

State of Alaska

Group Life and Voluntary Supplemental Benefits

Information Booklet

May 2026

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Member Portal: www.mybenefits.metlife.com

Voluntary Benefits Plan Administrator

State of Alaska Division of Retirement and Benefits

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Juneau, AK 99811-0203

Member Education Center

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Group Life/Voluntary Supplemental Benefits (VSB) Plan

HIGHLIGHTS

- Group Life benefits include employer-paid life and travel accident insurance, as well as employee-paid life and accidental death and dismemberment insurance.
- Voluntary Supplemental Benefits include life, accidental death and dismemberment, disability, and critical illness insurance.

Introduction

The State of Alaska Group Life plan includes employer-paid life and travel accident insurance and employee-paid life and accidental death and dismemberment insurance. The Voluntary Supplemental Benefits (VSB) plan includes employee-paid life, accidental death and dismemberment, critical illness, and long- and short-term disability insurance. The plans are administered by MetLife and enrollment is managed by Benefitfocus.

This booklet provides a summary of employee-paid benefits, which you may choose to enroll in if eligible. The information in this document can help you make an informed choice about which benefits are best for you and your family. Note that if you are eligible for employer-paid benefits, you will be automatically enrolled by your employer; those benefits are not covered here.

If you have questions about how the plan applies specifically to your situation, please contact the Division of Retirement and Benefits (Division), or refer to your certificate of insurance, which can be found on the Division's website at drb.alaska.gov/employee/lifedisability.html.

Please note that this booklet may be updated periodically to reflect changes in the plans. The most current edition can be found at the website above.

In case of conflict between this booklet and official plan documents or IRS regulations, the plan documents and regulations will determine benefits and eligibility. You are encouraged to review your certificate of insurance for full plan details. Your claim will be governed by the certificate in place at the time of loss.

Group Life/Voluntary Supplemental Benefits

The following voluntary plans are offered under VSB and Group Life:

- Select Life and Accidental Death and Dismemberment Insurance
- Supplemental Life Insurance
- Supplemental Spouse Life Insurance
- Supplemental Child Life Insurance
- Supplemental Accidental Death and Dismemberment Insurance
- Disability Insurance (Short-Term and/or Long-Term Disability)
- Critical Illness Insurance

Enrollment in any plan is optional – you have the flexibility to choose only the plans and coverage levels that meet your needs. Please note that the benefit plans available to you will depend on your employer and bargaining unit. You can contact your HR staff to confirm which of the above benefits you are eligible to elect, as well as any additional benefits that may be available to you.

Each benefit option has a premium, which may change from year to year. You can find the current premiums on the Division’s website. Premiums are paid twice per month through payroll deductions and may be deducted pre-tax or post-tax depending on the benefit.

Eligibility

The following employees are eligible to participate in voluntary benefits:

- State employees, except members of the Labor, Trades and Crafts (LTC) unit, the Teachers’ Retirement System (TRS), on-call employees, temporary employees, employees of the National Guard (including Emergency Guard), short-term non-permanent employees, student interns, leased employees, and emergency employees hired for natural disasters, including emergency firefighters.
- Employees of a participating political subdivision covered under the terms of the political subdivision’s participation agreement.

Dependents

A dependent is a person covered under a plan you elect, specifically your spouse and/or children. Eligibility criteria is included below; you can also refer to your certificate of insurance for more information.

The following plans offer dependent coverage in addition to employee coverage:

- Supplemental Accidental Death and Dismemberment
- Critical Illness Insurance

The following plans offer dependent coverage only:

- Supplemental Spouse Life
- Supplemental Child Life

You may enroll the following dependents in coverage under these benefit options:

- Your spouse
- Your children until they attain age 26
 - *Including natural children, adopted children, stepchildren, unmarried foster children who reside with you and are supported by you, or children for whom you are the legally appointed guardian who reside with you and are supported by you.*
- Your child age 26 and older who is permanently and totally disabled, and who:
 - remains incapable of self-sustaining employment because of a mental or physical disability; and
 - continues to qualify as a child, except for the age limit.

Your dependents will not be eligible for coverage if they are on active duty in the military (not including weekend or summer training for the reserve forces of the United States, including the National Guard).

Your dependent children's spouse or children are not eligible for coverage under the plan.

Electing Coverage

Benefit elections are made through the Benefitfocus portal (see *Contact Information* above). Once you are logged in to the portal, you will have the option to select or decline benefits, review premiums, review current benefits, and add dependents and beneficiaries.

Initial benefit elections, meaning your first elections after a qualifying change in employment, can only be made under the following circumstances:

New Employees

If you are a new employee, you must elect your voluntary benefit coverage within 31 days of the date you were hired.

Rehired Employees

If you previously terminated employment and are rehired with the same employer, you must follow the rules described for *New Employees* above.

Employees Returning from Leave Without Pay (LWOP)

If you return to work after LWOP and your coverage was canceled during your LWOP, you must elect your coverage within 31 days of your return to work. See *When Coverage Begins* and *Direct Bill During Leave Without Pay* for more information about how LWOP affects your benefits.

Employees Moving from a Nonparticipating Position

If you move from a position that does not participate in Voluntary Supplemental Benefits to one that does, you have 31 days from the date of the position change to elect coverage.

Bargaining Unit Change

If you change bargaining units, you will have a chance to change or enroll in benefits within 31 days of the bargaining unit change. If you were enrolled in benefits in your previous position and you remain eligible for those benefits under your new bargaining unit, your enrollment in your previous benefits will automatically continue, with the possible exception of Select Life; see the *Select Life* section for more details about when this benefit requires re-election.

Note: If you do not make elections within the timeframes outlined above, you waive enrollment for the rest of that benefit year unless you have a qualified status change (see *Change in Status* on the next page).

Changing Coverage

You may elect a new benefit, change an existing benefit, or cancel coverage during one of the following opportunities:

Open Enrollment

An open enrollment period is held annually each November. During this time, you can change your benefit elections for the following benefit year, which will begin January 1.

Elections made during open enrollment will remain in effect from January 1 until the end of the benefit year, December 31, unless you terminate your employment or change your elections following a qualified change in your family or employment status (see *Change in Status*, below).

If you make no elections during open enrollment, you will be automatically re-enrolled in the same benefit options you had in the prior year unless there is a special enrollment period requiring your participation.

If you are in leave without pay (LWOP) status when open enrollment begins, you may elect coverage either during open enrollment or within 31 days of the date you return to work. This does not apply to scattered LWOP, as defined below under *Employees Returning from Leave Without Pay*.

Change in Status

You may add, change, or cancel 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 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.

Benefit changes must be received within 31 days after a qualified status change.

