EMPLOYEE BENEFITS GUIDE

2023-2024

UNIVERSITY of ALASKA

Many Traditions One Alaska

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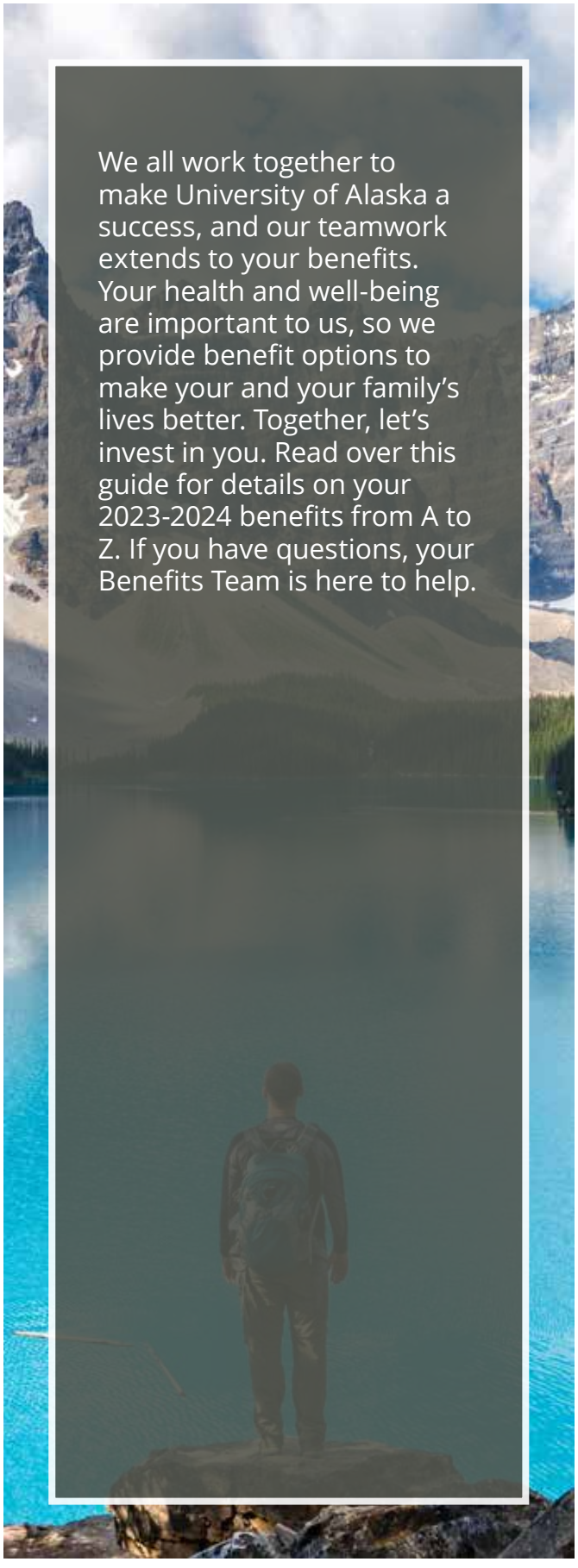


See **page 36** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to University of Alaska. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

ELIGIBILITY

The University of Alaska offers a variety of benefits to support you and your family's needs. Choose options that cover what's important to your unique lifestyle.

Eligibility

Regular full-time and regular part-time employees working at least 20 hours per week may elect one of the UA Choice Health Plans or opt out of coverage if already covered by another health plan.

When Does Coverage Begin?

New employees must choose to enroll in coverage - or waive coverage - within their first 30 days of employment. Beginning July 1, coverage will begin the pay period in which the employee elects coverage* and will remain on the plan for the remainder of the plan year (July 1, 2023 - June 30, 2024) unless they experience a life event. Employees who do not submit a form in their first 30 days will be defaulted into the Basic Health Care, Basic Dental, and Vision plans for employee only. If an employee is defaulted, the default coverage will begin on the 31st day.

*To be considered elected in that pay period, a form must be submitted by 5:00 p.m. Alaska time on the last Thursday of the pay period.

Open Enrollment is the one time each year that associates can make changes to their benefit elections unless they have a qualifying life event.

A qualifying life event can be marriage, divorce or legal separation, birth or adoption, death of a covered dependent, or a gain or loss of coverage due to a child's dependent status or a spouse's employment status. If you feel that you have experienced a life event, please contact UA HR. When a qualifying life event occurs, you must notify the Benefits Department and submit appropriate documentation within 30 days of the life event.

Eligible Dependents

Dependents eligible for coverage in the University of Alaska benefits plans include:

- Your lawful spouse unless legally separated. Wherever "spouse" is stated in the health, dental and vision care plans, a Financially Interdependent Partner (FIP) would also be included provided all requirements are met as specified by the University of Alaska. Health care deductions for FIPs are post-tax.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

PREPARING FOR ENROLLMENT

As a committed partner in your health, the University of Alaska absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your contribution.

Enrollment To-Do

Update your personal information.

Make sure that you have social security numbers, dates of birth, and supporting documentation ready to input while you are electing coverage.

Double-check covered and restricted medications.

If you make any changes to your plan, consider how it affects your prescription coverage.

Review available plan deductibles.

Take a look at your options – if you foresee a lot of medical needs this year, you might want a lower deductible. If not, you could switch to a higher deductible and enjoy lower premiums.

Consider an HSA or FSA.

An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals. See FSA vs HSA comparison on page 23 for more details on the differences between a FSA and HSA.

Switching from an FSA to an HSA?

Are you thinking of switching from the Premium or Basic Plans with an FSA to the HDHP and opening an HSA account? Per the IRS, you cannot have both an FSA and an HSA account active at the same time. Therefore, you cannot have any balance in your FSA after June 30, 2023, or you will not be able to contribute money to your HSA account until January 1, 2024. If you cannot contribute to your HSA account until January 1, 2024, you also cannot use future funds to pay for any expenses between July 1, 2023 and January 1, 2024.

Check to see if your pharmacy is in-network.

Going in-network often saves you money. Check for any plan changes to make sure your favorite pharmacy is still your best bet and is covered in-network.

Contact TouchCare for Enrollment Assistance.

Need help deciding which plan is right for you? TouchCare can walk you through the selection process to make sure you get the coverage you and your family need. Please refer to page 8 for details on how to contact TouchCare for enrollment assistance.

ENROLLMENT

How to Enroll in Benefits for FY24

1. Review this Enrollment Guide to learn about your medical, dental, and vision coverage options. You can also learn about additional benefits such as Supplemental Life and Accidental Death and Dismemberment (AD&D) insurance.
2. Decide if you want to participate in a pre-tax account - the Heath Care Flexible Spending Account (HC FSA), the Dependent Care Flexible Spending Account (DC FSA) or a Health Care Savings Account (HSA). You can enroll in an HC and DC FSA with any of the UA choice plans. You can also enroll in an HC or DC FSA if you choose to waive coverage because you have non-UA coverage. The HSA must be combined with a qualifying health plan. At UA, our compatible plan is the HDHP. If you have non-UA coverage and wish to enroll in the HSA, it is your responsibility to understand if your coverage is HSA qualifying.
3. To make your benefit choices, open the UA Choice Benefit Enrollment Form found on the UA Benefits website (https://www.alaska.edu/benefits) under Benefits Forms, and log in to the NextGen form using your UA credentials. The form will take you through your benefit options starting with healthcare. If you are adding dependents and need to submit documentation (birth certificates, marriage certificate, etc.), you can upload your documents right in the form.
4. Flexible Spending Accounts must be elected each year; they do not continue automatically. If you don't sign up for the Healthcare FSA or the Dependent Care FSA at enrollment, you will not have an FSA for FY24 unless you experience a major life event (birth, marriage, divorce, etc.) and enroll within 30 days of the event. You must use the money in your FSA by end of the Plan Year or the funds will be forfeited.
5. If you want to start Health Savings Account (HSA) payroll deductions, just enter the amount where indicated on the form. The HSA is a calendar year plan. Remember, the HSA money is yours to keep; it never forfeits and you decide whether to use it now or in the future.

