EMPLOYEE BENEFITS GUIDE

2025-2026

UNIVERSITY of ALASKA

Many Traditions One Alaska

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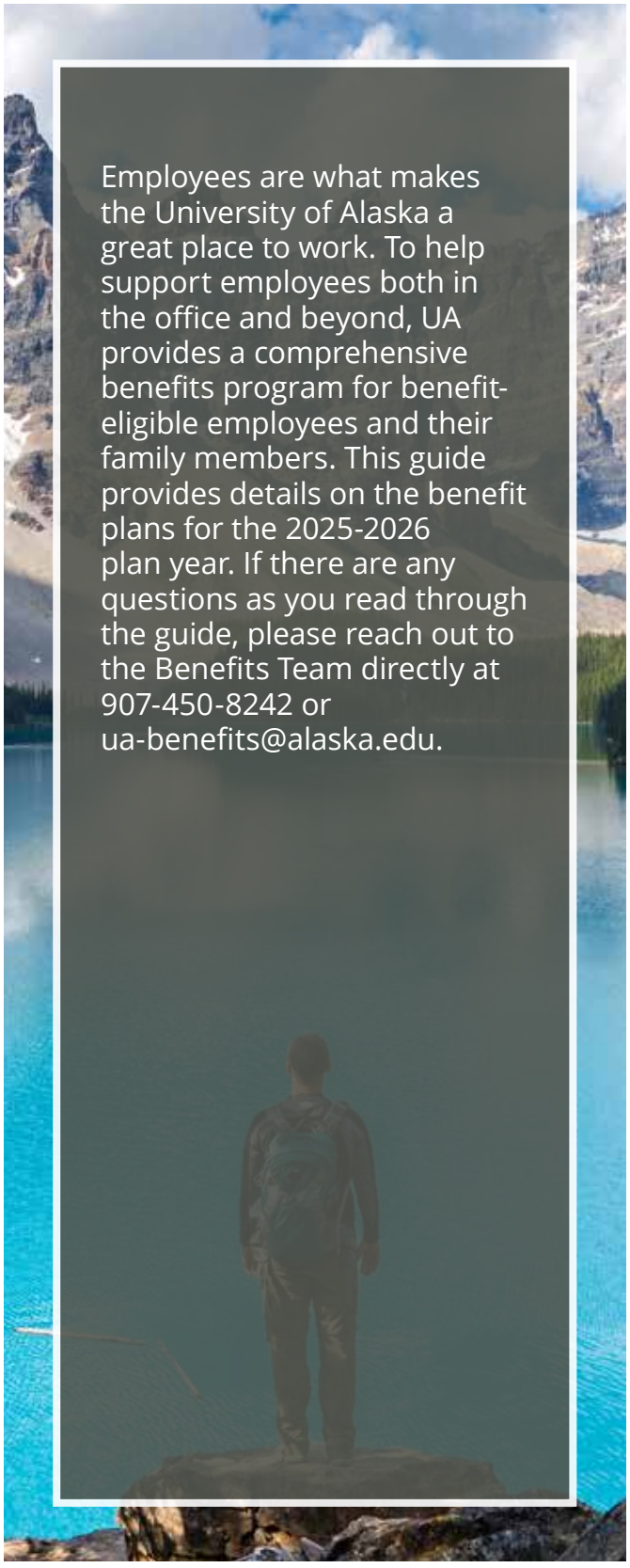


Employees are what makes the University of Alaska a great place to work. To help support employees both in the office and beyond, UA provides a comprehensive benefits program for benefit-eligible employees and their family members. This guide provides details on the benefit plans for the 2025-2026 plan year. If there are any questions as you read through the guide, please reach out to the Benefits Team directly at 907-450-8242 or ua-benefits@alaska.edu.

See **page 35** 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 employees and their family members. Employees can choose benefit options that cover what is most important to them.

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. Coverage can begin on an employee's first day as long as their form is submitted by the deadline.* Elections will remain in place for the remainder of the plan year (July 1, 2025 - June 30, 2026) unless the employee, the employee's spouse or Financially Interdependent Partner (FIP), or a dependent child experiences a Qualifying Life Event (see the next section below). Employees who do not submit a form in their first 30 days will be defaulted into the Copay Healthcare, 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 for first day coverage, a form must be submitted by 5:00pm Alaska time on the last Thursday of the first pay period. Otherwise, coverage will begin the first day of the following pay period. All forms must be submitted within an employee's first 30 days.

Open Enrollment and Qualifying Life Events

Open Enrollment is the one time each year that employees 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 an employee is unsure if they have experienced a Qualifying Life Event, please reach out to the Benefits Team at ua-benefits@alaska.edu or 907-450-8242 right away. When a Qualifying Life Event occurs, employees must notify the Benefits Team by submitting a Life Event Form with appropriate documentation within 30 days of the life event.

Eligible Dependents

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

- An employee's 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, dental, and vision 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 the employee or the employee's spouse/FIP).
- Dependent children who are over the age of 26, are unmarried, primarily supported by the employee, and are incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under a UA Choice Plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

PREPARING FOR ENROLLMENT

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

Enrollment To-Do

Locate personal documents.

Locate all Social Security numbers, dates of birth, and any supporting documentation that may be needed.

Double-check covered and restricted medications.

Consider how the different plans offered affect prescription coverage.

Review available plan deductibles.

Review the deductibles and out-of-pocket maximums for each of the plans offered. Depending on medical or prescription needs, a higher or lower deductible plan may make sense.

Consider an Health Savings Account (HSA) or Flexible Spending Account (FSA).

An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts can help with long-term financial goals. See HSA vs FSA comparison on page 22 for more details on the differences between a HSA and FSA.

