MY BENEFITS Journal

Alaska Railroad Corporation
Benefits for
Employees Represented by UTU
2023

All Aboard!
ENROLLMENT

On the Main Line
MEDICAL PLAN

Savor the Scenery
RETIREMENT PLANS

ALASKA RAILROAD

welcome

to My Benefits Journal

Every year our Alaska Railroad Corporation employees make important contributions to Alaska's transportation system and the lives of all Alaskans. It's because of the work you do and the spirit in which you do it make the Alaska Railroad Corporation a great place to work.

As always, we strive to provide you with affordable, high quality benefits, including our medical Plans that allow you to choose what is best for you and your family. Our dental coverage remains a separate Plan, so you have the option of waiving dental coverage.

We will continue to offer retirement plans, life insurance options, and many other valuable benefits as well.

While we provide you and your family with valuable benefits, it's most important that you understand them and your options in making wise choices. To that end, this guide provides easy-to-understand information about ARRC's benefits that will help you choose what's best for you and your family.

Review *My Benefits Journal,* discuss your situation and needs with your family, and hold on to it so you can refer to it later if you need to.

Thanks again for your service to ARRC and for helping to keep Alaska moving.

In good health,

Bill O'Leary
ARRC President & CEO

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all aboard!

Enrollment

Before you start your journey, make sure you have your ticket, luggage, camera, money, itinerary and everything else you need for your adventure.

When you travel, you have many decisions to make before and during your trip. The same level of planning and care goes into managing your benefits, too. This guide is your map through the benefits available to you; it will help you navigate all of the Plans features.

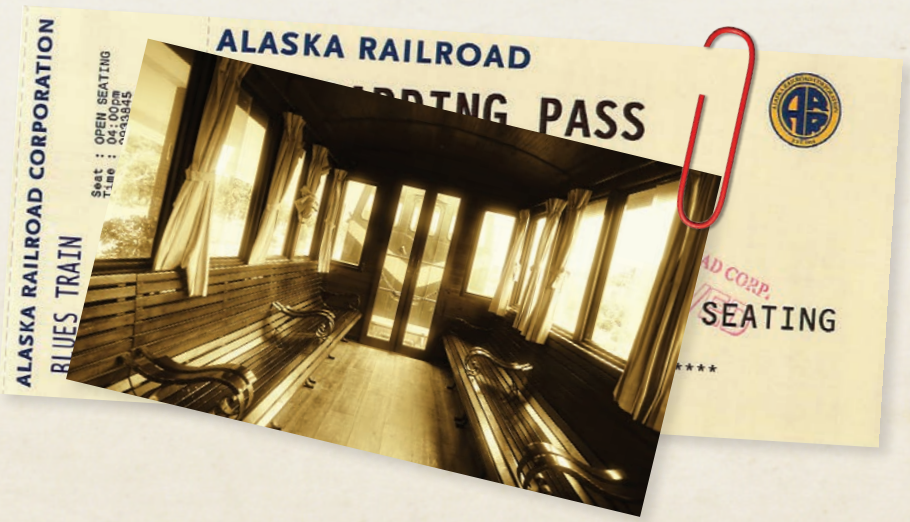
How to Enroll

If you're enrolling in benefits with the Alaska Railroad Corporation for the first time, you will receive your enrollment materials at the New-Employee Orientation. You may then submit your Benefits enrollment information/election form and separate FSA or HSA forms to Human Resources in one of four ways (see the **back page** of *My Benefits Journal* for contact information):

1. Mail—interoffice or U.S. mail
2. Fax
3. Email
4. Hand deliver

You may enroll or make changes:

- Within 31 days from your eligibility date;
- During the annual Open Enrollment; or
- Within 31 days from a qualifying life event (see **page 3**).



Qualifying Life Events

You can make certain benefit changes throughout the year when something significant happens in your life. Examples of qualifying life events include:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of legal spouse or dependent
- The gain or loss of other insurance coverage

If you experience a qualifying life event and want to enroll or change your enrollment, you must submit new benefits, FSA or HSA enrollment forms and proof of the event **to HR within 31 days from the date of the event**. If you don't, you must wait until the next Open Enrollment period to change your benefits.

Even if you don't make any enrollment changes, you must notify HR if you get married, divorced or widowed.

WHEN TO ENROLL OR MAKE CHANGES

Once a year during Open Enrollment, which is typically in late November, you can review your benefits and coverage, and make changes for the coming year.

SAVE MONEY WITH THE PRETAX PREMIUM ONLY PLAN (POP)

Your share of some insurance premiums are deducted from your paycheck before income tax is calculated. That means taxes are calculated on a smaller chunk of your income so you pay less tax and have more pay to take home.

Plan premiums that qualify for POP:

- Health Plan
- Railroad Employees' National Dental Plan
- ARRC Optional Dental Plan
- Basic Life and AD&D

planning your journey

All the Benefits Available to You

Before you begin your adventure, you not only pick a destination, you decide what you need to take with you, and what you want to see and do while you're exploring.

Planning is essential when you're considering your benefits adventure, too. When you start your journey, your needs are different from what they are at the end — and they may change a few times along the way. That's why it's important to review your benefits every year, even if you don't make any changes.

ARRC's benefits include:

- **Health Plan** — Four options for medical, prescription drug and hearing coverage, plus vision coverage (Gold, Gold Essentials, Blue and Blue Essentials)
- **Dental Plan** — ARRC Optional and Railroad Employees' National Plan (required for represented employees)
- **Health Savings Account** — Gold/Gold Essentials only
- **Flexible Spending Accounts —** Health Care FSA (Blue Plan only), Dependent Care FSA (Blue and Gold plans)
- **Life Insurance** — Basic Life and AD&D, Optional, Standard and Dependent Life
- **Employee Assistance Program** — ComPsych
- **Retirement Plans** — ARRC Pension and 401(k) Savings Plan
- **Retiree Medical Plan** — available to UTU-represented employees hired *before* March 4, 2016.
- **Paid time off —** Annual leave, sick leave, holidays
- **Free travel on Alaska Railroad**

Summary Plan Descriptions (SPDs) provide more details and information, and are found online for:

- Health Plan (see Summary of Benefits and Coverage)
- Dental Plan
- Life Insurance Plan
- Pension Plan
- 401(k) Savings Plan
- 457 Deferred Compensation Plan (Non-rep only)
- Flexible Spending Accounts

Find SPDs on our employee website, ***Inside Track*** at **insidetrack.akrr.com:**

- *Health Plan SPDs* are on ***Inside Track*** by navigating to BENEFITS > Health Insurance > Medical Health Insurance. Also view the Health Plan at **Premera.com**.
- *Pension Plan SPD* is on BENEFITS > Retirement Plans > Pension Plans. Also available at **myatessa.com**.
- *Tax Deferred Savings Plan SPD* is on BENEFITS > Retirement Plans > Tax Deferred Savings. Also available at **empower.com**.

Have you checked your beneficiaries lately?

Deciding who should receive your Life Insurance and Pension or Savings Plan benefits ensures your benefits go to the person — or people — you intend.

We encourage you to check your beneficiaries once a year. When life changes course, it's easy to forget this small but important detail. You may change your beneficiary any time during the year.

You can update your ARRC Pension Plan beneficiaries by downloading, printing and filling out the Beneficiary Designation for Pre-Retirement Death Benefits form at **myatessa.com**. Or, you can get the form from HR. Mail the completed form to Atéssa Benefits (see address on pagg 39).

For your 401(k) plan, update your beneficiaries at **empower.com**.

To change your life insurance or unpaid compensation beneficiaries, download, fill out and submit the Beneficiary Designation forms from **InsideTrack > Benefits > Insurance**, or contact HR.

the rail system

Health Plan

A comprehensive rail system comprises main lines, spurs and branch lines, whistle stops, large rail yards, everything trains need to run at peak performance so they can move people and freight.

All of ARRC's Health Plans are very comprehensive and include:

• Medical	• Pharmacy	• Doctor on Demand (virtual)
• Preventive Care	• Vision	• Coalition Health Clinic
• Hearing	• Large Provider Network	• Voluntary Medical Travel

Our health Plans are "self-funded." This means ARRC is financially responsible for paying medical claims. We contract with Premera Blue Cross Blue Shield of Alaska and VSP (Essentials Plans only) to administer the Plans. This arrangement provides ARRC flexibility in the kinds of benefits we can offer you without the limitations of state mandates or insured products. It also means that we all play an essential role in controlling overall costs.

In addition, ARRC pays the largest part of your premiums every pay period — 80% or more for the Blue, Blue Essentials, Gold and Gold Essentials Plans. This means that you pay between 15 and 20% of the total premium cost.

We encourage you to engage in your health and wellness. An easy way to do that is to take advantage of preventive health care, which both Plans cover at 100% when you visit a preferred provider. If you use a network provider, you won't pay any out-of-pocket fees for services such as annual checkups or screening mammograms.

WHO'S ELIGIBLE?

Eligibility Timeline

Represented employees are eligible after 90 days of cumulative service. Once eligible, employees must enroll within 31 days of becoming eligible.

Dependents

Eligible dependents are your:

- Legal spouse (must provide marriage certificate)
- Adult children up to age 26 (must provide birth or adoption certificate)
- Dependent children (must provide birth certificate, adoption certificate or court documents):
  - Biological children
  - Stepchildren
  - Adopted children and children placed with you for adoption
  - A child for whom you have court-appointed guardianship or custody

KEY TERMS

Knowing the vocabulary and your medical care options before you need help is an essential step to becoming a wise health care consumer.

We'll define some common terms, and then take you on a tour of your Health Plan benefits.

Deductible — A fixed amount of money you must spend on health care before ARRC's medical Plan starts paying. You must meet a new deductible each year. Once you meet it, you're only responsible for paying copays and coinsurance.

Coinsurance — The portion of a health care provider's fee that you must pay after you meet the deductible. You pay coinsurance plus any deductibles until you meet your out-of-pocket maximum. For example, if the Plan's allowed amount for an office visit is $100, your coinsurance payment of 20% is $20 if you've met your deductible. Your health care Plan pays the rest.

Out-of-pocket maximum — The yearly out-of-pocket maximum is the most your ARRC medical Plan requires you to pay toward the cost of your health care if you are using a Preferred Provider.

