from employment with the Employer, with or without cause;
3. goes on a lay-off or leave of absence; or
4. remains on a lay-off or leave of absence beyond the continuation period provided in the Individual Termination section of the Policy.

The Insured Employee may obtain converted long term disability insurance, without medical evidence of insurability. To be eligible for a converted policy, the Insured Employee must have been insured under the Employer's group plan for at least 12 months in a row, just before his or her insurance under the Policy terminated. The 12 months can be a combination of coverages under the Policy, and under any prior group long term disability plan which the Policy replaces.

APPLICATION. Application to convert must be made within 31 days after insurance under the Policy terminates. The converted benefits and amount of insurance may differ from those under the Policy.

CONDITIONS AND LIMITATIONS. This conversion privilege is not available to any Insured Employee whose insurance terminates because:

1. the Policy is terminated by the Employer or the Company;
2. the Policy is amended to exclude the class to which the Insured Employee belongs;
3. the Insured Employee no longer belongs to a class eligible for coverage under the Policy;
4. the Insured Employee retires or dies;
5. the Insured Employee fails to pay the required premium; or
6. the Insured Employee is Disabled under the terms of the Policy.

Also, this conversion privilege is not available to an Insured Employee who becomes insured for long term disability benefits under any other group plan; unless the other coverage takes effect more than 31 days after his or her insurance under the Policy terminates.

If an Insured Employee converts his or her Policy coverage, and later resumes active employment in an eligible class; then the Insured Employee's conversion coverage will terminate on the day before he or she is re-enrolled under the Policy. In no event will benefits be under both the Policy and the conversion coverage for the same period of Disability.

TOTAL DISABILITY MONTHLY BENEFIT

BENEFIT. The Company will pay a Total Disability Monthly Benefit to an Insured Employee, after the completion of the Elimination Period; if he or she:

1. is Totally Disabled;
2. is under the regular care of a Physician; and
3. at his or her own expense, submits proof of continued Total Disability and Physician's care to the Company upon request.

The Total Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Totally Disabled or dies;
2. the date the Maximum Benefit Period ends;
3. the date the Insured Employee is able, but chooses not to engage in Partial Disability Employment:
 - a. in his or her regular occupation, during the Own Occupation Period; or
 - b. in any gainful occupation, after the Own Occupation Period;
4. the date the Insured Employee fails to take a required medical exam, without good cause; or
5. the 60th day after the Company mails a request for additional proof, if not given.

AMOUNT. The amount of the Total Disability Monthly Benefit equals:

1. the Insured Employee's Basic Monthly Earnings multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
2. Other Income Benefits.

The amount of the Total Disability Monthly Benefit will not be less than the Minimum Monthly Benefit. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit and Maximum Benefit Period are shown in the Schedule of Benefits.

DEFINITION

"Total Disability" or "Totally Disabled" will be defined as follows.

1. During the Elimination Period and Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee is unable to perform each of the main duties of his or her regular occupation.
2. After the Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee is unable to perform each of the main duties of any gainful occupation which his or her training, education or experience will reasonably allow.

The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

PARTIAL DISABILITY MONTHLY BENEFIT

BENEFIT. The Company will pay a Partial Disability Monthly Benefit to an Insured Employee, after completion of the Elimination Period; if he or she:

1. is Disabled;
2. is engaged in Partial Disability Employment;
3. is earning at least 20% of Predisability Income when Partial Disability Employment begins;
4. is under the regular care of a Physician; and
5. at his or her own expense, submits proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

The Insured Employee does not have to be Totally Disabled prior to receiving Partial Disability Monthly Benefits. The Elimination Period may be satisfied by days of Total Disability, Partial Disability or any combination thereof.