Switching from an FSA to an HSA?

Thinking of switching from the Premium or Copay Plans with an FSA to the HDHP and opening an HSA account? Per the IRS, employees cannot have both an FSA and an HSA account active at the same time. Employees must have a $0 FSA balance on June 30, 2025; otherwise, they will not be able to contribute money to their HSA until January 1, 2026. If an employee cannot contribute to an HSA account until January 1, 2026, they also cannot use future funds to pay for any expenses between July 1, 2025 and January 1, 2026.

Check for an in-network pharmacy.

In-network pharmacies save employees money on their prescription costs. Employees are encouraged to confirm that the pharmacy they use is in network.

Contact TouchCare for enrollment assistance.

Need help deciding which plan to enroll in? Touchcare can walk employees and/or their dependents through the plan selection process to make sure that employees are selecting the coverage that works best for them and their families needs. Please refer to page 8 for details on how to contact TouchCare.

ENROLLMENT

How to Enroll in Benefits for FY26

1. Review this Enrollment Guide and the UA Benefits webpage at alaska.edu/benefits to learn about all benefit offerings.
2. Decide to participate in an optional pre-tax account — the Heath Care Flexible Spending Account (HC FSA), the Limited Purpose Flexible Spending Account (LP FSA), the Dependent Care Flexible Spending Account (DC FSA) or a Healthcare Savings Account (HSA). Employees can enroll in an HC or DC FSA with any of the UA choice plans. Employees can also enroll in an HC or DC FSA if they choose to waive coverage because they have non-UA coverage. Employees can only enroll in the LP FSA if they are eligible for, and contributing to, an HSA at the same time. The HSA must be combined with a qualifying health plan. At UA, the compatible plan is the HDHP. If an employee has non-UA coverage and wishes to enroll in the HSA, it is the employee's responsibility to understand if their coverage is HSA qualifying.
3. If unsure what plan to enroll in, contact TouchCare.
4. To make benefit choices, open the appropriate UA Choice Benefits Enrollment form found on the UA Benefits website (https://www.alaska.edu/benefits) under Benefits Forms, and log in to the NextGen form using UA credentials. The form will walk employees through the available benefit options starting with healthcare. If an employee is adding dependents, documentation may be required (birth certificates, marriage certificates, etc.). Documents can be uploaded directly to the form.
5. Flexible Spending Accounts (FSAs) must be elected each year; they do not continue automatically. If an employee does not sign up for the Healthcare FSA, Limited Purpose FSA, or the Dependent Care FSA at Open Enrollment, they will not have an FSA for FY26 unless they experience a major life event (birth, marriage, divorce, etc.) and enroll within 30 days of the event. Employees must use the money in their FSA by end of the Plan Year or the funds will be forfeited.
6. Health Savings Accounts (HSAs) can be enrolled or changed at any time during the plan year as long as the employee is in a qualifying plan. The HSA is a calendar year plan. Remember, the HSA money belongs to the employee; it never forfeits and employees decide whether to use it now or in the future.

New Employees

New employees have 30 days from their first day of employment to complete a healthcare enrollment form. A form must be submitted by all new employees — even if they are opting out because they have health coverage elsewhere.

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

How to Enroll

1. Employees will receive a detailed digital packet from the Benefits Team that outlines the benefits available.
2. Make 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 hire date.
   - Employees who are enrolling a spouse/FIP or dependent child(ren) must provide supporting documentation at the time of enrollment.

Tip: **Employees that had an FSA during the 2025-2026 plan year, and are moving to an HSA account, remember to use the complete balance by June 30, 2025, to avoid having to wait to fund an HSA until January 1, 2026.**

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 employees 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. Employees who are enrolling dependents for the first time must provide supporting documentation at time of enrollment.
   - To add dependents, employees must provide a birth certificate, marriage certificate, FIP paperwork, court documents or tax documents listing dependents.
   - Employees 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 they can change their benefits when they start a new job or during Open Enrollment. However, changes in an employee's life may permit them to update their coverage at other points in the year. Qualifying Life Events (QLEs) determined by the IRS could allow an employee to enroll in health insurance or change their elections outside of Open Enrollment.

Common Qualifying Life Events include:

- A change in employment status resulting in a gain or loss of eligibility
- A change in legal marital status (marriage, divorce or legal separation)
- Entitlement to Medicare or Medicaid
- A change in the number of 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 spouse's employment status that results in a loss or gain of coverage
- Changes in address or location that may affect eligible coverages

Some lesser-known Qualifying Life Events are:

- Turning 26 and losing coverage through a parent's plan
- Changes that update eligibility 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 employees have 60 days to add a newborn or newly placed or adopted child to the health, dental, and vision plans) or they must wait until the next Open Enrollment. Keep in mind that a change in coverage must be consistent with the change in status.

Questions regarding specific life events and the ability to request changes should be directed to University of Alaska's Benefits Team at ua-benefits@alaska.edu or 907-450-8242.

TOUCHCARE: HEALTHCARE CONCIERGE SERVICE

Who Is TouchCare?

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

How TouchCare Can Help:

As a TouchCare member, UA employees have a personal healthcare concierge assistant in their pocket. TouchCare is here to help answer any and all healthcare and benefit questions.

TouchCare services are designed to make employee lives easier!

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

Bill Negotiation
Employees can send invoices/bills to TouchCare and work with someone if they feel something is wrong. TouchCare will work on the employee's behalf to fix any errors.

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

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

How to Contact TouchCare:

Employees can reach a TouchCare Heath Assistant by calling 866-486-8242 (M-F, 4am - 5pm AKST), by visiting www.touchcare.com and logging in to the member portal, emailing assist@touchcare.com, or by downloading the TouchCare app on an Android or iOS device.