Out-of-pocket expenses include the annual deductible plus coinsurance you pay for doctor visits and other services. Once you reach this maximum, the Plan pays 100% of covered services for the rest of the calendar year if you are using a Preferred Provider. Any balance-billed amounts over the allowable charge from non-network providers do not count toward this maximum.

Copay — Blue Plan only: A fixed amount that you pay only on some generic prescription drugs. The copay doesn't apply to your deductible but it does count toward your out-of-pocket maximum.

on the main line

Medical Plan

Just as the main line is a railway system's primary channel between stations, the medical Plans are your main lines to staying healthy. They provide solid, affordable benefits that keep you and your family on track.

ARRC offers four Plans from which you may choose:

1. **Gold and Gold Essentials Plans** — a Consumer Directed Health Plan (CDHP) with an optional Health Savings Account (HSA)
2. **Blue and Blue Essentials Plans** — a Preferred Provider Plan (PPO)

WAIVING COVERAGE

You may waive ARRC's medical or optional dental coverage by checking the appropriate box on the enrollment form and completing the waiver form. If you waived medical coverage for a prior year, your waiver will continue unless you submit an enrollment form electing coverage.

The table on **page 9** shows which features are the same for both plans, and which ones are different. We'll explore the common features first, then review the details of each plan.

Selecting a provider

You may use any provider (doctor or hospital) you want, but you'll pay less coinsurance when you use Preferred providers:

Preferred providers – 20% (ARRC pays 80%)

Participating providers – 40% (ARRC pays 60%)

Non-contracted providers – 50% of 125% of Medicare

✔ = benefit is the same for both Plans

✔ = benefit is different in each Plan

BENEFIT	FOR MORE INFORMATION, SEE PAGE ...	GOLD PLANS CDHP	BLUE PLANS PPO
Premera Blue Cross Blue Shield of Alaska administrators	Back cover	✔	✔
Covers 100% preventive care from a preferred provider	10	✔	✔
Prescription drug coverage	15, 17, 18	✔	✔
Hearing coverage	15, 17	✔	✔
Vision coverage	15, 17	✔	✔
Dental coverage	30		
NurseLine – 24/7 advice	25	✔	✔
Doctor on Demand – virtual medical care	25	✔	✔
May use any provider, but you pay less with "Preferred" and "Participating" providers	10	✔	✔
Additional emergency room copay	17		✔
Hospital admission copay	17		✔
Health Savings Account (HSA)	13	✔	
Nicotine-user surcharge	10	✔	✔
Voluntary medical travel (and surgical services)	11	✔	✔
Access to Premera mobile site, website, and tools	26, 27	✔	✔
Coalition Health Center	26		✔
Prior authorization for certain procedures	11	✔	✔
Health Care FSA	32, 33		✔
Dependent Care FSA	32, 33	✔	✔
Premiums deducted from paycheck pretax (POP)	3	✔	✔

FEATURES OF ALL PLANS

Preventive care screenings

All Plans pay 100% of preventive care when you visit a Preferred or Participating provider, even if you haven't met your deductible. Here is a short list of covered services:

- Diagnostic tests, such as for blood pressure, diabetes and cholesterol
- Age-appropriate checkups
- Women's health services and healthy pregnancy care
- Immunizations and flu shots
- Cancer screenings, such as mammograms, colonoscopies, prostate exams and Pap tests
- Intervention for smoking, depression, alcohol use and mental health issues
- Find more information at Premera's website: **premera.com/visitor/care-essentials/preventive-care**

Provider tiers

With all the Plans, you may use any provider you choose — hospitals, doctors, other service providers — but you'll pay less when you use a Preferred or Participating provider.

All the Plans have these three provider tiers:

1. **Preferred provider** — Provides a discounted fee; your lowest out-of-pocket expense.
2. **Participating provider** — Accepts Premera's allowable charges, but doesn't have a discounted fee schedule.
3. **Non-contracted provider** — Doesn't have a contract with Premera.

If you cannot find a Preferred or Participating provider within 50 miles from your home, contact Premera before your appointment. For more information, contact Premera Customer Service at **800-508-4722**.

BLUE AND GOLD ESSENTIALS PLANS	PREFERRED PROVIDER	PARTICIPATING PROVIDER	NON-CONTRACTED PROVIDER
After you meet your deductible, you will pay (coinsurance) …	20%	40%	50% of 125% of Medicare
Is there billing for the balance between what is charged, and what the Plan pays?	No	No	Yes
Does the coinsurance count toward the out-of-pocket maximum?	Yes	Yes	No

BLUE AND GOLD PLANS	PREFERRED PROVIDER	PARTICIPATING PROVIDER	NON-CONTRACTED PROVIDER
After you meet your deductible, you will pay (coinsurance) …	20%	40%	50%
Is there billing for the balance between what is charged, and what the Plan pays?	No	No	Yes
Does the coinsurance count toward the out-of-pocket maximum?	Yes	Yes	Yes

Nicotine-use fee

If you use nicotine in any form, you'll pay a $25 per pay period surcharge — $650 a year — deducted on an after-tax basis from your paycheck. You don't have to pay this fee if you:

- have not used nicotine or e-cigarettes during the 90 days before you enroll, and
- don't intend to use them in the future

If you start using nicotine in any form, you must notify HR so the surcharge can be deducted from your paycheck. If you provide documentation from your physician indicating that stopping the use of nicotine products would be detrimental to your health, the surcharge will not imposed. However, you may be asked to complete other wellness tasks that would not interfere with your health. If it is discovered that you were not truthful about your nicotine use, you could be subject to disciplinary action and you will be charged the nicotine use surcharge.

Voluntary Surgical Services (including Medical Travel) Benefit

If you need surgery, explore **Surgery Plus**, a voluntary benefit that provides pre-planned, non-emergency surgical services. Many inpatient and outpatient procedures are eligible for this program.

ARRC will waive the Blue/Blue Essentials Plan deductible. In addition, ARRC will waive the coinsurance under all four (Gold/Gold Essentials and Blue/Blue Essentials) plans, if you take advantage of the program.

Surgery Plus travel partners will make air and ground travel as well as lodging reservations for you and a companion. The program covers your travel expenses, such as round-trip airfare, surface transportation, and lodging up to applicable IRS limits. For a list of approved procedures and providers, call **Surgery Plus** at 833-512-1172, or visit the **Surgery Plus** online portal at **ARRC.SurgeryPlus.com**.

Prior authorization requirement

If you use a Premera Preferred Provider or Surgery Plus, you do not need to get prior authorization. Preferred providers are required to obtain the prior authorization for you and if they forget, they pay the penalty. For non network providers you must get prior authorization from Premera before the procedure is done. If you don't, you'll pay a penalty of 50% of allowable charges, up to a maximum of $1,500 after you meet the deductible.

Virtual care options

For some situations, getting care over the phone, online or via video may be the right cost-effective choice for care. See the section on Choosing Your Route for more information on cost-effective resources, such as Doctor on Demand, Nurse Line and others.

Other features

Preventive drugs — Each Plan covers preventive prescription drugs.

Hearing — Hearing tests and hearing aids are covered under all four Plans but the amount of coverage is different for each Plan. Beginning in 2023, plans may cover over-the-counter (OTC) hearing aids (see **pages 15 and 17**).

Vision — For Essentials Plans, vision coverage is offered through a new and improved Vision Services Plan (VSP). Blue and Gold legacy plans include vision coverage via Premera. (see **pages 15 and 17**).

Dental — Dental coverage is not included in either Plan, but you may enroll in ARRC's Optional Dental Plan (see **page 30**).

Gold and Gold Essentials Plans

The Gold and Gold Essentials Plans are Consumer Directed Health Plans (CDHP), meaning they have a higher deductible than either the Blue or Blue Essentials Plans. It can be a good Plan option for people who don't use a lot of health care. You may also be eligible to participate in a Health Savings Account (HSA) to help you pay the higher deductible.

GOLD / GOLD ESSENTIALS PLAN PREMIUMS AND PREMIUM ADJUSTMENTS

UTU's three-year transition to newer health care plans is complete, and no premium adjustments remain. You pay 15% of the biweekly premium; ARRC pays 85%.

GOLD ESSENTIALS PLAN BIWEEKLY PREMIUMS		
You	You + 1	You + 2 or more
$54.55	$118.47	$147.68

GOLD PLAN BIWEEKLY PREMIUMS		
You	You + 1	You + 2 or more
$67.39	$156.98	$205.43

Below are annual deductibles and out-of-pocket (OOP) maximums for the Gold/Gold Essentials Plans.

PLAN PARTICIPANTS	ANNUAL DEDUCTIBLE	INDIVIDUAL OUT-OF-POCKET MAXIMUM	FAMILY OUT-OF-POCKET MAXIMUM
You only	$1,500	$5,300	N/A
You + 1	$3,900	$5,300	$12,900
You + 2 or more	$3,900	$5,300	$12,900

MEETING THE GOLD / GOLD ESSENTIALS PLAN DEDUCTIBLE

You pay the entire amount of doctor visits, medical procedures, some lab tests, and most prescriptions until you meet the annual in-network deductible. To help you pay deductible costs, you may open a Health Savings Account (HSA). For those enrolled in family coverage, the deductible applies to your entire family. When your family meets the deductible, coinsurance kicks in. For example, if combined medical plan expenses of a family of four add up to $3,900, you have met the annual deductible. Alternatively, if only one person has $3,900 of expenses, the family deductible is also met. .

ANNUAL OUT-OF-POCKET MAXIMUM FOR GOLD / GOLD ESSENTIALS

If you enroll in family coverage, once one covered family member meets the $5,300 individual OOP maximum, the Plan pays 100% of their qualified medical costs for the rest of the Plan (calendar) year. When your family meets the $12,900 OOP maximum, the Plan pays 100% of qualified medical costs for care for all family members for the rest of the Plan (calendar) year. Amounts you pay to non-network providers that exceed allowable charges are balance-billed amounts and do count toward meeting either the individual or family OOP maximums

HEALTH SAVINGS ACCOUNT

Because the Gold Essentials Plan has a higher deductible and no copays, you may enroll in a tax-free HSA to help pay those costs. You can put money into your HSA every pay period — an amount you choose up to the annual IRS limit — so it's there when you need it. ARRC will contribute to your account, too.