The Partial Disability Monthly Benefit will cease on the earliest of:

1. the date the Insured Employee ceases to be Partially Disabled or dies;
2. the date the Maximum Benefit Period ends;
3. the date the Insured Employee earns more than:
 - a. 99% of Predisability Income, until Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability; or
 - b. 85% of Predisability Income, after Partial Disability Monthly Benefits have been paid for 24 months for the same period of Disability;*
4. the date the Insured Employee is able, but chooses not to work full-time:
 - a. in his or her regular occupation, during the Own Occupation Period; or
 - b. in any gainful occupation, after the Own Occupation Period;
5. the date the Insured Employee fails to take a required medical exam, without good cause; or
6. the 60th day after the Company mails a request for additional proof, if not given.

*If the Insured Employee's earnings from Partial Disability Employment fluctuate, the Company has the option to average the most recent three months' earnings and continue the claim; provided that average does not exceed the percentage of Predisability Income allowed above. A Monthly Benefit will not be payable for any month during which earnings exceeded that percentage, however.

DEFINITIONS

"Full-Time" means the average number of hours the Insured Employee was regularly scheduled to work, at his or her regular occupation, during the month just prior to:

1. the date the Elimination Period begins; or
2. the date an approved leave of absence begins, if the Elimination Period begins while the Insured Employee is continuing coverage during a leave of absence.

"Partially Disabled" or **"Partial Disability"** will be defined as follows.

1. During the Elimination Period and Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee:
 - a. is unable to perform one or more of the main duties of his or her regular occupation, or is unable to perform such duties full-time; and
 - b. is engaged in Partial Disability Employment.
2. After the Own Occupation Period, it means that due to an Injury or Sickness the Insured Employee:
 - a. is unable to perform one or more of the main duties of any gainful occupation which his or her training, education or experience will reasonably allow; or is unable to perform such duties full-time; and
 - b. is engaged in Partial Disability Employment.

PARTIAL DISABILITY MONTHLY BENEFIT
(Continued)

BENEFIT AMOUNT. The Partial Disability Monthly Benefit will replace the Insured Employee's Lost Income; provided it does not exceed the Total Disability Monthly Benefit, which would otherwise be payable during Total Disability without the Partial Disability Employment.

Thus, the amount of the Partial Disability Monthly Benefit will equal the lesser of A or B below.

- A. **LOST INCOME:** The Insured Employee's Predisability Income, minus all Other Income Benefits (including earnings from Partial Disability Employment).
- B. **TOTAL DISABILITY MONTHLY BENEFIT** otherwise payable:
 - 1. The Insured Employee's Predisability Income multiplied by the Benefit Percentage (limited to the Maximum Monthly Benefit); minus
 - 2. Other Income Benefits, except for earnings from Partial Disability Employment.

The Partial Disability Monthly Benefit will never be less than the Minimum Monthly Benefit. The Benefit Percentage, Maximum Monthly Benefit, Minimum Monthly Benefit, and Maximum Benefit Period are shown in the Schedule of Benefits.

Progressive Calculation

OTHER INCOME BENEFITS

OTHER INCOME BENEFITS means those benefits shown below:

1. Any temporary or permanent benefits or awards which the Insured Employee receives under:
 - (a) Worker's or Workmen's Compensation Law;
 - (b) occupational disease law; or
 - (c) any other act or law of like intent.
2. Any disability income benefits which the Insured Employee receives under any compulsory benefit act or law, or any state disability plan.
3. Any disability income benefits which the Insured Employee receives under:
 - (a) any other group plan, sick leave or salary continuance plan of the Employer; or
 - (b) any federal, state, county or municipal retirement system as a result of the Insured Employee's job with the Employer.
4. Any Disability Benefits or Retirement Benefits the Insured Employee receives under a Retirement Plan.
5. Benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan or any similar plan or act as follows:
 - (a) disability or unreduced retirement benefits for which the Insured Employee and any spouse or child receives, because of the Insured Employee's Disability; or
 - (b) reduced retirement benefits received by the Insured Employee and any spouse or child because of the Insured Employee's receipt of reduced retirement benefits.
6. Earnings the Insured Employee earns or receives from any form of employment.

