Lincoln Life & Annuity Company of New York
A Stock Company Home Office Location: 120 Madison Street, Suite 1310, Syracuse, NY 13202
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. 000010193670 has been issued to

D'Addario & Company Inc.
(The Group Policyholder)

The issue date of the Policy is August 1, 2014.

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

Certificate of Insurance for Class 1

You are entitled to the benefits described in this Certificate if you are eligible for insurance under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. Nothing in the Policy invalidates or impairs any rights granted to you in this Certificate. If the provisions of this Certificate and the Policy do not agree, the provisions more favorable to you will apply.

IMPORTANT NOTICE(S): The Policy is issued and delivered in the State of New York. It is governed by the laws of that State. Nothing in the Policy invalidates or impairs any rights granted to you by New York insurance law. The Company's state of domicile is New York. The address of the Company's Group Insurance Service Office is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

This Certificate does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

Dennis R Glass
PRESIDENT

CERTIFICATE OF GROUP TERM LIFE INSURANCE

D'Addario & Company Inc.
000010193670
SCHEDULE OF INSURANCE

ELIGIBLE CLASS

Class 1 D'Addario Executives and Woodwinds Directors, Managers and Controllers

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

Year of Birth	Normal Retirement Age
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

Persons first employed in an eligible class after this Policy takes effect may be enrolled in accord with the terms of this Policy. (See the Eligibility and Effective Dates sections.)

D'Addario & Company Inc.
000010193670
SCHEDULE OF INSURANCE
For
Class 1 - D'Addario Executives and Woodwinds Directors, Managers and Controllers

MINIMUM HOURS: 40 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Dates of Coverages" section)
Two months of continuous Active Work

Basic Annual Earnings means your annual base salary or annualized hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the loss. It 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 or the amount for which premium has been paid; whichever is less.

LIFE INSURANCE

	Benefit Amount
Personal Life Insurance	Two times Basic Annual Earnings, rounded to the next higher $1,000; subject to a maximum of $500,000.

Personal Life Insurance will be reduced as follows:
- At age 70, benefits will reduce by 50% of the original amount.
Benefits will terminate when you retire.

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

D'Addario & Company Inc.
000010193670
SCHEDULE OF INSURANCE
For
Class 1 - D'Addario Executives and Woodwinds Directors, Managers and Controllers

AD&D INSURANCE

	Benefit Amount
AD&D Insurance Principal Sum	Two times Basic Annual Earnings, rounded to the next higher $1,000; subject to a maximum of $500,000.

AD&D Insurance will be reduced as follows:
- At age 70, benefits will reduce by 50% of the original amount.
Benefits will terminate when you retire.

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

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AMOUNT OF INSURANCE

The amount of your insurance is determined by the Schedule of Insurance in the Policy. The initial amount of coverage is the amount which applies to your class on the day your coverage takes effect. You may become eligible for increases in the amount of insurance in accord with the Schedule of Insurance. Any such increase will take effect on the latest of:

(1) the first day of the Insurance Month which coincides with or follows the date on which you become eligible for the increase, provided you are Actively at Work on that day;
(2) the day you resume Active Work, if you are not Actively at Work on the day the increase would otherwise take effect; or
(3) the day any required evidence of insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not you are Actively at Work.

DEFINITIONS

ACTIVE WORK or **ACTIVELY AT WORK** means an employee's full-time performance of all customary duties of his or her occupation at:

(1) the EMPLOYER'S place of business; or
(2) any other business location where the employee is required to travel.

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

(1) a Saturday, Sunday or holiday which is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) an non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is **not** due to the employee's own health condition.

COMPANY means Lincoln Life & Annuity Company of New York, a New York corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

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

EMPLOYEE or **FULL-TIME EMPLOYEE** means an employee of the EMPLOYER:

(1) whose employment with the EMPLOYER is the employee's principal occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance;
(4) who is a member of a class which is eligible for coverage under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who legally works in the United States.

EVIDENCE OF INSURABILITY means a statement of proof of your or your Dependents' medical history. The Company uses this to determine your or your Dependents' acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

INSURANCE MONTH means that period of time:
(1) beginning at 12:01 A.M. Standard Time, at the GROUP POLICYHOLDER'S place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means a licensed medical doctor, or other duly licensed practitioner of the healing arts who:
(1) is deemed by the state to be the same as a physician; and
(2) is acting within the scope of his or her license.

Physician does **not** include you or your relative. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of the same degree.

POLICY means the Group Insurance Policy issued by the Company to the Group Policyholder. A copy of the Policy may be examined upon request at the home office of the Group Policyholder.