New Employees

If you are a new employee, you have 30 days from your first day of employment to complete a healthcare enrollment form. This means that a form must be submitted by all new employees — even if you are opting out because you have health coverage elsewhere.

If no form is submitted in the 30-day election window, you will automatically be enrolled in the medical Basic Plan, the dental Basic Plan and the Vision Plan for employee-only coverage.

How to Enroll

1. Attend Benefits Overview (held on the 1st and 3rd Wednesday of the month) to receive information about the UA Choice Health Plans. Register to attend by contacting your HR Coordinator.
2. Make your elections by completing the UA Choice Benefit Enrollment Form available under Benefits Forms on the UA Benefits website https://www.alaska.edu/benefits within 30 days of your date of hire.
   - If enrolling dependents, you must provide supporting documentation at the time of enrollment.

Tip: **If you had an FSA account during the 2023-2024 plan year, and are moving to an HSA account, remember to use your complete balance by June 30, 2023, to avoid having to wait to fund your HSA until January 1, 2024.**

Current Employees

Outside of the annual Open Enrollment period, an employee may change an enrollment election only if there has been a qualifying life event. The most common examples of qualifying life events include birth of a child, change in marital status, acquisition of coverage, and loss of coverage.

Mid-year changes outside of Open Enrollment must be completed within 30 days of the date of the event, unless the event is birth of a child or adoption, then you have 60 days to enroll a newborn. All other changes (if any) need to be made in the 30 day window.

For more information about Qualifying Life Events, see page 7 of this guide.

How to Make Changes

1. Complete the Life Event Changes Form, available under Benefits Forms on the UA Benefits website https://www.alaska.edu/benefits to update your benefits within the appropriate timeline.
2. If you are enrolling dependents for the first time, you must provide supporting documentation at time of enrollment.
   - To add dependents, you must provide a birth certificate, marriage certificate, FIP paperwork, court documents or tax documents listing dependents.
   - You must provide court documents to drop a spouse, if due to separation or divorce.

Qualifying Life Events

What are **Qualifying Life Events?**

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of Open Enrollment.

Common qualifying life events include:

- A change in your employment status resulting in a gain or loss of eligibility
- A change in your legal marital status (marriage, divorce or legal separation)
- Entitlement to Medicare or Medicaid
- A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Eligibility for coverage through the Marketplace
- A change in your spouse's employment status that results in a loss or gain of coverage
- Changes in your address or location that may affect the coverage for which you are eligible

Some lesser-known qualifying life events are:

- Turning 26 and losing coverage through a parent's plan
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Death in the family (leading to change in dependents or loss of coverage)

When a Qualifying Life Event occurs, election changes must be made within 30 days (although you have 60 days to add your newborn or newly placed or adopted child to the health plan) or you must wait until the next open enrollment. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to University of Alaska's Benefits Team at ua-benefits@alaska.edu.

TOUCHCARE: YOUR HEALTHCARE CONCIERGE SERVICE

Who is TouchCare?

TouchCare is your personal healthcare concierge assistant that is available for all employees to provide free, confidential assistance to help take the stress out of health care decisions. TouchCare can help you to find in-network doctors, get cost estimates, deal with billing issues and explain your benefits... all at no cost to you.

How TouchCare Can Help:

As a TouchCare member, you have a personal healthcare concierge assistant in your pocket. We're here to help answer any and all of your healthcare and benefit questions.

We're here to help! TouchCare services were designed to make your life easier!

Benefit Navigation
TouchCare assists with more than just medical insurance. They also support members with voluntary benefits.

Bill Negotiation
Members can send invoices/bills to TouchCare and work with someone if they feel something is wrong. They will work on your behalf to fix any errors.

Cost Comparison
TouchCare Health Assistants ensure you never overpay for care by carefully researching all options and costs.

Provider Search
TouchCare can help navigate you to highly rated providers that are in-network and conveniently located.

How to Contact TouchCare:

Employees can reach a Health Assistant by calling 866-486-8242 (M-F, 8am – 9pm EST), by visiting www.touchcare.com and logging in to your member portal, emailing assist@touchcare.com, or by downloading the TouchCare app for your Android or iOS device.

APP
Download the TouchCare app on your iOS or Android device. Access all of the concierge services from your pocket!

Online Portal
Open a case, exchange messages, or upload plan documents to the TouchCare online portal via www.touchcare.com.

Phone
Call us: 866-486-8242
Available 8am – 9pm EST
Monday through Friday

Email
assist@touchcare.com
A Health Assistant will reply as soon as they're available.

MEDICAL BENEFITS

Medical benefits are provided through Premera Blue Cross Blue Shield of Alaska. Choose the plan that works best for your lifestyle. Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire FY24 Plan Year, unless you have a qualifying life event.

Medical Plan Summary

This chart summarizes the 2023-2024 medical coverage provided by Premera Blue Cross Blue Shield. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PREMIUM PLAN		BASIC PLAN		HDHP W HSA	
BIWEEKLY CONTRIBUTIONS						
EMPLOYEE ONLY	$135.97		$89.58		$75.58	
EMPLOYEE + SPOUSE	$290.05		$188.08		$157.16	
EMPLOYEE + CHILD(REN)	$197.55		$121.35		$98.16	
EMPLOYEE + FAMILY	$361.47		$225.08		$182.24	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$750		$1,250		$1,500	
FAMILY	$2,250		$3,000		$3,000	
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	60%*	80%*	60%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$4,250	N/A	$5,000	N/A	$5,000	N/A
FAMILY	$9,250	N/A	$11,000	N/A	$6,850	N/A
COPAYS/COINSURANCE - % OF COINSURANCE PAID BY THE MEMBER						
PREVENTIVE CARE	100% Covered	100% Covered	100% Covered	100% Covered	100% Covered	100% Covered
PRIMARY CARE	20%*	40%*	20%*	40%*	20%*	40%*
SPECIALIST SERVICES	20%*	40%*	20%*	40%*	20%*	40%*
TELEMEDICINE	20%*	40%*	20%*	40%*	20%*	40%*
URGENT CARE	20%*	Hospital-based: 20%* / Freestanding Center: 40%*	20%*	Hospital-based: 20%* / Freestanding Center: 40%*	20%*	Hospital-based: 20%* / Freestanding Center: 40%*
DIAGNOSTIC CARE	20%*	40%*	20%*	40%*	20%*	40%*
EMERGENCY ROOM	20%*	20%*	20%*	20%*	20%*	20%*

*After Deductible

For the Premium and Basic Plans, the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

For the HDHP, each covered individual is not required to meet the individual deductible. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

OUT-OF-POCKET COSTS

Deductible

The amount you must pay for covered services before your insurance starts paying its portion.