These Other Income Benefits are benefits resulting from the same Disability for which a Monthly Benefit is payable under the Policy.

An Insured Employee who may be entitled to some Other Income Benefit is required to actively pursue it; if he or she does not, Policy benefits may be denied or suspended.

COST-OF-LIVING FREEZE. After the first deduction for each of the Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS. Other Income Benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the time the Company expects the Insured Employee to live.

DEFINITIONS.

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

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

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

OTHER INCOME BENEFITS
(continued)

RETIREMENT BENEFIT when used with the term Retirement Plan, means a benefit which:

- (1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
- (2) does not represent contributions made by an Employee (payments which represent Employee contributions are deemed to be received over the Employee's expected remaining life regardless of when such payments are actually received); and
- (3) is payable upon:
 - (a) early or normal retirement; or
 - (b) disability, if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred.

RETIREMENT PLAN means a defined benefit or defined contribution plan which provides Retirement Benefits to Employees and which is not funded wholly by Employee contributions. The term shall **not** include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation. An Employer's Retirement Plan is deemed to include any Retirement Plan:

- (1) which is part of any federal, state, county, municipal or association retirement system; and
- (2) for which the Employee is eligible as a result of employment with the Employer.

RECURRENT DISABILITY

"Recurrent Disability" means a Disability due to an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Monthly Benefits were payable. A Recurrent Disability will be treated as follows.

1. A Recurrent Disability will be treated as a new period of Disability, and a new Elimination Period must be completed before further Monthly Benefits are payable; if the Insured Employee returns to his or her regular occupation on a full-time basis for six months or more.
2. A Recurrent Disability will be treated as part of the prior Disability, if an Insured Employee returns to his or her regular occupation on a full-time basis for less than six months.

To qualify for a Monthly Benefit, the Insured Employee must earn less than the percentage of Predisability Income specified in the Partial Disability Monthly Benefit section. Monthly Benefit payments will be subject to all other terms of the Policy for the prior Disability.

If an Insured Employee becomes eligible for coverage under any other group Long Term Disability policy, this Recurrent Disability provision will cease to apply to that Insured Employee.

EXCLUSIONS

GENERAL EXCLUSIONS. The Policy will not cover any period of Total or Partial Disability:

1. due to war, declared or undeclared, or any act of war;
2. due to intentionally self-inflicted injuries;
3. due to active participation in a riot;
4. due to the Insured Employee's committing of or the attempting to commit a felony;
5. during which the Insured Employee is incarcerated for the commission of a felony; or
6. during which the Insured Employee is not under the regular care of a Physician.

PRE-EXISTING CONDITION EXCLUSION. The Policy will not cover any Total or Partial Disability:

1. which is caused or contributed to by, or results from a Pre-Existing Condition; and
2. which begins in the first 12 months after the Insured Employee's Effective Date.

"Pre-Existing Condition" means a Sickness or Injury for which the Insured Employee received treatment within 3 months prior to the Insured Employee's Effective Date.

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

SPECIFIED INJURIES OR SICKNESSES LIMITATION

LIMITATION. If an Insured Employee is Disabled primarily due to one or more of the Specified Injuries or Sickesses defined below; then Partial or Total Disability Monthly Benefits:

1. will be payable subject to the terms of the Policy; but
2. will be limited to 24 months for any one period of Disability; unless the Insured Employee is confined to a Hospital.

"Specified Injuries or Sickesses" include any Mental Sickness, or Substance Abuse, as defined below.

CONDITIONS

1. If the Insured Employee is confined in a Hospital at the end of the 24th month for which Policy benefits are paid for the Specified Injury or Sickness; then benefits will be payable until he or she is discharged from that facility.
2. In no event will the Monthly Benefit be paid beyond the Maximum Benefit Period shown in the Schedule of Insurance, however.

