



State of Alaska

Optional Benefits Information Booklet

April
2010

The Alaska Department of Administration complies with Title II of the 1990 Americans with Disabilities Act (ADA). This publication is available in alternative communication formats upon request. To make necessary arrangements, contact the ADA Coordinator for the Division of Retirement and Benefits, at (907) 465-4460 or contact the TDD for the hearing impaired at (907) 465-2805.

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The death benefits and disability plans are insured and claims are paid by:

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Claims are filed with the Division at the address listed above.

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INTRODUCTION TO THE OPTIONAL BENEFITS PLAN

HIGHLIGHTS

- Optional benefits may be purchased with pretax payroll deductions.
- Benefits include life, accidental death and dismemberment, survivor, and disability insurance.
- A Dependent Care Assistance Plan can help you pay for day care expenses from pretax contributions.

INTRODUCTION

The Optional Benefits Plan gives you the flexibility to purchase the optional coverage which best suits your needs and circumstances. You purchase the benefits of your choice through pretax payroll deductions; your deductions will not be taxed as income by the IRS.

Because this plan takes advantage of IRS tax rules to provide pre-tax premiums, those rules govern the operations of the plan. It is important to review the options for electing and canceling coverage to ensure the best benefit selections for you and your family.

This booklet may be updated from time to time to reflect changes in the plans. Be sure you are using the most current edition, which is available from the division or its website.

This booklet summarizes the Optional Benefits plan and it is not possible to address every individual circumstance. If you have questions about how the plan pertains specifically to your situation, please contact the division.

In case of conflict between this booklet and official plan documents or IRS regulations, the documents and regulations will determine benefits and eligibility.

ELIGIBILITY

As of January 1, 2003, the following employees are eligible to participate in Optional Benefits:

- State employees not participating in Select Benefits, except members of the Labor, Trades and Crafts Unit and the Correspondence Teachers Unit.
- Employees of a participating political subdivision covered under the terms of the political subdivision's participation agreement.

Leased employees and emergency employees hired for natural disasters are not eligible.

OPTIONAL BENEFITS

If you are eligible, you may enroll in any of the available Optional Benefits, including the following:

- Life insurance
- Accidental Death and Dismemberment coverage
- Survivor benefits
- Disability benefits (short term and long term disability plans)
- Dependent Care Assistance Plan

Each benefit option has a cost, which may change from year to year. The current costs are listed on the premium card, a separate insert. In addition, you may contribute up to \$5,000 a year to the Dependent Care Assistance Plan. The cost of your benefits is deducted directly from your paycheck. The deduction will be made before federal income tax is withheld from your paycheck; therefore, your taxes will be less.

A N E X A M P L E . . .

Stephanie is a single employee who earns \$2,000 a month. The total monthly cost of her elected optional benefits is \$49 a month. Since federal income taxes will not be withheld from the \$49, Stephanie's monthly take-home pay will be reduced only \$35, and not the full \$49.

Plans such as this one are subject to complex tax rules. In some years, it's possible that employees with relatively high earnings will be limited in the amount of optional benefits they can purchase with nontaxable earnings. You will be notified if this ever applies to you.

BENEFIT YEAR

The benefit year is July 1 through June 30.

ELECTING COVERAGE

New Employees

You must elect coverage within 30 days of the date you were first hired. If you do not elect coverage within 30 days, you waive enrollment for that benefit year unless you have a qualified status change (see page 5).

Rehired Employees

Employees who are terminated and rehired in a *new* benefit year must enroll as described for new employees above.

Employees who are rehired in the same benefit year in which they terminated are re-enrolled in the same benefits they had during their previous employment.

Employees Moving from a Nonparticipating Position

Employees who move from a position that does not participate in Optional Benefits to one that does participate have 30 days from the date of the position change to elect coverage. If you do not elect coverage within 30 days, you waive enrollment for that benefit year unless you have a qualified status change (see page 5).

CHANGING COVERAGE

You may elect a new benefit, change an existing benefit, or delete coverage during one of the opportunities described below.

Open Enrollment

Open enrollment is held annually each May/June. Changes made during open enrollment are effective for the next benefit year starting July 1.

If you are on leave without pay or layoff on the date the open enrollment or benefit year begins, you may elect coverage either during open enrollment or within 30 days of the date you return to work.

If you do not change your benefits during the open enrollment, you will automatically be re-enrolled in the same benefits you had in the prior year. **Caution: participation in the Dependent Care Assistance Plan is not automatically renewed.** If you want to be in the reimbursement account, you **must** submit an enrollment during each open enrollment. The enrollment must be for **all** the benefits you want. If you are enrolled in one benefit year, including the Dependent Care Assistance Plan, and you don't submit an enrollment during

open enrollment, you will automatically be re-enrolled for any benefits you have, **but you will be dropped from the Dependent Care Assistance Plan.**

Elections made during open enrollment will remain in effect until the end of the benefit year, June 30, unless you terminate your employment or change your elections following a qualified change in your family or employment status (see next section).

Change in Status

You may add, change, or delete your elections following one of the qualified status changes shown below:

- You gain or lose a dependent through birth, adoption, marriage, divorce, or death.
- Your dependent child is no longer eligible under the terms of the plan.
- Your spouse terminates employment or begins an extended period of leave without pay or layoff.
- Your spouse begins employment or returns from an extended period of leave without pay.
- You or your spouse change employment status from full-time to part-time or vice versa.