SECTION 125 PLAN means a Cafeteria Plan or other flexible benefits plan, which:
(1) qualifies for favorable tax treatment under Section 125 of the U.S. Internal Revenue Code; and
(2) allows the payroll deduction of employee contributions for certain group insurance plans to be done on a pre-tax basis.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

GENERAL PROVISIONS

ENTIRE CONTRACT. The rights of the Group Policyholder, or of any Insured Person or Beneficiary under it, shall not be affected by any provision other than one contained in:

(1) the Policy or any riders or endorsements on it;
(2) any amendments to it signed by the Group Policyholder and the Company;
(3) the copy of the Group Policyholder's application attached to the Policy; or
(4) any individual statements signed by the Insured Persons and submitted in connection with the Policy.

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

All statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person relating to his or her insurability will be used to contest the coverage provided by the Policy or to reduce benefits, unless:

(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement is furnished to the Insured Person or Beneficiary.

TERM INSURANCE. The Policy will not provide paid-up insurance, or any loan or cash values, at any time.

MISSTATEMENT OF AGE. If an Insured Person's age has been misstated, premiums will be subject to an equitable adjustment. It will be retroactive and based upon the person's correct age. If the amount of benefit depends upon age, the benefit will be that which would have been payable, based upon the person's correct age.

WORKER'S COMPENSATION AND STATE DISABILITY BENEFITS. The Policy is not to be construed to provide benefits required by Worker's Compensation laws, the New York Disability Benefits Law, or any other state disability benefits law.

ELIGIBILITY

If you are a member of a class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

WAITING PERIOD. (See Schedule of Insurance).

EFFECTIVE DATES OF COVERAGES

Your insurance is effective on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the day you become eligible for the coverage;
(2) the day you resume Active Work, if you are not Actively at Work on the day you become eligible;
(3) the day you make written application for coverage; and sign:
    (a) a payroll deduction order, if you pay any part of the premium; or
    (b) an order to pay premiums from your Section 125 Plan account, if Employer contributions are paid through a Section 125 Plan (defined in the Definitions section); or
(4) the day the Company approves your coverage, if evidence of insurability is required.

Evidence of Insurability. Evidence of insurability is required if:

(1) you apply for coverage more than 31 days after you become eligible; or
(2) you make written application to re-enroll for coverage after you have requested:
    (a) to cancel your coverage;
    (b) to stop payroll deductions for the coverage; or
    (c) to stop premium payments from your Section 125 Plan account.

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

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

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

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

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

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

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

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

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

(1) the day the Policy terminates (but without prejudice to any claim incurred prior to termination);
(2) the day your Class is no longer eligible for insurance;
(3) the date you cease to be in a class of employees which is eligible for coverage under the Policy or die;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of the Policy providing that benefit terminates;
(8) the day your employment with the Employer terminates; or
(9) the day you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. If you send proof of military service, the Company will refund any unearned premium.

Exception – Continuation Rights. Ceasing Active Work terminates your eligibility. However, you may continue coverage as follows:

(1) If you are disabled due to illness or injury, then coverage may be continued:
    (a) until you are no longer disabled; or, for life insurance, until qualified for the Extension of Death Benefit under the Policy;
    (b) provided premium payments are made on your behalf.
    Throughout the period of continued coverage, you will be required to pay the Employer the premium which you would have been required to pay as an Active Employee.
(2) If you cease work due to a temporary lay off, an approved leave of absence, or a military leave; then coverage may be continued:
    (a) for three Insurance Months after the lay off or leave begins;
    (b) provided premium payments are made on your behalf.

If Personal Life Insurance ceases for any reason **except** nonpayment of premium, it may be possible to purchase an individual life policy. See the Conversion Privilege section of this Certificate.

DEATH BENEFIT

AMOUNT PAYABLE ON DEATH. Upon receipt of satisfactory proof of your death, the Company will pay a death benefit equal to the amount of Personal Life Insurance in effect on the date of your death. The benefit will be paid in accord with the Beneficiary section. Arrangements may be made to have this death benefit paid in installments.

FACILITY OF PAYMENT. Policy benefits may become payable to your estate. In that event, the Company has the option to pay one or more of the following: your surviving spouse, parent(s), child or children, brother(s) or sister(s). No payment made under this section may exceed $500. Any remaining amount of benefit will be paid as shown in the Beneficiary section.

SETTLEMENT OPTIONS. All or part of the Death Benefit may be received in installments. A written election to the Company may be made:

(1) by you, while living; or
(2) by your Beneficiary, if no such direction is in effect at the time of your death.

The election must comply with the Company's practices at the time it is made. It must provide for at least $2,000 to be paid in installments of at least $20 per month.

ASSIGNMENT. The Company will accept the absolute assignment of your Personal Life Insurance to a third party, as a gift or a viatical settlement. Such an assignment transfers all rights under the Policy, including the rights to:

(1) name and change the Beneficiary, unless an irrevocable Beneficiary has been named; and
(2) obtain an individual policy, by exercising the Conversion Privilege under this Policy.

However, the Company will not accept:

(1) a collateral assignment in connection with a debt; or
(2) an assignment of any Dependents Life Insurance under the Policy.