When Coverage Begins

The effective date of your coverage will be determined based on your qualifying event, as outlined below. Certain life insurance elections will require a Statement of Health, which can impact effective dates. You can refer to the *Supplemental Life Insurance* and *Spouse Supplemental Life* sections of this booklet for more details about when a Statement of Health is required.

New or Rehired Employees

Coverage begins on the first of the month following 31 days of employment. For example, if you begin work on March 15, you are covered on May 1. However, if you are rehired within 7 days of the loss of your previous coverage, your coverage will begin on your date of rehire provided you re-enroll in the same coverage.

Employees Returning from Leave Without Pay

There are two types of Leave Without Pay (LWOP):

- **Scattered LWOP** occurs when an employee runs out of or chooses not to use personal leave, for example during an extended medical absence.
- **An LWOP event** occurs when an employee is placed in inactive status; for example, seasonal employees become inactive when the season ends.

During a period of scattered LWOP, your voluntary benefits will continue while you are absent from work. If your paycheck amount is insufficient to cover your premium deductions while you are on scattered LWOP, your employer may collect any past due premiums through subsequent payroll deductions when you return to work.

During an LWOP event, coverage does not continue unless you elect to self-pay your premiums (see *Direct Bill During Leave Without Pay* section below). If you do not enroll in direct bill, you must re-enroll in your benefits within 31 days of your return to work. Coverage begins on the date of your return.

Bargaining Unit Change

If you change bargaining units, you 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 April 15, your coverage will begin on May 1. If the bargaining unit change is effective on the first of the month, coverage will be effective on the same day.

Change in Status

If you experience a change in status as described above, your new coverage will be effective on the first of the month following the qualifying event.

Open Enrollment

If you elect or change your benefits during an open enrollment period, those benefits or benefit changes will be effective on January 1 of the next benefit year.

When Dependent Coverage Begins

When you enroll in a benefit that provides dependent coverage, the coverage becomes effective according to the same rules outlined in the section above. However, there are some slight differences between the dependent plans:

Supplemental Spouse Life

- Depending on the amount elected, a Statement of Health (SOH) may be required; if so, the spouse's coverage will only become effective after the SOH is approved. See *Supplemental Spouse Life Insurance* for more details.

Supplemental Child Life

- Children who are eligible at the time of enrollment will be covered on the coverage effective date as outlined in the section above. New children will be covered as soon as they are eligible.

Supplemental Accidental Death and Dismemberment (Employee & Family)

- Dependents who are eligible at the time of enrollment will be covered on the coverage effective date as outlined in the section above. New dependents will be covered as soon as they are eligible.
- Coverage for a newborn child begins after 14 days rather than at birth.

Critical Illness

- Dependents must be entered in the enrollment platform to be covered under the plan.
- Dependents who are eligible at the time of enrollment will be covered on the coverage effective date as outlined in the section above. New dependents will be covered as soon as they are eligible.

When Coverage Ends

Coverage will end on the last day of the month in which:

- You terminate from employment (including through layoff).
- You move from a position which participates in voluntary benefits to a position that does not (for example, due to a bargaining unit change).
- You cease to be an eligible employee (for example, by changing from full-time to part-time status).
- Your employment status becomes inactive due to a Leave Without Pay (LWOP) event. You may however elect to continue coverage through direct bill (see *Direct Bill During Leave Without Pay* section below).
- You fail to pay the required premium.
- You terminate your benefits due to a qualifying change in status.
- You fail to re-elect Select Life following a bargaining unit change that requires re-election. See the *Select Life* section for more details.

Note that if you terminate your benefits during an open enrollment period, your benefits will end on December 31 of that year.

If you die, your coverage will end on your date of death.

If the plan is terminated, coverage will end on the date of plan termination.

When Dependent Coverage Ends

Your dependent's coverage ends on the same day as your coverage, unless one of the following occurs:

- You die. Coverage for your dependents ends on the date of death.
- You divorce. Coverage for your spouse ends on the date of divorce.
- Your dependent no longer meets eligibility requirements as described in the *Dependents* section above. Coverage ends on the last day of the month in which the dependent first fails to meet any of these requirements.
- You terminate coverage for your dependent. Coverage will end at the end of the month in which a qualified change in status occurs or at the end of the year if you change elections during open enrollment.

Direct Bill During Leave Without Pay

During an LWOP event, you may choose to continue your voluntary benefit coverage by self-paying premiums under the direct bill plan through Benefitfocus. You will receive a letter from Benefitfocus after your LWOP event begins with instructions related to direct bill. You can also set up your direct bill through the Benefitfocus portal or contact Benefitfocus directly for assistance.

If you choose to pay by direct bill, this coverage will begin the first day of the month after your LWOP event begins. For example, if you are placed in LWOP status on January 15, your coverage paid through payroll deduction will automatically end on January 31. If you enroll in direct bill, your coverage will resume effective February 1 with no break in coverage.

Coverage through direct bill will continue until you return to work, fail to make premium payments, or terminate coverage, whichever occurs sooner. See the *Employees Returning from Leave Without Pay* section above for more details about re-enrolling in benefits after your return to work.

Continuation of Coverage

If your coverage ends because you cease to be employed in an eligible position, either through termination or a bargaining unit change, you may be eligible to continue your coverage for yourself and your eligible dependents through portability or conversion.

- **Portability** is the option to continue the plan you had through your employer.
- **Conversion** is the option to continue your coverage through your own individual policy, which may differ from your employer's plan.

Both portability and conversion options are available for life insurance. Critical illness insurance can only be continued through portability. Disability and accidental death and dismemberment insurance plans cannot be continued after termination.

Premiums for ported or converted coverage will be different from what you paid as an employee. Additional information and instructions for continuing your coverage will be mailed to you as a courtesy when your coverage ends. It is your responsibility to notify MetLife in writing within 31 days of your loss of coverage if you wish to continue your coverage.

More information about insurance continuation options can be found in your certificate of insurance. You can also contact MetLife directly at the following phone numbers:

Customer Service	(800) 638-6420
Ported Policies	(866) 492-6983
Converted Policies	(877) 275-6387

Proof of Enrollment/Request

To process any requests related to your voluntary benefits enrollment or coverage, the Division must have a record of your application, election, or claim. If no record exists, you will need to provide reasonable proof that the document was sent to the Division, for example a certified mail receipt or a receipt stamp from the Division.

Future of the Plan

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

Life Insurance

HIGHLIGHTS

- There are two optional life insurance plans available for employees: Select Life and Supplemental Life.
- Both employee life insurance plans also include Accidental Death and Dismemberment Insurance options, as well as other additional features.
- There are two optional dependent life insurance plans available: Supplemental Spouse Life and Supplemental Child Life.