APP
Download the TouchCare app on an iOS or Android device.

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

Phone
Call: 866-486-8242
Available 4am - 5pm AKST
Monday through Friday

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

MEDICAL BENEFITS

Medical benefits are provided through Premera Blue Cross Blue Shield of Alaska. Employees can choose the plan that works best for their lifestyle. Consider the physician networks, premiums and out-of-pocket costs for each plan. The choice made now is effective for the entire FY26 Plan Year, unless an employee experiences a Qualifying Life Event. Contributions are deducted on a pre-tax basis.

Medical Plan Summary

This chart summarizes the FY26 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		COPAY PLAN		HDHP W HSA	
BI-WEEKLY CONTRIBUTIONS						
EMPLOYEE ONLY	$150.61		$54.38		$72.19	
EMPLOYEE + SPOUSE	$325.40		$116.02		$152.28	
EMPLOYEE + CHILD(REN)	$232.78		$80.34		$103.07	
EMPLOYEE + FAMILY	$420.66		$146.27		$186.59	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$1,400		$4,000		$2,200	
FAMILY	$4,200		$8,000		$4,400	
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	60%*	80%*	60%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$5,000	N/A	$6,000	N/A	$6,000	N/A
FAMILY	$10,000	N/A	$12,000	N/A	$8,150	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%*	$40	40%*	20%*	40%*
SPECIALIST SERVICES	20%*	40%*	$60	40%*	20%*	40%*
TELEMEDICINE	20%*	40%*	$40 Primary Care $60 Specialty	40%*	20%*	40%*
URGENT CARE	20%*	Hospital-based: 20%* / Freestanding Center: 40%*	$75	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 Copay Plans, the individual deductible amount must be met by each member enrolled under this medical coverage. If an employee has 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 an employee and their covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under the medical plan. The same typically applies for the out-of-pocket maximum.

OUT-OF-POCKET COSTS

Deductible

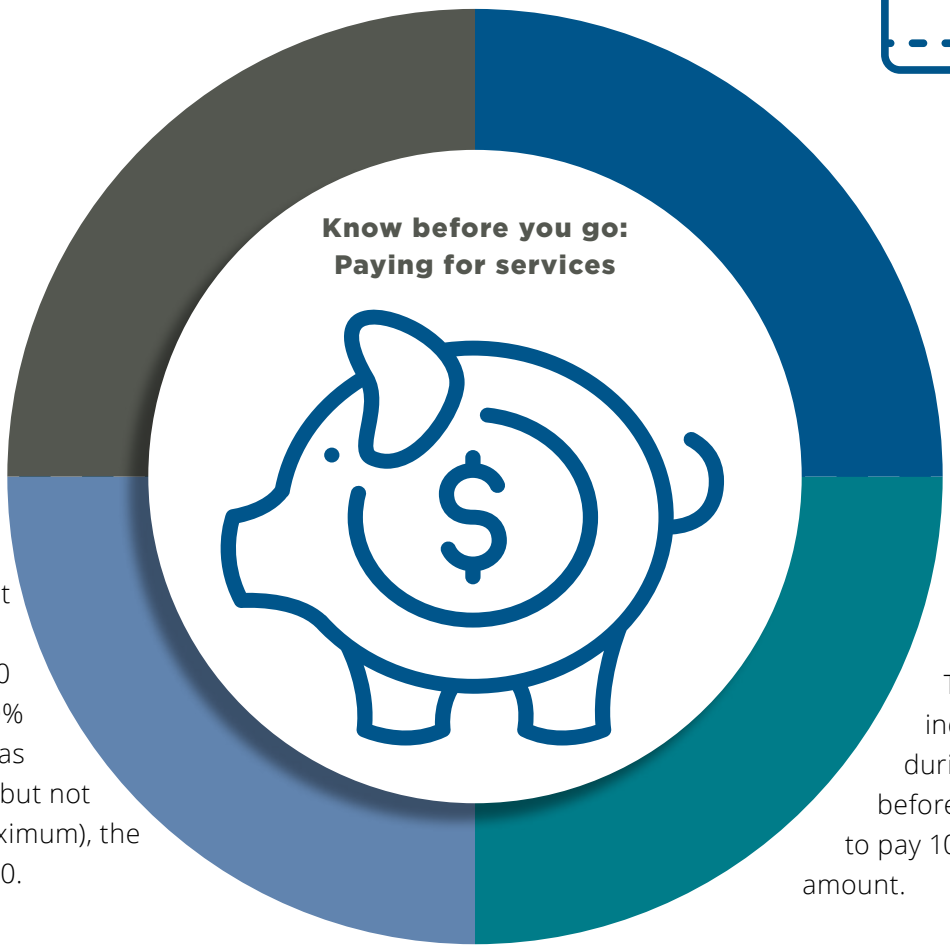
The amount an individual pays for covered services before insurance starts paying its portion.

UP TO DEDUCTIBLE

YOU PAY **100%**

Copay

The fixed amount an individual pays for healthcare services at the time they receive them.



Coinsurance

Percentage of the cost of a covered service. If an office visit is $100 and coinsurance is 20% (and the deductible has previously been met, but not the out-of-pocket maximum), the payment would be $20.

% YOU PAY

% PLAN PAYS

UP TO THE OUT-OF-POCKET MAXIMUM

AFTER DEDUCTIBLE IS REACHED

Out-of-Pocket Maximum

The most an individual will pay during the plan year before 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 100%.

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with a primary care physician to save time and money and remain 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 a doctor finds a new condition or potential risk during a preventative appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over the benefit summary to see what specific preventive services are provided.

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

WHERE TO GO FOR CARE

PRIMARY CARE CENTER

When to use:
Routine care or treatment for a current health issue. A primary care doctor knows their patients and their health history. They can access medical records, provide routine care, and manage medications.

