



**Group Long-Term Disability Insurance
Voluntary**

SUMMARY OF BENEFITS

Sponsored by: CITY OF WICHITA

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit

| | Monthly Benefit | Maximum Benefit Duration | Own Occupation Period | Elimination Period |
|-------------------------------|---|--|------------------------------|---------------------------|
| Employee Paid Plan | \$100 increments up to 60% of monthly salary Minimum: \$400 per month Maximum: \$8,000 per month | Later of Age 65 or Social Security Normal Retirement Age | 36 Months | 90 Days |
| Pre-Existing Condition | You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months, or you remain treatment free for a period of 3 consecutive months. | | | |
| Waiver of Premium | You will not be required to pay premium during any time of approved total or partial disability. | | | |
| Benefit Limitations | Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: No Limit | | | |

Enrolling for Coverage

Eligibility: All employees in an eligible class.
You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.

Semi-Monthly Premium Calculation**

| | | EXAMPLE | Attained Age | Premium Factor |
|---|--|---|---------------------|-----------------------|
| List your monthly earnings (*Maximum covered payroll is \$13,333 Monthly) | \$ _____ | \$5,417 | 0 - 29 | 0.00060 |
| Multiply by 60.00% Based on the amount shown on above, determine the coverage you want, not to exceed the number above | \$ _____ (Round down to the next lower \$100 increment) | \$3,250 (\$3,250 rounds down to \$3,200) | 30 - 34 | 0.00100 |
| Write the total amount of coverage you have elected, not to exceed the limit above | \$ _____ | \$3,200 | 35 - 39 | 0.00170 |
| Multiply by your premium factor | _____ | 0.00170 | 40 - 44 | 0.00250 |
| Your Estimated Semi-Monthly Premium** | \$ _____ | \$5.44 | 45 - 49 | 0.00370 |
| | | | 50 - 54 | 0.00570 |
| | | | 55 - 59 | 0.00775 |
| | | | 60 - 64 | 0.00790 |
| | | | 65 - 69 | 0.00690 |
| | | | 70 - 74 | 0.01225 |
| | | | 75 - 99 | 0.01225 |

**This is an estimate of premium cost.
Actual deductions may vary slightly due to rounding and payroll frequency.

Understanding Your Benefits

| | |
|-----------------------------------|---|
| Elimination Period | The number of days you must be disabled prior to collecting disability benefits. |
| Own Occupation | The occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles. |
| Total Disability | Due to an injury or illness, you are unable to perform each of the main duties of your own occupation on a full-time basis. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training. |
| Partial Disability | Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer and continue to receive benefits, which may enable you to receive 100% of your income during your time of disability. |
| Continuation of Disability | If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately with no new Elimination Period. |
| Benefit Duration Reduction | Your benefit duration may be reduced if you become disabled after age 65. |
| Pre-Existing Condition | Any sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to your coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date. |
| Benefit Exclusions | You will not receive benefits in the following circumstances: <ul style="list-style-type: none">• Your disability is the result of a self-inflicted injury.• You are not under the regular care of a doctor when requesting disability benefits.• You were involved in a felony commission, act of war, or participation in a riot.• You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer. |
| Benefit Reductions | Your benefits may be reduced if you are receiving benefits from any of the following sources: <ul style="list-style-type: none">• Any compulsory benefit act or law (such as state disability plans);• Any governmental retirement system earned as a result of working for the current policyholder;• Any disability or retirement benefit received under a retirement plan;• Any Social Security, or similar plan or act, benefits;• Earnings from any form of employment;• Workers compensation;• Salary continuance or employer contributions to an employer sponsored retirement plan. |
| Coverage Termination | Coverage will terminate when you terminate employment with this policyholder, or at your retirement. |

Additional Benefits

Progressive Income Benefit, Family Care Expense Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Program, Waiver of Premium and Portability

See your Schedule of Benefits on your Certificate for more information

For assistance or additional information Contact Lincoln Financial Group at

(800) 423-2765; reference ID: **CITYOFWICH**

www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Should there be a difference between this summary and the policy, the policy will govern.

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