Lincoln Financial Group®

Group Short-Term Disability Insurance Voluntary

SUMMARY OF BENEFITS

Sponsored by: **Nye County**

All Participants with approved Weekly Income Amounts as of June 30, 2014

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit	**Weekly Benefit**	**Elimination Period**	**Maximum Duration**
	Any $50 increment, with a minimum of $100 of coverage Maximum of $1,000 per week, not to exceed 60% of salary	Benefits begin on: Accident: 15th day Illness:15th day	11 weeks

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 6 months.
Integration of Benefits	Your benefits may be reduced by benefits received from state disability or worker's compensation programs. The total of all benefits received from this policy, state disability plans, worker's compensation programs and your employer's sick pay plan may not exceed 100% of your income prior to disability.

Additional Benefits

Portability
Rehab Assistance - 5%
Survivor Income - 3 Weeks
C-Section Benefit - 8 weeks
See your Schedule of Benefits on your Certificate for more information

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.

Monthly Premium Calculation**

			EXAMPLE Age 35
1	List your weekly earnings (Maximum covered payroll is $1,667 weekly)	$_____	$610
2	Multiply by 60%	$_____	$366
3	Determine the coverage you want, not to exceed the number on Line 2	(Round down to the next lower $50 increment)	($366 rounds down to $350)

Attained Age	Premium Factor
0 - 29	0.04950
30 - 34	0.04950
35 - 39	0.04950
40 - 44	0.04950
45 - 49	0.05170
50 - 54	0.05280
55 - 59	0.06380
60 - 64	0.07260
65 - 69	0.07590

4	Write the total amount of coverage you have elected	$_____	$350	70 - 74 0.07590 75 - 99 0.07590
5	Multiply by the premium factor	_____	0.04950	
6	Your Estimated Monthly Premium	$_____	$17.33	

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

Understanding Your Benefits	
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	Partial Disability means that, 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. Benefits may be payable if the requirements that our outlined in your Certificate of Coverage are met. Partial disability benefits allow you to work and earn income from your employer and continue to receive benefits. See Certificate of Coverage for details.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 2 weeks of returning to work, you will begin receiving benefits again immediately.
Pre-Existing Condition	Any sickness or injury for which you have 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.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • 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 the insured earns or receives from any form of employment; • You are receiving sick leave pay from your employer. • Disability income benefits received under state disability benefit laws.
Rehabilitation Assistance Benefit	Employees who participate in an approved rehabilitation program are eligible to receive an additional percent of benefit. Additionally, approved program costs may be reimbursed.
Survivor Income	A benefit may be paid to your survivor for additional months if you should die while you were eligible to receive benefits under this policy.
Coverage Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **NYECOUNTY**	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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