What type of care would they provide?*
- Routine checkups
- Preventive services
- Immunizations
- 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 to use:
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 elected medical insurance coverage.

TELEMEDICINE

When to use:
Care is needed for a minor illness or ailment that can be managed directly from the 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 the Summary of Benefits depending on the medical plan that has been elected.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

DO THE 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 to use:
Care is needed 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

When to use:
Immediate treatment is needed for a serious life-threatening condition. If a situation seems life-threatening, call 911 or the local emergency number immediately.

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

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

*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

Virtual medicine is a convenient and easy way to talk to a doctor fast from the comfort of home. Whether sick or just too "on the go," virtual medicine is there to help.

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 an in-network provider's office.
- 24-Hour NurseLine — Call the number on the back of the member ID card.
- TalkSpace for mental health needs. Download the app on a mobile device and register today.
- Boulder Care for substance use disorder treatment. Download the app on a mobile device and register today.
- 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 the benefits coverage and a list of network pharmacies is available online at www.premera.com or by calling the Customer Care number on the back of the ID Card. Costs are 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		COPAY 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	Not Covered	100% Covered	Not Covered	100% Covered	100% Covered
PREFERRED GENERIC**	$10 Copay	Not Covered	$10 Copay	Not Covered	20%*	Not Covered
PREFERRED BRAND NAME	$30 Copay	Not Covered	$30 Copay	Not Covered	20%*	Not Covered
SPECIALTY DRUGS	$100 Copay	Not Covered	$100 Copay	Not Covered	20%*	Not Covered
NON-PREFERRED	30%	Not Covered	30%	Not Covered	20%*	Not Covered
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

**Employees may be eligible to fill a Preferred Generic Prescription for a 90-day supply for 3 times the 30-day copay or coinsurance amount. Employees are encouraged to confirm with their pharmacy and/or physician.

Preventive Medications

Most preventive medications are covered at no cost on all plans. Employees should confirm with their pharmacy when they fill their 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? Generic prescription drugs are a more affordable option. They 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 FSA standards. 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 specific drugs, visit www.fda.gov.

Maintenance Medications

Employees who are taking a drug on a regular basis to control or treat an ongoing or chronic condition will be able to get their first two fills at a retail pharmacy but then will need to use the mail order pharmacy for future refills. If an employee does not use the mail order pharmacy for their 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

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 an employee is 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 the provider if a new prescription is needed. Providers may also call Accredo directly once their patient is enrolled to fill ongoing prescriptions. Certain Specialty Drugs through the Premium and Copay 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 the 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 employees save money on certain specialty medications. Contact SaveonSP directly at 1-800-683-1074 to find out what medications are eligible. Participation is voluntary and employees must contact them prior to filling a prescription.

- If an employee participates in this program, the 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 the employee.
- Prescriptions will still be filled through **Accredo,** the 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 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 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. Contributions are deducted on a pre-tax basis.

Network Dentists

Employees who use a dentist that doesn't participate in the plan's network, out-of-pocket costs will be higher, and employees may be 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
BI-WEEKLY 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 dental coverage to keep a healthy smile.**

VISION BENEFITS

Don't wear glasses? Employees and their dependents are still encouraged to get an annual eye exam to catch both eye and overall health issues. University of Alaska provides a quality vision care benefit through VSP. Contributions are deducted on a pre-tax basis.

VISION PLAN

BI-WEEKLY 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	
PROGRESSIVE	$25 copay	Up to $75 reimbursement	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	Up to a $150 allowance that covers both fitting & evaluation and the purchase of contact lenses	No Coverage	Every 24 months
CONTACTS	Up to a $150 allowance that covers both fitting & evaluation and the purchase of contact lenses	Up to $105 reimbursement	
FRAMES			
COPAY	$25 copay	Up to $70 reimbursement	Every 24 months
ALLOWANCE	Standard Frame: up to $150 or Featured Brands: up to $170 + 20% off the remaining amount		
OTHER SERVICES			
DIABETIC EYE CARE	$20 copay Copay is waived if member has a diagnosis of diabetes	No Coverage	As needed

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

LightCare: **Protect against digital eye strain or the sun's ultraviolet rays. With VSP LightCare™, members can use their frame and lens benefit to get non-prescription eyewear from their VSP® network doctor.**

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

Eyewear: **Use the 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 benefit information. Based on applicable laws; benefits may vary by location.

HEALTH SAVINGS ACCOUNT (HSA)

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. Employees must be enrolled in UA's HDHP or a qualifying plan to participate.

An HSA can be used for qualified expenses for employees, their spouse, and/or tax dependent(s), even if they're not covered by a UA Choice 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.

HSAs Are Employee Owned

An HSA is a personal bank account that employees own and administer. Employees decide how much to contribute, when to use the money for medical services and when to reimburse. HSA members 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 when an employee changes plans or jobs.

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

Eligibility

UA employees are eligible to contribute to an HSA if:

- They are enrolled in an HSA-eligible High Deductible Health Plan (HDHP).
- They are not covered by their spouse's or parent's non-HDHP.
- They were not previously contributing to a Flexible Spending Account (FSA) or will not have any balance in their FSA after June 30, 2025.
- They or their spouse does not have a Healthcare Flexible Spending Account (HC FSA) or Health Reimbursement Account (HRA).
- They are not eligible to be claimed as a dependent on someone else's tax return.
- They are not enrolled in Medicare or TRICARE.
- They 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, employees must be enrolled in an eligible plan. At UA, our eligible plan is the HDHP. If an employee has coverage elsewhere, it is their responsibility to make sure that the plan is HSA compatible before opening an HSA account. If unsure about the qualifying status of enrolled plan(s), please contact TouchCare to discuss.