Your coverage change must be consistent with the qualified status change. For example, if the number of your children change through marriage, divorce, birth or adoption, you may change your Dependent Care Assistance Plan. You may not change your Dependent Care Assistance Plan if you marry but do not gain a dependent child as a result.

You may change life, AD&D, survivor and disability benefits following any qualified status change.

Benefit changes must be received within 30 days after a qualified status change.

WHEN COVERAGE BEGINS

Coverage begins on the dates described below assuming you have sufficient salary to pay the premiums.

New/Rehired Employees

Coverage begins on the first of the month following 30 days of employment. For example, if you begin work on March 15, you are covered on May 1.

Employees Returning from Leave Without Pay or Layoff

When you return from leave without pay or layoff, you are covered on the first of the month following your return to work. For example, if you return to work from leave without pay on July 15, coverage begins on August 1.

Employees Moving from a Nonparticipating Unit

Employees who move from a bargaining unit that does not participate in Optional Benefits to a bargaining unit that does will be covered on the first of the month after the bargaining unit change occurs. For example, if your bargaining unit change is effective on October 15, your Optional Benefits would begin on November 1. If the bargaining unit change is effective on the first of the month, Optional Benefits are also effective on that day.

Newborn Children

Coverage for a newborn child begins immediately under the Dependent Care Assistance Plan and after 14 days under the Accidental Death and Dismemberment benefit, assuming you are enrolled in those options at that time.

WHEN COVERAGE ENDS

Coverage under Optional Benefits ends at the earliest time that one of the following occurs:

Employees on Leave Without Pay or Layoff

Coverage ends on the last day of the month in which you were last in pay status. For example, if you worked or were on paid leave status on January 15 and then placed on leave without pay or layoff, coverage ends on January 31.

Employees Who Terminate Employment

Coverage ends on the last day of the month in which you last worked. For example, if you last worked on January 15 and terminated your employment, coverage ends on January 31.

Dependents

Coverage for a dependent (under the Accidental Death and Dismemberment option that cover dependents) ends on the same day as your coverage, unless:

- you divorce. Coverage for your spouse ends on the date the divorce is final; or
- your child no longer meets **all** eligibility requirements (see page 18). Coverage ends on the last day of the month in which the child first fails to meet any of these requirements.

Employees Moving to a Nonparticipating Unit

Coverage ends on the last day of the month in which you move from a position which participates in Optional Benefits to a position that does not.

Failure to Pay the Required Premium

Coverage terminates at the end of the month for which the last required premium was paid.

RECEIPT OF DOCUMENTS/ ENROLLMENT

If the Division has no record of receipt of an application, election or claim, the document will have no effect unless you can provide reasonable proof that the document was sent to the Division. Reasonable proof includes such items as a certified mail receipt or a receipt stamp from the Division of Retirement and Benefits.

All Optional Benefits documents should be sent directly to the Division. The Division will not be bound to any action due to receipt of a document at a location other than the Division or proper claim office.

FUTURE OF THE PLAN

Although the State of Alaska intends to maintain the Optional Benefits plan indefinitely, the State reserves the right to alter, amend, delete, cancel or otherwise change the plans or components of the plan at any time.

DEATH BENEFITS

INTRODUCTION

The Optional Benefits offers three types of coverage that pay benefits in the event of your death; Life Insurance, Accidental Death and Dismemberment (AD&D) and Survivor Benefits. You may elect one or more of the death benefits. You may also elect to cover your eligible family members under the AD&D benefit.

These death benefits pay in addition to any other death benefits you may have such as Basic and Optional Life available to most State employees or other employer-provided or private life insurance plans. When considering electing death benefits, you should consider other death benefits you already have.

Certain restrictions are placed on the amount and combination of death benefits you may elect due to tax rules.

Death benefits are term insurance. This means they build up no cash value like a private life insurance policy does but also means they are generally less expensive than private policies might be.

PREMIUMS

Death benefit premiums are determined by your age as of July 1 of the benefit year for which you enroll. For example, if you are newly hired or have a status change and your enrollment is effective on November 1, your age will be calculated as of July 1 of that year. If you enroll during an open enrollment period, premium calculations are based on your age as of July 1 of the new benefit year.

Your age and premium are recalculated annually based on your age as of July 1. This premium remains in effect for entire benefit year.

BENEFICIARIES

Death benefits are paid to the beneficiary or beneficiaries you designate when you enroll in the plan.

If you have elected the AD&D benefit and are dismembered or a covered family member dies or is dismembered, benefits will be paid to you.

To name a beneficiary, you must complete a Beneficiary Designation form, available from the division or its website. You may name one or more beneficiaries for each death benefit. If you name more than one beneficiary, you must designate the percentage to be paid to each person. Also, you should name a contingent beneficiary in case your primary beneficiary dies before receiving benefits.

To change your beneficiary **at any time**, submit a revised Beneficiary Designation form to the division. The change will become effective on the date the division receives your form.

If you do not designate a beneficiary or if no beneficiary survives you, the death benefits are paid to the first survivor in the order shown below:

- your spouse,
- your children in equal parts,
- your parents in equal parts,
- your estate.