You can use the money in your HSA tax-free only for eligible medical expenses. In addition, the money rolls over every year and can earn interest. The account is yours even if you retire or leave ARRC for any reason.

Premera's partner, ConnectYourCare (CYC), administers the HSA and manages HSA bank accounts.

Triple tax advantage

The money you put into the account from your paycheck is deducted before taxes are calculated on your income. Your HSA contributions are tax-free — and as long as you use the money in your account to pay for qualified health care expenses, it's tax-free, too.

Like a regular savings account, the HSA earns interest and is protected by the Federal Deposit Insurance Corporation (FDIC). You may invest your unused HSA dollars when your balance reaches $1,000 so you can earn even more. The interest and investment dollars you earn are tax-free.

What are qualified health care expenses?

You may use your HSA to pay health care costs that count toward your deductible and to pay your coinsurance. You also may use the money for prescription drugs and eligible dental and vision expenses, like eyeglasses or contacts. The 2020 CARES Act expanded eligible expenses to include more than 20,000 additional products including over-the-counter drugs and medicines (fever reducers, cold remedies, etc.) that no longer require a prescription, and menstrual care products. For a complete list of qualified expenses, visit **www.irs.gov**, *Publication 502*.

HSA contribution limits

The IRS sets the limits on how much can be contributed to an HSA each year. Limits are:

- You only: $3,850
- You plus one or more (family): $7,750
- You may contribute an additional $1,000 in the year in which you turn age 55, or if you are over 55.

	ARRC CONTRIBUTION	YOUR CONTRIBUTION	ANNUAL MAXIMUM CONTRIBUTION
You only	$500	Up to $3,350	$3,850
You + 1 (family)	$1,000	Up to $6,750	$7,750
You + 2 or more (family)	$1,500	Up to $6,250	$7,750

For 12-month employees, ARRC will contribute 50% in January and 50% in July. ARRC contributions are prorated for new and seasonal employees, and for employees returning from layoff, based on the number of pay periods each employee is enrolled in the Gold or Gold Essentials Plan (CDHP) (see the HSA Payment Schedule table on **page 44**).

Additional IRS rules apply for employees who do not remain in the Gold or Gold Essentials Plan (CDHP) for the remainder of the year, or whose contributions exceed applicable prorated IRS maximums if they are enrolled in the Gold or Gold Essentials Plan (CDHP) for less than the entire calendar year. As indicated below, you are responsible for understanding HSA-related tax rules and should consider seeking advice from a tax advisor.

Important HSA details

Here are some key things to know about HSAs:

- You can only enroll in an HSA if you are enrolled in the Gold or Gold Essentials Plans.
- You cannot enroll in an HSA if you're:
  - covered under another health plan that doesn't qualify for an HSA — traditional PPO plan, Medicare, Medicaid, TRICARE, Indian Health Services
  - claimed as a dependent on another person's tax return
- Special rules apply if you use VA health services — contact Premera if you have questions.
- You must be able to open a bank account in the United States.
- If you don't open an HSA by the end of the year, your contributions return to you as taxable income.
- You can pay your eligible medical expenses:
  - With the debit card you receive when you open your HSA
  - By online bill pay
  - With online reimbursement
- You can only spend the amount of money in your account.
- You must save your medical receipts for your tax records.
- You're responsible for understanding HSA-related tax rules — visit **www.irs.gov**, *Publication 969*, or seek advice from a tax advisor
- You cannot be actively enrolled in a Health Care FSA and an HSA.
  - If you are enrolled in a Health Care FSA and are changing to the Gold / Gold Essentials Plan, you must end your Health Care FSA enrollment.
  - You cannot transfer Health Care FSA funds to an HSA.
- You can only use HSA funds to pay for qualified health care expenses of you and your tax dependents.
  - If you enroll a family member in your Gold / Gold Essentials Plan, but they don't qualify as your tax dependent, you cannot use your HSA funds to pay their medical expenses.
    - ◇ For example, your adult child under age 26 may be enrolled on the Gold / Gold Essentials Plan, but may not be your tax dependent.
    - ◇ In that case, they may open their own HSA and contribute up to the annual family maximum (contributions are after-tax and are tax deductible).
    - ◇ If you don't enroll a family member in your Gold / Gold Essentials Plan, but they do qualify as your tax dependent, you may use HSA funds to pay their medical expenses.
    - ◇ For example, your spouse may be covered under their employer's health plan, but if he or she is your tax dependent, you can use your HSA to pay for his or her qualified expenses

PHARMACY PLAN

The Gold and Gold Essentials Plans both provide prescription drug benefits. For details, see the separate Prescription Drug Plan section, beginning on **page 18**.

HEARING

The Gold and Gold Essentials Plans includes hearing coverage that pays for most of the customary cost of a hearing exam, and provides an allowance for hearing aids. Hearing aids are now available over-the-counter (OTC), and by choosing OTC hardware, you may be able to greatly reduce your costs. The plan will help cover hearing aids ONLY if a plan-recognized provider prescribes hearing aids as necessary, and after your deductible is met. Benefit details include:

	DEDUCTIBLE	EXAMS	HARDWARE	FREQUENCY
Hearing	Yes	80% Of UCR[1]	$1,500 Maximum[2]	Every 3 calendar years

1 Usual, customary and reasonable charges.
2 Includes hearing aids and hearing aid maintenance.

VISION / VSP FOR ESSENTIALS

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions.

If you are enrolled in **Blue or Gold legacy plans**, vision coverage is provided through Premera, but must be elected at no extra charge. Coverage includes 90% of annual eye exam UCR cost[1] and a $200 annual allowance for glasses or contact lenses. There's no deductible.

VSP - New for Essentials Plans ONLY

When you enroll in Blue or Gold Essentials, the new VSP Signature Plan will be your vision plan. VSP offers improved benefits compared to the legacy vision plan. Plan highlights within the VSP network:

- No coinsurance cost for a comprehensive *WellVision* exam.
- Contact lens exam (fitting and evaluation) is covered after copay.
- Routine retinal screening is covered after no more than a $39 copay.
- Glass or plastic single vision, lined bifocal, lined trifocal or lenticular lenses are covered in full.
- Popular lens enhancements are covered in full, including anti-reflective coating, polycarbonate lenses, standard progressive lenses, UV and scratch coating.
- If you choose an out-of-network provider, coverage is based on a schedule of allowances.
- Glasses frames OR contact lens materials are covered up to $200. This benefit renews annually.
- Exclusive VSP member extras and discounts.

A detailed summary of the VSP plan is outlined on ***Inside Track*** **> BENEFITS > Health Insurance > Vision Benefits.**

Create a VSP account at **www.vsp.com**, and then log in to view your benefits and other coverage information. Find a VSP provider at **www.vsp.com** or call VSP at **800-877-7195**.

Blue and Blue Essentials Plans

If you enroll in the Blue or Blue Essentials Plans, you'll pay a higher biweekly premium than for the Gold or Gold Essentials Plans, but your deductible and coinsurance will be lower.

BLUE / BLUE ESSENTIALS PLAN PREMIUMS AND PREMIUM ADJUSTMENTS

UTU's three-year transition to newer health care plans is complete, and no premium adjustments remain. You pay 20% of the biweekly premium; ARRC pays 80%.

BLUE ESSENTIALS PLAN BIWEEKLY PREMIUMS		
You	You + 1	You + 2 or more
$83.68	$189.05	$240.68

BLUE PLAN BIWEEKLY PREMIUMS		
You	You + 1	You + 2 or more
$96.51	$189.05	$240.68

Below are annual deductibles and out-of-pocket (OOP) maximums for the Blue/Blue Essentials Plans.

OUT-OF-POCKET COSTS	MAXIMUM YEARLY AMOUNT
INDIVIDUAL Calendar-year deductible[1]	$1,000 per person
INDIVIDUAL OOP maximum – deductible[1] and coinsurance/copay[2]	$3,500 per year
FAMILY Calendar-year deductible[1]	$3,000 per year
FAMILY OOP maximum – deductible[1] and coinsurance/copay[2]	$10,500 per year

1 Does not include separate deductibles for being admitted to a hospital and for visiting an emergency room (see **next page***).*

2 Copays for generic prescription drugs count toward your out-of-pocket maximum.

MEETING THE BLUE / BLUE ESSENTIALS PLAN DEDUCTIBLE

An annual in-network deductible applies for most services (e.g., doctor visits, medical procedures and some lab tests). Once you meet the deductible, you and the plan share costs through coinsurance. There is a separate copay required for your hospital admissions ($250 per admission) and for emergency room visits ($100 per visit). These separate copays DO NOT count toward your annual medical deductible. For those enrolled in family coverage, the annual individual and family deductible applies to your entire family. When your family meets the family deductible, coinsurance kicks in. However, if one person in the family meets the individual deductible amount of $1,000, coinsurance will kick in for his/her qualified medical costs. For example, if the combined medical expenses of a family of four add up to $3,000, you have met the annual family deductible.

ANNUAL OUT-OF-POCKET MAXIMUM FOR BLUE / BLUE ESSENTIALS

The Blue or Blue Essentials Plan's out-of-pocket (OOP) maximum is the most you have to pay during the calendar year for in-network health care services. There is no OOP maximum for out-of-network expenses. The individual in-network OOP maximum is $3,500. Once a covered family member meets the $3,500 individual maximum, the plan pays 100% of his/her qualified medical costs for the rest of the year. The family in-network OOP maximum is $10,500. Once attained, the plan pays 100% of qualified medical costs for care for all family members for the rest of the year.

ER AND HOSPITAL ADMISSION COPAYS

Did you know that visiting the emergency room can cost up to 28 times more than going to your doctor, an urgent care clinic or Doctor on Demand To encourage the use of more cost-effective medical care in non-emergencies, the Blue and Blue Essentials Plans have an additional $100 emergency room copay. You'll also pay a separate $250 copay each time you're admitted to a hospital. However, if you're admitted to the hospital from the ER, your ER copay will be waived.

