



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
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. GL 000403005364 has been issued to
A. H. Belo
(The Group Policyholder)

The Policy Effective Date is January 1, 2016

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

Employee Only Plan

You are entitled to the benefit 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.

WORKERS' COMPENSATION NOTICE

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

A handwritten signature in cursive script that reads "Dennis R. Glass".

PRESIDENT

CERTIFICATE OF GROUP INSURANCE

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

A. H. Belo
000403005364

SCHEDULE OF INSURANCE

CLASS 1

All Full-Time Employees electing the Employee only Plan

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

MINIMUM HOURS: 30 hours per week

VOLUNTARY AD&D INSURANCE - EMPLOYEE ONLY PLAN

PRINCIPAL SUM

Your (Employee) Coverage

Option 1:	One times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$500,000.
Option 2	Two times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$500,000.
Option 3:	Three times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$500,000.
Option 4:	Four times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$500,000.
Option 5:	Five times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$500,000.
Option 6:	Six times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$500,000.

Benefits will terminate when you retire.

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 commissions, 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.

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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 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; or
- (2) the day you resume Active Work, if you are not Actively at Work on the day the increase would otherwise take effect.

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 excused or emergency leave of absence (except a medical leave).

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

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

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

FULL-TIME EMPLOYEE means an employee of the EMPLOYER:

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

INSURANCE MONTH means:

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

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

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

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

ELIGIBILITY

If you are a Full-Time Employee and a member of an employee class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

- (1) the date of issue of the Policy; or
- (2) the day you complete the Waiting Period.

WAITING PERIOD. (See Schedule of Insurance.)

EFFECTIVE DATES OF COVERAGES

Your insurance is effective on the latest of:

- (1) the first day of the Insurance Month coinciding with or next following the date 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; or
- (3) the day you sign your payroll deduction form and apply for coverage, if you pay any part of the premium.

EXCEPTION. If your coverage terminates due to an approved leave of absence or a military leave, any Waiting Period or evidence of insurability requirement will be waived upon your return; provided you apply or are reenrolled within 31 days after resuming Active Work.

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

- (1) the day the Policy terminates;
- (2) the last day of the Insurance Month in which you request termination of your coverage;
- (3) the last day of the period for which the premium for your insurance has been paid;
- (4) the day you cease to be a member of an employee class shown in the Schedule of Insurance;
- (5) with respect to any particular insurance benefit, the date that part of the Policy providing such benefit terminates;
- (6) the last day of the Insurance Month in which your employment with the Employer terminates;
or
- (7) the day you enter the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

Ceasing Active Work terminates your eligibility. However, it may be possible to continue all or part of your insurance during a temporary lay off, leave of absence or military leave; or while you are unable to work due to sickness or injury. The conditions concerning such a continuance may be found in the Policy. See your Employer for this information.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable as a result of your death will be paid to your named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made 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 sibling or siblings in equal shares; or, if none
- (5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has. Such payment will release the Company from any further obligation for your death benefit.

If the person who would otherwise receive payment dies:

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

payment will be made as if you had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment card, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the Beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only you or your assignee may change your Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT

If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of you or your Beneficiary;
- (2) a person who has incurred expense as a result of your last illness or death;
- (3) the personal representative of your estate; or
- (4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed \$250. Any payment made in good faith under this Section will fully discharge the Company to the extent of the payment.

SETTLEMENT OPTIONS

All or part of any death or dismemberment benefit may be received in installments by making written election to the Company. Such an election may be made:

- (1) by you while living; or
- (2) by the person who is to receive payment, if no such election is in effect at the time of your death.

Any such election must comply with the Company's practices at the time it is made. The amount applied under a settlement option must be at least \$2,000. It must be sufficient to provide a payment of at least \$20 per month.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

DEATH OR DISMEMBERMENT BENEFIT. The Company will pay the benefit listed below, if:

- (1) you or your Dependent sustains a covered accidental bodily injury while insured under this provision; and
- (2) that injury directly causes one of the following losses within 365 days after the date of the accident.

The loss must result directly from the injury and from no other causes.

LOSS

BENEFIT

Loss of Life	Principal Sum
Loss of One Member (Hand, Foot or Eye)	1/2 Principal Sum
Loss of Two or More Members	Principal Sum
Loss of Thumb and Index Finger	1/4 Principal Sum
Loss of Both Speech and Hearing in Both Ears	Principal Sum
Loss of Either Speech or Hearing in Both Ears	1/2 Principal Sum
Loss of Hearing in One Ear	1/4 Principal Sum
Quadriplegia (Paralysis of Both Arms and Both Legs)	Principal Sum
Paraplegia (Paralysis of Both Legs)	1/2 Principal Sum
Hemiplegia (Paralysis of Arm and Leg of Same Side)	1/2 Principal Sum

The Principal Sum for your class is shown in the Schedule of Insurance. Under a Family Plan, the Principal Sum which applies to each Dependent is also shown. The Principal Sum for a Dependent is based upon family make-up at the time of the loss.