If you designate more than one beneficiary and do not specify the interest of each, the beneficiaries share equally. If any beneficiary dies before you, the interest of that beneficiary is paid in equal shares to any beneficiaries who survive you.

Please note if you designate your minor child as your beneficiary, the benefit will be paid to their guardian or court-appointed conservator. Some restrictions apply to the amount of each benefit that may be paid to a minor beneficiary. You may want to consider a trust fund for any minor children.

Once payments begin to your beneficiaries under the Survivor benefit, they must designate their own beneficiary to receive any remaining unpaid monthly benefits in the event of their death.

WAIVER OF PREMIUM WITH DISABILITY

If, before age 60, you become totally disabled and unable to perform any work or engage in any occupation for wage or profit for nine consecutive months, you may apply for a premium waiver. If the waiver is granted, your insurance remains in force without any premium payment as long as you remain disabled. A waiver of premium application must be received by the Division within ninety days of the date you are totally disabled.

After approval, you must furnish proof of disability during the three-month period immediately before each anniversary of the premium waiver to the life carrier. The life carrier has the right to have a designated physician examine you, but not more than once in any 12-month period after your disability waiver has been in force for two years.

If you die while insured under this provision, the life carrier is liable only if written notice of the claim is given to the home office within one year from the date of your death. The notice must contain written proof that continuance of total disability existed until the date of death.

Total disability under this provision means you are unable to engage in any occupation for wage or profit. If you suffer the entire and irrecoverable loss of both hands by severance through or above the wrists, or loss of both feet by severance through or above the ankles, or one hand through or above the wrist and one foot through or above the ankle, the disability is considered total unless and until you resume an occupation for wage or profit.

If you elected coverage under the conversion privilege before you were eligible for the disability waiver, you are granted all benefits under this provision in exchange for surrendering your individual policy without claim except for refund of premium, less loans or premium refunds paid under the individual policy. Nothing in the disability waiver provision permits you to have a greater amount of insurance than the amount you had while employed.

All benefits under this provision terminate immediately on the earliest of:

- the date your total disability ends;
- the anniversary of your discontinued premium payments, if your insurance ended before that and you failed to show proof of continued disability; or
- the date you fail to submit a medical examination that is requested by the life carrier.

After your coverage terminates, you become eligible for all rights and benefits provided under conversion privileges as though your employment had terminated unless you go back to work and again become eligible for benefits under this plan.

ASSIGNMENT OF POLICY

You may assign your life insurance by completing a transfer of ownership form. This means all rights and privileges of the policy would transfer to the new owner. Since an assignment of this nature is irrevocable, and tax laws have a direct effect on assignment, you should consult an accountant or attorney before assigning your life insurance. Your AD&D insurance and Survivor benefit cannot be assigned. Your death benefits are not subject to the claims of creditors.

CONVERSION PRIVILEGE

If coverage ends because you terminate employment or become disabled, you may convert to any form of individual policy of life insurance customarily issued by the carrier (without double indemnity or disability riders), except term insurance. No evidence of your good health is required.

You must apply for conversion and pay the premium within 31 days after termination of coverage. The amount of the premium will be based on your age and the amount of insurance you have elected. If you die during this 31-day period, the amount of insurance you were entitled to convert will be paid to your beneficiary, whether or not you applied for conversion.

LIFE INSURANCE

LIFE INSURANCE HIGHLIGHTS

- Employee coverage only.
- Payments made at death regardless of the cause.

INTRODUCTION

If you die from any cause while covered under this plan, the Life Insurance plan will pay benefits to your designated beneficiary or beneficiaries.

Life Insurance has no exclusions or pre-existing conditions limitation. Benefits are paid regardless of the cause of death.

WHO MAY BE COVERED

This plan is available to employees only. Dependents are not covered under the plan.

AMOUNT OF COVERAGE

Life Insurance pays in a lump sum to your beneficiary or beneficiaries. You may enroll for one of the following amounts of life insurance:

\$10,000

\$20,000

\$30,000

\$40,000

\$48,000

If you enroll in Survivor Benefits, you cannot enroll in more than \$10,000 of this life insurance.

If you want to enroll in the AD&D plan, you must enroll for at least \$10,000 of this life insurance coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT(AD&D) PLAN

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) HIGHLIGHTS

- “Employee only” or “employee and family” coverage.
- Employee benefit amount for accidental death is \$100,000.
- Dependent benefit amounts are based on family composition at time of loss.
- Accidental dismemberment benefit amounts are based on the type of dismemberment.

INTRODUCTION

The Accidental Death and Dismemberment (AD&D) plan will pay benefits for death or serious injury resulting from a covered accident.

To enroll in the AD&D plan, you must be enrolled for at least \$10,000 of Life Insurance benefits.

WHO MAY BE COVERED

This plan is available for yourself only or yourself and your family. If you elect to cover your family, your eligible dependents include:

- Your spouse. You may be legally separated but not divorced.
- Your children from 14 days old up to 23 years of age **only** if they are:
 - your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;
 - unmarried and chiefly dependent upon you for support; and
 - living with you in a normal parent-child relationship;
 - This provision is waived for natural/adopted children of the employee who are living with a divorced spouse, assuming all other criteria is met.
 - Only stepchildren living with the employee 50% of the time or more are covered under this plan.