To be binding upon the Company, an assignment must be in a form acceptable to the Company; be filed at the Company's Group Insurance Service Office (or other office designated by the Company); and be accepted in writing by the Company.

The assignment:

(1) will take effect as of the date it was signed, even if you are not alive when it is received; and
(2) will not apply to any payment the Company makes before receiving your notice of the assignment.

The Company assumes no obligation as to the validity of any assignment.

BENEFICIARY

PAYMENT TO BENEFICIARY. Your Beneficiary is the person or persons named on your enrollment card. There may be more than one surviving Beneficiary when you die. In that event, they will share equally, unless your Beneficiary designation states otherwise.

NO BENEFICIARY AT DEATH. If you have not named a Beneficiary, or if no named Beneficiary is living when you die; then the death benefit will be paid to your:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving brothers and sisters in equal shares; or, if none
(5) estate, or in accord with the Facility of Payment section of the Policy.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section of the Policy.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class of relatives to receive payment. The Company will make payment based upon the affidavit it has, unless it receives notice of a valid claim by some other person:

(1) at its Group Insurance Service Office;
(2) before paying the proceeds.

Such payment will release the Company from any further obligation for your life insurance benefit.

If your Beneficiary dies:

(1) within 15 days of your death; and
(2) before the Company receives satisfactory proof of your death;

then payment will be made as if you had survived that Beneficiary, unless other provisions have been made.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. Your Beneficiary's consent is not required, unless an irrevocable Beneficiary has been named. You may do so by filing a written notice with the Company, on a form it approves, at its Group Insurance Service Office. The change:

(1) will take effect as of the date it was signed, even if you are not alive when it is received; and
(2) will not apply to any payment the Company makes before receiving your notice of the change.

When applying for a conversion policy under the Conversion Privilege section, you must name a Beneficiary. It may be someone other than the person named under the group Policy. In that event, the application for the conversion policy will be treated as a written notice of change of Beneficiary.

EXTENSION OF DEATH BENEFIT

BENEFIT. Your life insurance will be continued, without payment of premiums, if:
(1) you incur a Permanent Total Disability while insured and before reaching age 60;
(2) you send the Company written notice during the period of disability, while living; and
(3) you submit satisfactory proof of Permanent Total Disability:
    (a) within the 7th through 12th months of disability; or:
    (b) as soon as reasonably possible after that.

Failure to give notice or submit proof by the end of the 12th month of such disability will not invalidate or reduce a claim, if proof is furnished:
(1) as soon as reasonably possible; and
(2) not later than the end of the 24th month of disability (unless you lacked legal capacity).

"Permanent Total Disability" means that, due to a sickness or injury, you:
(1) are unable to engage in any employment or occupation for which you are or become qualified by reason of education, training or experience;
(2) remain continuously unable to do so for at least 6 months in a row; and
(3) do not engage in any gainful employment or occupation during that period.

PREMIUM PAYMENT. Premium payments must continue until you are approved for this benefit, or the Policy terminates, if earlier. Upon receipt of satisfactory proof, the Company will refund up to 12 months' premium paid for your life insurance, from your 1st day of Permanent Total Disability.

AMOUNT CONTINUED. The amount of Personal Life Insurance continued by this section:
(1) will be the amount in effect on the day your Permanent Total Disability begins; and
(2) will be subject to the reductions and terminations in effect under the Policy on the day your Permanent Total Disability begins.

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

ADDITIONAL PROOF. At any time during this continuation, the Company may require you:
(1) to submit further proof of your continued Permanent Total Disability; and
(2) to be examined by a Physician of the Company's choice, as often as reasonably necessary.

After the first two years of Permanent Total Disability, the Company will not request proof or an exam more than once a year. Proof will be at your expense.

Exception: If the Company requests to have you examined by a Physician of its choice, the exam will be at the Company's expense.

If you die after submitting proof, further proof must be submitted to the Company showing that your Permanent Total Disability continued until death.

If you die within 12 months after your Permanent Total Disability begins, but before submitting proof:
(1) your death benefit will still be paid under the terms of the Policy; but
(2) the Company must first receive satisfactory proof that your Permanent Total Disability continued from your last day of Active Work until your date of death.

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

(1) the day your Permanent Total Disability ends;
(2) the day you fail to take a required medical examination;
(3) the 60th day after the Company mails a request for additional proof, if it is not given;
(4) the effective date of your individual conversion policy, with respect to any amount of life insurance converted in accord with the Conversion Privilege section; or
(5) the day you reach Social Security Normal Retirement AGE (SSNRA), as shown in the Schedule of Insurance.

RIGHTS AFTER TERMINATION. If life insurance extended under this section ends, and you **do not return** to a class eligible for Policy coverage, then you or your Dependent may exercise the Conversion Privilege. To do so, you must make written application and the first premium payment within 31 days after your Permanent Total Disability ends. You may elect term life insurance for a one-year period, prior to the issuance of a term life or whole life conversion policy. See the Conversion Privilege, Conditions 1, 2 and 3, for details.