MAXIMUM PER PERSON. If you or your Dependent sustains more than one loss resulting from the same accident, the benefit:

- (1) will be the one largest amount listed; and
- (2) will not exceed the Principal Sum for all of that person's losses combined.

TO WHOM PAYABLE. Benefits for your loss of life will be paid to your Beneficiary. If you did not name a Beneficiary, or no named Beneficiary survives you; then your death benefit will be paid to your estate. If your Beneficiary is a minor, or the Company believes your Beneficiary lacks legal capacity; then up to \$250 may be paid to someone else in accord with the Facility of Payment section of the Policy. Under a Family Plan, benefits for a Dependent's loss of life will be payable to you. Any other benefits will be paid to the Insured Person.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

DEFINITIONS. "Beneficiary" means the person(s) named on your enrollment form. You may change the Beneficiary by filing a written notice of the change with the Company at its Group Insurance Service Office.

"Loss of a Member" includes the following:

- (1) "Loss of Hand or Foot," which means complete severance through or above the wrist or ankle joint. (In South Carolina, "Loss of Hand" can also mean the loss of four whole fingers from one hand.)
- (2) "Loss of an Eye," which means total and irrevocable loss of sight in that eye.

"Loss of Thumb and Index Finger" means severance of the thumb and index finger of the same hand, through or above the joint closest to the wrist. (In California, it can also mean loss by complete severance of at least one whole phalanx of each.)

"Loss of Speech" means total and irrevocable loss of audible communication.

"Loss of Hearing" means permanent and total deafness in that ear. The deafness cannot be corrected to any functional degree by any aid or device.

"Paralysis" means complete and irreversible loss or use of an arm or leg (without severance).

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions section.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT
INSURANCE--CONTINUED**

FELONIOUS ASSAULT BENEFIT. The Company will pay an additional 25% of your Principal Sum, if:

- (1) you suffer a loss for which an Accidental Death and Dismemberment benefit is payable;
- (2) the injury or death takes place while you are on the business of, or on any premises of, the Group Policyholder or Employer; and
- (3) the injury or death is the direct result of:
 - (a) a robbery, holdup, or attempted robbery or holdup;
 - (b) a kidnapping during a holdup; or
 - (c) a felonious assault.

DEFINITION. "Felonious Assault" means one inflicted by persons other than fellow employees or members of your family or household.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions which follow.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

MONTHLY COMA BENEFIT. The Company will pay a Monthly Coma Benefit, while you or your covered Dependent remains in a continuous coma; provided:

- (1) the coma is caused by an Injury sustained while insured under the Policy;
- (2) the coma begins within 365 days after the date of the accident; and
- (3) you remain in the coma for at least 31 days in a row.

The coma must result directly from the Injury and from no other causes.

This Monthly Coma Benefit:

- (1) will be payable for each month the person is in a continuous coma; but
- (2) in no event will more than 36 months of benefits be paid.

No Monthly Coma Benefit will be paid after the coma ends; whether by death, recovery, or any other change of condition. If, when the coma ends, benefits are due for a period of less than a month; then payment will be prorated. The daily rate will equal 1/30 of the Monthly Coma Benefit.

AMOUNT. The Monthly Coma Benefit will equal 1% of the difference between:

- (1) the Principal Sum that would be payable for your or your Dependent's accidental death; and
- (2) the amount of any benefits paid or payable under the Policy for that person's other Scheduled Losses as a result of the same accident.

In no event will the total benefits payable for all of a person's Scheduled Losses resulting from the same accident exceed the Principal Sum, which would be payable for that person's accidental death.

SUBSEQUENT LOSS. If, you or your Dependent later suffers another Scheduled Loss covered by the Policy, due to the same accident that caused the coma; then the benefit paid for the later loss will equal:

- (1) the benefit stated in the Schedule of Insurance; reduced by
- (2) the total amount of benefits paid, including the Monthly Coma Benefits paid, for the same person's Scheduled Losses as a result of that accident.

If the person continues to qualify for a Monthly Coma Benefit after such other loss; then the amount of the Monthly Coma Benefit will be redetermined, as shown above.

PROOF. You or your Beneficiary is responsible for providing the Company proof of the continuing comatose condition. The Company retains the right to investigate, to determine whether the coma exists and continues.

TO WHOM PAYABLE. The Monthly Coma Benefit for you will be paid in accord with the Beneficiary section. If you are insured under the Family Plan, the Monthly Coma Benefit for your covered Dependent will be paid to you.