Children incapable of earning their own living because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to rely chiefly on you for support. You must furnish the health carrier evidence of the incapacity, proof the incapacity existed before age 23 and proof of financial dependency. This proof must be provided no later than 31 days after their 23rd birthday or the date they become covered under the plan, whichever is later. The health

carrier has the right to require proof of the ongoing incapacity and dependency and the right to examine your child as often as needed as long as the incapacity continues. Assuming you continue to cover your dependents, children are covered as long as the incapacity exists, they meet the definition of children, except for age, and you continue to give proof of the incapacity or have examinations as required.

If the AD&D plan covers more than one family member, each eligible family member may be covered both as an employee and as a dependent, or as the dependent of more than one employee. For example, you elect coverage for employee and family and your spouse elects coverage for themselves only. If your spouse dies accidentally, your AD&D benefit for your spouse would be paid to you and their AD&D benefit would be paid to their beneficiary.

AMOUNT OF COVERAGE

The full benefit amount for employees who enroll in this plan is \$100,000. If you enroll your family, the benefits payable for a loss incurred by a family member will be based on the composition of your family at the time of the loss. This is shown in the following table:

| Family Composition at Time of Loss | Full Benefit Amount |
|---|----------------------------|
| Employee, Spouse and Dependent Children | |
| • Employee | \$100,000 |
| • Spouse | 40,000 |
| • Each Child | 5,000 |
| Employee and Spouse | |
| • Employee | \$100,000 |
| • Spouse | 50,000 |
| Employee and Dependent Children | |
| • Employee | \$100,000 |
| • Each Child | 10,000 |

The plan will pay benefits if a covered individual dies or suffers a covered loss within 100 days after, and as the result of, an accidental injury, independent of all other causes. Benefits will be paid as follows:

| For the loss of... | The plan will pay... |
|---|-----------------------------|
| Life | Full benefit amount |
| Both eyes, feet or hands or any combination thereof | Full benefit amount |
| One eye, one foot or one hand | 1/2 of full benefit amount |
| Thumb and index finger of same hand | 1/4 of full benefit amount |

As used above, "loss" for hands and feet means complete severance through or above the wrist or ankle joint; for eyes, complete and irrevocable loss of sight. Loss of sight must be certified as being entire and irrecoverable by a licensed physician specializing in ophthalmology and certified by the American Board of Ophthalmology.

EXCLUSIONS

The AD&D plan will not pay benefits for a loss resulting from any of the following:

- Suicide or suicide attempt by the covered person while sane or insane.
- Disease or bacterial infections, except pyogenic infections which occur through an accidental cut or wound.
- Injury sustained while serving as a pilot or crew member of any aircraft, **except** when traveling on State business.

- Declared or undeclared war or any act thereof.
- Service in the armed forces of any country or international authority unless the services does not exceed 30 days.

SURVIVOR BENEFITS

SURVIVOR BENEFITS HIGHLIGHTS

- Coverage for employee only.
- Payments made at death regardless of the cause.
- You select the payment duration.

INTRODUCTION

If you die from any cause while covered under this plan, the Survivor Benefits will pay benefits to your designated beneficiary or beneficiaries.

Survivor Benefits have no exclusions or pre-existing conditions limitation. Benefits are paid regardless of the cause of death.

WHO MAY BE COVERED

This plan is available to employees only. Dependents are not covered under the plan.

AMOUNT OF COVERAGE

If you die while covered, your designated beneficiary will receive the benefit amount paid in monthly payments over a

specified period of years. You select the payout period. The monthly amount payable to your beneficiary will be based on your elected period as follows:

| Available Payout Period | Monthly Benefits |
|--------------------------------|-------------------------|
| 5 years | \$765 |
| 10 years | \$455 |
| 15 years | \$360 |
| 20 years | \$315 |
| 25 years | \$290 |
| 30 years | \$275 |

If you enroll in Survivor Benefits, you cannot enroll in more than \$10,000 of Life Insurance.

DEATH BENEFITS GENERAL PROVISIONS

APPLICABLE LAW AND VENUE

This policy is issued and delivered in the State of Alaska and is governed by the laws of the State of Alaska. Any and all suits or legal proceedings of any kind brought against the State must be filed in the First Judicial District, Juneau, Alaska, within one year from the date of payment of the death claim.

FACILITY OF PAYMENT

All sums that become payable because an insured person dies are paid as the plan specifies. The payment sum will not exceed the amount specified in Alaska Statute (AS) 21.48.160 to any persons that the life carrier determines are equitably entitled by reason of having incurred funeral or other expenses in conjunction with your last illness or death.

If the beneficiary cannot produce a valid receipt, the life carrier has the option of making payments that do not exceed \$50 per month to any person or institution that assumes custody and principal support of the beneficiary, until a duly-appointed guardian or committee for the beneficiary makes a claim. Any payment made in accordance with this provision discharges the life carrier to the extent of such payment.

INCONTESTABILITY

The validity of the life plan will not be contested, except for nonpayment of premiums, after it has been in force for two

years. No statement that any member insured under this Life plan makes relating to insurability will be used to contest the validity of the insurance.

MISSTATEMENT OF AGE

If your age is misstated, the amount payable is the full amount of insurance to which you are entitled at your true age. A premium adjustment will be made so the actual premium required at your true age is paid.