UP TO DEDUCTIBLE

YOU PAY **100%**

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Know before you go: Paying for services

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

% YOU PAY

% PLAN PAYS

AFTER DEDUCTIBLE IS REACHED

UP TO THE OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

AFTER OUT-OF-POCKET MAXIMUM IS REACHED

PLAN PAYS **100%** THROUGH END OF PLAN YEAR

PREVENTIVE CARE

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders

- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Please refer to alaska.edu/benefits for benefit information and access to benefit summaries.

WHERE TO GO FOR CARE

PRIMARY CARE CENTER

When would I use this?
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

NURSE LINE

When would I use this?
You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

What type of care would they provide?*
Answers to questions regarding:
- Symptoms
- Medications and side effects
- Self-care home treatments
- When to seek care

What are the costs and time considerations?**
- Nurse lines are available 24 hours a day, 7 days a week.
- This service is free as part of your elected medical insurance coverage.

TELEMEDICINE

When would I use this?
You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems
- Behavioral Health
- Substance Use Disorder

What are the costs and time considerations?**
- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter. Please refer to your Summary of Benefits depending on the medical plan that you have elected.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER

When would I use this?
You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance that is usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first

EMERGENCY ROOM

What are the costs and time considerations?**
- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

When would I use this?
You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*
- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

*This is a sample list of services and may not be all-inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

VIRTUAL MEDICINE

When you're sick, the last thing you want to do is leave the comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual medicine is a convenient and easy way to talk to a doctor fast.

Telemedicine benefits are available to employees and their families through the following options:

- Doctor On Demand — video-based care from a doctor, 24/7. Get started with Doctor On Demand: https://patient.doctorondemand.com.
- Telemedicine services offered through your in-network provider's office.
- 24-Hour NurseLine — Call the number on the back of your member ID card.
- CirrusMD allows you to securely chat with a dedicated doctor within 60 seconds for urgent care needs. Download the app on your mobile device and register today.
- Talkspace for mental health needs. Download the app on your mobile device and register today.
- Boulder Care for substance use disorder treatment. Download the app on your mobile device and register today.
- WorkIt Health for substance use disorder treatment. Download the app on your mobile device and register today.
- Brightline offers virtual behavioral health care for children and families. Call 888-224-7332 or visit hellobrightline.com/PremeraAK-access.
- Physical therapy, for joint and muscle health, is now available virtually through Omada. Log in to Premera MyCare to connect with in-network providers.

Telemedicine can be used to treat many medical conditions including:

- Cold & Flu
- Bronchitis
- Urinary Tract Infections
- Respiratory Infections
- Sinus Problems

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

The Prescription Drug Program is coordinated through Premera Blue Cross Blue Shield of Alaska. Information on your benefits coverage and a list of network pharmacies is available online at www.premera.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic Preventive, Preferred Generic, Preferred Brand Name, Specialty Drugs, and Non-Preferred.

	PREMIUM PLAN		BASIC PLAN		HDHP W HSA	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RX OUT-OF-POCKET MAXIMUM (OOP)	Rx OOP Max $1,000 Ind / $1,700 Family		Rx OOP Max $1,000 Ind / $1,700 Family		HDHP RX expenses are included within the medical deductible and OOP Max.	
RETAIL RX (30-DAY SUPPLY) - % OF COINSURANCE PAID BY THE MEMBER						
GENERIC PREVENTIVE	100% Covered	100% Covered	100% Covered	100% Covered	100% Covered	100% Covered
PREFERRED GENERIC**	$10 Copay	$10 Copay	$10 Copay	$10 Copay	20%*	20%*
PREFERRED BRAND NAME	$30 Copay	$30 Copay	$30 Copay	$30 Copay	20%*	20%*
SPECIALTY DRUGS	$100 Copay	Not Covered	$100 Copay	Not Covered	20%*	20%*
NON-PREFERRED	30%	30%	30%	30%	20%*	20%*
MAIL ORDER RX (90-DAY SUPPLY) - % OF COINSURANCE PAID BY THE MEMBER						
GENERIC PREVENTIVE	100% Covered	Not Covered	100% Covered	Not Covered	100% Covered	Not Covered
PREFERRED GENERIC	$20 Copay	Not Covered	$20 Copay	Not Covered	20%*	Not Covered
PREFERRED BRAND NAME	$60 Copay	Not Covered	$60 Copay	Not Covered	20%*	Not Covered
SPECIALTY DRUGS	$110 Copay	Not Covered	$110 Copay	Not Covered	20%*	Not Covered

*After Deductible

**You may be eligible to fill a Preferred Generic prescription for a 90-day supply for 3 times the 30-day copay or coinsurance amount. Please confirm with your pharmacy and/or physician.

Preventive Medications

Most preventive medications are covered at no cost to you on all plans. Confirm with your pharmacy when you fill your prescription. For a list of current preventive medications, please refer to the PV Core Plus drug list available through Premera's website (https://www.premera.com/documents/052924.pdf). This drug list applies to all three UA Choice Plans.

For more information on alternatives for non-preferred or excluded drugs, please visit Premera's website at www.premera.com.

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Maintenance Medications

If you take a drug on a regular basis to control or treat an ongoing or chronic condition, you will be able to get your first two fills at a retail pharmacy but then will need to use the mail order pharmacy for future refills. If you don't use the mail order pharmacy for your maintenance drugs, the regular retail copay will be doubled for the same 30 day supply. Find out which drugs make the list of Maintenance Medications and view the Maintenance Medication Exempt List to find exceptions.

Maintenance Medications:
https://www.alaska.edu/hr/benefits/documents-and-forms/pharmacy/maintenance-medication-list.pdf

Maintenance Medication Exempt List:
https://www.alaska.edu/hr/benefits/documents-and-forms/pharmacy/maintenance-exempt-list.pdf

Specialty Medications

Patients with rare or complex chronic medical conditions need the extra help to manage medications and costs. Premera's Specialty Pharmacy Program provides a full complement of specialized drugs and services by partnering with specialty pharmacies to help educate, provide clinical support for dosing and potential side effects, and to help you with ordering medication and assess delivery options.

If you are taking medications for a complex chronic medical condition contact Accredo, an Express Scripts Specialty Pharmacy. Call toll-free at 877-244-2995 to enroll and ask an Accredo representative to call your provider if a new prescription is needed. Your provider may also call Accredo directly once you are enrolled to fill ongoing prescriptions. Certain Specialty Drugs through the Premium and Basic Plans have a $100 copay for up to a 30-day supply through the Accredo Health Group. Specialty Drugs through the HDHP require 20% coinsurance after your deductible has been met. For more information on the Premera Specialty Pharmacy Program, Accredo Health Group and a list of Specialty Drugs, please visit http://www.premera.com/wa/provider/pharmacy/pharmacy-services/specialty-pharmacy/.

SaveonSP Specialty Coupon Program

The University of Alaska is collaborating with Express-Scripts' program, **SaveonSP,** to help you save money on certain specialty medications. Contact SaveonSP directly at 1-800-683-1074 to find out if your current medication is eligible. Participation is voluntary and you must contact them prior to filling your prescription.

- If you participate in this program, your copay will be covered under the SaveonSP program for the specialty medications included in the program, which will result in no out-of-pocket costs to you.
- Your prescriptions will still be filled through **Accredo,** your existing Specialty Pharmacy.

Current SaveonSP Medication List:
http://www.premera.com/saveonsp

The prescription drugs included in the SaveonSP program are classified as Non-Essential Health Benefits under the Affordable Care Act. Because of this, the prescription drug is not required to apply towards your out-of-pocket accumulators.