When you're not sure if you should use Doctor on Demand, visit your doctor, urgent care or emergency room, call the 24-hour NurseLine for advice on what kind of care you need for your illness or injury. See **page 25** for more information.

PHARMACY PLANS

Blue Plan prescription drug benefits provide four tiers, or levels, of coverage. For details about coverage, see the separate section on the Pharmacy Plan, beginning on **page 18**.

Blue Essentials Plan prescription drug benefits are through Premera's Essentials formulary. For details about coverage, see the separate section on the Essentials Pharmacy Plan, beginning on **page 19**.

HEARING

The Blue and Blue Essentials Plans includes hearing coverage that pays for most of the customary cost of a hearing exam, and provides an allowance for hearing aids. Hearing aids are now available over-the-counter (OTC), and by choosing OTC hardware, you may be able to greatly reduce your costs. The plan will help cover hearing aids ONLY if a plan-recognized provider prescribes hearing aids as necessary. There's no deductible. Benefit details include:

	DEDUCTIBLE	EXAMS	HARDWARE	FREQUENCY
Hearing	None	80% Of UCR[1]	$800 Maximum[2]	Every 3 calendar years

1 Usual, customary and reasonable charges.
2 Includes hearing aids and hearing aid maintenance.

VISION / VSP FOR ESSENTIALS

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions.

If you are enrolled in **Blue or Gold legacy plans**, vision coverage is provided through Premera, but must be elected at no extra charge. Coverage includes 90% of the customary cost of an eye exam and a $200 annual allowance for glasses or contact lenses. There's no deductible.

VSP - New for Essentials Plans ONLY

When you enroll in Blue or Gold Essentials, the new VSP Signature Plan will be your vision plan. VSP offers improved benefits compared to the legacy vision plan. The VSP plan is the same for the Blue and Golde Essentials plans. Highlights of the VPS plan coverage are outlined on **page 15**.

Find more information about the VSP plan on ***Inside Track*** **> BENEFITS > Health Insurance > Vision Benefits.** Create a VSP account at **www.vsp.com**, where you can find a VSP provider, and login to view your benefits and coverage. Questions? call VSP at **800-877-7195**.

choosing your ride

Prescription Drug Plans

One of the best things about traveling by train is choosing which car to ride in. Do you sit in the dome car to get the best views or have a snack in the club car?

While the Blue, Blue Essentials, Gold and Gold Essentials Plans cover prescription drugs a little differently, there are common features:

Step Therapy — Some conditions, like arthritis, high blood pressure and allergies, require long-term medications. Step therapy is a way to start with medications at the lowest cost and lowest risk "step," gradually "stepping up" to more expensive — and sometimes more risky — drugs, if necessary. If you're starting a long-term medication that requires step therapy, we encourage you to learn as much as you can about your condition and medications so that you're an active participant in managing your care.

"Dispense as Written"— If your doctor writes a prescription with this on it, your pharmacist cannot substitute a generic drug, even if one is available. You'll pay the coinsurance and the difference in cost between the generic drug and brand name drug.

Specialty Drugs — These are medications that typically cost more and treat complex conditions that require special handling and monitoring. If your doctor prescribes a specialty drug, you must fill that prescription through the specialty pharmacy — Accredo. If your prescription falls into the specialty category, you will receive a letter from Premera instructing you to use specialty pharmacies.

Mail Order — You may buy many prescriptions through the mail order program, which is usually less than retail cost.

BLUE AND GOLD PLAN PRESCRIPTION DRUG COVERAGE

Prescription drug cost and coverage are based on their category or "tier" as described in the following table:

TIER 1	TIER 2	TIER 3	TIER 4
GENERIC	PREFERRED BRAND	NON-PREFERRED BRAND	SPECIALTY
The formulary's lowest cost drugs have the same active ingredients — with the same quality, strength, effectiveness, and purity — as their brand name versions.	These are certain brand name drugs that are included in Premera's formulary (i.e., its list of preferred drugs).	These drugs are not on Premera's formulary list.	These are certain drugs used to treat complex health conditions.

Prescription drugs for tobacco cessation and contraceptives are covered at 100%.

Blue Plan Prescription Drug Coverage

If you are covered by the Blue Plan, you pay a copay for generic drugs and coinsurance for brand name and specialty drugs. Your copay or coinsurance amounts are based the drug's tier, as noted above. Under the Blue Plan, here's what you can expect to pay for a prescription (30-day to 90-day supply):

FORMULARY TIER	RETAIL	MAIL ORDER
Tier 1 – Generic Drugs	30-day supply or 90-day supply: $15 copay	n/a
Tier 2 – Preferred Brand Drugs	30-day supply; You pay 20% of the drug's cost, not to exceed $75 per prescription	90-day supply: You pay 20% of the drug's cost, not to exceed $75 per prescription
Tier 3 – Non-Preferred Drugs	30-day supply; You pay 50% of the drug's cost, not to exceed $75 per prescription	90-day supply: You pay 50% of the drug's cost, not to exceed $75 per prescription
Tier 4 – Specialty Drugs	n/a	30-day supply; You pay 50% of the drug's cost, not to exceed $100 per prescription

Gold Plan Prescription Drug Coverage

The Gold Plan covers 100% of nearly 200 preventive maintenance drug costs. Reference a complete list of covered medications, including 100%-covered preventive drugs, with a link found on the **BENEFITS/Health Insurance/Medical Health Insurance** page of ARRC's emloyee website ***Inside Track.*** Drugs marked with ACA PV are Affordable Care Act preventive medications available at no cost.

For all other prescriptions, you pay the full cost until your medical plan deductible is met, then you pay 20% of the cost until you reach the out-of-pocket maximum. The cost of a drug is determined by the tier it falls into.

ESSENTIALS FORMULARY

The Essentials formulary is an innovative prescription plan consisting of four "tiers" — or levels — of coverage as described in the table below. There is at least one drug within each drug class, and your doctor will have options to prescribe new preferred generic, preferred brand and preferred specialty medications. The formulary also includes some non-preferred medications available at a higher cost.

TIER 1	TIER 2	TIER 3	TIER 4
PREFERRED GENERIC	PREFERRED BRAND	PREFERRED SPECIALTY	NON-PREFERRED
The formulary's lowest cost drugs have the same active ingredients — with the same quality, strength, effectiveness, and purity — as their brand name versions.	These are certain brand name drugs that do not yet have a generic equivalent. Your share of the cost is higher when compared to Tier 1.	These are certain drugs used to treat complex health conditions.	While included in the Essentials formulary, these drugs have preferred equivalents at a lower cost. You pay the highest share of the cost for these drugs.

The Essentials formulary does not cover some drugs. These include low-value, high-cost drugs; drugs that have lower-cost alternatives (including over-the-counter options); competing brands; and drugs that are considered to be priced at unacceptably high levels.

To see a list of drugs included in the Essentials formulary, visit **www.premera.com** and select **Covered Drugs** at the bottom of the landing page. Select **E1/E4** for Blue Essentials or for Gold Essentials Plans.

Blue Essentials Plan Prescription Drug Coverage

Under the Blue Essentials Plan, your share of the cost is based on the drug's formulary tier. Here's what you can expect to pay at the pharmacy for a prescription (30-day to 90-day supply):

FORMULARY TIER	RETAIL	MAIL ORDER
Tier 1 – Generic Drugs	30-day or 90-day supply: You pay $10	n/a
Tier 2 – Preferred Brand Drugs	30-day supply: You pay 20% of the drug's cost, not to exceed $75 per prescription	90-day supply: You pay 20% of the drug's cost, not to exceed $75 per prescription
Tier 3 – Preferred Specialty Drugs	n/a	30-day supply: You pay 30% of the drug's cost, not to exceed $150 per prescription
Tier 4 – Non-Preferred Drugs	30-day supply: You pay 50% of the drug's cost, not to exceed $150 per prescription	90-day supply: You pay 50% of the drug's cost, not to exceed $150 per prescription

Gold Essentials Plan Prescription Drug Coverage

The Gold Essential Plan covers 100% of nearly 200 preventive maintenance drug costs. Reference a complete list of covered medications, including 100%-covered preventive drugs, with a link found on the **BENEFITS > Health Insurance > Medical Health Insurance** page of our website ***Inside Track.*** Drugs marked with ACA PV are Affordable Care Act preventive medications available at no cost.

For all other prescriptions, you pay the full cost until your medical plan deductible is met, then you pay 20% of the cost until you reach the out-of-pocket maximum. A drug's cost and availability are determined by the tier it falls into.

Keeping track

Comparing Plans

GOLD/GOLD ESSENTIALS AND BLUE/BLUE ESSENTIALS COMPARISON CHART

BENEFIT	GOLD AND GOLD ESSENTIALS PLANS	BLUE AND BLUE ESSENTIALS PLANS
Preventive care from Preferred and Participating Providers	Covers 100%	Covers 100%
Preventive maintenance prescriptions	Covers 100% of 192 medicines	Costs and coverage vary
Deductible	Higher	Lower
Biweekly premiums	Lower	Higher
Hearing coverage	Yes ($1,500 hearing aid allowance)	Yes ($800 hearing aid alllowance)
VSP Vision coverage (Essentials ONLY)	Yes (Gold Essentials Plan)	Yes (Blue Essentials Plan)
Legacy Vision coverage	Yes (Gold Plan)	Yes (Blue Plan)
Separate Emergency Room copay	No	$100 per visit
Separate hospital admission copay	No	$250 per admission
Copays	None	On most generic drug prescriptions
Voluntary medical travel	Yes	Yes
Doctor on Demand virtual care	Yes	Yes
Coalition Health Center	No	$20 per visit
Includes dental coverage	No	No
% of biweekly payment YOU pay	15%	20%

PEOPLE LIKE ME

When you consider your next adventure, you probably compare the cost of transportation, lodging and food. You may need to make trade-offs based on your needs. When choosing a health Plan, it helps to consider the health care needs of you and your family. The following examples show the approximate out-of-pocket expenses under each Plan for various situations — including one that may be similar to you. *Estimated costs shown are for these illustrations and should not be considered exact pricing.*

Meet Jeremy — You only

Jeremy is a healthy, active 20-something. During the year, he will:

- get an annual physical
- visit his family doctor once
- need two generic prescriptions (not mail ordered)

Because Jeremy doesn't need much medical care, he won't meet his annual deductible. Under each of the medical plan options using Preferred Providers, Jeremy will pay approximately:

	GOLD PLAN	BLUE PLAN
Annual medical Plan premium	$1,418 ($54.55 x 26)	$2,176 ($83.68 x 26)
Participant's HSA contributions	$500	N/A
Out-of-pocket costs:		
• Annual exam – preventive (estimated cost: $200)	$0	$0
• Family doctor visit (estimated cost: $200)	$200	$200
• Prescriptions – 2 monthly generic retail; 1 preventive (Annual cost: $$360 ea = $720)	$360 $0 for preventive; Full for non-preventive	$240 two x $10 per generic x 12 months
HSA account reimbursement of participant contributions	-$500	N/A
ARRC HSA contributions	-$500	N/A
TOTAL ANNUAL COST	**$1,478**	**$2,616**

Meet Peter and Penelope — You + 1 dependent

Peter and Penelope are in their early 50s. During the year:

- They both get annual physicals.
- Peter will get a diagnostic colonoscopy (not preventive). Penelope will get a preventive mammogram.
- In May, Peter will suffer a heart attack requiring bypass surgery. He admitted to hospital via ER.
- Peter takes generic preventive cholesterol medication. Penelope takes non-preventive medication for her thyroid.