"Coma" means being in a state of complete mental unresponsiveness, with no evidence of appropriate responses to stimulation.

"Scheduled Loss" means any of the following losses, if covered under the Policy: loss of life, member(s), speech or hearing, paralysis, permanent total disability, coma or common disaster. It does not include any additional seat belt, felonious assault, child care, education, spouse training, spouse critical period, monthly survivors or monthly in-hospital benefits which may be included under the Policy.

EXCLUSIONS. Benefits will not be paid:

- (1) when the person remains in a coma for less than 31 days in a row; or
- (2) for any loss excluded under the Voluntary Accidental Death and Dismemberment Exclusions section.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)
INSURANCE--CONTINUED**

EXCLUSIONS. No benefit will be paid for loss resulting from:

- (1) intentionally self-inflicted injury or attempted injury, while sane or insane;
- (2) war or any act of war (whether declared or undeclared);
- (3) any accident occurring while you or your covered Dependent is serving on full-time active duty in the armed forces of any state or country (except for duty of 30 days or less for training in the Reserves or National Guard);
- (4) travel or flight in (or boarding or leaving) any aircraft or device which can fly above the earth's surface, if:
 - (a) the aircraft or device is being used for tests, experimental purposes, or travel beyond the earth's atmosphere (or is designed for such travel);
 - (b) the aircraft or device is being used by or for any military authority (except for aircraft flown by the U.S. Military Aircraft Command or similar service of any country);
 - (c) the aircraft or device is other than a chartered aircraft; and it is being used by or for the Group Policyholder, Employer or its subsidiary or affiliate (whether it is owned, leased, operated or controlled as defined below);
 - (d) you or your covered Dependent is serving as a pilot, crew member or student taking a flying lesson (and is not riding as a passenger); or
 - (e) you or your covered Dependent is hang-gliding or parachuting (except where a parachute jump must be made for self-preservation);
- (5) you or your covered Dependent's commission of a felony;
- (6) sickness, disease or bodily infirmity; except for:
 - (a) a bacterial infection resulting from an accidental cut or wound; or
 - (b) the accidental ingestion of a poisonous food substance; or
- (7) you or your covered Dependent's driving a motor vehicle while intoxicated, impaired or under the influence of drugs (except for drugs taken as prescribed by a licensed physician).

DEFINITIONS. As used in this section, "Owned Aircraft" means one the Group Policyholder or Employer holds legal or equitable title to; and can use, alter or sell as desired.

"Leased Aircraft" means one the Group Policyholder or Employer does not own, but can use as desired for the term of a written lease. The time will be longer than a few days or one or two trips. The aircraft cannot be altered or sold without the owner's consent.

"Operated or Controlled Aircraft" means one the Group Policyholder or Employer does not own; but has leased, rented or borrowed and can use as desired for more than 10 straight days. It cannot be altered or sold without the owner's consent.

"Chartered Aircraft" means one the Group Policyholder or Employer does not own; but has hired for one purpose, one trip or general use. The time may not exceed 10 straight days or 15 days in any one year. One or more aircraft hired on a regular or frequent basis are not chartered.

"Intoxicated", "Impaired", or "Under the Influence of Drugs" shall be as defined by the jurisdiction where the accident occurs. The exclusion will apply whether or not the driver is convicted.

DISAPPEARANCE BENEFIT

BENEFIT. The Company will pay a Disappearance Benefit if, while insured for Accidental Death and Dismemberment Insurance under the Policy, your body has not been found within one year of a forced landing, stranding, sinking or wrecking of a conveyance in which you were an occupant. It shall be deemed, subject to all other terms and provisions of the Policy, that you have suffered a loss of life.

The Benefit amount payable will be as defined in the Death or Dismemberment Benefit section of the Policy.

TO WHOM PAYABLE. Benefits for your loss of life will be paid in accord with the Beneficiary section.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of the Policy.

EXPOSURE BENEFIT

BENEFIT. The Company will pay an Exposure Benefit, if, while insured for Accidental Death and Dismemberment Insurance under the Policy, you:

- (1) are unavoidably exposed to the elements; and
- (2) as a result of such exposure suffer a loss for which benefits are otherwise payable.

The Benefit amount payable will be as defined in the Death or Dismemberment Benefit section of the Policy.

TO WHOM PAYABLE. Benefits for your loss of life will be paid in accord with the Beneficiary section. Any other benefits will be paid to you.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of the Policy.

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 the Insured Person's 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 Employer.

"Intoxicated," "Impaired," or "Under the Influence of Drugs" shall be defined as by the jurisdiction where the accident occurs.