The medications and associated copays included in this program are subject to plan clinical rules and subject to change.

DENTAL BENEFITS

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! University of Alaska offers affordable plan options for routine care and beyond. Coverage is available from Premera Blue Cross Blue Shield of Alaska.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond those that are Reasonable and Customary (R&C). To find a network dentist, visit Premera Blue Cross at www.premera.com.

	PREMIUM PLAN	BASIC PLAN
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$7.97	$3.16
EMPLOYEE + SPOUSE	$16.21	$6.59
EMPLOYEE + CHILD(REN)	$15.44	$5.20
EMPLOYEE + FAMILY	$25.94	$9.55
	IN-NETWORK	**IN-NETWORK**
ANNUAL DEDUCTIBLE		
PER MEMBER / PER FAMILY	$50/$150 Does not apply to Preventive	$50/$150 Does not apply to Preventive
ANNUAL MAXIMUM		
PER PERSON	$3,500	$2,000
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100% Covered No Deductible Applied**	100% Covered No Deductible Applied**
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	80%*	80%*
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	50%*	50%*
ORTHODONTICS	50%	50%
ORTHODONTIC LIFETIME MAXIMUM	$3,500	$1,500

*After Deductible has been met

**Subject to individual provider service fees. Members are encouraged to review costs with providers prior to services.

Thoughts & Tips: **Only 60% of adults ages 20 to 64 have been to the dentist in the past year. Take advantage of your dental coverage to keep your smile healthy.**

VISION BENEFITS

Don't wear glasses? You should still get an annual eye exam to catch both eye and overall health issues. University of Alaska provides you and your family access to quality vision care with a comprehensive vision benefit through VSP.

VISION PLAN

BIWEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$0.60		
EMPLOYEE + SPOUSE	$1.27		
EMPLOYEE + CHILD(REN)	$1.09		
EMPLOYEE + FAMILY	$1.90		
	IN-NETWORK	**OUT-OF-NETWORK**	**FREQUENCY**
EXAMS			
COPAY	$10 copay	Up to $50 reimbursement	Every 12 months
LENSES			
SINGLE VISION	$25 copay	Up to $50 reimbursement	Every 24 months
BIFOCAL	$25 copay	Up to $75 reimbursement	
TRIFOCAL	$25 copay	Up to $100 reimbursement	
LENTICULAR	$25 copay	Up to $125 reimbursement	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	No charge	No Coverage	Every 24 months
ELECTIVE	No charge	Up to $105 reimbursement	
MEDICALLY NECESSARY	No charge	Up to $210 reimbursement	
FRAMES			
COPAY	$25 copay	Up to $70 less the $25 copay	Every 24 months
ALLOWANCE	Standard Frame: up to $150 or Featured Brands: up to $170 + 20% off the remaining amount	Up to $70 reimbursement	
OTHER SERVICES			
DIABETIC EYE CARE	$20 copay	No Coverage	As needed

For a more detailed vision plan summary, please visit www.alaska.edu/benefits.

LightCare: **Protect your eyes against digital eye strain or the sun's ultraviolet rays, even if you don't wear prescription glasses. With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor.**

Eye Exam: **A fully covered WellVision Exam®***

Eyewear: **Use your frame and lens allowance toward ready-made:**
• non-prescription sunglasses or • non-prescription blue light filtering glasses

*Register and log in to vsp.com to review your benefit information. Based on applicable laws; benefits may vary by location.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in UA's HDHP or a qualifying plan to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Your Money. Your Account.

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over unused HSA funds to the next year or let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs.

Bank of America Benefit Solutions will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible plan and not otherwise covered by a non-eligible plan (this includes spouse coverage, Medicare and TRICARE).
- You are not covered by your spouse's non-HDHP.
- You were not previously contributing to a Flexible Spending Account (FSA) or will not have any balance in your FSA after June 30, 2023.
- Your spouse does not have a Healthcare Flexible Spending Account (HC FSA) or Health Reimbursement Account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

How to Enroll/Make Changes

To enroll in the University of Alaska's HSA, you must be enrolled in an eligible plan. At UA, our eligible plan is the HDHP. If you have coverage elsewhere, it is your responsibility to make sure that it is HSA compatible before opening an HSA account. If you are unsure about the qualifying status of your plan(s), please contact TouchCare to discuss.

New Employees

New employees elect their health coverage within their first 30 days of hire. If you enroll in the HDHP, or otherwise meet the HSA eligibility requirements listed above, you may enroll in the HSA. The New Employee Enrollment Form can be found on https://www.alaska.edu/benefits.

Current Employees

Once you have determined you meet all the HSA eligibility requirements listed above, you can elect an HSA. You can start, stop, or change your biweekly contributions at any time during the plan year. The HSA form can be found at https://www.alaska.edu/benefits.

Reminder: **If you are switching from an FSA account to an HSA account, you cannot have any balance in your FSA after June 30, 2023. If there is even $1 in your FSA on July 1, 2023, you will not be able to contribute money to your HSA account until January 1, 2024.**

Thoughts & Tips: **It's up to you how much to contribute to your HSA. Buying a new house or sending a kid to college? You can contribute less this year. Paid off your student loans or got a new job? Stash the annual max in your account.**

HSAs and Taxes

HSA contributions are made through payroll deductions on a pre-tax basis. Once you begin deductions, an account will automatically be established with Bank of America Benefit Solutions. Your HSA is a personal bank account that you own and administer. There are action items required of you to complete the setup of your account. Be on the lookout for a Welcome Packet in the mail from Bank of America. Once you complete the set up of your account directly with Bank of America and verified bank account information has been sent to the University of Alaska, your contributions will be sent to your HSA.

The money in your HSA (including interest and investment earnings) grows tax free. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2023, contributions are limited to the following:

2023 HSA FUNDING LIMITS	
EMPLOYEE	$3,850
FAMILY	$7,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

The University of Alaska HSA is established with Bank of America Benefit Solutions. You may be able to roll over funds from another HSA. For more information, contact Bank of America Benefit Solutions at https://myhealth.bankofamerica.com.

While the University of Alaska provides convenient payroll deductions for the HSA, all aspects of managing and maintaining the account as well as complying with IRS guidelines remain the responsibility of the employee.

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses. You may enroll in an FSA regardless of if you choose a UA Choice plan or not.

Healthcare Flexible Spending Account

Funds in your Healthcare FSA can be used for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay.

2023 FSA FUNDING LIMITS	
HEALTHCARE FSA	$3,050
DEPENDENT CARE FSA	$5,000

Using the Account

Employees enrolled in the Healthcare FSA will need to contact ASIFlex to request a debit card for their account. You can use your ASIFlex debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

If you are unable to use your debit card and have to pay out of pocket, you may be eligible for reimbursement from your account. Employees will need to submit a claim form along with the required documentation. Contact ASIFlex with reimbursement questions. If you need to submit a receipt, ASIFlex will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2023-2024 plan year.
- Funds cannot be transferred between FSAs.
- For the Healthcare FSA, all funds selected will be immediately available to you on day one of your plan and you do not need to wait to accrue the funds.
- For Dependent Care FSA, you may only use funds that have accrued in your account. Elected annual contributions are not immediately available at the beginning of the plan year.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You cannot have a Healthcare FSA and an HSA in the same Plan Year.
- You can have a Dependent Care FSA and HSA in the same Plan Year.
- You must "use it or lose it"; however, the Healthcare FSA and Dependent Care FSA do include a 90-day run-out period (September 30th deadline) after the end of the Plan Year for expenses to be reimbursed that incurred during the Plan Year. Any unclaimed funds at the end of the run out are forfeited and returned to your employer.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement of services rendered while an active employee.
- Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

Thoughts & Tips: **Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.**

FSA VS HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for eligible healthcare costs. Which one is best for you?