DEFINITIONS

"Hospital," as used in this provision, means:

1. a general hospital which:
 - a. is licensed, approved or certified by the state where it is located;
 - b. is recognized by the Joint Commission on the Accreditation of Hospitals; or
 - c. is operated to treat resident inpatients; has a registered nurse always on duty; and has a lab, x-ray facility and place where major surgery is performed; and
2. a skilled nursing care facility or unit, which provides convalescent or nursing care; and which is recognized as a skilled nursing care facility under Medicare.

The term Hospital also includes:

1. a Mental Hospital when treatment is for a Mental Sickness; and
2. a Treatment Center when treatment is for Substance Abuse.

"Mental Hospital" means a health care facility (or its psychiatric unit) which:

1. is licensed, certified or approved as a mental hospital by the state where it is located;
2. is equipped to treat resident inpatients' mental diseases or disorders; and
3. has a resident psychiatrist on duty or on call at all times.

"Mental Sickness" means any emotional, behavioral, psychological, personality, adjustment, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome; regardless of its cause. It includes, but is not limited to:

1. schizophrenia or schizoaffective disorder;
2. bipolar affective disorder, manic depression, or other psychosis; and
3. obsessive-compulsive, depressive, panic or anxiety disorders.

These conditions are usually treated by a psychiatrist, a clinical psychologist or other qualified mental health care provider. Treatment usually involves psychotherapy, psychotropic drugs or similar methods of treatment.

Mental Sickness does **not** include irreversible dementia resulting from:

1. stroke, trauma, viral infection, Alzheimer's disease; or
2. other conditions which are not usually treated by a mental health care provider using psychotherapy, psychotropic drugs, or similar methods of treatment.

"Substance Abuse" means alcoholism, drug abuse, or chemical dependency of any type.

"Treatment Center" means a health care facility (or its medical or psychiatric unit) which:

1. is licensed, certified or approved by the state where it is located;
2. has a program for inpatient treatment of substance abuse; and
3. provides such treatment based upon a written plan approved and supervised by a Physician.

VOLUNTARY VOCATIONAL REHABILITATION BENEFIT PROVISION

BENEFIT. If an Insured Employee is Disabled and is receiving Policy benefits; then he or she may be eligible for a Vocational Rehabilitation Benefit. This Benefit consists of services which may include:

1. vocational evaluation, counseling, training or job placement;
2. job modification or special equipment; and
3. other services which the Company deems reasonably necessary to help the Insured Employee return to work.

The Company will determine the Insured Employee's eligibility and the amount of any Benefit payable.

ELIGIBILITY. An Insured Employee may be eligible for this Benefit, if the Company finds that he or she:

1. has a Disability that prevents the performance of his or her regular occupation; and, after the Own Occupation Period, also lacks the skills, training or experience needed to perform any other gainful occupation;
2. has the physical and mental abilities needed to complete a Program; and
3. is reasonably expected to return to work after completing the Program; in view of his or her degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under the Insured Employee's health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. Either the Company, the Insured Employee, or his or her Physician may first propose vocational rehabilitation. When a Program is approved by the Company, the Policy's definition of "Disability" will be waived during the rehabilitation period; but it will be reapplied after the Program ends. The Company will determine the amount and duration of any Long Term Disability benefits payable after the Program ends, in accord with Policy provisions.

DEFINITION

"Program" means a written vocational rehabilitation program which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

REASONABLE ACCOMMODATION BENEFIT

If an Insured Employee of the Employer is Disabled, and is receiving Policy benefits; then the Employer may be eligible for a Reasonable Accommodation Benefit. This Benefit reimburses the Employer for 50% of the expense incurred for reasonable accommodation services for the Insured Employee; but will not exceed:

1. a maximum benefit of \$5,000 for any one Insured Employee; or
2. the Company's expected liability for the Insured Employee's Long Term Disability claim (whichever is less).

Such services may include:

1. providing the Insured Employee a more accessible parking space or entrance;
2. removing barriers or hazards to the Insured Employee from the worksite;
3. special seating, furniture or equipment for the Insured Employee's work station;
4. providing special training materials or translation services during the Insured Employee's training; and
5. other services the Company deems reasonably necessary to help the Insured Employee return to work with the Employer.