Under each of the medical pan options, using Preferred Providers, Peter and Penelope will pay approximately:

	GOLD PLAN	BLUE PLAN
Annual medical Plan premium	$3,080 ($118.47 x 26)	$4,915 ($189.05 x 26)
Participant's HSA contributions	$3,350	N/A
Out-of-pocket costs:		
• Annual exams – 2 preventive (estimated cost: $400)	$0	$0
• Mammogram – preventive (est. cost: $150)	$0	$0
• Colonoscopy – diagnostic (estimated cost: $4,500)	$4,020 $3900 deductible + 20% (4500-3900)	$1,700 $1000 deductible + 20% (4500-1000)
• Heart attack, bypass surgery – 4 days inpatient stay and inpatient surgery (estimated cost: $85,000)	$1,420 $5,300 OOP max - $4,020 already paid	$1,800 $3,500 OOP max - $1,700 already paid
• Prescriptions – 1 monthly generic retail preventive (cholesterol) 1 monthly brand formulary retail (thyroid RBF, not preventive) (Annual cost: $240 cholesterol; $744 thyroid)	$149 $0 for preventive 20% of brand Rx ($744) since family deductible is met	$149 $0 for Peter's Rx as his OOP max is met. 20% of $744 for Penelope brand Rx
HSA account reimbursement of participant contributions	-$3,350	N/A
ARRC HSA contribution	-$1,000	N/A
TOTAL ANNUAL COST	**$7,669**	**$8,564**

Meet the Wessens — You + 2 or more dependents

Anne and Doug Wessen are in their mid-30s with a son and daughter, and a baby on the way this year.

- Each family member gets an annual checkup.
- The youngest child will have two urgent care visits for ear infections.
- The family needs four prescriptions, filled at local pharmacies.
- Anne's baby is delivered at the hospital.

Under each of the medical plan options, using Preferred Providers, Anne and Doug will pay approximately:

	GOLD PLAN	BLUE PLAN
Annual medical Plan premium	$3,840 ($147.68 x 26)	$6,258 ($240.68 x 26)
Participant's HSA contributions	$2,000	N/A
Out-of-pocket costs:		
• Annual exams – 4 preventive (estimated cost: $800)	$0 (preventive)	$0 (preventive)
• Prenatal care – 6 doctor visits (estimated cost per visit: $180)	$0 (healthy pregnancy)	$0 (healthy pregnancy)
• Urgent care – 2 visits (Cost: $225 each)	$450	$450
• Hospital stays – 2 days (estimated cost: $27,000)	$5,300 3900 deduct + 20% is over OOP max	$3,750 $3,500 OOP max. + 250 hospital deduct.
• Prescriptions – 4 monthly generic. 2 Rx are preventive. (Cost: $360 each annually)	$720 $0 for 2 preventive; full cost for other 2	$480 $10 per generic x 12 mo x 4 Rx
HSA account reimbursement of participant contributions	-$2,000	N/A
ARRC HSA contribution	-$1,500	N/A
TOTAL ANNUAL COST	**$8,810**	**$10,938**

IMPORTANT TAX FORMS

During the first part of the calendar year, ARRC will send you **Form 1095-C** related to your health care coverage. The IRS doesn't require you to submit documentation of health coverage with your tax return; however, you must keep all forms in case you're audited.

If you're enrolled in the Gold Plan and have a Health Savings Account (HSA), you must file HSA-related **Form 8889** with your tax return. Prepare and file this form using information about your HSA account activity, which is provided in two documents available from your Premera account online:

- **5498-SA** shows all contributions made to your HSA account during the tax year
- **1099-SA** shows how much HSA money you spent during the year

choosing your route

Cost-effective Options and Resources

THINGS TO CONSIDER - CHOOSING CARE WISELY

When you need to see a health care provider, you have these options:

- Primary care physician
- Urgent care clinic
- Doctor on Demand virtual care
- Hospital emergency room

YOUR DOCTOR	URGENT CARE CLINIC	EMERGENCY ROOM	DOCTOR ON DEMAND	COALITION CLINIC	NURSELINE
Preventive care	Bladder infection	Chest pain, breathing problems	Bladder infection	Bladder infection	If you're not sure which option is best for you, call NurseLine for advice 24/7, 1-800-841-8343
Manage existing conditions	Ear or eye infections, cough, sore throat, congestion	Broken bones, head injuries, sudden vision loss	Ear or eye infections, cough, sore throat, congestion	Ear or eye infections, cough, sore throat, congestion	
Follow-up care	Insect bites, minor burns, rashes	Extreme pain	Insect bites, minor burns, rashes	Insect bites, minor burns, rashes	
Referrals to specialists	Mild fever	Loss of consciousness	Mild fever	Mild fever	
Undiagnosed problems	Sprains, minor injuries	Severe burns	Shingles	Shingles	
Prescriptions	Prescriptions	Prescriptions	Prescriptions	Prescriptions	
Behavioral health, and more	And more	Suspected drug or alcohol overdose, or poisoning	Behavioral health	Behavioral health	
		Infants under 3 months old with high fever or need immediate care	Fungal infections	Children over the age of 5	
YOUR AVERAGE COST PER VISIT					
$200	$200	$2,500	$0	Blue Essentials Plan: $20	FREE

DOCTOR ON DEMAND IS A VIRTUAL MEDICAL CARE OFFERING

Medical issues don't always happen when it's easy to get to a doctor. With Doctor on Demand virtual medical care, you get immediate, convenient access to care — consultations, diagnoses and prescriptions — whenever and wherever you need it.

Doctor on Demand is not meant to replace your primary care provider (PCP) or in-person, face-to-face visits. But, when you can't get to your doctor because you are traveling, the weather is bad, or your doctor is booked, Doctor on Demand is a convenient alternative to an urgent care clinic and a lower-cost alternative to an Emergency Room visit when your medical need is not an emergency.

Doctor on Demand providers can diagnose, recommend treatment and prescribe medication when appropriate for many non-urgent medical care issues. Common conditions that Doctor on Demand physicians can address include sinus problems, respiratory infections, allergies, urinary tract infections, cold and flu symptoms and other non-emergency illnesses.

For the Blue and Blue Essentials Plans, you pay $0 for a Doctor on Demand visit or dermatology consultation. For the Gold and Gold Essentials Plans, you pay $60 per visit until you meet the plan deductible; then, you pay 20% coinsurance until you meet the annual out-of-pocket in-network maximum.

Here's how it works:

1. **Register** — Log on to **doctorondemand.com/microsite/premera/**. Fill out a health history, like you would at a doctor's office, and register your covered family members.
2. **Consult a physician** — You can talk to a Doctor on Demand physician any time by logging into your online account, or by calling. Provide your contact information and current location. A doctor will call you back right away or at a time you request.
3. **Benefits and payment** — Doctor on Demand will know what coinsurance and deductible apply. You can pay by credit or debit card, HSA or FSA card, or through PayPal.
4. **Continuity of care with PCP** — After your appointment, Doctor on Demand will send a record of the consult to your PCP to keep your regular doctor in the loop on your health and medical care.

NurseLine

Real emergencies do happen. When they do, call 911. If you're not sure what to do or where to go for help, and you need some advice, call NurseLine, Premera's 24/7 service for help. A registered nurse will help you decide how to treat your symptoms.

- Your call is answered quickly.
- The nurse asks you the right questions, helps you decide what to do, then can help you find the nearest in-network provider or pharmacy if you need one.
- The nurse stays on the line as long as it takes to decide.

COALITION HEALTH CLINIC

Only Alaska Railroad employees on the Blue Essentials plan can use the Coalition Health Center (CHC), a cost effective full service primary care solution with walk-in options for acute and unexpected medical needs. For railroaders who have a regular medical provider, the center is an additional cost-effective medical solution, and is not intended to replace your existing primary care provider.

Located in Anchorage, Fairbanks and Wasilla, the Coalition Health Centers are staffed by physicians, physician assistants, and nurse practitioners. Clinics offer a variety of services, including, but not limited to, treating and/or providing:

- cough, cold, sore throat, ear ache, rash
- sprains, strains and minor lacerations
- minor injury and in-office procedures
- lab tests and X-rays
- flu shots and immunizations
- physicals
- women's care
- unexpected illness
- disease management
- medication management

Cost to Blue and Blue Essentials Plan participants

The following CHC costs apply to all clinic locations, and to both active and retired employees with Blue Essentials.

SERVICE	COST
Office visit	$20*
Generic drugs, labs and X-rays	$0
No-Show fee	$75*

* *does not count toward your deductible or out-of-pocket expense.*

PREMERA ONLINE & MOBILE APP

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Register on **Premera.com** as soon as you have your member ID card. Creating an account provides access to all the great tools the website offers.