Introduction

The Voluntary Supplemental Benefits and Group Life plans include two optional life insurance plans for employees:

- **Select Life** (automatically includes Accidental Death and Dismemberment)
- **Supplemental Life**
 - Supplemental Accidental Death and Dismemberment is offered as a separate benefit if a minimum of \$10,000 in Supplemental Life Insurance has been elected.

If you elect optional employee life insurance, you will also receive access to additional features such as will preparation assistance, estate resolution services, grief counseling, and more at no additional cost. See *MetLife Advantages* for more details.

There are also two dependent life insurance plans available:

- **Supplemental Spouse Life**
- **Supplemental Child Life**
 - Supplemental Child Life covers all eligible children in your family.

Below, you will find additional information about the life and accidental death and dismemberment plans, additional features, and benefits available to your beneficiaries in the event of your death.

Select vs. Supplemental Life Comparison

The table below compares the two voluntary employee life plans:

Plan	Select Life	Supplemental Life
Benefit Amount	Salary-based: <ul style="list-style-type: none"> • Equal to annual earnings up to \$100,000 for Supervisory Unit, Confidential Unit, Correctional Officers • Equal to annual earnings up to \$60,000 for all others 	Available in increments: <ul style="list-style-type: none"> • \$10,000 • \$50,000 • \$100,000 • \$200,000 • \$300,000 • \$400,000 • \$500,000 • \$600,000 • \$700,000 • \$800,000
Evidence of Insurability	No Statement of Health required	Statement of Health required above \$300,000 and for late enrollees
Premium Amount	Based on age and wage	Based on age and volume elected
Taxability	Premiums are deducted post-tax	Premiums are deducted pre-tax up to the IRS-determined threshold, thereafter calculated with imputed income (see tax section on next page)
Accidental Death & Dismemberment (AD&D)	Included in Select Life	Offered separately if at least \$10,000 Supplemental Life is elected
Dependent Coverage	None	Dependents can be covered under AD&D policy
Continued at Retirement	Can be converted to Retiree Optional Life for Defined Benefit Retirees only. Can also be continued through portability/conversion as an individual policy.	Can only be continued through portability or conversion as an individual policy.

Pre-Tax and Post-Tax Premiums

Premiums for Select Life are deducted post-tax, meaning you pay your regular income tax on those premiums. Premiums for Supplemental Life Insurance volumes are pre-tax for lower amounts, however if your total life insurance under Basic Life and Supplemental Life exceeds \$50,000 of coverage, the premiums attributable to volumes over \$50,000 will be post-tax and will show on your W-2 as imputed income. Imputed income is the addition of the value of non-cash compensation to an employee's taxable wages in order to properly withhold income and employment taxes.

Waiver of Premium for Total Disability

If you become totally disabled as defined in the certificate of coverage, you may be eligible for a waiver of your Select Life and Supplemental Life insurance premiums while you are totally disabled.

Your premium waiver will begin after you have satisfied a 9-month waiting period of continuous disability. The waiver of premium will remain in place until you reach age 65, recover, die, or if you fail to provide proof of your disability or refuse examination, whichever occurs sooner.

If you terminate employment during the 9-month waiting period, you are encouraged to continue coverage through the portability or conversion options described above so that you may complete the 9-month waiting period. Once the 9-month waiting period has been completed and your waiver of premium has been approved, the premiums you paid for your ported or converted policy during the waiting period will be refunded. If a refund is due for premiums you paid while you were still an employee, this will be handled separately by MetLife and Benefitfocus.

If you return to work after completing part or all of the 9-month waiting period and later have to stop working due to the same or a related total disability, this will be considered a continuation of your disability and you will be given credit for the prior partial or total completion of the waiting period, provided your coverage under the plan has been continuous.

Please reach out to MetLife for assistance in navigating this process.

Beneficiaries

Death benefits are paid to the beneficiary or beneficiaries you designate when you enroll in the plan or when you subsequently update your beneficiaries. If you have elected dependent coverage and a covered family member dies, the death benefits will be paid to you.

To name a beneficiary, you must complete the beneficiary designation in the Benefitfocus enrollment portal. You may name one or more beneficiaries for each benefit. Beneficiaries can be people, organizations, trusts, or estates.

If you name more than one beneficiary, you must designate the percentage to be paid to each beneficiary. You should also name a contingent beneficiary in the event your primary beneficiary dies before receiving benefits. If any beneficiary dies before you, the portion that beneficiary would have received is paid in equal shares to the designated beneficiaries who survive you.

Divorce, dissolution, or annulment of your marriage will automatically cancel your spouse's rights as beneficiary under your life insurance policy. If you wish to keep an ex-spouse as a designated beneficiary, you must submit an updated beneficiary designation after the divorce, dissolution, or annulment event occurs.

You can change your beneficiary **at any time** by updating your beneficiary information in the Benefitfocus enrollment portal. The change will become effective on the date the change is made with Benefitfocus.

If you do not designate a beneficiary or if no beneficiary survives you, the death benefits are paid to the first survivor based on the laws in the state in which the death occurs, generally in the order shown below:

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

If you designate your minor child as your beneficiary, the benefit cannot be paid until guardianship has been established, even if the guardian is a biological parent. For minor children, creating a trust fund is an option.

Filing a Claim

If possible, claims for life insurance should be filed as soon as possible after the death occurs. Claims for accidental death and dismemberment insurance should be filed within 20 days of the date of loss. You can file a claim by contacting your employer or Benefitfocus.

You will be required to provide proof of loss before your claim can be processed. Additional information to support your claim may be requested if necessary.

Life Insurance and AD&D Appeals

If your claim is denied and you or your beneficiaries would like to file an appeal, you will need to submit a written appeal to MetLife within 60 days of receiving the denial decision for your claim. Your appeal letter will need to include information about the policy and claim, as well as the reason you feel the claim was improperly denied. You can include any additional documents or records you feel should be considered. You may also request records pertaining to the claim through a written request to MetLife.

Appeals should be submitted in writing to:

MetLife

P.O. Box 6100
Scranton, PA 18505

MetLife will evaluate your appeal and communicate their decision within 60 days of the date your appeal was received. Under certain circumstances, MetLife's review may take longer (up to an additional 60 days). You will be informed if additional time is needed to consider your appeal.

Select Life and Accidental Death and Dismemberment

HIGHLIGHTS

- Provides coverage for the employee only.
- Benefit amount is equal to your basic annual earnings, rounded to the nearest \$1,000, up to a maximum that depends on your bargaining unit.
- Pays double the benefit amount in the case of accidental death.
- Accidental dismemberment benefit amounts are based on the type of dismemberment.
- Can be continued at retirement under a Defined Benefit retirement.

Introduction

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

- Life insurance benefits are paid for death regardless of cause.
- AD&D benefits are payable for losses occurring within 100 days of an accident and because of accidental bodily injury, independent of all other causes, or for accidental loss of life.