	FLEXIBLE SPENDING ACCOUNTS	HEALTH SAVINGS ACCOUNTS
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You can elect a Healthcare FSA and/or a Dependent Care FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You must enroll for an FSA each Plan Year; prior elections will not rollover. You cannot be enrolled in both a Healthcare FSA and an HSA.	1. You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction. Funds are spent tax free when used for qualified expenses.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free when used for qualified expenses.
CONTRIBUTIONS	You can contribute according to IRS limits. The contribution limit for the Healthcare FSA for 2023 is $3,050.	You can contribute according to IRS limits. The contribution limit for 2023 is $3,850 for individuals and $7,750 for families. If you are 55 or older, you may make an annual "catch-up" contribution of $1,000.
PAYMENT	You can use an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement. For the Healthcare FSA, all funds selected will be immediately available to you on day one of your plan and you do not need to wait to accrue the funds. For Dependent Care FSA, you may only use funds that have accrued in your account. Elected annual contributions are not immediately available at the beginning of the plan year.	You can use an HSA debit card to pay for qualified expenses. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or you may use another account to pay for services and save the money in your HSA for future expenses or retirement.
ROLL OVER OR GRACE PERIOD	You must use the money in the account by end of Plan Year; however, the Healthcare FSA and Dependent Care FSA do include a 90-day run-out period after the end of the Plan Year for expenses to be reimbursed that incurred during the Plan Year. Any unclaimed funds at the end of the run out are forfeited and returned to your employer.	HSA funds roll over from year to year. The money is always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

SURVIVOR BENEFITS

Survivor benefits provide financial protection and security in the event of a death or accident. Securing life insurance now ensures your family will be protected for the future.

UA Paid Basic Life Insurance

University of Alaska provides employees with Basic Life Insurance through Securian Life Insurance Co. This guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life insurance benefit is $100,000. If you are a full-time employee, you automatically receive Basic Life Insurance even if you elect to waive other coverage. Monthly premiums are 100% paid by the employer. There is an IRS tax implication for life insurance plans in excess of $50,000. The imputed cost of coverage in excess of $50,000 must be included in income, using the IRS Premium Table, and is subject to Medicare taxes.

BASIC EMPLOYEE LIFE INSURANCE	
COVERAGE AMOUNT	$100,000
WHO PAYS	University of Alaska
BENEFITS PAYABLE	In the event of your death.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Naming a Beneficiary

Your beneficiary is the person(s) you designate to receive your Life Insurance benefits in the event of your death. This includes any benefits payable under UA Paid Basic Life Insurance, Voluntary Accident Death & Dismemberment (AD&D), and/or Supplemental Life Insurance benefits offered by the University of Alaska.

If you need assistance, contact ua-benefits@alaska.edu or your own legal counsel.

Evidence of Insurability (EOI)

EOI is the information that Securian uses to verify your good health when you are purchasing voluntary life insurance. EOI is required if you are:

- Electing an insurance amount higher than the guaranteed amount for your plan.
- Already enrolled up to the guaranteed amount and want to increase coverage.

EOI must be completed online at https://alaska.edu/hr/benefits/documents-and-forms/open-enrollment/fy23-electronic-eoi-instructions.pdf. In some cases, you may be auto-approved for coverage. If not, Securian will review your application and contact you if more information is required. In all cases, Securian will notify you of your application outcome.

Voluntary Accidental Death & Dismemberment Insurance (AD&D)

The UA Paid Basic Life Insurance provided to you by the University of Alaska may not be enough to cover expenses in a time of need. Eligible employees may purchase additional Voluntary AD&D Insurance. Premiums are paid through payroll deductions.

FY24 AD&D RATES (26 PAYROLLS)

COVERAGE TYPE	BI-WEEKLY COST	ANNUAL COST
EMPLOYEE ONLY	$2.63	$68.40
EMPLOYEE + FAMILY	$5.26	$136.80

VOLUNTARY AD&D INSURANCE	
COVERAGE AMOUNT	This optional coverage provides a lump sum benefit to you or your beneficiary if you or a covered family member die or suffer certain injuries as the result of an accident.
WHO PAYS	Employee
BENEFITS PAYABLE	If you lose a limb or suffer paralysis in an accident. This benefit is in addition to the Basic Life benefit.
MAXIMUM BENEFIT	$300,000 for you and a percent for your family members, depending on the make-up of your family at the time of a qualifying accident
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Supplemental Term Life Insurance

Employees may purchase Supplemental Term Life Insurance to enhance the UA Paid Basic Life Insurance. Employee Supplemental Term Life Insurance can be purchased in $50,000 increments up to a maximum of $600,000. Employees may also purchase Supplemental Term Life Insurance for their spouse/Financially Interdependent Partner (FIP) and/or child(ren).

EMPLOYEE SUPPLEMENTAL TERM LIFE	
COVERAGE AMOUNT	Up to $600,000 of supplemental coverage in $50,000 increments
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your death. This benefit is in addition to the Basic Life benefit.
MAXIMUM BENEFIT	$600,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	EOI is required when electing over $200,000 Age 65+: EOI is required when electing over $100,000
SPOUSE SUPPLEMENTAL TERM LIFE	
COVERAGE AMOUNT	Up to $150,000 of voluntary coverage in $10,000 increments
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your spouse's death.
MAXIMUM BENEFIT	$150,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	You can elect up to $50,000 without having to answer medical history questions. Any coverage you wish to add after you are first eligible or any amount over $50,000 is subject to the Evidence of Insurability process.
CHILD SUPPLEMENTAL TERM LIFE	
COVERAGE AMOUNT	Flat amount of $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your child's death.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	None

If you fail to submit required documentation within the requested time frame, your requested coverage will be denied.

FY24 Supplemental Life Insurance Rates

VOLUNTARY EMPLOYEE LIFE INSURANCE

BI-WEEKLY RATES (26 PAYROLLS)

	UNDER 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$50,000	$0.65	$1.02	$1.18	$1.66	$2.49	$4.06	$7.57	$10.15	$21.97
$100,000	$1.29	$2.03	$2.35	$3.32	$4.98	$8.12	$15.14	$20.31	$43.94
$150,000	$1.94	$3.05	$3.53	$4.98	$7.48	$12.18	$22.71	$30.46	$65.91
$200,000	$2.58	$4.06	$4.71	$6.65	$9.97	$16.25	$30.28	$40.62	$87.88
$250,000	$3.23	$5.08	$5.88	$8.31	$12.46	$20.31	$37.85	$50.77	$109.85
$300,000	$3.88	$6.09	$7.06	$9.97	$14.95	$24.37	$45.42	$60.92	$131.82
$350,000	$4.52	$7.11	$8.24	$11.63	$17.45	$28.43	$52.98	$71.08	$153.78
$400,000	$5.17	$8.12	$9.42	$13.29	$19.94	$32.49	$60.55	$81.23	$175.75
$450,000	$5.82	$9.14	$10.59	$14.95	$22.43	$36.55	$68.12	$91.38	$197.72
$500,000	$6.46	$10.15	$11.77	$16.62	$24.92	$40.62	$75.69	$101.54	$219.69
$550,000	$7.11	$11.17	$12.95	$18.28	$27.42	$44.68	$83.26	$111.69	$241.66
$600,000	$7.75	$12.18	$14.12	$19.94	$29.91	$48.74	$90.83	$121.85	$263.63