New Employees

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

Current Employees

Once an employee has determined they meet all the HSA eligibility requirements listed above, they can elect an HSA. Employees can start, stop, or change bi-weekly contributions at any time during the plan year. The HSA form can be found at https://www.alaska.edu/benefits.

HSAs and Taxes

HSA contributions are made through payroll deductions on a pre-tax basis. The HSA is a personal bank account that the employee owns and administers. There are action items required to complete the setup of the account. Be on the lookout for a Welcome Packet in the mail from Bank of America. Once the setup of the account is completed with Bank of America, contributions can be sent via payroll deduction to the employee's HSA.

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

Reminder: **If switching from an FSA account to an HSA account, there cannot be any balance in an FSA after June 30, 2025. If there is even $1 in an FSA on July 1, 2025, HSA contributions cannot begin until January 1, 2026.**

*State income taxes are also waived on HSA contributions in almost all states.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and the account holder is younger than age 65, federal tax income must be paid on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where HSA funds are spent.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2025, contributions are limited to the following:

2025 HSA FUNDING LIMITS	
EMPLOYEE ONLY HDHP COVERAGE	$4,300
FAMILY HDHP COVERAGE	$8,550
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

HSA contributions over the IRS annual contribution limits are not tax deductible and are generally subject to a 6% excise tax.

If contributions exceeded the limits, there are two options:

- Remove the excess contributions and the net income attributable to the excess contribution before filing federal income tax return (including extensions). Income tax will be paid on the excess removed, but there will not be any penalty tax incurred.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The University of Alaska HSA is established with Bank of America Benefit Solutions. Employees 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.

Thoughts & Tips: **Because HSA funds never expire, contributing the annual maximum to an HSA can help individuals save to pay for healthcare expenses tax-free after retirement.**

FLEXIBLE SPENDING ACCOUNTS (FSA)

A Flexible Spending Account (FSA) is a special tax-free account that employees can elect to help pay for certain out-of-pocket expenses during the plan year.

2025 FSA FUNDING LIMITS	
HEALTHCARE FSA	$3,300
LIMITED PURPOSE FSA	$3,300
DEPENDENT CARE FSA	$5,000

Healthcare Flexible Spending Account

Employees can contribute up to $3,300 FY26 for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces taxable income and increases take-home pay. Employees can even pay for eligible expenses with an FSA debit card at the same time they receive them — no waiting for reimbursement.

Limited Purpose Flexible Spending Account

A Limited Purpose Flexible Spending Account (LP FSA) works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses. The FY26 contribution limit is $3,300. Employees must be enrolled in a qualified plan and be contributing to UA's HSA to enroll in a LP FSA.

Thoughts & Tips: **The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.**

Dependent Care Flexible Spending Account

Employees may opt to participate in the Dependent Care FSA — even if they don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from the Dependent Care FSA is limited to the total amount that is currently deposited in the account.

- With the Dependent Care FSA, employees 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.
- Employees 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 employees and/or their spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent or spouse/FIP)
- 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 a FIP and a FIP's child(ren) **may not** be reimbursed under the FSA programs. Check with a tax advisor to determine if any exceptions apply.

Using the Account

The University of Alaska partners with ASIFlex to administer all FSA accounts. For the Healthcare and Limited Purpose FSAs, a debit card can be used 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 the card is used at an ineligible location.

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

While FSA debit cards allows payment 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, the FSA debit card could be turned off and the expense deemed taxable.

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

General Rules

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

- Expenses must occur during the FY26 plan year.
- Funds cannot be transferred between FSAs.
- For the Healthcare FSA and Limited Purpose FSA, all funds selected will be immediately available on day one of the plan and employees do not need to wait to accrue the funds.
- For Dependent Care FSA, only funds that have accrued in the account can be used. Elected annual contributions are not immediately available at the beginning of the plan year.
- Employees cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- Employees cannot have a Healthcare FSA and an HSA in the same Plan Year.
- Employees can have a Dependent Care FSA and HSA in the same Plan Year.
- Employees must be enrolled in a qualified HDHP and contributing to a UA HSA to enroll in the Limited Purpose Flexible Spending Account (LP FSA).
- FSAs are "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 the employer. If an employee is moving to an HSA beginning July 1, 2025, they do not have access to the runout period as they must have a $0 FSA balance as of June 30, 2025.
- Employees cannot change their 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 $155,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

FSA VS HSA

Flexible Spending Accounts		Health Savings Accounts
The employer owns the FSA. If an employee leaves their employer, they lose access to the account unless they have a COBRA right.	**OWNERSHIP**	Employees own their HSA. It is a savings account in their name, and employees always have access to the funds, even if they change jobs.
Employees can elect a Healthcare FSA and/or a Dependent Care FSA even if they waive other coverage. Employees cannot make changes to their contribution during the Plan Year without a Qualifying Life Event. Employees must enroll for an FSA each Plan Year; prior elections will not roll over. Employees cannot be enrolled in both a Healthcare FSA and an HSA. Employees can be enrolled in a Limited Purpose FSA, a Dependent Care FSA and an HSA at the same time.	**ELIGIBILITY & ENROLLMENT**	1. Employees must be enrolled in a Qualified HDHP to contribute money to their HSA. Employees cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. 2. Employees can change their contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	**TAXATION**	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.
Employees can contribute up to $3,300 in 2025 to a Healthcare FSA or Limited Purpose FSA. Employees can contribute up to $5,000 to a Dependent Care FSA. This amount may be increased annually by the IRS.	**CONTRIBUTIONS**	The contribution limit for 2025 is $4,300 for individuals and $8,550 for families. Those who are 55 or older may make an annual "catch-up" contribution of $1,000. This amount may be increased annually by the IRS.
Employees can use an FSA debit card to pay for eligible expenses. If not, employees pay up front and submit receipts for reimbursement. For the Healthcare FSA and Limited Purpose FSA, all funds selected will be immediately available on day one of the plan and employees do not need to wait to accrue the funds. For Dependent Care FSA, only funds that have accrued in the account can be used. DC FSA elected annual contributions are not immediately available at the beginning of the plan year.	**PAYMENT**	Employees can use an HSA debit card to pay for qualified expenses. They can also use online bill payment services from the HSA financial bank. Employees decide when to use the money in their HSA to pay for qualified expenses, or they may use another account to pay for services and save the money in the HSA for future expenses or retirement.
Employees must use the money in the account by end of Plan Year; however, the FSAs 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 the employer.	**ROLLOVER OR GRACE PERIOD**	HSA funds roll over from year to year. The account is portable, the money is always the employee's and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	**QUALIFIED EXPENSES**	Physician services, hospital services, prescriptions, menstrual products, PPE, 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.