"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 Benefits is not paid under the Policy for your death; or
- (2) at the time of the accident, you or any other person who was driving the auto in which you were traveling:
 - (a) was driving without a valid drivers' license;
 - (b) was driving in excess of the legal speed limit; or
 - (c) was driving while intoxicated, impaired, or under the influence of drugs (except for drugs taken as prescribed by a Physician for the driver's use).

The above limitations will apply, whether or not the driver is convicted.

COMMON CARRIER ACCIDENT BENEFIT

BENEFIT. The Company will increase your Death or Dismemberment Benefit to two times the amount otherwise payable, not to exceed \$1,000,000; provided you suffer a covered loss from a Common Carrier Accident while insured for Accidental Death and Dismemberment Insurance under the Policy.

MAXIMUM PER PERSON. If you sustain more than one loss resulting from the same accident, then the benefit:

- (1) will not exceed two times your Principal Sum for all of your covered losses combined; and
- (2) will not exceed an overall maximum of \$1,000,000.

The loss must result directly from the Common Carrier Accident and from no other causes.

TO WHOM PAYABLE. Benefits for your loss of life will be paid in accord with the Beneficiary section. Any other benefits will be paid to you.

DEFINITIONS.

"Common Carrier Accident" means a covered accidental bodily injury, which is sustained while riding as a fare paying passenger (not a pilot, operator or crew member) in or on, boarding or getting off from a Common Carrier.

"Common Carrier" means any land, air or water conveyance operated under a license to transport passengers for hire.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Exclusions or Limitations section of the Policy.

**CLAIMS PROCEDURES
FOR LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

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

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of an accidental death or dismemberment claim must be given within 20 days after the loss occurs; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) your name and address; and
- (2) the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you 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 claim within 90 days after the date of the loss; or 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. In addition to the information requested on the claim form, 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.
- (4) Any other items the Company may reasonably require in support of the claim.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

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.

If you fail to cooperate with an examiner or fail to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under the Policy will be paid:

- (1) immediately after the Company receives complete proof of claim and confirms liability; and
- (2) in any event, within 60 days after the Company receives acceptable proof of claim.

TO WHOM PAYABLE

Death. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment and Settlement Options sections of the Policy. If the Policy includes Dependent Life Insurance; then 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 you do not survive that Dependent.

Dismemberment. If the Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than your death benefit, will be paid to you.

CLAIMS PROCEDURES (Continued)

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; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within:

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

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then 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 the special circumstances which require the delay, and 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 or dismemberment claim; or
- (2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit available under the Policy.

If the Company fails to do so; then 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; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:

- (1) 60 days after receiving a denial notice of a death or dismemberment claim; or
- (2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit available under the Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review 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 explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

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

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit available under the Policy, the 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.

CLAIMS PROCEDURES (Continued)

Delay Notice. If the Company needs more time to process an appeal, in a special case; then 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: If the Company needs more information from the claimant 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 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 section. 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 you, or from 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 the date written proof of claim is required.

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 AD&D Insurance for Employees of A. H. Belo.

The name, address and ZIP code of the Sponsor of the Plan is: A. H. Belo, 508 Young Street, Dallas, TX, 75202.

Employer Identification Number (EIN): 38-3765318 IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: A. H. Belo, 508 Young Street, Dallas, TX, 75202, (214) 977-5911.

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.

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 AD&D and Dependent AD&D 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. The Certificate also contains the Schedule of Insurance which includes the amount of Personal AD&D Principal Sum, Dependent AD&D 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 30 hours per week.

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

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

CONTRIBUTIONS: You are required to make contributions for Personal 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 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 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 The Lincoln National Life Insurance Company 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. The Lincoln National Life Insurance Company 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.

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.

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.

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.

TOLL-FREE TELEPHONE NUMBERS FOR INFORMATION AND COMPLAINTS

IMPORTANT NOTICE

To obtain information or make a complaint: You may call The Lincoln National Life Insurance Company's toll-free telephone number for information or to make a complaint at 1-800-423-2765.

You may also write to The Lincoln National Life Insurance Company at:
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance
P.O. Box #149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web: <http://www.tdi.texas.gov>

E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja: Usted puede llamar al numero de telefono gratis de The Lincoln National Life Insurance Company para informacion o para someter una queja al 1-800-423-2765.

Usted tambien puede escribir a The Lincoln National Life Insurance Company:
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al 1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas
P.O. Box #149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web: <http://www.tdi.texas.gov>

E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)**

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (“the Association”) administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, ONLY if the following conditions are met:
 - (1) The policyholder has a policy with a company domiciled in Texas;
 - (2) The policyholder’s state of residence has a similar guaranty association; and
 - (3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder’s state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us



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; 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; 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 trained on the importance of data privacy.

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; or
- For which an authorization is required.

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

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.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

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

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