VOLUNTARY SPOUSE LIFE INSURANCE

BI-WEEKLY RATES (26 PAYROLLS)

	UNDER 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$10,000	$0.13	$0.20	$0.24	$0.33	$0.50	$0.81	$1.51	$2.03	$4.39
$20,000	$0.26	$0.41	$0.47	$0.66	$1.00	$1.62	$3.03	$4.06	$8.79
$30,000	$0.39	$0.61	$0.71	$1.00	$1.50	$2.44	$4.54	$6.09	$13.18
$40,000	$0.52	$0.81	$0.94	$1.33	$1.99	$3.25	$6.06	$8.12	$17.58
$50,000	$0.65	$1.02	$1.18	$1.66	$2.49	$4.06	$7.57	$10.15	$21.97
$60,000	$0.78	$1.22	$1.41	$1.99	$2.99	$4.87	$9.08	$12.18	$26.36
$70,000	$0.90	$1.42	$1.65	$2.33	$3.49	$5.69	$10.60	$14.22	$30.76
$80,000	$1.03	$1.62	$1.88	$2.66	$3.99	$6.50	$12.11	$16.25	$35.15
$90,000	$1.16	$1.83	$2.12	$2.99	$4.49	$7.31	$13.62	$18.28	$39.54
$100,000	$1.29	$2.03	$2.35	$3.32	$4.98	$8.12	$15.14	$20.31	$43.94
$110,000	$1.42	$2.23	$2.59	$3.66	$5.48	$8.94	$16.65	$22.34	$48.33
$120,000	$1.55	$2.44	$2.82	$3.99	$5.98	$9.75	$18.17	$24.37	$52.73
$130,000	$1.68	$2.64	$3.06	$4.32	$6.48	$10.56	$19.68	$26.40	$57.12
$140,000	$1.81	$2.84	$3.30	$4.65	$6.98	$11.37	$21.19	$28.43	$61.51
$150,000	$1.94	$3.05	$3.53	$4.98	$7.48	$12.18	$22.71	$30.46	$65.91

VOLUNTARY CHILD LIFE INSURANCE

BI-WEEKLY RATE FOR $10,000 OF COVERAGE

COVERAGE TYPE	BI-WEEKLY COST
CHILD (UP TO AGE 26)	$0.462

If you need assistance calculating your rates and estimate costs, go to this website for further information http://www.lifebenefits.com/UA.

ABSENCE MANAGEMENT & INCOME PROTECTION

You and your loved ones depend on your regular income. That's why the University of Alaska utilizes UNUM for absence management and disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or you reach retirement age.

UNUM Absence Management

The University of Alaska uses UNUM for Short Term Disability, Long Term Disability, Family and Medical Leave Act (FMLA) leave management and Americans with Disability Act (ADA) accommodations. UNUM's Absence Management Specialist team will assist you with your disability and/or other leave of absence needs.

Employees will be assisted with:

- Simplified claim processes.
- Technical strength in the outsourcing and administration of complex FMLA, disability, and all other leave management including day one absence.
- Integrated team of claim and clinical resources dedicated to servicing University of Alaska employees.
- Web-based technology platform and comprehensive information-reporting database.

UNUM is One Solution from First Call to Return to Work

Please call the toll-free absence reporting number at 866-779-1054 (M-F, 4am-4pm Alaska time) and identify your employer, University of Alaska, or visit www.unum.com and follow the claim submission instructions. Unum's intake specialists gather the needed information to determine the type of claim(s), next steps and to start the claim process.

When to Call UNUM

- When you are unable to work due to illness, injury or pregnancy.
- When you need to be absent from work to care for an immediate family member who has a serious health condition.
- When you need to care for a child due to birth, adoption or foster care placement.
- When you need to be absent from work for a qualifying exigency leave because your spouse, son, daughter, or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- When you need to care for your spouse, child, parent or next of kin undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list for a serious illness or injury incurred or aggravated in the line of duty on active duty in the Armed Forces (includes the National Guard or Reserves). This includes a veteran who was discharged from the Armed Forces for reasons other than dishonorable within the 5 year period before the employee's first day of leave.
- When you need any other type of leave that may be covered by applicable state leave laws.
- Thirty days before a planned leave based on prescheduled medical treatment related to a serious health condition for you or your family member, or the expected birth, adoption or foster care placement of a child.

Please refer to the DOL FMLA Poster on Employee Rights & Responsibilities under the Family and Medical Leave Act.

Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or the Benefits Team for details.

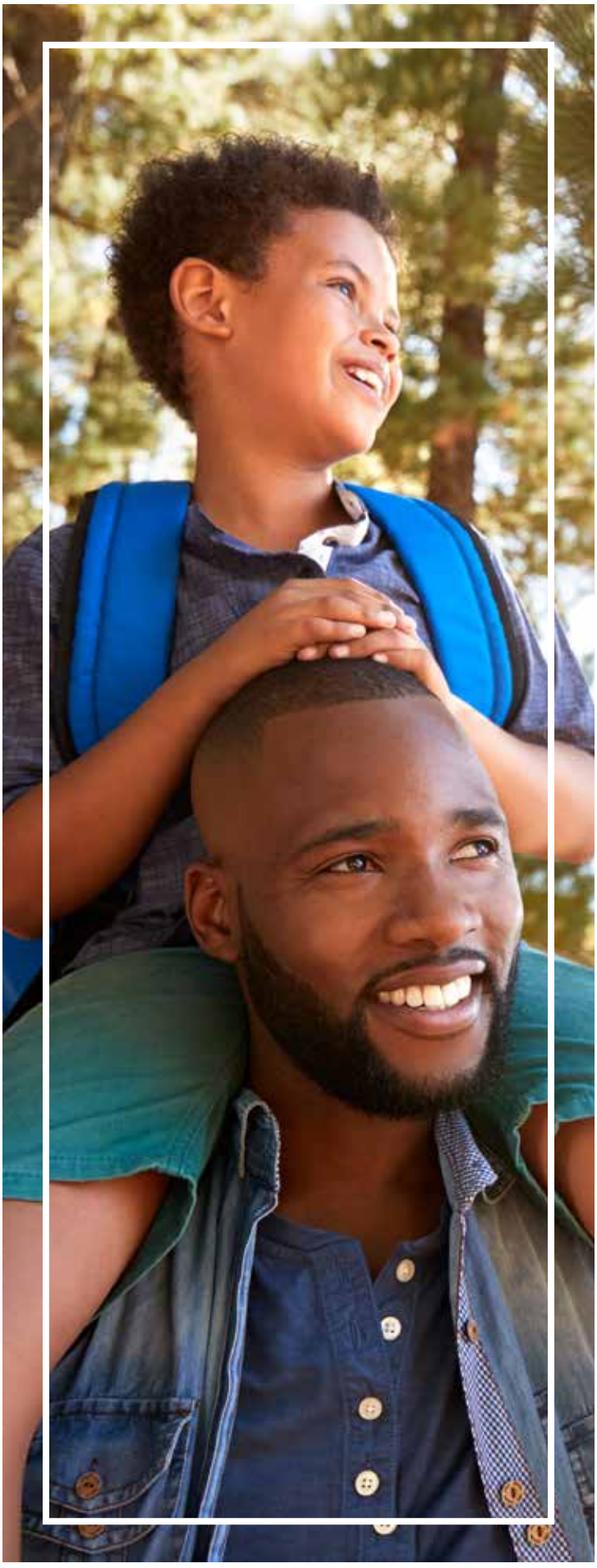
WEEKLY MAXIMUM BENEFIT	$800
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	11 weeks

The 14 day Elimination Period is unpaid unless supplemented with sick leave.