ELIGIBILITY FOR BENEFIT. The Company will determine the Employer's eligibility to receive the Benefit. To qualify for the Benefit, the Employer must have an Insured Employee:

1. whose Disability prevents the performance of his or her regular occupation at the Employer's worksite;
2. who has the physical and mental abilities needed to perform his or her own or another occupation at the Employer's worksite; but only with the help of the proposed accommodation; and
3. who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation Benefit is less than the expected liability for the Insured Employee's Long Term Disability claim.

WRITTEN PROPOSAL. The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

1. the Employer;
2. the Insured Employee; and
3. his or her Physician, when appropriate.

The proposal must state the purpose of the proposed accommodation; and the times, dates and costs of the services.

CONDITIONS. Either the Company, the Employer, the Insured Employee, or his or her Physician may first propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will then reimburse the Employer, upon receipt of proof that the Employer:

1. has provided the services for the Insured Employee; and
2. has paid the provider for the services.

PRIOR INSURANCE CREDIT UPON TRANSFER OF INSURANCE CARRIERS

To prevent loss of coverage for an Employee because of a transfer of insurance carriers, the Policy will provide Prior Insurance Credit for employees insured under the prior carrier's policy on its termination date as follows.

FAILURE TO BE ACTIVELY-AT-WORK DUE TO INJURY OR SICKNESS. Subject to premium payments, the Policy will provide coverage to an Employee:

1. who was insured by the prior carrier's policy at the time of transfer; and
2. who was not Actively-At-Work due to Injury or Sickness on the Policy's Effective Date.

The coverage will be that provided by the prior carrier's policy, had it remained in force. The Company will pay:

1. the benefit that the prior carrier would have paid; minus
2. any amount for which the prior carrier is liable.

DISABILITY DUE TO A PRE-EXISTING CONDITION. Benefits may be payable for a Total Disability due to a Pre-Existing Condition for an Employee who:

1. was insured by the prior carrier's policy at the time of transfer; and
2. was Actively-At-Work and insured under the Policy on the Policy's Effective Date.

The benefits will be determined as follows:

1. The Company will apply the Policy's Pre-Existing Condition Exclusion. If the Insured Employee qualifies for benefits, such Insured Employee will be paid according to the Policy's benefit schedule.
2. If the Insured Employee cannot satisfy the Policy's Pre-Existing Condition Exclusion, but can satisfy the prior carrier's pre-existing condition exclusion giving consideration towards continuous time insured under both policies; then he or she will be paid in accord with the benefit schedule and all other terms, conditions and limitations of:
 - a. the Policy without applying the Pre-Existing Condition Exclusion; or
 - b. the prior carrier's policy;whichever is less.
3. If the Insured Employee cannot satisfy the Pre-Existing Condition Exclusion of the Policy or that of the prior carrier, no benefit will be paid.

FAMILY INCOME BENEFIT

The Company will pay a lump sum benefit to the Eligible Survivor, when proof is received that an Insured Employee died:

1. after Disability had continued for 180 or more consecutive days; and
2. while receiving a Monthly Benefit.

The benefit will be equal to three times the Insured Employee's Last Monthly Benefit.

"Last Monthly Benefit" means the gross Monthly Benefit payable to the Insured Employee immediately prior to death. Any reductions for Other Income Benefits, or for earnings the Insured Employee received for Partial Disability Employment, will not apply.

"Eligible Survivor" means the Insured Employee's:

1. surviving spouse; or, if none
2. surviving children who are under age 25 on the Insured Employee's date of death.

If payment becomes due to the Insured Employee's children; then payment will be made to:

1. the surviving children, in equal shares; or
2. a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, the children.