SURVIVOR BENEFITS

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

UA Paid Basic Life Insurance

University of Alaska provides benefit-eligible 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.

The Basic Life insurance benefit is $100,000. All benefit-eligible employees are automatically enrolled in Basic Life Insurance at no cost to the employee. The Basic LIfe Insurance election cannot be waived. 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. For more information, visit https://www.alaska.edu/hr/benefits/insurance/basic-life.php.

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

Naming a Beneficiary

Beneficiaries are the person(s) designated to receive Life Insurance benefits in the event of a covered individual's 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 assistance is needed, contact the Benefits Team at ua-benefits@alaska.edu or 907-450-8242. Alternatively, employees can reach out to their own legal counsel.

Evidence of Insurability (EOI)

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

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

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

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 an employee's death. This benefit is in addition to the Basic Life benefit.
MAXIMUM BENEFIT	$600,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Employees can elect up to $200,000 (Guarantee Issue) without completing EOI. EE 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 an employee's spouse/FIP's death.
MAXIMUM BENEFIT	$150,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Employees can elect up to $50,000 (Guarantee Issue) without their spouses/FIP needing to complete an EOI. Spouse/FIP age 65+: EOI is required when electing over $20,000
CHILD SUPPLEMENTAL TERM LIFE	
COVERAGE AMOUNT	Flat amount of $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of a covered child's death.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	None

If a required EOI is not submitted within the requested time frame, the requested coverage will be denied if over Guarantee Issue.

Voluntary Accidental Death & Dismemberment Insurance (AD&D)

The UA Paid Basic Life Insurance provided to employees 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 post-tax.

FY26 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 if a covered individual or a covered family member die or suffer certain injuries as the result of an accident.
WHO PAYS	Employee
BENEFITS PAYABLE	Loss of a limb or suffer paralysis in an accident. This benefit is in addition to the Basic Life benefit.
MAXIMUM BENEFIT	$300,000 for the covered employee and a percent for any covered family members, depending on the make-up of your family at the time of a qualifying accident
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

FY26 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 assistance is needed calculating your rates and estimate costs, go to http://www.lifebenefits.com/UA.

ABSENCE MANAGEMENT & INCOME PROTECTION

Employees and their families depend on regular income. That is why the University of Alaska partners with UNUM for absence management and disability coverage to provide financial protection in the event an employee cannot work as a result of a debilitating injury. A portion of an employee's income is protected until they can return to work or they reach retirement age.

UNUM Absence Management

The University of Alaska partners with UNUM for Short-term Disability, Long-term Disability, and Family and Medical Leave Act (FMLA). UNUM's Absence Management Specialist team will assist employees with a 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

Call the toll-free absence reporting number at 866-779-1054 (M-F, 4am-4pm Alaska time) or visit www.unum.com and follow the claim submission instructions. UNUM's specialist gather the needed information to determine the type of claim(s), next steps, and to start the claim process.

When to Call UNUM

- When unable to work due to illness, injury or pregnancy.
- Absence needed from work to care for an immediate family member who has a serious health condition.
- Caring for a child due to birth, adoption or foster care placement.
- Absences needed for a qualifying exigency leave because an employee's 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.
- Care needed for a 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.
- Other leaves as applicable by appropriate state leave laws.
- Thirty days before a planned leave based on prescheduled medical treatment related to a serious health condition for the employee or employee's 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.

Voluntary Short-Term Disability Insurance

Short-Term Disability benefits are available to employees at an additional cost. This insurance replaces 60% of income if an employee becomes partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See the plan documents or the Benefits Team for details.