NOTICE OF DEATH

Written notice of death must be given to the division within 30 days of the date of death, or as soon as reasonably possible.

PAYMENT OF CLAIMS

All amounts payable for loss of life are paid to the designated beneficiary in accordance with and subject to the provisions of the life plan. All other amounts payable under this provision are paid to you. Written notice of claim must be given to the division, within 30 days after the occurrence or the beginning of any loss that this provision covers, or as soon as is reasonably possible. Notice given by or on behalf of the claimant to the Division, with sufficient information to identify the insured, is considered notice.

RIGHT OF EXAMINATION

The life carrier has the right and opportunity to examine the injured member as often as it may reasonably require during the pending claim, and also, where not forbidden by law, the right and opportunity to conduct an autopsy in case of death.

DISABILITY BENEFITS

INTRODUCTION

There are two disability plans available through Optional Benefits; Short-Term Disability (STD) and Long-Term Disability (LTD). These plans are designed to replace a portion of your income if you become disabled and are unable to work due to illness or injury. You may enroll separately for the short-term plan or one of the long-term plans or a combination of the short-term plan with one long-term plan.

WHO MAY BE COVERED

This plan is available to employees only. Dependents are not covered under the plan.

ABOUT THE PLANS

Pre-existing Conditions

These plans will not cover a disability which occurs during the first 24 months of your current period of coverage if the disability is caused by, contributed to, or is a consequence of a "pre-existing condition." A pre-existing condition is a condition, including pregnancy, for which you received diagnosis, tests, or treatment or for which you took drugs or medicines prescribed or recommended by a physician, within

12 months before your current coverage under this plan began. You have a pre-existing condition if:

- you received medical treatment, consultation, care, or services including diagnostic testing or took prescribed drugs or medicines, or
- you had symptoms for which an ordinarily prudent person would have consulted a health care provider.

For example, if you select coverage during the open enrollment period in June 2003, your coverage is effective July 1, 2003, assuming you are in pay status and the premium is paid for July. If you took medication at any time between July 1, 2002 and July 1, 2003, you have a pre-existing condition. If that condition causes you to become disabled between July 1, 2003 and June 30, 2005, no benefits will be paid. If a different, new condition disables you or if your disability begins after June 30, 2005, benefits would be available.

Other Income Benefits

Disability benefits will be reduced by any “other income benefits” paid to you or your family due to your disability or retirement as follows:

- Income received by you from any employer or from any occupation for compensation or profit (other than in connection with an approved rehabilitation program).
- Disability, retirement or unemployment benefits required or provided for by law, including:
 - disability retirement,
 - disability benefits under workers’ compensation laws or similar laws, to compensate for:
 - loss of past and future wages,

- impairment of earnings capacity or diminished ability to compete in the open labor market, or
- any degree of permanent impairment or loss of bodily function or capacity,
- benefits paid under the Jones Act,
- retirement benefits based on length of service,
- unemployment compensation benefits,
- no-fault wage replacement benefits,
- statutory disability benefits,
- disability and retirement benefits under the Federal Social Security Act, the Canada Pension plan, and the Quebec Pension plan, or
- disability, retirement or unemployment benefits provided under any group insurance or pension plan or any other arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including sick leave and disability benefits from any State-sponsored or funded retirement system.

If you receive “other income” in a single lump sum, that payment will be subtracted from your disability benefit over 60 months. The disability carrier will have the right to make retroactive adjustments for any lump sum payments received from a retroactive award.

If there is an increase in your government benefits during a period of total disability, the increase will not be considered as “other income benefits” unless it results from a change in the number of your family members, or it results from a correction in the calculation of the benefit level originally established for your disability.

Payments from defined contribution plans, such as the Alaska Supplemental Annuity Plan and Deferred Compensation Plan, and Social Security benefits paid to your dependent children 18 years or older, are not considered “other income benefits.”

AN EXAMPLE . . .

| | |
|-------------------------|----------------|
| Monthly Base Wage | \$4,000 |
| Plan C Selected | <u>x 70%</u> |
| Maximum Monthly Benefit | \$2,800 |
| Retirement Benefit | <u>\$1,000</u> |
| LTD Benefit Payable | \$1,800 |

In this example, you would receive an extra \$1,800 per month from the disability plan after your retirement benefit is taken into account.

Benefits Payments Are Taxable

Since these disability plans are part of Optional Benefits, you have the advantage of paying for coverage with earnings deducted from your salary *before* federal income taxes are withheld. This reduces the cost of your coverage. Due to these tax advantages, however, **disability benefit payments you receive from the plans are subject to federal income tax.**

Filing Claims

You must apply for disability benefits under these plans within one year after the date you become totally disabled.

The carrier, at its own expense, has the right to examine you if you have filed a claim. Examinations may be made as often as they are reasonably required during the period for which you claim benefits.

Payments

The carrier has the right to recover any overpayment of disability benefits either directly from you or by deduction from your future monthly benefit payments.

Pregnancy Coverage

Benefits for a totally disabling pregnancy-related condition are paid to female employees on the same basis as for any other condition. As with any disability, a physician must certify that the employee is totally disabled, and additional evidence may be required before a determination is made whether benefits will be paid.