If your Permanent Total Disability ends, and you **do return** to an eligible class**,** then your Policy coverage will resume:

(1) when premium payments are resumed; and
(2) any conversion policy is surrendered as provided below.

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

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

then benefits will be payable under the terms of the Policy.

However:

(1) the conversion policy must first be surrendered to the Company; and
(2) no claim may be made under the conversion policy, except for refund of premium less any dividends and policy loans.

ACCELERATED DEATH BENEFIT

BENEFIT. The Accelerated Death Benefit is an advance payment of part of your Personal Life Insurance. If you are diagnosed by a Physician as Terminally Ill; then it may be paid to you, in a lump sum, once during your lifetime. To qualify you must:

(1) have satisfied the Active Work requirement under the Policy; and
(2) have at least $2,000 of Personal Life Insurance under the Policy on the day before the Accelerated Death Benefit is paid.

Receiving the Accelerated Death Benefit will reduce the Death Benefit payable at your death, as shown on the next page.

DEFINITIONS. "Remaining Life Insurance" means the amount of Personal Life Insurance which remains in force on your life after an Accelerated Death Benefit is paid.

"Terminally Ill" means you have a medical condition which is expected to cause your death within 12 months.

APPLYING FOR THE ACCELERATED DEATH BENEFIT. To withdraw the Accelerated Death Benefit, you (or your legal representative) must send the Company:

(1) written election of the Accelerated Death Benefit, on a special claim form which the Company supplied within the prior 30 days; and
(2) satisfactory proof that you are Terminally Ill, including a Physician's written statement.

Within 5 days of receiving your claim form, the Company will send you a written notice showing:

(1) the amount of the Accelerated Death Benefit requested, and the amount to be paid in cash;
(2) the amount of Life Insurance which would be payable at death, if no Accelerated Death Benefit is withdrawn;
(3) the Remaining Life Insurance which would be payable at death, after payment of the requested Accelerated Death Benefit is withdrawn; and
(4) the effect upon premium payments for the Remaining Life Insurance.

Before making payment, the Company will allow you a period of 5 days from the date on which the written notice is transmitted to review this information. No benefit will be paid during the review period. You may revoke the request to withdraw the Accelerated Death Benefit, at any time before the Company makes payment.

The Company reserves the right to decide whether the proof is satisfactory. The Company may have you examined, at its own expense, by one or more Physicians of its choice.

AMOUNT OF THE ACCELERATED DEATH BENEFIT. You may elect to withdraw an Accelerated Death Benefit in any $1,000 increment. The amount is subject to:

(1) a minimum of $50,000 or 25% of your amount of Personal Life Insurance (whichever is less); and
(2) a maximum of $250,000 or 75% of your amount of Personal Life Insurance (whichever is less).

To determine the Accelerated Death Benefit, the Company will use the amount of your Personal Life Insurance in force on the day before payment is made.

Exception: Your Personal Life Insurance may be scheduled to reduce within 12 months of the date you apply for an Accelerated Death Benefit. In that event, the Company will use the reduced amount.

CONDITIONS. The Accelerated Death Benefit is available only on your Personal Life Insurance in force under the Policy. It is not available:

(1) on any Dependent Life Insurance under the Policy; or
(2) on any conversion coverage purchased in accord with the Conversion Privilege.

The Accelerated Death Benefit is available only to you. It will not be paid when the Company knows of a third party's interest in the proceeds. The Accelerated Death Benefit will not be available when any part of your Personal Life Insurance must be paid:

(1) to your child, spouse or former spouse;
(2) pursuant to a legal separation agreement, divorce decree, child support order or other court order.

You may have named an irrevocable beneficiary, assigned coverage, or filed for bankruptcy. In that event, an Accelerated Death Benefit will be paid only with the written consent of your beneficiary, your assignee, or the bankruptcy court.

EFFECT ON AMOUNT OF LIFE INSURANCE. After an Accelerated Death Benefit is paid, the Remaining Life Insurance in force on your life will equal:

(1) the amount of your Personal Life Insurance in effect on the day before the Accelerated Death Benefit is paid; minus
(2) the amount of the Accelerated Death Benefit withdrawn.

Upon payment of an Accelerated Death Benefit, the Company will issue a new Certificate or amendment, showing the amount of Remaining Life Insurance. This amount will remain in effect:

(1) subject to timely payment of premiums; unless the Insured Person has qualified for an Extension of Death Benefit under the Policy; and
(2) subject to any age reduction and termination provisions contained in the Policy.

You may exercise the Conversion Privilege after an Accelerated Death Benefit is paid. In that case, the amount of the conversion policy will not exceed the amount of your Remaining Life Insurance.

You may have Accidental Death and Dismemberment benefits under the Policy. In that case, the Principal Sum will not be affected by the payment of an Accelerated Death Benefit.