Who May Be Covered

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

Premiums

Select Life and AD&D premiums are determined by your age and wage, updated annually each January 1. This premium rate remains in effect for the entire benefit year, unless you experience a qualifying bargaining unit change and re-elect the benefit with a new maximum. You can find the Select Life and AD&D premiums for the current benefit year on the Division's website.

Amount of Coverage

The benefit amount is equal to your basic annual earnings, rounded to the nearest \$1,000, with a maximum amount of \$100,000 for Correctional Officers, Supervisory, and Confidential Unit employees and \$60,000 for all others.

Benefits will pay as follows:

<i>For the Loss of...</i>	<i>Benefit Payable</i>
Life	100%
Loss of a hand permanently severed at or above the wrist	50%
Loss of a foot permanently severed at or above the ankle	50%
Loss of sight in one eye	50%
Loss of any combination of hand, foot, and sight in one eye	100%

Continuation at Retirement

If you are in a Defined Benefit retirement plan and you participate in the Select Life plan as an active employee, you may be eligible to continue this coverage at the time of retirement from the Public Employees', Teachers', Judicial, or Elected Public Officers' Retirement Systems. If you are eligible and elect this coverage at retirement, your Select Life plan will become the Optional Life plan, with a few differences in benefits and premiums. More information can be found on the Division's website.

Please note that Defined Contribution retirement plan members are not eligible to continue Select Life as Optional Life; however, conversion and portability options are still available. Once a member has separated from employment (regardless of retirement plan), information will be sent by mail from MetLife regarding portability and conversion options.

Supplemental Life Insurance

HIGHLIGHTS

- Provides coverage to the employee only.
- Multiple coverage options available for increased flexibility.

Introduction

The Supplemental Life Insurance plan offers multiple coverage levels to employees so you can elect the coverage amount that best fits your and your family's needs. Supplemental Life pays in a lump sum upon the employee's death, regardless of cause.

To enroll in the Supplemental AD&D plan outlined in the next section, you must enroll in at least \$10,000 of this life insurance coverage and separately elect your Supplemental AD&D plan.

Who May Be Covered

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

Amount of Coverage

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

- \$10,000
- \$50,000
- \$100,000
- \$200,000
- \$300,000
- \$400,000
- \$500,000
- \$600,000
- \$700,000
- \$800,000

Any amount over \$300,000 or any increase in coverage level after initial enrollment will require evidence of insurability (see below).

Premiums

Supplemental Life premiums are determined by the amount of coverage you elect and by your age as of January 1 of the benefit year. Your age and premium are recalculated annually based on your age as of January 1. Once calculated, this premium remains in effect for the entire benefit year.

You can find the current premium rates on the Division's website.

Statement of Health

When electing Supplemental Life coverage, you may be required to submit evidence of your insurability, also known as a Statement of Health, before your benefit can become effective.

A Statement of Health is required when:

- You are newly eligible to elect coverage and you elect an amount **greater than \$300,000**. While your Statement of Health is pending approval, your coverage will remain at \$300,000.
- You increase your coverage during an open enrollment period or following a qualifying status change **by more than one level** (i.e. from \$10,000 to \$100,000) or to an amount **greater than \$300,000**. While your Statement of Health is pending approval, your coverage will increase by only one level (up to \$300,000).
- You are electing Supplemental Life for the first time during an open enrollment period or following a qualifying status change after not electing coverage when first eligible; this is referred to as "late entry" and requires a Statement of Health at any level of coverage. You will not be covered until your Statement of Health is approved.

When you enroll in Supplemental Life Insurance through the Benefitfocus portal, you will be prompted to complete the MetLife Statement of Health. You can also contact MetLife directly to obtain a paper copy of this form.

Once your Statement of Health has been approved, your higher level of coverage will begin the first of the month following the approval. If you are denied coverage at the higher level, you will remain at the level of coverage you were eligible to receive or receive no coverage if you are a late entrant.

Supplemental Accidental Death and Dismemberment

HIGHLIGHTS

- Provides “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 the time of loss.
- Accidental dismemberment benefit amounts are based on the type of dismemberment.
- Only available if you are enrolled in Supplemental Life Insurance.

Introduction

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

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

Who May Be Covered

This plan is available for yourself only or yourself and your family. Family coverage includes your spouse and/or your children as defined under the *Dependents* section earlier in this document.

If the AD&D plan covers more than one family member who is an eligible employee of the State of Alaska or participating political subdivision, 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 beneficiaries.

Amount of Coverage

The full benefit amount for employees who enroll in this plan is \$100,000. If you elect Supplemental AD&D for employee and 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 (No Children)	
• Employee	• \$100,000
• Spouse	• \$50,000
Employee and Dependent Children (No Spouse)	
• Employee	• \$100,000
• Each Child	• \$10,000

The plan will pay benefits if you or a covered dependent die or suffer 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...	Benefit Payable
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 eyes means complete and irrevocable loss of sight. You and/or your provider may need to provide additional information about your loss before your claim can be processed.

Premiums

The Supplemental AD&D premiums are flat rates that depend on the coverage level elected: employee only or employee and family. You can find the current premiums for Supplemental AD&D on the Division's website.

Exclusions

The Supplemental AD&D plan pays benefits if your death or dismemberment is caused by an accident, with some exclusions. You may be required to provide additional information to demonstrate that your claim is not excluded from benefits.

Examples of circumstances in which the plan will not pay benefits are accidents resulting from self-inflicted injury; from participation in a riot, rebellion, or war; from the commission of a felony; from travel in an aircraft in a role other than as a passenger (except when traveling on State business); and others.

For the full list of exclusions where the plan will not pay benefits, please refer to your certificate of insurance.

Spouse Supplemental Life

HIGHLIGHTS

- In addition to life insurance benefits for themselves, employees can elect life insurance for a spouse.
- Multiple coverage options are available for increased flexibility.

Introduction

Regardless of whether you enroll in Supplemental Life for yourself, you are eligible to elect life insurance for your spouse, called Spouse Supplemental Life. This coverage can offer protection in case of a loss, for example to help cover the sudden gap in family income or assist with funeral costs.

Who May Be Covered

Your eligible spouse may be covered under the Spouse Life Insurance plan. For more information about spouse eligibility, review the *Dependents* section earlier in this booklet.

Amount of Coverage

Spouse Supplemental Life is available in \$10,000 increments from \$10,000 to \$100,000. See *Evidence of Insurability* below for when a Statement of Health is required.

Premiums

Spouse Supplemental Life premiums are determined by your age and the amount of coverage you elect. Your age and premium are recalculated annually based on your age as of January 1. Once calculated, this premium remains in effect for the entire benefit year.

You can find the Spouse Supplemental Life Insurance premium rates for the current benefit year on the Division's website.