Waiver of Premium

Premium payment is waived during the waiting periods if you are disabled.

Limitations

The Disability Plans will not pay benefits when any of the following occur:

- You are no longer totally disabled.
- You are no longer under the care of a legally qualified physician. You must be personally seen and treated by a physician to be considered under the physician's care.
- You begin work at a reasonable occupation, receive compensation or profit, or are paid leave.
- You fail to furnish required proof of the continuance of total disability or refuse to be examined when required.
- Your disability benefit period ends, as shown in the *Duration of Payments* sections.

- You die. If you have a surviving spouse or children, they will be eligible for a three-month survivor benefit as described in the LTD section, *Survivor Income Benefit*.

If the plans terminate while you are receiving disability benefits, your benefits will not be affected.

Exclusions

The Disability Plans will not cover any disability which results from the following:

- Intentionally self-inflicted injuries.
- Your commission of, or your attempt to commit, a crime for which you have been convicted under state or federal law.
- War, or any act of war (whether war is declared or not), insurrection, rebellion, or active participation in a riot or civil commotion.
- Loss of professional licenses, occupational licenses or certification.
- Any period of disability during which you are incarcerated.

SHORT-TERM DISABILITY

SHORT-TERM DISABILITY HIGHLIGHTS

- Pays \$210 per calendar week of disability minus other disability and retirement benefits.
- Benefits begin on the 31st day of your absence due to total disability or when all accrued paid leave has been exhausted, whichever is later.
- Benefits are reduced by other income.
- Benefits may continue for up to 180 days from the date of disability.

INTRODUCTION

You may elect the short term disability benefit alone or with one of the long term disability benefits. Since payments from other income sources, like leave time or workers' compensation, are deducted from any STD benefit you are entitled to, you should know how much leave you have available for your use.

WHEN BENEFITS ARE PAYABLE

If you become disabled while enrolled in the Short-Term Disability (STD) plan, benefits will begin the 31st day of a disability absence or when all paid leave has been exhausted, **whichever is later.**

For example, if you are disabled and stop working on April 15, you would be eligible for benefits on May 15. If you were still in pay status on that date, benefits would start after your paid leave was exhausted.

A “disability absence” is any absence from work caused by an injury or a disease. To receive benefits, you must first submit medical certification of your disability from your physician.

BENEFIT AMOUNT

Your weekly benefit will be \$210, minus any other disability or retirement benefits you receive as described in the section, *Other Income Benefits*. Partial weeks of disability will be prorated at \$30 per day.

DURATION OF PAYMENTS

Benefits may be paid for a period of disability of up to 180 days which begin on the date you are first disabled or until Long-Term Disability benefits commence, regardless of whether full benefits have been realized.

RECURRING PERIODS OF DISABILITY

One “period of disability” may include more than one disability absence. Disability absences due to the same or related causes and separated by less than two consecutive weeks of full-time work will be considered to be the same period of disability. A new disability absence due to a cause different from that of any prior disability must be separated from the prior disability by at least one day of full-time active work for you to become eligible for a new maximum period of payment.

LONG-TERM DISABILITY

LONG-TERM DISABILITY HIGHLIGHTS

- Two coverage options are available:
 - benefit equal to 50% of monthly base pay.
 - benefit equal to 70% of monthly base pay.
- Benefits are reduced by income payable from other sources such as retirement benefits or workers' compensation.
- Maximum monthly benefit is \$8,000; minimum is \$100.
- 180 day waiting period.

INTRODUCTION

The Long-Term Disability (LTD) plan is designed to pay benefits for a total disability which lasts an extensive period of time. This plan offers a choice of two benefit options. If you enroll, you may elect a benefit equal to:

- 50% of your base monthly pay; or
- 70% of your base monthly pay.

These percentages reflect combined payment from this plan and payments for disability or retirement as described in the section *Other Income Benefits*. Your monthly premium will depend on the option you choose and the amount of your monthly base pay.

BENEFIT AMOUNT

Depending upon which LTD plan you are enrolled in at the time of your disability, your monthly benefit will equal either 50% or 70% of your monthly base pay, reduced by any “other income.”

“Monthly base pay” is your pay of record on April 1 for the benefit year beginning on the first day of the following July. It excludes bonuses, overtime, and other compensation. Adjustments may be made for part-time or newly hired employees.

For both options, the maximum monthly benefit payable is \$8,000, and the minimum benefit is \$100 per month. Appropriate adjustments will be made for partial months.

WHEN BENEFITS ARE PAYABLE

To receive benefits from this plan, you must be totally disabled. That is, you are unable to work at any reasonable occupation due to sickness or injury, and are under the care of a physician. Medical certification is required.

Benefits will begin after you have completed a 180-day waiting period of total disability. This waiting period begins on the day you are both totally disabled and under the care of a physician. You will be considered disabled no earlier than 31 days before the date you are first seen and treated by a qualified physician for the cause of your disability.

DURATION OF PAYMENTS

If you are disabled at age 60 or younger, benefits may be paid to you until you reach age 65. If you are disabled at age 61 or over, the following table shows how long payments may be made.

| Age at Disability | Duration of Benefit Payments |
|--------------------------|-------------------------------------|
| 60 or younger | To age 65 |
| 61 | 48 months |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 24 months |
| 67 | 18 months |
| 68 | 18 months |
| 69 | 18 months |
| 70 or over | 12 months |

No more than 24 months of benefits will be paid if a total disability is caused by one of the following:

- mental or nervous conditions.
- conditions caused by or contributed to by chemical dependency or hallucinogenic substances.