EFFECT ON DEATH BENEFIT. If you die after receiving an Accelerated Death Benefit, the amount of Remaining Life Insurance in force on the date of your death will be paid as a Death Benefit. Payment will be made in accord with the Beneficiary section of the Policy.

If you die after applying for an Accelerated Death Benefit, but before the Company has made payment, then:

(1) your request will be void; and
(2) no Accelerated Death Benefit will be paid.

The amount of Personal Life Insurance in force on the date of your death will be paid in accord with the Beneficiary section of the Policy.

EFFECT ON TAXES AND GOVERNMENT BENEFITS. Any Accelerated Death Benefit amount withdrawn may be taxable income to you. Receipt of the Accelerated Death Benefit may also affect your eligibility for:

(1) Medicaid;
(2) Aid to Families with Dependent Children;
(3) Supplemental Security Income; and
(4) other government benefits.

But no health care facility, as defined in Section 20 of New York Public Health Law, can require a person to withdraw an Accelerated Death Benefit as a condition of receiving health care there.

For these reasons, you should consult a qualified tax or legal advisor, or any appropriate social service agency, before applying for an Accelerated Death Benefit. The Company is not responsible for any tax owed or government benefit denied, as a result of the Accelerated Death Benefit payment.

LIMITATION. No Accelerated Death Benefit will be paid if you are Terminally Ill due to:

(1) a suicide attempt, during your first two years of coverage under the Policy; or
(2) an intentionally self-inflicted injury.

CONVERSION PRIVILEGE

GENERAL BENEFIT. An individual life policy, known as a conversion policy, may be purchased from the Company without evidence of insurability, if all or part of your life insurance under the Policy terminates because of:

(1) your termination of employment or membership in an eligible class;
(2) a reduction in the amount of coverage due to age; a change in class; or a Policy amendment, to take effect immediately or at any later date; or
(3) termination of the Policy.

At your option, the conversion policy or policies will cover any Dependents whose Policy coverage was terminated or reduced, due to one of the above events. A conversion policy will also be available to any Dependents whose life insurance under the Policy is terminated or reduced, due to:

(1) your death, divorce or annulment; or
(2) your Dependent child's ceasing to be an eligible dependent.

To purchase a conversion policy, you or your Dependent must make written application and the first premium payment, within 31 days after life insurance is terminated or reduced.

EFFECTIVE DATES. The coverage provided by an individual conversion policy issued under this Section will take effect immediately upon termination of the person's group insurance under the Policy.

CONDITIONS

1. **Conversion Policy.** Any policy issued under this Conversion Privilege will:
   (a) be for an amount that does not exceed the amount of life insurance which was terminated or by which life insurance was reduced, less any Replacement Coverage (defined below);
   (b) be on any life insurance form then issued by the Company, at the age and amount for which application is made (except term life insurance is available only as provided below);
   (c) be issued without disability or other supplemental benefits; and
   (d) require premiums based on the class of risk to which the person then belongs, and the form and amount of the policy at his or her attained age.

   "Replacement Coverage," as used in this section, means any amount of group term life insurance for which you become eligible:
   (a) under any group policy issued or reinstated by the Company or any other insurer;
   (b) within 45 days after the Policy is terminated by the Group Policyholder or the Company.

2. **Term Life Insurance for One Year.** A conversion policy may be issued for a reason other than your termination of employment or membership due to Permanent Total Disability. In that case, the applicant may elect:
   (a) term life insurance for a one-year period;
   (b) prior to the issuance of a whole life conversion policy as described above.

3. **Term Life Insurance for Longer Period.** A conversion policy may be issued because of your termination of employment or membership due to Permanent Total Disability. In that case, the applicant may elect:
   (a) term life insurance for a one-year period;
   (b) prior to the issuance of a term life or whole life conversion policy as described above.

   To qualify for a term life conversion policy, you must send the Company written notice during your period of disability, while living. You must furnish satisfactory proof of Permanent Total Disability:
   (a) within the 7th through the 12th months of such disability; or
   (b) as soon as reasonably possible after that.

   Failure to give notice and furnish proof by the end of the 12th month of disability will not invalidate or reduce a claim, if proof is furnished:
   (a) as soon as reasonably possible; and
   (b) not later than the end of the 24th month of disability (unless you lacked legal capacity).

   "Permanent Total Disability" means that due to a sickness or injury you:
   (a) are unable to engage in any employment or occupation for which you are or become qualified by reason of education, training or experience;
   (b) remain continuously unable to do so for at least 12 months in a row; and
   (c) do not engage in any gainful employment or occupation during that period.

4. **Premium Mode.** At the Insured Person's or Dependent's option, the premium for the conversion policy or term life insurance policy will be payable in any mode the Company customarily offers under that policy.

5. **Contestable Period.** You may have made a statement regarding insurability under the group Policy. If so, that statement may be used:
   (a) to contest the validity of the individual conversion policy; but only
   (b) to the extent it could have been used to contest the validity of your coverage under the group Policy, had it remained in effect.