Evidence of Insurability (Statement of Health)

When electing Spouse Supplemental Life coverage, you may be required to submit evidence of your spouse's insurability, also known as a Statement of Health, before your spouse's coverage can become effective.

A Statement of Health is required when:

- You are newly eligible to elect Spouse Supplemental Life coverage and you elect an amount **greater than \$50,000**. While your spouse's Statement of Health is pending approval, the coverage level will remain at \$50,000.
- You increase Spouse Supplemental Life coverage during an open enrollment period or following a qualifying status change **by more than one level** (i.e. from \$10,000 to \$30,000) or to an amount **greater than \$50,000**. While your Statement of Health is pending approval, your coverage will increase by only one level (up to \$50,000).
- You are electing Spouse Supplemental Life for the first time during an open enrollment period or following a qualifying status change after not electing coverage when first eligible; this is referred to as "late entry" and requires a Statement of Health at any level of coverage. Your spouse will not be covered until the Statement of Health is approved.

When you enroll in Spouse Supplemental Life Insurance through the Benefitfocus portal, you will be prompted to complete the MetLife Statement of Health for your spouse. You can also contact MetLife directly to obtain a paper copy of this form.

Once your spouse's Statement of Health has been approved, the higher level of coverage will begin the first of the month following the approval. If your spouse is denied coverage at the higher level, your Spouse Supplemental Life will remain at the level of coverage your spouse was eligible to receive or receive no coverage if you are a late entrant.

Exclusions

There is an exclusion under this plan for death caused by self-inflicted injury.

Child Supplemental Life

HIGHLIGHTS

- In addition to life insurance for themselves, employees can elect life insurance for eligible children in their family.
- All eligible children will be covered under the same plan, with the same premium; separate plans are not needed for each child.
- Multiple coverage options are available for increased flexibility.

Introduction

Regardless of whether you enroll in Supplemental Life for yourself or a spouse, you are eligible to elect life insurance for your eligible child(ren), called Child Supplemental Life. This coverage can offer protection in the event of a loss, for example to assist with funeral costs.

Who May Be Covered

Your eligible children may be covered under the same Child Supplemental Life plan. All eligible children will be covered under the same Child Life policy, meaning you do not have to pay for a separate plan for each child. Your premium will remain the same regardless of the number of eligible children covered under the plan (see *Premiums* below for more details).

For more information about child eligibility, review the *Dependents* section earlier in this booklet.

Amount of Coverage

Supplemental Child Life is available in the following amounts:

- \$5,000
 - \$10,000
 - \$15,000
 - \$20,000
-

Premiums

Supplemental Child Life premiums are determined by the amount of coverage you elect. You can find the Supplemental Life Insurance premium rates for the current benefit year on the Division's website.

Exclusions

There is an exclusion under this plan for death caused by self-inflicted injury.

Evidence of Insurability (Statement of Health)

Evidence of Insurability is not required for Child Supplemental Life.

MetLife Advantages

HIGHLIGHTS

- Employee life insurance benefits include several complimentary features:
 - Grief counseling
 - Beneficiary claim assistance
 - Will preparation services
 - Estate resolution services

Introduction

If you are enrolled in Select Life or Supplemental Life (for employees, not dependents), there are additional features available to assist you and your family, as described below.

Grief Counseling

You, your dependents, and your beneficiaries have access to grief counseling sessions and funeral-related concierge services to help cope with a loss, at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. Simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in person or by phone. You are entitled to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet. In addition, you have access to funeral assistance to locate funeral homes and cemetery options, obtain funeral cost estimates and comparisons, and more.

Access these services by calling TELUS Health at (888) 319-7819 or log on to one.telushealth.com (username: *metlifeassist*; password: *support*). You can also find a helpful funeral planning guide at metlife.com/funeralplanning.

WillsCenter.com

You and your spouse have access to *WillsCenter.com*, an online document service to prepare and update a will, living will, power of attorney, funeral directive, memorandum of wishes, or HIPAA authorization form in a secure 24/7 environment at no additional cost. This service is available with all life coverages. Log on to *WillsCenter.com* to register as a new user.

Will Preparation

When you enroll for life coverage, you will automatically receive access to will preparation services at no extra cost to you. Both you and your spouse will have unlimited in-person or telephone access to one of MetLife Legal Plans' nationwide network of 18,500+ participating attorneys for guidance and/or consultation, and preparation of or updating a will, living will or power of attorney. When you use a participating plan attorney, there will be no charge for the services.

You also have the flexibility of using an attorney who is not participating in the MetLife Legal Plans network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.

Like life insurance, a carefully prepared will (simple or complex), living will, and power of attorney are important.

- A will lets you define your most important decisions, such as who will care for your children or inherit your property.
- A living will ensures your wishes are carried out and protects your loved ones from having to make very difficult and personal medical decisions by themselves. Also called an "advanced directive," it is a document authorized by statutes in all states that allows you to provide written instructions regarding the use of extraordinary life-support measures and to appoint someone as your proxy or representative to make decisions on maintaining extraordinary life-support if you should become incapacitated and unable to communicate your wishes.
- Powers of attorney allow you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated.

Visit [legalplans.com/estateplanning](https://www.legalplans.com/estateplanning) to get started, or call (800) 821-6400 and a Client Service Representative will assist you.

Beneficiary Claim Assistance

This program is designed to help beneficiaries sort through the details and serious questions about claims and financial needs during a difficult time. MetLife has arranged for Barnum Financial Professionals to be available for assistance in person or by telephone at 1-877-275-6387 to help with filing life insurance claims, government benefits, and financial questions.

Estate Resolution Services

MetLife Estate Resolution Services (ERS) offer personal service and compassion assistance to help probate your and your spouse's estates. Probate services are provided in person or over the phone to the representative (executor or administrator) of your estate or the estate of your spouse, if either of you die. Estate Resolution Services include preparation of documents and representation at court proceedings needed to transfer the probate assets from the estate to the heirs and completion of correspondence necessary to transfer non-probate assets. ERS covers participating plan attorneys' fees for telephone and face-to-face consultations or for the administrator or executor to discuss general questions about the probate process. Call (800) 821-6400 to use these services.

Transition Solutions

Transition Solutions provides assistance for important, time-sensitive benefit and financial decisions due to changes in benefits, including:

- Group life insurance continuation options
- Reduction in benefits for active or retired employees
- Benefits coordination due to layoff, merger, acquisition, or bankruptcy
- Termination of a defined contribution plan
- Retiree group life elimination

Specially trained financial professionals from Barnum Financial Group can assist you with your questions. They can provide information on insurance options which may include identifying other lower-cost alternatives and financial decisions.

- Participating employees will receive a letter in the mail from MetLife on behalf of the State of Alaska with personalized options and decisions available. A Barnum Financial Group financial professional may also call to assist with benefit decisions and adhering to strict timelines.