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available at no cost. LTD insurance replaces 60% of your income up to a monthly maximum benefit if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or the Benefits Team for details.

MONTHLY MAXIMUM BENEFIT	$3,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.



EMPLOYEE ASSISTANCE PROGRAM

University of Alaska cares about you and wants you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Employee Assistance Program

The University of Alaska's Employee Assistance Program is through Vivacity/ComPsych. Through their integrated GuidanceResources continuum, ComPsych EAPs deliver a comprehensive, global approach to addressing employee problems so that organizations stay ahead of workforce issues, enabling them to maximize productivity and contain costs. They ensure that employees receive the right help at the right time, which results in better focus at work, greater productivity, less absenteeism, and reduced medical costs.

You have 24-hour access to helpful resources by phone, and the EAP benefit includes eight visits per issue with a licensed professional. All services provided are confidential and will not be shared with University of Alaska. **You may access information, benefits, educational materials and more either by phone at 800-697-0353 or online at guidanceresources.com.**

Use App - GuidanceNowSM / Koa Foundations and Web ID - UofAK to login.

Additional Services Available:

- LegalConnect – includes a free, 30-minute in-person consult, 25% reduction in fees for additional time and 24/7 access to telephonic and web resources for divorce, adoption, family law, wills, trusts and more.
- Financial Connect - 24/7 access to telephonic and web resources for retirement planning, taxes, Relocation, mortgages, insurance, budgeting, debt, bankruptcy and more.
- FamilySource - 24/7 access to telephonic and web resources, referrals for work-life needs such as child and elder care, hiring movers or home repair contractors, planning events or locating pet care.
- GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for articles, podcasts, videos, slideshows, on-demand trainings, "Ask the Expert" personal responses to your questions and more.
- Well-being and Lifestyle Coaching - Telephonic or video support for a variety of lower acuity behavioral health issues that affect an individual's well-being and ability to reach personal goals.
- Take the Highroad - Up to $45 reimbursement on cab, Uber, or Lyft, one time per person per year.

GLOSSARY

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services. The University offers this service through TouchCare. For more information about TouchCare, please see page 8.

Health Savings Account (HSA) – A personal healthcare bank account funded by your tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP or other qualifying non-UA coverage to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – An HDHP is health coverage with 1) a higher annual deductible than typical health plans and 2) maximum limit on the sum of the annual deductible and out-of-pocket medical expenses that the taxpayer must pay for covered expenses. Out-of-pocket expenses include copayments and cost sharing but do not include premiums. The IRS has ruled that an HDHP can cover certain types of preventive care without a deductible, or with a deductible that is less than the annual deductible applicable to all other services. Generally, preventive care services do not include any service, benefit, or medication to treat an existing illness, injury, or condition. In situations where the treatment is incidental or ancillary to a preventive care service or screening, the treatment may fall within the safe-harbor for preventive care. See IRS Notices 2004-23, 2004-50. 2013-57 and 2019-45, available on www.irs.gov, for details on these situations.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage. For the 2023-2024 Plan Year, Open Enrollment is from April 17, 2023 to May 5, 2023.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

PREMERA ADDITIONAL BENEFITS

The University of Alaska has partnered with Premera to provide the following benefits to help you live a healthier life and to promote healthy families. If you are enrolled in a Premera UA Choice Health Plan, you are eligible for the following additional benefits.

Livongo Diabetes & Hypertension Management

Livongo means "Living the healthier life I want."

This program is offered at no cost to the University of Alaska employees and covered dependents who are enrolled in a UA Choice Health Plan and meet the criteria required by Livongo. The program provides support and medical supplies for diabetes, diabetes prevention, and hypertension.

Through the Livongo mobile app on an iPhone or Android smartphone you can receive care and support from Livongo staff to help manage your health condition.

Effortless Data Collection – Cellular meter provides real-time feedback for glucose reading. Food and activity tracking to understand lifestyle habits. 24/7 remote monitoring.

Personalized Health Action Plans – Livongo provides personalized activities to drive small changes for big wins. Health Nudges™ delivers calls to action when members are most receptive.

Diabetes Made Easier at No Cost to You – Unlimited supplies, smart meter and coaching at no cost.

Visit the Livongo website to see if you qualify. welcome.livongo.com/PREMERA

BestBeginnings

Giving families the best possible start with a comprehensive maternity program for all phases of your journey. From pregnancy to delivery, postpartum care, and newborn care, BestBeginnings provides you information and support all along the way.

The BestBeginnings App – Record your medical milestones, prepare for doctor visits, log your health history and test results, research questions before and after delivery, and track your baby's growth. It's also a link to your healthcare plan so you have one less thing to think about.

Clinical Support – Call **855-756-0797** to speak with a Personal Health Support (PHS) clinician, here for you when you need them - especially helpful for moms who are over age 35 or have a history of multiple births, pre-term birth, miscarriage, or complicating health conditions.

Maternity and Newborn Benefits – Under your medical plan, you have access to prenatal care, postpartum care, breast pumps, and more.

Visit **premera.com/care-essentials/pregnancy** to discover more about your maternity benefits.

Prenatal Care

Pregnancy, childbirth, and related conditions are covered on the same basis as any other condition for all female members. Covered services include:

- Screening and diagnostic procedures during pregnancy
- Related genetic counseling when medically necessary
- Medically necessary services and supplies related to home births
- Inpatient hospital services for up to 48 hours after a vaginal birth and 96 hours after a cesarean birth.

Helpful information about pregnancy and proper prenatal care is available by calling the 24-Hour NurseLine at 1-800-841-8343.

TalkSpace

With TalkSpace, you can easily connect to therapists and psychiatrists by video, phone call, and text for about the same cost as an in-person visit. To access this service:

- Sign up for Talkspace at Premera's dedicated Talkspace website by visiting www.premera.com/visitor/mentalhealth
- Get matched with the best therapist for you
- Start messaging your therapist right away

Brightline

Feeling like your child is stressed, depressed, anxious, or having to navigate tough transitions? Interested in more resources or skills to build as a parent or caregiver? Brightline provides confidential video visits with licensed clinicians, coaching programs to help tackle everyday challenges, and on-the-go access to content, resources, and chat with a coach. Get started today:

Step 1: Sign up at Premera's dedicated Brightline website by visiting www.hellobrightline.com/premera?referrer=access

Step 2: Create an account and access your premium Connect+ membership

Step 3: Answer a few questions to get the right care

Step 4: Schedule your first appointment

If you have any questions, reach out directly to the Brightline team at 1-888-224-7332.

Substance Use Disorders

Premera offers BoulderCare and Workit Health for opioid use disorders and addiction treatment, respectively. These services are offered virtually allowing for easy access to employees on a UA Choice Health Plan.

Get connected with a professional today by visiting Boulder Care's website at start.boulder.care or the Workit Health website at www.workithealth.com/insurance/premera/.