6. **Suicide Exclusion.** The individual conversion policy may include a suicide exclusion. If so, it will cease to apply two years after the date you became insured under the group Policy.

NOTICE OF CONVERSION PRIVILEGE. When your Personal Insurance terminates or reduces for a reason entitling you to convert, written notice of the right to convert is to be:
   (1) given personally to you;
   (2) mailed by the Group Policyholder to you, at your last known address; or
   (3) mailed by the Company to you, at your last known address, as furnished by the Group Policyholder.

This written notice is to be given within 15 days before or after the termination or reduction of Policy coverage. If the written notice is not given on time, the 31-day conversion period will be extended as follows.
   (1) If the written notice is given more than 15 days but less than 90 days after the termination or reduction, the conversion period will be extended to the 45th day following the date of the notice.
   (2) If the written notice is not given within 90 days after the termination or reduction, the conversion privilege will end on the 90th day following the termination or reduction.

DEATH DURING CONVERSION PERIOD. The Company will pay a death benefit under the Policy, if you:

(1) are entitled to purchase a conversion policy; and
(2) die within the applicable 31, 45 or 90-day application period shown above.

This death benefit will equal the amount of the Personal Life Insurance which could have been converted. It will be paid even if no one applied for the conversion policy. If the first premium was paid for the conversion policy, then:

(1) the amount of the premium will be refunded; and
(2) the conversion policy will be void.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT. If you sustain an accidental bodily injury which directly causes one of the following Losses within 365 days of the date of that injury, then the Company will pay the Benefit listed:

LOSS	BENEFIT
Loss of one hand by severance at or above the wrist	One-half the Principal Sum
Loss of one foot by severance at or above the ankle	One-half the Principal Sum
Irrecoverable loss of the sight in one eye	One-half the Principal Sum
Any combination of two or more of the losses listed above	Principal Sum
Loss of life	Principal Sum

The total benefit for all losses resulting from the same accident may not exceed the Principal Sum. The Principal Sum for your class is shown in the Schedule of Insurance.

Benefits for loss of life will be paid to your named Beneficiary. All other benefits will be paid to you.

LIMITATIONS. Benefits are not payable for any loss to which a contributing cause is:
(1) suicide, attempted suicide, or intentional self-inflicted injury;
(2) bodily or mental disease, or treatment of these;
(3) your participation in a riot;
(4) duty as a member of any military, naval or air force;
(5) war or any act of war, declared or undeclared;
(6) your participation in the commission of a felony;
(7) aviation; except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
(8) your being under the influence of any narcotic; unless administered on the advice of a Physician; or
(9) your driving a motor vehicle while intoxicated.

"Intoxicated" shall be as defined by the jurisdiction where the accident occurs.

"Narcotic" means any substance which:
(1) is classified as such by the American Psychiatric Association; and
(2) is subject to legal restriction or requires a Physician's written prescription.

The term includes (but is not limited to) cannabis, cocaine, opiates, amphetamines, hallucinogens, sedatives, hypnotics and anxiolytics.

SAFE DRIVER BENEFIT

BENEFIT. If you die as a direct result of a covered auto accident, for which Accidental Death and Dismemberment Benefits are payable; then:

(1) an additional Seat Belt Benefit will be payable, if you were wearing a properly fastened seat belt at the time of the accident; and
(2) an additional Air Bag Benefit will be payable, if the auto was equipped with air bag(s).

The Seat Belt Benefit equals $10,000 or 10% of the Principal Sum, whichever is less; and the Air Bag Benefit equals $10,000 or 10% of the Principal Sum, whichever is less. The Seat Belt Benefit and the Air Bag Benefit will not be less than $1,000. The Principal Sum is the amount payable because of your accidental death.

A copy of the police report must be submitted with the claim. The position of the seat belt or presence of an air bag must be certified by:

(1) the official accident report; or
(2) the coroner, traffic officer or other investigating officer.

Upon receipt of satisfactory written proof, the additional benefit will be paid in accord with the Beneficiary section.

DEFINITIONS. As used in this provision:

"Auto" means a 4-wheel passenger car, station wagon, jeep, pick-up truck or van-type car. It must be licensed for use on public highways. It includes a car owned or leased by the Group Policyholder.

"Intoxicated" shall be defined as by the jurisdiction where the accident occurs.

"Narcotic" means any substance which:

(1) is classified as such by the American Psychiatric Association; and
(2) is subject to legal restriction or requires a Physician's written prescription.

The term includes (but is not limited to) cannabis, cocaine, opiates, amphetamines, hallucinogens, sedatives, hypnotics and anxiolytics.

"Seat Belt" means a properly installed:

(1) seat belt or lap and shoulder restraint; or
(2) other restraint approved by the National Highway Traffic Safety Administration.