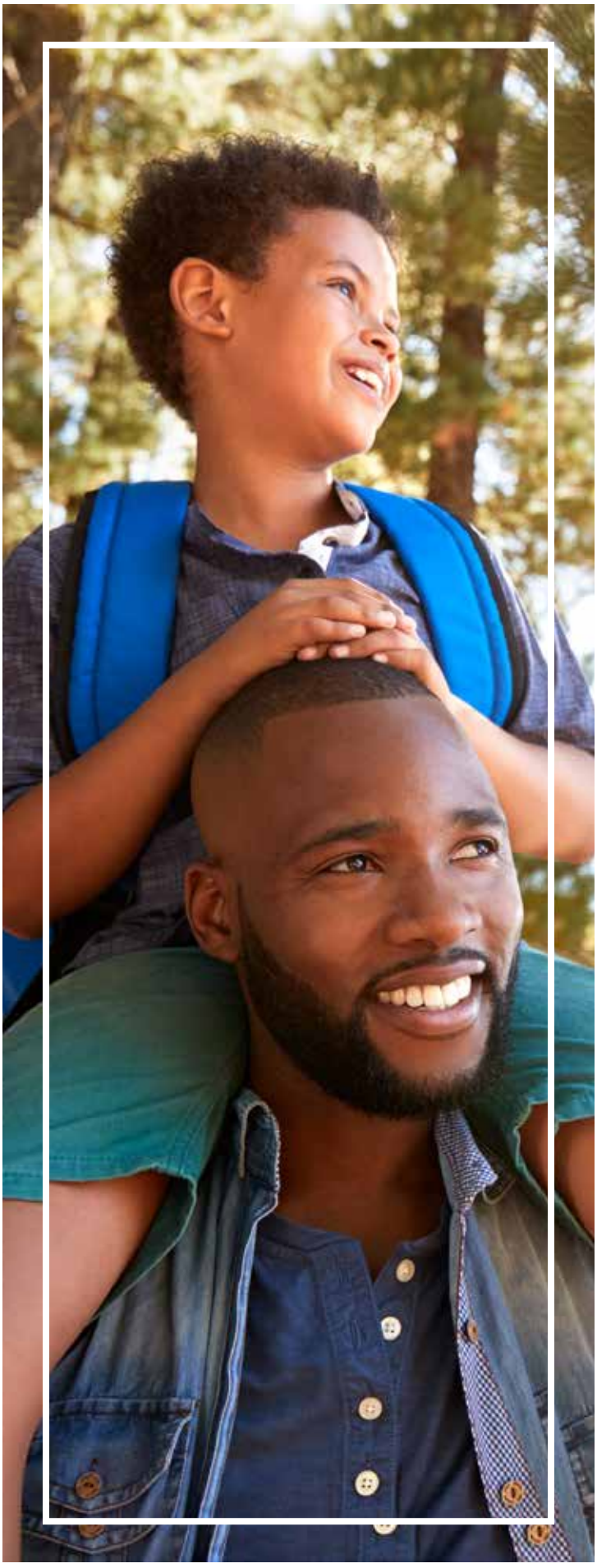
WEEKLY MAXIMUM BENEFIT	$800
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	11 weeks

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

Long-term Disability Insurance

Long-term Disability benefits are available at no cost. This insurance replaces 60% of income up to a monthly maximum benefit if an employee becomes become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See the 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 the employee is disabled or until Social Security Normal Retirement Age, whichever is sooner.



EMPLOYEE ASSISTANCE PROGRAM

The University of Alaska offers additional benefits to help make employee's 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.

Employees 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. **Employees may access information, benefits, educational materials and more either by phone at 800-697-0353 or online at guidanceresources.com.**

Use App - GuidanceNow℠ / Koa Foundations and Web ID - UofAK to log in.

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 – 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 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.

PREMERA ADDITIONAL BENEFITS

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

Diabetes, Hypertension, and Weight Management

The Livongo - Powered by Teladoc program is offered at no cost to 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, hypertension, and weight management.

Through the Livongo mobile app on an iPhone or Android smartphone, enrolled members can receive care and support from Livongo staff to help manage their 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.

Supplies 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 the journey. From pregnancy to delivery, postpartum care, and newborn care, BestBeginnings provides information and support all along the way.

The BestBeginnings App – Record medical milestones, prepare for doctor visits, log health history and test results, research questions before and after delivery, and track baby's growth.

Clinical Support – Call **855-756-0797** to speak with a Personal Health Support (PHS) clinician. This is 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 the medical plan, employees and their spouses/FIPs 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, members 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 a therapist
- Start messaging the therapist right away

eviCore for Outpatient Rehabilitation Management

Premera's Outpatient Rehabilitation Management Program through eviCore helps members get the right care for their condition, avoiding unnecessary treatments and costs. eviCore works as a partner to provide a medical-necessity review and authorization of treatment plans related to outpatient rehabilitation.

Step 1: Members have an initial consultation with their doctor to create a treatment plan. The treatment plan is then submitted by the provider to eviCore via a Prior Authorization (PA). Review this page to see how PA with eviCore works.

Step 2: eviCore reviews and will approve the treatment plan if it meets clinical practice guidelines and requirements. If approved, the member receives care based on the treatment plan.

If denied, the provider can appeal or revise the treatment plan to align it with practice guidelines.

For more information, go to www.evicore.com.

BoulderCare

Premera offers BoulderCare for substance use disorders and addition treatment. 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.

MASA ACCESS EMERGENCY TRANSPORTATION

MASA protects families against uncovered costs for emergency transportation and will be there for you beyond your initial ride with expert coordination services on call to manage complex transport needs during or after your emergency — such as getting home safely for continued care.

MASA is coverage and care to protect enrolled members from the unexpected. With MASA, there is no "out-of-network" ambulance. Just send MASA the bill when it arrives, and they will work to ensure charges are covered and even pay an indemnity benefit directly to the enrolled member. There are two plans bundled for a greater value: Emergent Plus and Indemnity Plus. These plans are directly billed to employees on a monthly basis. A payroll deduction is not supported for this benefit.

FY26 MASA RATES

COVERAGE TYPE	MONTHLY COST	ANNUAL COST
EMPLOYEE ONLY	$24.75	$297.00
EMPLOYEE + FAMILY	$37.50	$450.00

Emergent Plus Plan Includes:

Emergency Ground Ambulance Coverage
Covers out-of-pocket expenses for emergency ground transportation to a medical facility.

Emergency Air Ambulance Coverage
Covers out-of-pocket expenses for emergency air transportation to a medical facility.

Hospital to Hospital Ambulance Coverage
When specialized care is required but not available at the initial emergency facility, covers out-of-pocket expenses for the ground or air ambulance transfer to the nearest appropriate medical facility.