1. Go to **www.Premera.com**
2. Create a new account by following the prompts after clicking "Get Started"

Here are some things you can do online:

- Check your benefits and eligibility.
- Check your claims activity.
- Get an estimate on what surgery will cost in Alaska or the Lower 48.
- Find a network doctor and pharmacy.
- Order and refill prescriptions.
- Read about treatment options.
- Review your personal health record.
- Take quizzes to test your health and wellness IQ.
- Look through a medical library with videos, photos and information about common health issues
- Go paperless: Get your explanations of benefits and other documents in your email. This also helps reduce ARRC Plan administrative expenses.

You also can access Premera's robust Wellness Program. Find links to member discounts on products and services, wellness tools and support. Many user-friendly features on **Premera.com** make staying up on your health and wellness easier than ever.

Get Premera Mobile

With this smart phone app, you can find a doctor, have a one-touch connection to the NurseLine and customer service, and email proof of coverage to your provider. The free app is available for most smart phones.

CARE COMPASS 360°

To help you be "the little engine that could," Premera's CareCompass360° provides holistic support if you have complex or chronic medical conditions. Your participation in the program is voluntary. There is no cost to you.

If you have a health condition that requires coordinated care from more than one provider, CareCompass360° will set you on the right track with its "whole person" approach to health support, including:

- Disease management
- Substance abuse management
- Case management services
- Care transition management services

Whole Care

In addition to the services listed above, CareCompass360°'s program provides pain management, oncology resources and behavioral support to serve you and your family, no matter what kind of care you need.

The goal is to help you improve the quality of your life while reducing the amount you spend on health care.

What you can expect from CareCompass360°:

- Single point of contact for all of your care
- Easy-to-use and accessible resources, including telephonic coaching
- The help you need, when you need it
- More active support to make improving your health easier
- Outreach and care personalized just for you

To find out if CareCompass360° is right for you, call Premera Customer Service at **800-508-4722**.

Other Virtual Health Care Services through Premera

Premera Blue Cross / Blue Shield offers a virtual health care network offering several options to access quality health care, when and where you need it.

Doctors on Demand is the one such virtual care option, with details covered on **page 25.** There are several other virtual options that complement and work in concert with Doctors on Demand and in-person providers.

Most virtual programs are fully covered by ARRC Essentials health plans. Contact Premera Customer Service at **800-508-4722** for more information on any of the following:

- **TalkSpace** — mental health therapy available online via dialog with behavioral health therapists and psychiatrists. For more information about Premera's behavioral health programs, including TalkSpace, visit blue.premera.com/bhsupport/
- **Physical therapy** — PT support with smartphone access to experienced physical therapists and assistive technology. Features end-to-end evidence-based musculoskeletal (MSK) care to treat and support you back to health.
- **Addiction help** — virtual treatment through private connection to professionals that specialize in opioid and alcohol use disorders to achieve recovery wherever you are. WorkIt Health and Boulder Care both offer opiod and alcohol use disordes through video visits, live chat and text messaging with a therapist. For more information, visit boulder.care/getstarted and Workithealth.com/premera
- **Whole Body Health** — Premera virtual providers are integrated into our health plans, providing easy access to virtual primary care, urgent care and mental health care solutions online. These providers include MyCare Alaska and Doctor on Demand (available directly from Premera Mobile App) and TalkSpace.

Additional Telephonic Services

- **Emotional Distrress Crisis** — call or text 988 for the Suicide & Crisis Lifeline 24/7, or chat with a counselor at **988lifeline.org.** This is a service provided by and for the public.

COLOR - PREVENTIVE AND PROACTIVE HEALTH CARE

Through a partnership with Color, the railroad offers two services that help employees with proactive and personalized health care decisions.

Color Geonomics

The Color Geonomics program helps employees personalize their health care with genetic insights. Active employees are eligible for this benefit.

The program starts with an at-home test that provides the means to analyze genes associated with risks for common cancers and heart conditions, as well as how the body may process certain medications.

Testing is followed by genetic counseling by board-certified and licensed counselors to answer questions, provide education and consultation on relevant next steps.

Color Essential Care

In 2023, the Alaska Railroad added the Color Essential Care program, which is available to employees as well as health plan-covered spouses and/or dependents 18 years and older.

Like the Color Geonomics, the Color Essential Care program takes place from the comfort of home. Through at-home testing and online assessment, the program delivers valuable primary and preventive care services. This starts with identifying risks through a health questionnaire, vitals, bloodwork and other screenings. For example:

- Cardiometabolic screenings assess risks for diabetes, hypertension and more.
- Assessments for common cancers and mental health risks identify and bridge gaps in care.

Medical specialists follow up evaluation and referrals to address any potential health issues.

Routinely checking these health measurements is important to maintaining your health and preventing disease.

More information

For more information about either of these programs, visit **color.com/alaskarailroad.**

the branch line

Dental Plans

Main lines are essential to move people and goods from place to place. Branch lines play an important role because they connect to major routes. Keeping them in working order is important.

Maintaining your oral health supports your overall health, which helps everything run smoothly. It's like that with your vision and hearing, too.

ARRC OPTIONAL DENTAL PLAN

You may enroll yourself and eligible family members in the ARRC Optional Dental Plan. The dental Plan is separate from the medical Plans, so you can enroll in the Dental Plan even if you waive medical coverage. The annual maximum benefit paid is $2,000.

RAILROAD EMPLOYEES' NATIONAL DENTAL PLAN

If you're a represented employee, your union requires you to enroll in the Railroad Employees' National Dental Plan, offered to railroads throughout the U.S. and administered by Aetna.

Premium deductions begin on your date of hire; benefits begin after 12 months of cumulative service.

If you enroll in the Optional Dental Plan, you'll be covered by two Plans. Once National Dental coverage starts, it's the primary Dental Plan.

Optional Dental Plan and National Dental Plan biweekly contributions

COVERAGE TIER	OPTIONAL DENTAL PLAN	RAILROAD EMPLOYEES' NATIONAL DENTAL PLAN
	YOUR COST	
You only	$5.84	$31.89
You + 1	$13.84	
You + 2 or more	$18.22	

Optional Dental Plan and National Dental Plan benefits

	OPTIONAL DENTAL PLAN	RAILROAD EMPLOYEES' NATIONAL DENTAL PLAN
Annual deductible	None	$50 per person; $100 per family
Annual maximum benefit per person	$2,000	$1,500
Preventive care[1]	100% of UCR[2]	100% of UCR
Routine services	90% of UCR	80% of UCR
Major services	50% of UCR	50% of UCR
Orthodontia (children only)	$2,000 lifetime maximum	50% of UCR; $1,000 maximum every 5 years

1 Optional Dental Plan: Includes sealants in permanent teeth of dependents up to age 19.
2 Usual, customary and reasonable charges.

Dental Eligibility Timelines

Represented Employees

Day 1:
Enrolled in the National Dental Plan. Premiums deducted from day one.

Day 90:
Eligible to participate in the ARRC medical and/or dental Plans.

12 months:
National Dental benefits start. If you enroll in ARRC dental Plan, you will have dental coverage under both Plans. National Dental is primary.

extra support

Flexible Spending Accounts

To make sure rail lines can support tons of moving steel, the foundation and support — subgrade, ballast and ties — must be sturdy and reliable.

Flexible Spending Accounts (FSAs) keep your financial foundation strong by allowing you to set aside pretax money every paycheck to pay for out-of-pocket medical and dependent care costs. Then, when you incur unreimbursed medical costs or dependent care expenses, you can use the money tax-free. There are two types of FSAs:

- Health Care FSA — If you are actively contributing to an HSA, you cannot enroll in a Health Care FSA
- Dependent Care FSA (DCAP)

Just as laying rail lines properly is an important investment in train travel safety, carefully calculating how much to put into your FSAs is an important investment in your financial security. FSAs are "use it or lose it." Any money remaining in your account at the end of the year goes away. However, there is a grace period during which you may use the previous year's FSA funds for eligible expenses you incur during the prior year and *typically* through to March 15 of the following year. And, typically, you must file claims for reimbursement by April 30 the following year.

Because FSA money doesn't roll over, you must re-enroll every year you want to participate. Consider your needs carefully before choosing how much to contribute so you don't lose any unused funds.

FLEXIBLE SPENDING ACCOUNT BIWEEKLY ADMINISTRATIVE FEES	
One account (Health Care FSA or DCAP)	$1.20
Both accounts — Health Care FSA and DCAP	$2.40

WHO'S ELIGIBLE?*

Eligibility dates	To become eligible, you must: • Be employed in a year-round job • Have 12 months of continuous employment before the new Plan Year, with no unpaid leaves or layoffs • Anticipate continuous employment for the next 12 months Once eligible, enroll: • Within 31 days from a qualified life event, or • During Open Enrollment
Health Care FSA annual contribution limit	• $1,500 UTU-represented
Dependent Care FSA annual contribution limit	$5,000

** **NOTE: You can enroll in the FSA and DCSA even if you do not enroll in either a health care plan or a dental plan.***

HEALTH CARE FSA - BLUE / BLUE ESSENTIALS PLANS ONLY

You can use your Health Care FSA to pay out-of-pocket medical, dental, vision and hearing expenses. Some examples include:

- Your health Plan deductibles and coinsurance
- Laser eye surgery • Hearing aids • Adult orthodontia

In response to the pandemic, the CARES Act of 2020 expanded the eligible expenses to include more than 20,000 products including over-the-counter drugs and medicines that no longer require a prescription (fever reducers, cold remedies, etc.) as well as menstrual care products.

DEPENDENT CARE FSA - BLUE AND GOLD PLANS

You can use the money you put into this account to pay eligible dependent care costs so you and your spouse can work, look for work or attend school full time. The maximum Dependent Care FSA contribution is $5,000 per year (married filing jointly).

Generally, an eligible dependent is:

- Your child under 13 years old
- A disabled spouse or dependent of any age who lives with you

Eligible expenses include:

- Private child care
- Child care at a day camp or preschool
- After-school care
- Elder care for an incapacitated adult who lives with you

The two kinds of FSAs are separate accounts. You may contribute to both but you can't use Health Care FSAs to pay for dependent care costs or vice versa.

traveling the trestle

Life Insurance

Trestles have enabled trains to traverse steep canyons, rapid rivers and placid lakes for two centuries. Without this framework, trains could not have touched so many lives.