LIMITATIONS. Safe Driver Benefits will not be paid if:

(1) the Accidental Death and Dismemberment Benefit is not paid under the Policy for your death;
(2) at the time of the accident, you were driving while intoxicated; or
(3) at the time of the accident, you were under the influence of any narcotic (except when taken on the advice of a Physician).

CLAIMS PROCEDURES
FOR LIFE BENEFITS

NOTE: This Certificate may include an Extension of Death Benefit or an Accelerated Death Benefit. If so, please refer to that section for special claim procedures.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you or your Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

PROOF OF CLAIM. Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of death. Documentation must include:

(1) a certified copy of the death certificate, for proof of death;
(2) a signed authorization for the Company to obtain more information; and
(3) any other items the Company may reasonably require in support of the claim.

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

(1) by a Physician of the Company's choice;
(2) as often as reasonably required.

The Company may delay benefits until an exam is completed, if:

(1) you fail to cooperate with an examiner, fail to take an exam, or delay an exam scheduled by the Company; and
(2) the Company determines that the failure or delay is without good cause.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment, and Settlement Options sections of the Policy.

The Policy may include Dependent Life Insurance. If so, any benefits payable for an insured Dependent's death will be paid to:

(1) you, if you survive that Dependent; or
(2) your Beneficiary or in accord with the Facility of Payment section, if the you do not survive that Dependent.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim, the written notice will:

(1) explain the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) inform the claimant of the right to request a review of the Company's decision, and the procedure and time limit for doing so; and
(3) describe any additional information or items needed to support the claim.

If reasonably possible, the Company will send this notice within:

(1) 90 days after receiving the first proof of a death claim; or
(2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy.

Delay Notice. If the Company needs more time to process a claim, due to special circumstances, an extension will be permitted. If needed, the Company will send the claimant a written delay notice:
(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:
(1) the special circumstances which require the delay; and
(2) when a decision can be expected.

In any event, the Company must send written notice of its decision within:
(1) 180 days after receiving the first proof of a death claim; or
(2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy.

If the Company fails to do so, there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time periods for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:
(1) 60 days after receiving a denial notice of a death claim; or
(2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy.

To request a review, the claimant must send the Company:
(1) a written request; and
(2) any written comments or other items to support the claim.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:
(1) any further appeal procedures available under the Policy;
(2) the claimant's right to access relevant claim information; and
(3) the right to bring legal action.

For a death claim, the notice will be sent:
(1) within 60 days after the Company receives the request for review; or
(2) within 120 days, if a special case requires more time.

For a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy, the notice will be sent:
(1) within 45 days after the Company receives the request for review; or
(2) within 90 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case, it will send the claimant a written delay notice by the 30th day after receiving the request for review. The notice will explain:
(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time periods for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this provision. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) 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, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from you or your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after written proof of claim is required to be given.

CLAIMS PROCEDURES
FOR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

NOTICE OF CLAIM. Written notice of an accidental death or dismemberment claim must be given:
(1) within 30 days after the loss occurs; or
(2) as soon as reasonably possible after that.

The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address and the number of the Policy.

Exception: Failure to give notice of claim within the required time period will not invalidate or reduce the claim if it is shown that the notice was furnished as soon as reasonably possible.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you or your Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

PROOF OF CLAIM. The Company must be given written proof of an accidental death or dismemberment claim:
(1) within 90 days after the date of the loss; or
(2) as soon as reasonably possible after that.

Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. Documentation must include:
(1) a certified copy of the death certificate, for proof of death;
(2) a copy of any police report, for proof of accidental death or dismemberment;
(3) a signed authorization for the Company to obtain more information; and
(4) any other items the Company may reasonably require in support of the claim.

Exception: Failure to furnish proof of claim within the required time period will not invalidate or reduce the claim if it is shown that the notice was furnished as soon as reasonably possible.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have you examined:
(1) by a Physician of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

The Company may delay benefits until an exam is completed, if:
(1) you fail to cooperate with an examiner, fail to take an exam, or delay an exam scheduled by the Company; and
(2) the Company determines that the failure or delay is without good cause.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. Any benefits payable for your death will be paid to your Beneficiary. Any benefit (other than your death benefit) will be paid to you.

Facility of Payment. All or part of your accidental death benefit may become payable to your estate when:
(1) there is no surviving Beneficiary to receive such benefit; or
(2) the Beneficiary is a minor or other person who is not considered competent to give a valid release.

In that event, the Company has the option to pay one or more of the following:
(1) your surviving spouse, parent(s), child or children; or
(2) your surviving brother(s) or sister(s).

No payment made under this Facility of Payment section may exceed $500. Any payment made in good faith under this section will fully discharge the Company, to the extent of the payment. Any remaining benefit will remain payable to your estate.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim, the written notice will:
(1) explain the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) inform the claimant of the right to appeal the denial, and the procedure and time limit for doing so; and
(3) describe any additional information or items needed to support the claim.