Repatriation Near Home Coverage
Should continued care be needed, and the enrolled member's care provider has approved moving the enrolled member to a hospital nearer to the enrolled member's home, MASA coordinates and covers the expense for ambulance transportation to the approved medical facility.

Indemnity Plus Includes:

Emergency Ground Ambulance Coverage
MASA pays an indemnity benefit of $250 for emergency ground transportation to a medical facility.

Emergency Air Ambulance Coverage
MASA pays an indemnity benefit of $10,000 for emergency air transportation to a medical facility.

Contact Information

Employees can add the MASA app to their phones to see their member id number, benefit information, claim status, etc.

Customer Service: 877-503-0585
Monday through Friday (5am - 1pm AKST)
www.masaaccess.com

Global Transport Hotline
Call Toll-Free 800-643-9023
24-Hour Access to Services.

BENEFITS ENHANCEMENT PROGRAM - POWERED BY CORESTREAM

University of Alaska provides employees with access to Lifestyle plans that will help them and their families lead a life of balance and ease. Benefits described below are deducted through payroll post-tax with the exception of ASPCA Pet Insurance which is self-bill.

Accident

Accident coverage, available through The Hartford, provides benefits for employees and their covered family members if there are 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 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 a covered individual is diagnosed with a covered disease or condition. This money can be used in any way the covered member would like. For example, it can be used for expenses not covered by the medical plan, lost wages, childcare, travel, home health care costs, or any 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 a covered member if they have a covered stay in a hospital or intensive care unit. Covered members can use the benefits from this policy to help pay for 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. Employees can help protect themselves while Allstate ID monitors millions of transactions every second, alerting covered members 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.

Prepaid Legal

LegalShield offers employees and their families value, convenience and peace of mind by giving them 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 a personal 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 Coverage℠ can help give pets 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 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, dental, and vision care benefits are deducted from an employee's paycheck on a pre-tax basis. Health, dental, and vision care deductions for FIPs are post-tax.

MEDICAL

PREMIUM PLAN

$1,400 Individual Deductible, $4,200 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$150.61	N/A	$150.61	$3,916
EE + SPOUSE	$150.61	$174.79	$325.40	$8,460
EE + CHILD(REN)	$150.61	$82.17	$232.78	$6,052
EE + FAMILY	$150.61	$270.05	$420.66	$10,937

COPAY PLAN

$4,000 Individual Deductible $8,000 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$54.38	N/A	$54.38	$1,414
EE + SPOUSE	$54.38	$61.64	$116.02	$3,017
EE + CHILD(REN)	$54.38	$25.96	$80.34	$2,089
EE + FAMILY	$54.38	$91.89	$146.27	$3,803

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

$2,200 Individual Deductible OR $4,400 Family Deductible	EMPLOYEE BI-WEEKLY CHARGE	DEPENDENT BI-WEEKLY CHARGE	TOTAL BI-WEEKLY CHARGE	ANNUAL CHARGE
EMPLOYEE (EE)	$72.19	N/A	$72.19	$1,877
EE + SPOUSE	$72.19	$80.09	$152.28	$3,959
EE + CHILD(REN)	$72.19	$30.88	$103.07	$2,680
EE + FAMILY	$72.19	$114.40	$186.59	$4,851

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
EE + SPOUSE	$7.97	$8.24	$16.21	$421
EE + CHILD(REN)	$7.97	$7.47	$15.44	$401
EE + FAMILY	$7.97	$17.97	$25.94	$674

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
EE + SPOUSE	$3.16	$3.43	$6.59	$171
EE + CHILD(REN)	$3.16	$2.04	$5.20	$135
EE + FAMILY	$3.16	$6.39	$9.55	$248

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	$33.00
EE + CHILD(REN)	$0.60	$0.49	$1.09	$28.20
EE + FAMILY	$0.60	$1.30	$1.90	$49.32

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

ABSENCE MANAGEMENT AND INCOME PROTECTION
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 - Powered by Teladoc
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

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

EMERGENCY TRANSPORTATION
MASA Access
www.masaaccess.com
877-503-0585
800-643-9023 - Global 24/7
Policy #: B2BUOA

UNIVERSITY OF ALASKA BENEFITS TEAM
PO Box 755140
Fairbanks, AK 99775-5140
907-450-8242
ua-benefits@alaska.edu

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 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 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, 2025
Name of Entity/Sender:	University of Alaska
Contact—Position/Office:	Benefits Team
Address:	212 Butrovich Building PO Box 755140 Fairbanks, AK - 99775 United States
Phone Number:	907-450-8242

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 907-450-8242.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare 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 907-450-8242.

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 907-450-8242.

Illinois Essential Health Benefit (EHB) Listing

Employer Name: University of Alaska

Employer State of Situs: Alaska

Name of Issuer: Premera

Plan Marketing Name: Premera Plans

Plan Year: 2025

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone Anchored Hearing Aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 - 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (Vasectomy Men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency Services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24 – 25	Yes
17	Reconstructive Surgery		Pgs. 25 – 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants – Human Organ Transplants (Including Transportation & Lodging)		Pgs. 18 & 31	Yes

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory Services	Pgs. 6 & 12	Yes
22	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 – 9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory Acute and Chronic Pain Medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See All Kids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage		Pgs. 26 – 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription Drugs	Pgs. 29 – 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31– 32	Yes
36	Mammography – Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis – Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/Prostate-Specific Antigen Tests/Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (Women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 – 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

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.
- **Limited Purpose FSA –** Designed to complement a Health Savings Account, a Limited Purpose FSA allows for reimbursement of eligible dental and vision expenses.
- **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 2025-2026 Plan Year, Open Enrollment is from April 15, 2024, to May 3, 2024.

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.

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