Disability Benefits

HIGHLIGHTS

- There are two disability insurance plans: Short-Term Disability and Long-Term Disability.
- Disability insurance is available to the employee only.
- Benefits are reduced by income payable from other sources such as retirement benefits or workers' compensation.
- Disability insurance covers both physical and mental health conditions.

Introduction

There are two disability plans available through Voluntary Supplemental Benefits: Short-Term Disability (STD) and Long-Term Disability (LTD). These plans are designed to replace a portion of your income if you become physically or mentally 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 plan options, or a combination of the short-term plan with one long-term plan.

Who May Be Covered

These plans are available to employees only. Dependents are not covered under the disability plans.

Benefit Payments

The amount, frequency, and duration of your benefit payments will depend on which disability plan(s) you elect. Please refer to the *Short-Term Disability* and *Long-Term Disability* sections below for details on the benefits available under each plan. General rules that apply to benefit payments under both Short-Term and Long-Term Disability plans are outlined here.

Other Income Benefits

Your disability benefits will be reduced by any “other income benefits” paid to you while you are disabled, for example:

- disability, retirement, or unemployment benefits
- personal or sick leave
- income received from working while disabled, with exceptions outlined in the *Rehabilitation Program Incentive* sections below.

For the complete list of “other income benefits,” you can refer to the certificate of insurance for your plan.

Benefit Reduction Example

Monthly Base Wage	\$4,000
LTD 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 \$1,800 per month from the LTD plan after your retirement benefit is taken into account.

Benefit Payments Are Taxable

Your premiums are paid 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.**

Overpayments

If you receive any overpayment of disability benefits, MetLife has the right to recover the overpayment either directly from you or by deduction from your future monthly benefit payments.

Filing Claims

If you are unable to report for active work due to an illness or injury, and you think you may be disabled, you should contact MetLife at (866) 729-9200 to initiate a claim. We recommend that you do so within 14 days (for Short-Term Disability) or 20 days (for Long-Term Disability) after the first day you are unable to report for active work so your claim can be processed in a timely manner. Claims should be filed no later than one year after the date you become totally disabled.

If you know in advance that you will become temporarily disabled (for example, due to a medical procedure), you can call MetLife as you plan for your absence.

When you file an initial claim for disability benefits, both the notice of claim and the required proof should be sent to the Division within 90 days after the end of the elimination period. The elimination period is the waiting period after you become disabled before benefits are payable. Different elimination periods apply to the Short-Term and Long-Term Disability plans; please see the applicable sections below for details.

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

When Benefit Payments End

Disability benefit payments will end when any of the following occurs:

- You are no longer totally disabled.
- You fail to provide required proof of your continued total disability or refuse to be examined when required.
- You reach the maximum benefit period (see *Duration of Payments* under the *Short-Term Disability* and *Long-Term Disability* sections below).
- You cease or refuse to participate in a required rehabilitation program.
- You die.

A 36-month limitation applies to some mental and nervous disorders or diseases as well as any disability that results from alcohol, drug, or substance abuse or addiction. For details, please call MetLife.

What's Not Covered?

Certain exclusions apply to these disability plans. The plans will not cover any disability which results from the following:

- Intentionally self-inflicted injuries or attempted suicide.
- War, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act.
- Your active participation in a riot.
- Your commission of or attempt to commit or take part in a felony.

The STD plan contains additional exclusions for disability caused or contributed to by elective medical or cosmetic procedures. Please refer to your certificate for the full list of excluded procedures.

Disability Appeals

If your claim is denied and you would like to file an appeal, you will need to submit a written appeal to MetLife within 180 days of the date on the denial letter for your claim. Your appeal letter will need to include information about the policy and claim, as well as the reason you feel the claim was improperly denied or your benefits reduced. You can include any additional documents or records you feel should be considered. You may also request records pertaining to the claim through a written request to MetLife.

Appeals should be submitted in writing to:

MetLife Disability

P.O. Box 14592

Lexington, KY 40512-4592

Fax: 1-844-380-0569

Email: DisabilityAppeals@metlife.com

MetLife will evaluate your appeal and communicate their decision within 45 days of the date your appeal was received. Under certain circumstances, MetLife's review may take longer (up to an additional 45 days). You will be informed if additional time is needed to consider your appeal.

Empathy Leave Support

MetLife provides additional support to disability claimants through their partnership with Empathy Leave Support. Empathy is an app designed to help employees feel supported and confident throughout their leave – emotionally, physically, financially, and as they prepare to return to work.

This resource provides personalized guidance in the areas that can most impact your leave experience: your social connections, mental health, physical health, financial concerns, and work dynamics. Through daily check-ins and expert resources, the Leave Support app guides you through each phase of leave, helping you build healthy routines and supporting your transition back to work.

Short-Term Disability

HIGHLIGHTS

- Weekly benefit pays 60% of your pre-disability earnings up to a weekly maximum of \$577, subject to reduction from other income benefits.
- Benefits begin after you'd been disabled and off work for 7 days and you are not in pay status from accrued or donated leave.
- Benefits may continue for up to 180 days from the date of disability.
- No pre-existing condition limitations.

Introduction

Short-Term Disability (STD) protects you in the event of a brief absence from work. It can also fill in the waiting (elimination) period before Long-Term Disability benefits begin. You may elect the Short-Term Disability plan alone or with one of the Long-Term Disability plans.

Please note that payments from other income sources, like personal leave or workers' compensation, can reduce any STD benefit you are entitled to. This means that if you have an extensive leave bank, your benefits may be delayed. You will work with your case manager to coordinate your STD benefit with your personal leave and any other income.

Who May Be Covered

Coverage is available for the employee only. Dependents may not be covered under this plan.

Premiums

The Short-Term Disability Plan has a flat monthly premium cost that is the same for all participants in the plan. To view the current premiums, please visit the Division's website.

Amount of Coverage

Your weekly benefit will be 60% of your pre-disability earnings, up to a maximum of \$577 per week, minus any other income benefits you receive as described in the section *Other Income Benefits* above.

The minimum weekly benefit is the greater of 10% of the benefit you would be eligible for before reductions for other income or \$25. Partial weeks of disability will be prorated on a per day rate.

“Pre-disability earnings” is your pay of record on October 1 of the prior benefit year. Adjustments may be made for part-time, seasonal, or newly hired employees.

When Benefits Are Payable

If you become disabled while enrolled in the Short-Term Disability plan, benefits will begin after the later of:

- 7 days of disability
- the date you stop receiving paid leave

For example:

- If you are disabled and stop working on April 15 with no personal or sick leave, you would be eligible for benefits on April 22.
- If you are disabled and stop working on April 15, but your personal leave lasts until May 15, you would be eligible for benefits on May 16.

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.