If, after the first 24 months of benefits, you are confined as an inpatient in a hospital for more than 30 days for treatment of one of these conditions, benefits will continue until you have been free of confinement for that condition for a total of 90 days during any 12-month period. The section *Recurring Period of Disability* will not apply.

RECURRING PERIODS OF DISABILITY

Once a period of total disability has ended, any new period of disability will be treated separately. Two or more separate periods of total disability occurring while you are covered under this plan and resulting from the same or related causes will be considered as one period if they are separated by less than three months.

SURVIVOR INCOME BENEFIT

If you die while receiving LTD benefits, a survivor benefit equal to three months of benefits will be paid to your surviving spouse or dependent children. This amount will not be reduced by “other income benefits.”

DEPENDENT CARE ASSISTANCE PLAN (DCAP)

DEPENDENT CARE ASSISTANCE PLAN HIGHLIGHTS

- This plan can help pay costs of care while you work.
- You may contribute up to \$5,000 of annual earnings to your individual plan account; further IRS limitations may apply.
- You may request reimbursement from the plan for eligible Dependent Care costs, up to the balance in your account.
- Careful budgeting is important because the IRS requires you to forfeit any balance remaining in your account after all eligible expenses have been paid. In other words, use it or lose it.

INTRODUCTION

If you pay someone to take care of your children, elderly relatives, or other dependents while you work, the Dependent Care Assistance Plan can help ease the financial strain.

You do not pay federal income taxes on the portion of eligible earnings you contribute to the plan. As a result, if you participate, you may save money on your care costs.

HOW THE PLAN WORKS

If you choose to participate in the Dependent Care Assistance Plan, you choose the *monthly amount* you want to contribute. Your contribution must be in whole dollars. The minimum amount you may contribute is \$25 per month (\$300 per year); the maximum amount allowed by the IRS is \$5,000 per year.

The amount of contributions you elect will be deducted from your paycheck in equal amounts throughout the year. If you are on leave without pay or don't have enough payroll in a month, a contribution will not be taken that month and will not be made up from any future payroll. Your contributions are automatically stopped when the \$5,000 limit is reached.

Your contributions are deposited into your individual account. Federal income taxes are not withheld on the amount you contribute. Throughout the benefit year, you may request reimbursement from the plan for eligible costs you have incurred. You will be reimbursed up to the balance in your individual account. If you terminate, services must be provided before or on the last day of the month in which you terminated your employment.

USE IT OR LOSE IT

A word of caution: due to the tax advantages, the Dependent Care Assistance Plan is strictly regulated. According to the IRS, you must forfeit any money remaining in your plan account after all your eligible expenses for the year have been reimbursed. In other words, if you don't use it, you lose it. Most employees find, however, that they can take full advantage of the plan by carefully budgeting for upcoming expenses.

ELIGIBLE DEPENDENTS

To be reimbursed by the plan, expenses must be for the care of your dependents, which include:

- children under age 13 for whom you or your spouse claim federal income tax exemptions.
- your spouse or other individuals who live in your home, rely on you for more than half their financial support, and are mentally or physically unable to take care of themselves.

ELIGIBLE EXPENSES

Eligible Dependent Care expenses are those which would otherwise qualify for a tax credit under Internal Revenue Service regulations. Your Dependent Care expenses must be employment-related. For instance, you may use the plan to pay for child care expenses while you work, but you may not use the plan for a babysitter while you go to a movie.

The benefit year is from July 1 to June 30. If you are hired after July 1, services must be provided on or after the first of the month in which your first Dependent Care deduction was taken from your paycheck. For example, if you are hired on September 15 and enroll at that time, your first deduction will be in November and the plan can only reimburse services received on or after November 1.

Eligible Dependent Care costs are reimbursable whether services are provided inside or outside your home. If services are provided outside your home, however, the following restrictions apply:

- Day care center expenses are reimbursable only if the center complies with state and local laws. In most cases, that means the facility must be licensed.

- Services provided in someone's home are reimbursable. If seven or more people are cared for, however, the home would probably be considered a day care center, and state and local laws would apply.
- Services provided outside your home for anyone other than your child under age 13, a parent for example, are reimbursable only if the dependent spends at least eight hours each day in your home.

You cannot be reimbursed for expenses which have been paid from other sources such as another employer's plan or your spouse's plan. If you receive a duplicate reimbursement, you must declare the second payment as taxable income.

For more information about eligible expenses, please refer to the tax instructions for filing *Federal Income Tax Form 1040* and IRS Publication #503 *Child and Dependent Care Expenses*. These publications are available from, the public library, your local Internal Revenue Service office or the IRS website.

LIMITATIONS AND EXCLUSIONS

You cannot use your Dependent Care account to reimburse costs for the following:

- services provided by someone you claim as a dependent on your federal income tax form,
- kindergarten or other primarily educational expenses,
- services provided by any of your children younger than age 19 on December 31 of the year in which the expenses are incurred; or
- overnight camp.