Life Insurance can be your family's "trestle" if you die, or suffer loss of a limb or eyesight; it can help carry your loved ones through difficult times. Your Life Insurance needs may change over time, so check your benefits every year to make sure they are still appropriate.

New employees may enroll within 31 days from their eligibility date. If you wish to enroll or increase coverage later, you must submit Evidence of Insurability to the insurance company. The insurance company may approve or deny your request, or approve a lower benefit.

WHO'S ELIGIBLE?

There are four life insurance Plan options; however, you must enroll in Basic Life and Accidental Death and Dismemberment (AD&D) if you want to enroll in any of the others.

	REPRESENTED EMPLOYEES
Eligibility dates	Eligible 90 days after hire date. Enroll within 31 days of your eligibility date.
	With Evidence of Insurability, you may enroll in Basic Life/AD&D within 31 days from a qualified life event or during Open Enrollment. If you are enrolled in Basic Life, you may add after-tax options (Optional Life, Standard Life, Dependent Life) any time of year with approved Evidence of Insurability.

LIFE INSURANCE OPTIONS, AT A GLANCE

TYPE OF INSURANCE	WHO'S COVERED	BENEFIT	
Basic Life[1] AD&D[1]	Employee	Twice (2 x) your basic annual pay, up to a maximum of $75,000.	
		Accidental death: Basic Life amount Dismemberment: Benefits vary	
Optional Life: 1–5x salary options[2]	Employee	1x salary: $50,000 max 2x salary: $100,000 max 3x salary: $150,000 max	4x salary: $200,000 max 5x salary: $250,000 max (no AD&D)
Standard Life[2]	Employee	$10,000 (no AD&D)	
Dependent Life[2]	Legal spouse	$5,000	
	Dependent children	$100 – $2,500 (depending on age)	

1 Employee and ARRC share the premium cost. Employee's cost is 2/3 of the total; qualifies for pretax payment.
2 Employee pays full cost of premium; payment is after tax.

BASIC LIFE AND AD&D EMPLOYEE'S BIWEEKLY COST (PER $1,000 OF COVERAGE)	
Non-nicotine user rate	Nicotine user rate
$.07	$0.92

OPTIONAL LIFE EMPLOYEE'S BIWEEKLY COST (PER $1,000 OF COVERAGE)		
	Non-nicotine user rate	Nicotine user rate
Under age 35	$.027	$.036
35 – 39	$.036	$.045
40 – 44	$.059	$.082
45 – 49	$.091	$.127
50 – 54	$.141	$.195
55 – 59	$.264	$.370
60 and over	$.410	$.580

STANDARD LIFE EMPLOYEE'S BIWEEKLY COST (FLAT RATE)	
Non-nicotine user rate	Nicotine user rate
$1.12	$1.52

DEPENDENT LIFE EMPLOYEE'S BIWEEKLY COST (FLAT RATE)
$ .52

staying on track

Employee Assistance Program with ComPsych

Track ties, train cars, signals, knuckles, switches, brakes — they all need maintenance and repair to stay in working order.

Sometimes, we may need to do a little repair in our lives to stay on track. ARRC's Employee Assistance Program (EAP) can help with life's "derailments"— big and small.

ComPsych provides ARRC's EAP services. The services are free, confidential counseling and referral services that can help you deal with life's challenges such as:

- Changes in your financial situation
- Family or relationship problems
- Over-work or conflicts at work
- Feelings of depression or anxiety
- Quitting nicotine use
- Substance abuse
- Caring for children or aging parents

You, your spouse and dependent children up to age 26 are covered and eligible to use the EAP from your hire date. Each person is eligible for up to eight face-to-face counseling visits per issue each year. The EAP also provides support and guidance to supervisors and managers who need help dealing with workplace issues.

Through ComPsych, all employees and covered family members have access to legal and financial services consultations.

ComPsych provides licensed, experienced counselors in Anchorage, Fairbanks, Eagle River and the Mat-Su Valley, as well as nationwide. EAP counselors also are available by phone 24 hours a day, seven days a week (see back cover for contact information).

For more information and tools, such as self-assessments, depression screenings, wellness tips and community resources:

- Call Toll: **833-306-0101**
- Visit: **GuidanceResources.com**
- App: **GuidanceNow**
- Web ID: **ARRC**

savor the scenery

Retirement Plans

When you travel by airplane, you don't get to see much. When you take a train, the experience is all yours; you can relax, take in the countryside — and enjoy the moment.

When you have financial peace of mind, you can truly appreciate the view from your retirement. Saving early will help you reach your retirement goals so you can maintain your current lifestyle, live your dreams — and enjoy the moment.

ARRC provides two retirement Plans to represented employees. Experts say you will probably need a combination of plans to be truly prepared for retirement. ARRC's Plans are:

- Alaska Railroad Corporation Pension Plan — administered by Atéssa
- 401(k) Tax Deferred Savings Plan — administered by Empower

Once you start participating in the Pension Plan, no Social Security is deducted from your pay; however, the Medicare tax is still withheld.

WHEN ARE WE ELIGIBLE?

PLAN	UTU-REPRESENTED EMPLOYEES
ARRC Pension Plan	Hire date
401(k) Tax Deferred Savings Plan	After 520 Subject-to-Retirement cumulative hours

RETIREMENT PLAN CONTRIBUTIONS

PLAN	UTU-REPRESENTED EMPLOYEES
ARRC Pension Plan	Pretax 9% of base annual earnings
401(k) Tax Deferred Savings Plan	• Pretax or Roth after-tax • 1-50% of base annual earnings • No ARRC match

ALASKA RAILROAD PENSION PLAN (ALL EMPLOYEES)

You must participate in, and contribute to, the Pension Plan.

This is a defined benefit Pension Plan that can help provide financial security in your retirement.

If vested, you may receive a pension at retirement age. Participants vest with five years of eligible vesting service. Survivor and disability benefits are available after you're vested.

Tier 1

UTU employees hired for the first time before March 4, 2016, are in Tier 1 of the Pension Plan.

- Normal retirement age is 62 for Tier 1.
- Tier 1 participants may retire at age 58 with early *unreduced* benefits.
- Tier 1 participants may retire at age 55 *with reduced* early retirement benefits.

The difference between vested service and credited service

Vested service — You are vested in the Alaska Railroad Corporation Pension Plan after you earn five years of eligible vesting service. This means once you are vested, if you leave your job for any reason, you are guaranteed to receive a future benefit for the years and months of service earned before you ended your employment, unless you withdraw your contributions. No vesting service is earned while in layoff status.

Credited service — This is used to calculate the amount of your actual pension benefit. It includes your years of service during which you participated in the Plan ***and*** contributed. You cannot earn credited service while on leave of absence, workers' compensation or layoff.

Tier 2

UTU employees hired for the first time after March 3, 2016, are in Tier 2 of the Pension Plan

- Normal retirement age is 65 for Tier 2.
- Tier 2 participants may retire at age 60 *with reduced* early retirement benefits.

The formulas

The Tier 1 formula for a monthly normal retirement benefit is the sum of:

- 2% x final average earnings x credited service

PLUS

- 0.5% x final average earnings x credited service that is earned after 2005 and after completing 10 years of credited service.

Tier 2 formula for a normal monthly retirement benefit is:

- 2% x final average earnings x credited service

For both tiers, your final average earnings are figured from the three highest consecutive years of earnings as defined by the Plan.

Termination of Employment

If you're vested, you have three options:

1. You may start receiving the monthly pension benefit if you're at early retirement, early unreduced (Tier 1 only) retirement, or normal retirement age.
2. You may leave your contributions in the Plan if you're not at a retirement age. Then request benefits when you reach early, early unreduced (Tier 1 only), or normal retirement age.
3. You may withdraw your contributions plus 4.5% interest for Tier 1, or 3-month Treasury rate for Tier 2. If you choose this option, you will not receive a monthly pension benefit.

If you're not vested, you have two options:

1. You may withdraw your contributions plus 4.5% interest (3-mo. Treasury rate for Tier 2).
2. If your account balance is more than $1,000, you may delay withdrawing your contribution amount until your required minimum distribution (RMD) age.

NOTE: All distributions shall be determined and made in accordance with the required minimum distribution regulations.

ATÉSSA BENEFITS

Participants are also encouraged to register to use Atéssa's website, **myatessa.com** for access to their Corporation Pension Plan information.

See your contribution account balance, run retirement estimates, and download a Beneficiary Form and Pension SPD.

Contact Atéssa online, by phone or in writing:

ATTN: ARRC Pension Administration
16959 Bernardo Center Drive, Suite 221
San Diego, CA 92128

myatessa.com

Phone: 888-309-0041

M-F, 7:00 a.m. to 4:30 p.m. PT
Fax: 858-753-6254

401(K) SAVINGS PLAN

To sweeten your retirement, ARRC offers another way to save — and will even chip in. Once you're eligible for this tax-deferred Plan, you may enroll at any time. Empower administers this Plan.

Cost

The annual administrative / record-keeping fee of $39 is charged monthly at $3.25.

Features

You may save for retirement on a pretax or Roth after-tax basis. Saving is easy because your contributions are made directly from your paycheck. The Plan offers 25 investment options.

You choose the amount you want to save — from 1 to 50% of your annual regular earnings, up to the annual dollar limit set by the IRS. Participants age 50 and older can make "catch-up" contributions of up to annual limits set by the IRS.

ARRC does not provide a match for UTU-represented employees.

If you need investment assistance, Empower provides these services:

1. Financial Engines (free service)
2. Age 50+ Advice (free service)
3. Advisory Services (fee charged)

EMPOWER ONLINE AND VOICE SYSTEM

Participants are encouraged to register to use Empower's website, **empower.com**, to access their 401(k) savings Plan.

You can enjoy immediate access to your account information and conduct most transactions 24 hours a day, seven days a week. You also can take advantage of these other convenient features:

401(k) account changes and requests — Change your 401(k) deferral percentage, and sign up for automatic deferral increases. You also can change your investment options or allocation, and request loans and hardship distributions from your 401(k) Plan.

Extensive portfolio analysis — Find easy-to-read graphs and charts showing your portfolio's asset allocation, industry weightings, investment styles and many other factors that may affect your retirement.