Pregnancy Coverage

If you are pregnant or have a totally disabling pregnancy-related condition, benefits will be paid to you on the same basis as for any other condition. As with any disability, a physician must certify your disability, and additional evidence may be required before a benefit eligibility determination is made.

Duration of Payments

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

Recurring Periods of Disability

One “period of disability” may include more than one disability absence. If you have multiple disability absences that are due to the same or related causes, separated by 60 calendar days or less of full-time work, these will be considered 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.

Incentives

Rehabilitation Program Incentive

If you participate in a rehabilitation program, your weekly benefit will be increased by an amount equal to 10% of the weekly benefit. This increase will be applied before your monthly benefit is reduced by any other income.

Work Incentive

If you work while you are disabled and receiving weekly benefits, your weekly benefit will not be reduced by the amount you earn from working, unless the sum of your adjusted weekly benefit, the amount you earn from working, and your other income exceeds 100% of your pre-disability earnings. In that case, the minimum weekly benefit will also not apply.

Family Care Incentive

If you work or participate in a rehabilitation program while you are disabled, you can be reimbursed for up to \$100 for weekly expenses you incur for care provided to family members.

Specifically, you can be reimbursed for:

- Childcare for your or your spouse's child (natural, adopted, or under a legal guardianship) who is under age 13, living with you, and dependent on you for support.
- Care for a family member who is incapable of independent living, regardless of age, due to mental or physical handicap, who is living with you, and who is chiefly dependent on you for support.

Please note that childcare must be provided by a licensed childcare provider, who may not be a member of your immediate family or living in your residence. Care to your incapacitated family member may not be provided by a member of your immediate family.

If you provide proof that you have incurred these expenses, you will receive reimbursement payments on a weekly basis starting with your fourth weekly benefit payment. Payments will not be made beyond the maximum benefit period. Please note that we will not reimburse you for any expenses for which you are eligible for payment from any other source.

Moving Expense Incentive

If you participate in a rehabilitation program while you are disabled, and you decide to move to a new residence recommended as part of the rehabilitation program, you may be reimbursed for approved moving expenses.

Moving expenses must be approved by MetLife in advance, and you will need to send proof that you have incurred the expenses for moving. You will not be reimbursed for moving expenses for services provided by a member of your immediate family or someone who is living in your residence.

Long-Term Disability

HIGHLIGHTS

- Two coverage options are available, paid in a monthly benefit equal to either 60% or 70% of your pre-disability earnings, with limitations.
- Maximum monthly benefit is \$12,000; minimum is \$100.
- 180 day waiting period before benefits begin.

Introduction

Long-Term Disability (LTD) protects you in the event of an extended disability. Benefits begin after you've been disabled and off work for at least 180 days.

Your monthly premium will depend on the option you choose, your age, and the amount of your pre-disability pay.

Who May Be Covered

Coverage is available for the employee only. Dependents may not be covered under this plan.

Premiums

Your premium is based on the coverage level you select, your age, and your monthly base wage. Your wage is updated as of October 1 for the benefit year that begins the following January 1.

Please visit the Division's website to view the Long-Term Disability premium rates for the current year.

Waiver of Premium

Premium payment is waived during the waiting period if you are disabled. Contact MetLife for more information.

Amount of Coverage

This plan offers a choice of two benefit options. If you enroll, you may elect a monthly benefit equal to:

- Plan B: 60% of your monthly pre-disability earnings
- Plan C: 70% of your monthly pre-disability earnings

The maximum monthly benefit payable is \$12,000 and the minimum benefit is \$100 per month. Appropriate adjustments will be made for partial months. These benefit payments may be reduced by any other income you receive as described in the *Other Income Benefits* section above. An alternative lump sum payment option may be available at MetLife's discretion.

“Pre-disability earnings” is your pay of record on October 1 of the year prior to the year in which your disability occurs. Adjustments may be made for part-time, seasonal, or newly hired employees.

When Benefits Are Payable

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

Once your claim is filed, 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.

Pre-Existing Conditions

The LTD plan will not cover a disability which occurs during the first 12 months of your current period of coverage if the disability results from a “pre-existing condition.” Your condition is considered pre-existing if within 3 months prior to your coverage effective date:

- you received medical treatment, consultation, care, or services for the condition;
- you took prescribed medications or had medications prescribed for the condition.

Duration of Payments

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

Age at Disability	Duration of Benefit Payments
less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

No more than 36 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 36 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 Periods of Disability* will not apply.

Recurring Periods of Disability

If You Return to Active Work Before Completing Your Elimination Period

If you return to active work for a period of 60 days or less before completing your elimination period, then become disabled again due to the same or related sickness or accidental injury, you will not be required to complete a new elimination period. The days you were previously absent from work will count toward the completion of your elimination period.

If you return to active work for a period of more than 60 days, and then become disabled again, you will have to complete a new elimination period.

For purposes of this provision, the term “active work” only includes those days you actually work.

If You Return to Active Work After Completing Your Elimination Period

If, after completing your elimination period, you return to active work for a period of 180 calendar days or less, then become disabled again due to the same or related sickness or accidental injury, you will not be required to complete a new elimination period. The disability will be considered part of the original disability for the purpose of determining benefits, and the same pre-disability earnings previously used will be used again.

If you return to active work for a period of more than 180 calendar days and then become disabled again, you will have to complete a new elimination period.

For purposes of this provision, the term “active work” includes all of the continuous days which follow your return to work for which you are not disabled.

Incentives

Rehabilitation Program Incentive

If you participate in a rehabilitation program, your monthly benefit may be increased by an amount equal to 10% of the monthly benefit. This increase will be applied before your monthly benefit is reduced by any other income.

Work Incentive

If you work while you are disabled and receiving monthly benefits, your monthly benefit will not be reduced by the amount you earn from working, unless the sum of your adjusted monthly benefit, the amount you earn from working, and your other income exceeds 100% of your pre-disability earnings. In that case, the minimum weekly benefit will also not apply.

After the first 24 months of disability, your monthly benefit will be reduced by 50% of the amount you earn from working while disabled.

Family Care Incentive

If you work or participate in a rehabilitation program while you are disabled, you can be reimbursed for up to \$400 for monthly expenses you incur from providing care to family members.

Specifically, you can be reimbursed for:

- Childcare for your or your spouse's child (natural, adopted, or under a legal guardianship) who is under age 13, living with you, and dependent on you for support.
- Care for a family member who is incapable of independent living, regardless of age, due to mental or physical handicap, who is living with you, and who is chiefly dependent on you for support.

Please note that childcare must be provided by a licensed childcare provider, who may not be a member of your immediate family or living in your residence. Care to your incapacitated family member may not be provided by a member of your immediate family.