IF YOUR SPOUSE IS UNEMPLOYED, A STUDENT, OR INCAPABLE OF SELF-CARE

Generally, you do not qualify for nontaxable reimbursement of Dependent Care expenses if your spouse is unemployed. You may qualify for reimbursement from the plan, however, if your unemployed spouse is:

- a full-time student; or
- incapable of self care.

In these two cases, the IRS will assume that your spouse has an income of \$250 per month if you have one dependent, or \$500 per month if you have two or more dependents.

The maximum amount you may be reimbursed is based on your spouse's "assumed" income. If he or she works part-time, the maximum amount you may be reimbursed is your spouse's assumed income or actual earned income, whichever is greater.

AN EXAMPLE . . .

Jerry and his wife Ruth have two children. Since Ruth is a full-time student for nine months each year, her assumed income is \$400 for each month she is a student, or \$3,600 a year (9 x \$400). Consequently, Jerry can receive up to \$3,600 a year in nontaxable reimbursement from his Dependent Care Assistance Plan.

IRS REIMBURSEMENT LIMITATIONS

When deciding how much to contribute to the plan, you should consider the following limits, set by the IRS, on the amount of nontaxable reimbursement you may receive each year:

- If you are single, the most you may receive from this plan and any other plan combined is \$5,000 in nontaxable reimbursement per year.
- If you are married and filing jointly, the maximum amount your household may receive is \$5,000 per year. If you are married and filing separately, the most you as an individual may receive is \$2,500.
- If you are single, your total nontaxable reimbursement for Dependent Care from this plan and any other plan cannot exceed your annual earned income. Earned income means wages, salaries, tips, and other employee compensation, plus net earnings from self-employment. If you are married, your total nontaxable reimbursement cannot exceed your or your spouse's earned income for the year, whichever is less.

AN EXAMPLE . . .

Next year Sarah will earn \$30,000. Her husband, Frank, will earn \$4,000 from his part-time job. The most Sarah may receive from the plan as nontaxable reimbursement is \$4,000.

BENEFITS CAN BE TAXABLE

It's important to consider the limits set by the IRS because you will be required to pay taxes on reimbursements that exceed the limits. This might happen, for example, if your spouse's income is unexpectedly reduced, and your reimbursement exceeds his or her annual earnings.

You will have to report the excess as taxable income when filing your federal income tax.

REIMBURSEMENT PLAN VERSUS TAX CREDIT

Currently, the IRS allows you to take a tax credit for Dependent Care on your tax return. The tax credit is subtracted from federal income tax, whereas this plan reduces your taxable income. You cannot take the credit on your tax return for expenses reimbursed by this plan. Furthermore, the tax credit available will be reduced dollar for dollar by the amount you are reimbursed by this plan. You will have to decide which is better for you financially—the tax credit or the Dependent Care Assistance Plan.

Since tax laws are complicated and subject to change, you should re-examine your tax situation every year, and discuss it with your tax specialist.

BUDGETING FOR YOUR PLAN

The Dependent Care Assistance Plan can save you money if you budget your expenses carefully. Keep in mind that *you must forfeit any money remaining in your account at the end of the year* after all eligible expenses have been paid. Most employees find, however, they can avoid the risk of forfeiture by planning ahead.

When considering how much to contribute, remember your contributions will be deducted from your paycheck for the entire year, not just for a few months at a time. For example, say you expect to incur \$600 in Dependent Care costs only during the summer, when your children are out of school. To budget for your anticipated summer expenses, you could contribute \$50 per month (\$600 for the entire year or 12 x \$50).

Here are some questions to consider when budgeting for the plan:

- Do you need child care throughout the year or only during your children's summer vacation?
- Is your spouse a full-time student or planning to return to school?
- Does your Dependent Care center qualify for reimbursement?
- Does your spouse participate in a Dependent Care reimbursement plan?
- Does your spouse work a rotating shift? How will this affect your Dependent Care needs?
- Do you and your spouse file separate or joint income tax returns?

SUBMITTING CLAIMS FOR REIMBURSEMENT

To be reimbursed for eligible expenses, you must file a claim for reimbursement. You may file a claim once a month. If you have more than one bill, file all the month's bills together. If you have more than one provider, you may submit more than one claim. You have 60 days after the end of the benefit year, or until August 30, to file a claim for expenses incurred during the year.

To file a claim, complete and submit a *Request for Reimbursement* form to the division, along with an itemized invoice from your provider. The invoice must contain the following information:

- Provider's name, address, and Tax Identification Number (TIN) or Social Security Number (SSN). The TIN or SSN is especially important because you will have to provide the

information when you file your tax return. If you don't, the amount you were reimbursed for that provider's services will be taxable.

- Name of the dependent who received the care and his or her relationship to you.
- Period covered and charges.

The *Request for Reimbursement* form has a section which can be used in place of a separate invoice. The forms are available from your human resources office, the division, or its web site.

Claims over \$25 will be reimbursed up to the amount of your request. If there isn't enough money in your account to pay the full amount, you'll be reimbursed up to your account balance. The remainder will be paid later, after there is a sufficient balance. If you submit a claim for \$25 or less, you will be reimbursed only after your accumulated claims exceed \$25. Final claims submitted after the end of the benefit year will be reimbursed, regardless of the amount, up to the balance in your account.