Three Month Survivor Benefit

**CALIFORNIA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER**

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these type of insurance are members of the California Life and Health Insurance Guaranty Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guaranty Association may not provide coverage for the policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

| | | |
|--|----|--|
| California Life & Health Insurance Guaranty Association P.O. Box 16860 Beverly Hills, CA 90209-3319 | or | Consumer Communications Bureau California Department of Insurance 300 South Spring Street Los Angeles, CA 90013 |
|--|----|--|

The state law that provides for this safety-net coverage is called the California Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guaranty Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contractholders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the life insurance company would owe under a life policy or annuity contract up to
- \$100,000 in cash surrender values,
- \$100,000 in present value of annuities; or
- \$250,000 in life insurance death benefits.
- A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

SUMMARY PLAN DESCRIPTION

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

The name of the Plan is: Group Long Term Disability Insurance for Employees of Cortina Systems, Inc..

The name, address and ZIP code of the Sponsor of the Plan is: Cortina Systems, Inc., 840 W California Avenue #100, Sunnyvale, CA, 94086.

Employer Identification Number (EIN): 94-3401917

IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: Cortina Systems, Inc., 840 W California Avenue #100, Sunnyvale, CA, 94086, (408) 481-2415.

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

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

Type of Plan. The benefits provided under the Plan are: Group Long Term Disability Insurance benefits.

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

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits, Pre-Existing Condition Limitation, Exclusions and Prior Carrier Credit provisions. The Certificate also contains the Schedule of Benefits which includes information on the Benefit Percentage, Maximum and Minimum Monthly Benefits, Elimination Period, Maximum Benefit Period, Own Occupation Period and Waiting Period. If your Booklet, Certificate or Schedule of Benefits has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

Eligibility. Full-time employees working at least 30 hours per week.

Employees become eligible on the first day of active full-time employment.

Contributions. Insured employees are not required to contribute to the cost of the coverage.

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

The name and section of relevant Collective Bargaining Agreements: None

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

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

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Group Insurance Service Office of The Lincoln National Life Insurance Company. To expedite the processing of your claim, instructions on the claim form should be followed carefully; be sure all questions are answered fully. In accordance with ERISA, The Lincoln National Life Insurance Company will send you a written notice of its claim decision within:

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

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial, how a review of the decision may be requested, and whether more information is needed to support the claim. You may request a review of the claim by making a written request to The Lincoln National Life Insurance Company within:

- 180 days after receiving a denial notice of a claim.

This written request for review should state the reasons why you feel the claim should not have been denied and should include any additional documentation to support your claim. You may also submit for consideration additional questions or comments you feel are appropriate, and you may review certain non-privileged information relating to the request for review. The Lincoln National Life Insurance Company will make a full and fair review of the claim and provide a final written decision to you within:

- 45 days after receiving the request for review (90 days under special circumstances).

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

Statement of ERISA Rights

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

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

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

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

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

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

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

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



LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

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

INFORMATION WE MAY COLLECT AND USE

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

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

HOW WE USE YOUR PERSONAL INFORMATION

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

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

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

SECURITY OF INFORMATION

Keeping your information safe is one of our most important responsibilities. We maintain physical, electronic and procedural safeguards to protect your information. Our employees are authorized to access your information only when they need it to provide you with products and services or to maintain your accounts. Employees who have access to your personal information are required to keep it strictly confidential. We provide training to our employees about the importance of protecting the privacy of your information.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Services Compliance-Privacy, 6C-00
1300 S. Clinton St.
Fort Wayne, IN 46801

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

| | |
|---|---|
| Allied Professional Advisors, Inc. | Lincoln Financial Advisors Corporation |
| First Penn-Pacific Life Insurance Company | Lincoln Investment Advisors Corporation |
| Hampshire Funding, Inc. | Lincoln Life & Annuity Company of New York |
| Jefferson Pilot Securities Corporation | Lincoln Variable Insurance Products Trust |
| JPSC Insurance Services, Inc. | The Lincoln National Life Insurance Company |

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request, we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company