The claim decision notice will be sent within 15 days after the Company resolves the claim. It will be sent within 60 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:
(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:
(1) the special circumstances which require the delay; and
(2) when a decision can be expected.

If the claimant does not receive a written decision by the 60th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from the claimant to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above 60-day time limit for claim processing.

REVIEW PROCEDURE. Within 60 days after receiving a denial notice, the claimant 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.

He or she may request certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will 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, the notice will also describe:
(1) any further appeal procedures available under the Policy;
(2) the claimant's right to access relevant claim information; and
(3) the right to bring legal action.

This notice will be sent within 60 days after the Company receives the request for review, if reasonably possible.

Delay Notice. If the Company needs more than 60 days to process an appeal, in a special case, it will send the claimant a written delay notice by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above 60-day time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this provision. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) 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, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

(1) reduce future benefits until full reimbursement is made; or
(2) recover such overpayments from you or your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after written proof of claim is required to be given.

NOTICE TO CERTIFICATE HOLDERS

POLICY TERMINATION. If the Policy is to be terminated by the Company for a reason other than nonpayment of premium by the Group Policyholder, the Company will give the Group Policyholder advance notice of its intent to terminate the Policy. You will be informed of this event by the Group Policyholder at least 31 days prior to the Policy's termination date; unless the Group Policyholder:

(1) has taken steps to avoid Policy termination; or
(2) has contracted with another insurer to provide similar, continuous coverage.

In the event the Group Policyholder or Company terminates the Policy and the Group Policyholder does not provide replacement coverage with another carrier, please see the Conversion Privilege provision in this Certificate:

(1) for when to expect a notice; and
(2) for the time periods allowed to convert, if no notice is given.

NOTICE TO CERTIFICATE HOLDERS
INSURED FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

POLICY TERMINATION. If the Accidental Death and Dismemberment coverage is to be terminated by the Company for a reason other than nonpayment of premium by the Group Policyholder, the Company will give the Group Policyholder advance notice of its intent to terminate the Policy coverage. You will be informed of this event by the Group Policyholder at least 31 days prior to the Policy coverage's termination date; unless the Group Policyholder:

(1) has taken steps to avoid Policy coverage termination; or
(2) has contracted with another insurer to provide similar, continuous coverage.

SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by Lincoln Life & Annuity Company of New York of Syracuse, New York, 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 Life, Accidental Death and Dismemberment Insurance for Employees of D'Addario & Company Inc..

The name, address and ZIP code of the Sponsor of the Plan is: D'Addario & Company Inc., 595 Smith Street, Farmingdale, NY, 11735.

Employer Identification Number (EIN): 11-2288999 IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: D'Addario & Company Inc., 595 Smith Street, Farmingdale, NY, 11735, (631) 439-3212.

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 Lincoln Life & Annuity Company of New York. Lincoln Life & Annuity Company of New York 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.

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 Lincoln Life & Annuity Company of New York whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska.

Type of Plan. The benefits provided under the Plan are: Group Life, Accidental Death and Dismemberment Insurance benefits.

Type of Funding Arrangement: Lincoln Life & Annuity Company of New York.

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits. The Certificate also contains the Schedule of Insurance which includes the amount of Personal Life insurance, AD&D Principal Sum, Dependent Life amounts (if any), Waiting Period and age reduction information. If your Booklet, Certificate or Schedule of Insurance has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

Eligibility. Full-time employees working at least 40 hours per week.

Employees become eligible on the first of the month coinciding with or next following completion of 2 months of active full-time employment.

CONTRIBUTIONS: You are not required to make contributions for Personal Life & AD&D Insurance.

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

The name and section of relevant Collective Bargaining Agreements: None

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

Loss of Benefits. The Plan Administrator may terminate the policy, or subject to Lincoln Life & Annuity Company of New York'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 Lincoln Life & Annuity Company of New York. 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, Lincoln Life & Annuity Company of New York will send you or your beneficiary a written notice of its claim decision within:

- 90 days after receiving the first proof of a death or dismemberment claim (180 days under special circumstances);
- 45 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy (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, or another person on your behalf, may request a review of the claim by making a written request Lincoln Life & Annuity Company of New York within:

- 60 days after receiving a denial notice of a death or dismemberment claim;
- 180 days after receiving a denial notice of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy.

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. Lincoln Life & Annuity Company of New York will make a full and fair review of the claim and provide a final written decision to you or your beneficiary within:

- 60 days after receiving the request for a review of a death or dismemberment claim (120 days under special circumstances);
- 45 days after receiving the request for review of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy (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®

Lincoln Financial Group® Privacy Practices Notice

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

Information We May Collect And Use

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

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

How We Use Your Personal Information

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

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

Security of Information

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

Your Rights Regarding Your Personal Information

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

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

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

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

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

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

If you have questions about your personal information, please provide your full name, address and telephone number and either email your question to our Data Subject Access Request Team at DSAR@lfg.com or mail to:

Lincoln Financial Group
ATTN: Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

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

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