Comprehensive performance reports — View your personal rate of return and other up-to-date performance data.

Convenient e-delivery — View fund reports, prospectuses, trade confirmations, proxy materials and most types of account statements online.

Advisory Services — If you want to delegate ongoing discretionary investment management to a professional investment advisor, you can take advantage of Empower's portfolio management advisory services for an additional fee.

Empower Voice Response System — Enables you to monitor the activity in your Plan accounts, and obtain fund price and yield information. You can obtain your account balance, confirm your investment allocations for future contributions or request a transaction.

regular maintenance

Retiree Medical Plan

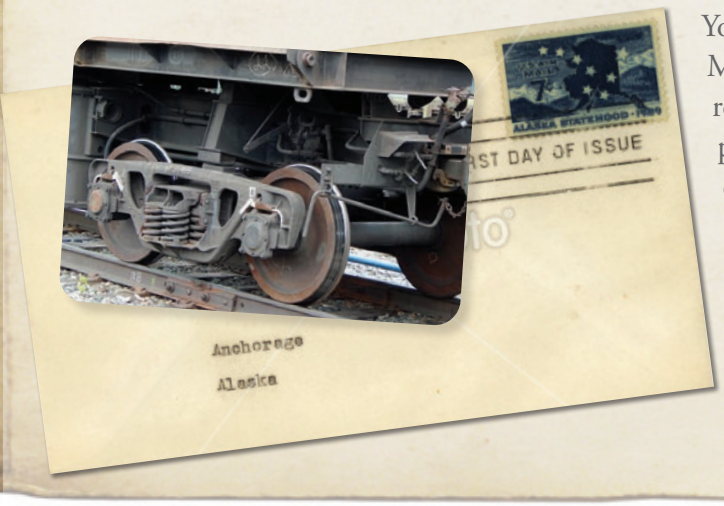
Tracks, cars and locomotives can last a long time with routine maintenance and some extra care.

Continuing your medical coverage when you retire can help keep you rolling along, too. Retiree medical coverage is available to UTU-represented employees hired before March 4, 2016; and who are actively receiving a *monthly* pension benefit.

It's also available to eligible family members enrolled in the ARRC Health Plan at the time of the employee's retirement or at the beginning of Corporate Pension disability benefits. You have 30 days from the date of retirement, cessation of COBRA following separation from service to retire, or the disability benefits start date, to enroll in the Plan. If you elect to decline retiree medical coverage, your decision is final; you cannot request coverage at a later date.

The retiree Plan includes the same benefits provided to active employees, except the plan does not cover dental, vision and hearing services. If you elect coverage, you'll be enrolled in the same health plan — Blue/Blue Essentials or Gold/Gold Essentials — that you were at the time of retirement. There will be annual Open Enrollment periods when you can select the coverage you want for the upcoming year. There is no HSA contribution made for retirees who choose a Gold/Gold Essentials Plan, but you can use any funds remaining in your HSA for medical expenses after you retire.

ARRC pays 40% of anUTU retiree's premium cost, starting at age 58. Pension participants receiving disability benefits receive the 40% cost share at any age, regardless of union or management status. Early retirees can participate in the Plan by paying 100% of the premium until they reach the age threshold for premium cost sharing.



You must enroll in Medicare Part A and B at age 65, or your Medicare-eligible age, if sooner. Your cost for the railroad's retiree medical plan decreases as Medicare becomes the primary plan for enrollees. However, you do not need to enroll in Medicare Part D. ARRC determined that retiree prescription drug coverage is considered Creditable Coverage under Medicare.

bells and whistles

Other Benefits

Whether you're a passenger on a day-long tour or riding cross-country in a berth, it's the extras that make traveling by train so much fun.

The bells and whistles of our benefits include:

- Leave and holidays
- Rail Travel Program

LEAVE AND HOLIDAYS

All employees start accruing leave starting on their hire date.

YEARS OF SERVICE	BIWEEKLY ACCRUAL RATE
Annual Leave	**UTU-REPRESENTED**
0–3 years of service	4 hours
3–15 years of service	6 hours (10 hours in 25th pay period)
15 years +	8 hours
Maximum annual leave carryover from year to year	256 hours
Sick Leave	
No accrual limit	4 hours

PAID HOLIDAYS				
New Year's Day	Memorial Day	Labor Day	Veterans Day	Thanksgiving Friday
Presidents Day	4th of July	Columbus Day	Thanksgiving	Christmas Day

RAIL TRAVEL PROGRAM

All employees, their spouses, dependent children, parents and parents-in-law may ride the Alaska Railroad free on a space-available basis. You're eligible for free travel as of your hire date. Retirees and their spouses also are eligible for free travel.

To take advantage of this great program, just fill out the Rail Pass Request Form from HR.

for more information

References Materials

LEGAL DOCUMENTATION

The Alaska Railroad is required by federal law to provide benefit plan participants with certain legal notices each year. This important information is available electronically online. You can review the document using the URL address below or use your smart phon's camera to read the QR Code at right.

https://online.flippingbook.com/view/273339113/

Please read carefully and share with your family members. This document contains important benefit program notices. Some notices are required by law and other notices contain helpful information. These notices are updated from time to time and some federal notices are updated annually. Be sure you are reviewing an updated version. *The electronic document was updated at the end of 2022.* If you have any questions, please contact ARRC Human Resources at 907-265-2220.

LABOR AGREEMENTS

Many benefits are dictated by terms outlined in collective bargaining agreements (CBA) that have been negotiated with five unions:

- Alaska Railroad Workers (ARW) Local 183
- American Train Dispatchers Association (ATDA)
- International Brotherhood of Teamsters (IBT) Local 959
- Transportation Communications Union (TCU) Local 6067
- United Transportation Union (UTU) Local 1626

Current CBAs are available on our employee website ***Inside Track.*** Use the URL below, or the QR Code at riggt to review the contracts.

https://insidetrack.akrr.com/references/labor-and-hr-references/labor-agreements

ENROLLMENT INSTRUCTIONS

Submit Benefits Enrollment Information/Election Form and FSA Enrollment Form one of four ways:

1. **Mail or interoffice mail:**
   Alaska Railroad Corporation | Attn: HR
   PO Box 107500 | Anchorage 99510-7500
2. **Fax:** 907-265-2542
3. **Email:** HRBenefits@akrr.com
4. **Hand deliver:** Human Resources (GOB)
   327 W. Ship Creek Avenue in Anchorage

HSA ACCOUNT REFERENCE

Below is a general HSA Payment Schedule for HSA account holder reference.

HEALTH SAVINGS ACCOUNT PAYMENT SCHEDULE

FIRST PAYMENT (PP #)	% OF YEAR	EE FIRST PAYMENT	EE1 FIRST PAYMENT	FAM FIRST PAYMENT	SECOND PAYMENT (PP #)	EE SECOND PAYMENT	EE1 SECOND PAYMENT	FAM SECOND PAYMENT
1	1.00	250.00	500.00	750.00	14	250.00	500.00	750.00
2	0.96	240.38	480.77	721.15	14	240.38	480.77	721.15
3	0.92	230.77	461.54	692.31	15	230.77	461.54	692.31
4	0.88	221.15	442.31	663.46	15	221.15	442.31	663.46
5	0.85	211.54	423.08	634.62	16	211.54	423.08	634.62
6	0.81	201.92	403.85	605.77	16	201.92	403.85	605.77
7	0.77	192.31	384.62	576.92	17	192.31	384.62	576.92
8	0.73	182.69	365.38	548.08	17	182.69	365.38	548.08
9	0.69	173.08	346.15	519.23	18	173.08	346.15	519.23
10	0.65	163.46	326.92	490.38	18	163.46	326.92	490.38
11	0.62	153.85	307.69	461.54	19	153.85	307.69	461.54
12	0.58	144.23	288.46	432.69	19	144.23	288.46	432.69
13	0.54	134.62	269.23	403.85	20	134.62	269.23	403.85
14	0.50	125.00	250.00	375.00	20	125.00	250.00	375.00
15	0.46	115.38	230.77	346.15	21	115.38	230.77	346.15
16	0.42	105.77	211.54	317.31	21	105.77	211.54	317.31
17	0.38	96.15	192.31	288.46	22	96.15	192.31	288.46
18	0.35	86.54	173.08	259.62	22	86.54	173.08	259.62
19	0.31	76.92	153.85	230.77	23	76.92	153.85	230.77
20	0.27	67.31	134.62	201.92	23	67.31	134.62	201.92
21	0.23	57.69	115.38	173.08	24	57.69	115.38	173.08
22	0.19	48.08	96.15	144.23	24	48.08	96.15	144.23
23	0.15	38.46	76.92	115.38	25	38.46	76.92	115.38
24	0.12	28.85	57.69	86.54	25	28.85	57.69	86.54
25	0.08	19.23	38.46	57.69	26	19.23	38.46	57.69
26	0.04	9.62	19.23	28.85	26	9.62	19.23	28.85

Benefits Directory - Contacts

SERVICE		WEBSITE/EMAIL	PHONE
ARRC Health Plan, Group 1038789 (Medical; prescription drug, including mail order; dental; vision; and hearing) AND Flexible Spending or Health Savings Accounts	Premera Blue Cross Blue Shield of Alaska	**Premera.com**	Customer Service 8 a.m. – 5 p.m. Monday – Friday 800-508-4722 24-hour NurseLine 800-841-8343 FSA: 800-941-6121
VSP Signature Plan Vision Coverage	Vision Services Program (VSP)	**VSP.com**	800-877-7195
National Dental Plan Group 12000 (represented employees)	Aetna for National Railway Labor Conference	**Aetna.com**	877-277-3368
Employee Assistance Program (EAP)	ComPsych	**GuidanceResources.com**	833-306-0101
Pension Plan	Atéssa Benefits	**Myatessa.com**	888-309-0041
401(k) Savings Plan 090587 457 Deferred Compensation Plan 078043	Empower	**Empower.com**	800-232-0859
Life insurance	Hartford Life Insurance Co.	**HRBenefits@akrr.com**	907-265-2220
Customer service or any benefit enrollment	ARRC Human Resources	**HRBenefits@akrr.com**	907-265-2220