If you provide proof that you have incurred these expenses, you will receive reimbursement payments on a monthly basis up to 24 monthly benefit payments. Please note that we will not reimburse you for any expenses for which you are eligible for payment from any other source.

Moving Expense Incentive

If you participate in a rehabilitation program while you are disabled, and you decide to move to a new residence recommended as part of the rehabilitation program, you may be reimbursed for moving expenses if approved by MetLife in advance. You will need to send proof that you have incurred the expenses for moving. The services cannot be reimbursed if provided by a member of your immediate family or someone who is living in your residence.

Survivor Income Benefit

If you die while you are disabled and you were entitled to receive monthly benefits under this Long-Term Disability plan, a single sum survivor income benefit will be paid to your beneficiaries. Proof of your death must be submitted.

Benefit Amount

The benefit amount will be equal to three times either:

- the monthly benefit you receive for the calendar month immediately preceding your death; or
- the monthly benefit you were entitled to receive for the month you die, if you die during the first month that disability benefits are payable.

The benefit amount will be reduced by any overpayment due.

Critical Illness Insurance

HIGHLIGHTS

- Pays a monetary lump sum when you or your covered dependent experience a qualified medical illness.
- Pays a \$50 annual benefit per covered person if you take at least one health screening or prevention measure throughout the benefit year.

Introduction

The Critical Illness Insurance plan can pay a lump sum upon certain diagnoses. Diagnoses include cancer, heart attack, major organ transplant, kidney failure, Alzheimer's disease, and other critical illnesses.

Critical illness insurance can complement your existing medical coverage and help fill financial gaps caused by expenses such as mortgage payments, hiring household help, or treatment not covered by your medical plan.

Critical illness insurance provides several features that could be valuable to you, including:

- No coordination with other insurance benefits.
- A lump-sum benefit that you can use as you feel necessary.
- Benefits are paid regardless of what is covered by medical insurance.

Who May Be Covered

This plan is available in four tiers:

- Employee Only
- Employee and Spouse
- Employee and Child(ren)
- Employee, Spouse, and Child(ren)

Please see the *Dependents* section earlier in this booklet for more details about dependent eligibility.

Amount of Coverage

You can elect one of two levels of coverage:

- \$15,000
- \$30,000

The amount of the benefit payment you receive will depend on the type of illness and whether the condition is new or recurring. If you elect dependent coverage, your dependents will be eligible for a benefit amount equal to 50% of your initial benefit amount, provided your dependent is not subject to a medical restriction as outlined in the certificate of coverage.

The table below provides examples of covered conditions and the applicable benefit amounts. See your certificate of insurance for the full list of covered conditions and benefit amounts.

Critical Illness Plan		
Covered Conditions	Initial Benefit Amount	Recurrence Benefit Amount
Benign Brain Tumor	100%	100% of Initial Benefit
Invasive Cancer	100%	100% of Initial Benefit
Non-Invasive Cancer	25%	100% of Initial Benefit
Skin Cancer	5% but no less than \$250	None
Heart Attack	100%	100% of Initial Benefit
Stroke	100%	100% of Initial Benefit
Coronary Artery Bypass Graft	50% or 100%	100% of Initial Benefit
Kidney Failure	100%	None
Major Organ Transplant	100%	None
Severe Burn	100%	100% of Initial Benefit
7 Childhood Diseases	100%	None
11 Infectious Disease Conditions	25%	None
11 Progressive Disease Conditions	100%	None

Benefit Separation Period

If you receive a benefit payment for a covered condition, a benefit separation period will follow. A benefit separation period is a waiting period during which the plan may pay reduced benefits or no benefits for any additional occurrences of a covered condition (either the same or different condition).

There are two types of benefit separation periods:

- The Initial Benefit Separation Period refers to the amount of time that must elapse before you qualify for the full initial benefit payment for a different covered condition.
- The Recurrence Benefit Separation Period refers to the amount of time that must elapse before you qualify for the recurrence benefit payment for another occurrence of the same covered condition.

The timeline of each benefit separation period is as follows:

Initial Benefit	30 days
Recurrence Benefit	90 days

Please note that if you experience an occurrence of a different covered condition during the Initial Benefit Separation Period, a partial benefit may still be payable if the benefit you received for your earlier covered condition is less than the benefit due for the later covered condition. In such cases, the difference between the two benefit amounts will be paid to ensure you receive the full value of the higher of the two initial benefit amounts.

Health Screening Benefit

The Critical Illness plan offers an additional Health Screening Benefit if you or your covered dependents take certain health screening/prevention measures while you are enrolled in the plan, such as routine physical exams, blood tests, and screening for various conditions, among others. If you or a covered dependent receive one of these services, MetLife will pay a health screening benefit of \$50 to each covered person who received a health screening service. This benefit will be paid only once in the benefit year and can only be paid if you file a claim with proof of your health screening.

Please refer to the “Health Screening Benefit” section in your certificate of coverage for the full list of eligible screening/prevention measures.

Premiums

Premiums are based on age, coverage tier, and coverage level. Please visit the Division's website to view the current Critical Illness premiums.

Filing a Claim

If you are diagnosed with or experience an occurrence of a covered condition, you should inform MetLife of your condition within 30 days. You will be provided with a claim form which must be submitted to MetLife within 90 days along with proof of your condition. If you are unable to meet these deadlines, you are still encouraged to file a claim. MetLife will consider your individual circumstances when your claim is reviewed.

In the event that you die before a claim has been paid, your designated beneficiaries will receive the benefit that was payable to you. You can designate beneficiaries by logging in to your MetLife member account and completing the beneficiary form. If there are no designated or surviving beneficiaries at the time of your death, MetLife will determine the beneficiary according to the following order:

- Your spouse
- Your child(ren), if there is no surviving spouse
- Your parent(s), if there is no surviving child
- Your sibling(s), if there is no surviving parent
- Your estate, if there is no surviving sibling

If your beneficiary is a minor, MetLife will issue the benefit payment to the child's guardian.

When contacting MetLife, please be prepared to provide the policy number and group number for the plan you are calling about. These numbers can be found on your certificate of insurance or by logging in to mybenefits.metlife.com or the MetLife app.

Critical Illness Insurance Appeals

If your claim is denied and you would like to file an appeal, you will need to submit a written appeal to MetLife within one year of receiving the denial decision for your claim. Your appeal letter will need to include information about the policy and claim, as well as the reason you feel the claim was improperly denied. You can include any additional documents or records you feel should be considered.

Appeals should be submitted in writing to:

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
P.O. Box 80826
Lincoln, NE 68501-7350
Fax: 1-855-306-7350
Email: AHMetLifeClaims@MetLife.com

MetLife will evaluate your appeal and communicate their decision within 45 days of the date your appeal was received. Under certain circumstances, MetLife's review may take longer. You will be informed if additional time is needed to consider your appeal.

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