VOLUNTARY ADDITIONAL BENEFITS

University of Alaska provides you with access to Lifestyle plans that will help you lead a life of balance and ease.

Accident

Accident coverage, available through The Hartford, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage offers an additional layer of protection that can help you pay deductibles, copays, and even typical expenses such as mortgage or car payments. For more information, visit alaskaedu.corestream.com.

Critical Illness

Critical illness coverage through The Hartford pays a lump-sum benefit of either $15,000 or $30,000 if you are diagnosed with a covered disease or condition. You can use this money however you like. For example, it can be used for expenses not covered by your medical plan, lost wages, childcare, travel, home health care costs, or any of your regular household expenses. This plan also pays a wellness incentive of $50 for claims following a qualified wellness exam. For more information, visit alaskaedu.corestream.com.

Hospital Indemnity

Hospital indemnity coverage through The Hartford pays cash benefits directly to you if you have a covered stay in a hospital or intensive care unit. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities. For more information, visit alaskaedu.corestream.com.

Identity Theft

Access to identity theft protection is available on a voluntary basis through Allstate ID! In an always on, ever connected world, the risk of identity theft is real. There is a new identity fraud victim every two seconds. You can help protect yourself while Allstate ID monitors millions of transactions every second, alerting you to suspicious activity by text, phone or email. This protection is different than free credit monitoring and offers a full set of features to help proactively protect you and your covered family members against identity theft.

Prepaid Legal

LegalShield offers you and your family value, convenience and peace of mind by giving you low-cost access to attorneys for a wide variety of personal legal services. Payments are made conveniently and easily through payroll deductions. It's like having your own attorney on retainer, but for a lot less. For more information, visit alaskaedu.corestream.com.

ASPCA Pet Insurance

Save up to 10% on ASPCA Pet Health Insurance! Complete CoverageSM can help you give your pet the best care possible with less worry about the cost.

- Use any vet, specialist, or emergency clinic
- Submit claims easily online, by fax, or by mail
- Get your payouts fast by direct deposit or check
- Sign up in minutes anytime on any device using the custom link and code below

To enroll in the ASPCA Pet Health Insurance, enroll directly with the ASPCA at this website:

URL: www.aspcapetinsurance.com/UniversityofAlaska
Priority Code: EBUniversityofAlaska

RATES

Medical, Dental & Vision Premiums

Premium contributions for comprehensive health benefits are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your bi-weekly contributions.

MEDICAL

PREMIUM PLAN

$750 Individual Deductible, $2,250 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$135.97	N/A	$135.97	$3,535.22
EE + SPOUSE	$135.97	$154.08	$290.05	$7,541.30
EE + CHILD(REN)	$135.97	$61.58	$197.55	$5,136.30
EE + FAMILY	$135.97	$225.50	$361.47	$9,398.22

BASIC PLAN

$1,250 Individual Deductible $3,000 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$89.58	N/A	$89.58	$2,329.08
EE + SPOUSE	$89.58	$98.50	$188.08	$4,890.08
EE + CHILD(REN)	$89.58	$31.77	$121.35	$3,155.10
EE + FAMILY	$89.58	$135.50	$225.08	$5,852.08

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH OPTIONAL HEALTH SAVINGS ACCOUNT (HSA)

$1,500 Individual Deductible OR $3,000 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$75.58	N/A	$75.58	$1,965.08
EE + SPOUSE	$75.58	$81.58	$157.16	$4,086.16
EE + CHILD(REN)	$75.58	$22.58	$98.16	$2,552.16
EE + FAMILY	$75.58	$106.66	$182.24	$4,738.24

DENTAL

PREMIUM PLAN

	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE"	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$7.97	N/A	$7.97	$207.22
EE + SPOUSE	$7.97	$8.24	$16.21	$421.46
EE + CHILD(REN)	$7.97	$7.47	$15.44	$401.44
EE + FAMILY	$7.97	$17.97	$25.94	$674.44

BASIC PLAN

	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$3.16	N/A	$3.16	$82.16
EE + SPOUSE	$3.16	$3.43	$6.59	$171.34
EE + CHILD(REN)	$3.16	$2.04	$5.20	$135.20
EE + FAMILY	$3.16	$6.39	$9.55	$248.30

VISION

	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$0.60	N/A	$0.60	$15.60
EE + SPOUSE	$0.60	$0.67	$1.27	$33.02
EE + CHILD(REN)	$0.60	$0.49	$1.09	$28.34
EE + FAMILY	$0.60	$1.30	$1.90	$49.40

IMPORTANT CONTACTS

MEDICAL
Premera Blue Cross Blue Shield
of Alaska
800-332-4059
www.premera.com
Policy #: 1000033

TELEMEDICINE
Doctor On Demand
800-997-6196
https://patient.doctorondemand.com/register/

DENTAL
Premera Blue Cross Blue Shield
of Alaska
800-364-2982
www.premera.com
Policy #: 1000033

VISION
VSP
800-877-7195
www.vsp.com
Policy #: 12238098

HEALTH SAVINGS ACCOUNT
Bank of America Benefit Solutions
866-791-0250
https:///myhealth.bankofamerica.com

FLEXIBLE SPENDING ACCOUNTS
ASIFlex
800-659-3035
www.asiflex.com

LIFE AND AD&D
Securian Life Insurance Co
866-293-6047
www.securian.com
Policy #: 70229

DISABILITY
Unum
www.unum.com
STD Policy #: 927232
LTD Policy #: 713501

HEALTHCARE ADVOCACY & TRANSPARENCY
Touchcare
866-486-8242
www.touchcare.com
assist@touchcare.com

EMPLOYEE ASSISTANCE PROGRAM
Vivacity/ComPsych
800-697-0353
www.guidanceresources.com

PREMERA ADDITIONAL BENEFITS
Livongo
welcome.livongo.com/PREMERA

BestBeginnings
855-756-0797
www.premera.com/care-essentials/pregnancy

Prenatal Care NurseLine
800-841-8343

TalkSpace
www.premera.com/visitor/mentalhealth

Brightline
888-224-7332
www.hellobrightline.com/PremeraAK-access

Substance Use Disorders
Boulder
866-901-4860
start.boulder.care

Workit Health
855-659-7734
www.workithealth.com/insurance/premera/

UNIVERSITY OF ALASKA BENEFITS TEAM
PO Box 755140
Fairbanks, AK 99775-5140
907-450-8200

VOLUNTARY ADDITIONAL BENEFITS
Corestream
via Hartford (Accident, Critical Illness, Hospital)
via LegalShield (Prepaid Legal)
via Allstate ID (Identity Theft)
907-331-6938
alaskaedu.corestream.com
universityofalaskasupport@corestream.com

ASPCA
www.aspcapetinsurance.com/UniversityofAlaska
Priority Code: EBUniversityofAlaska

Required Notices

Important Notice from University of Alaska About Your Prescription Drug Coverage and Medicare under the Premera Blue Cross Blue Shield Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University of Alaska and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. University of Alaska has determined that the prescription drug coverage offered by the Premera Blue Cross Blue Shield plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current University of Alaska coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with University of Alaska and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through University of Alaska changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2023
Name of Entity/Sender:	University of Alaska
Contact—Position/Office:	Benefits Team
Address:	PO Box 755140 Fairbanks, AK 99775-5140
Phone Number:	907-450-8200

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Benefits Team at 907-450-8200.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Benefits Team at 907-450-8200.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Benefits Team at 907-450-8200.

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