MY BENEFITS Journal

Alaska Railroad Corporation
Benefits for Employees
Represented by ARW, TCU and UTU

2022

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.

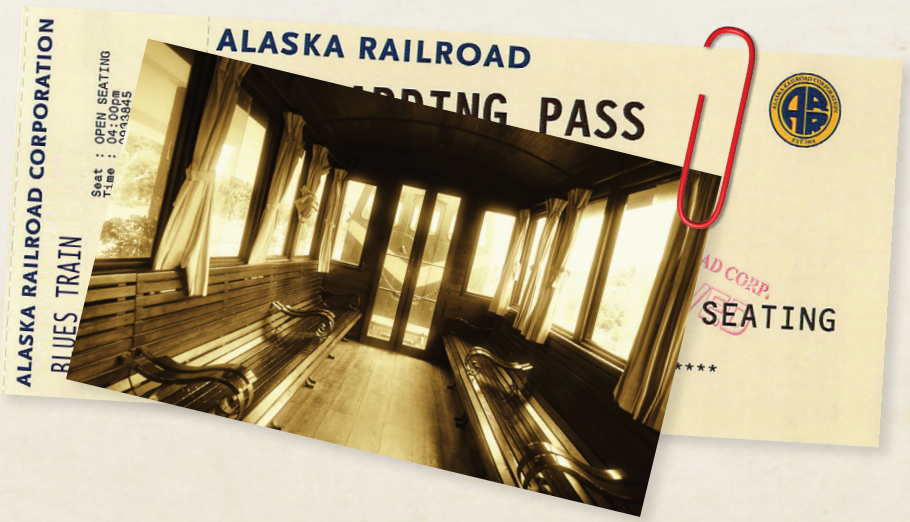
How to Enroll

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** — Two options for medical, prescription drug and hearing coverage, plus vision coverage
- **Dental Plan** — ARRC Optional and Railroad Employees' National Plan (required for represented employees)
- **Health Savings Account** — Gold Plan only
- **Flexible Spending Accounts —** Health Care FSA (Blue Plan only), Dependent Care FSA (Blue and Gold)
- **Life Insurance** — Basic Life and AD&D, Optional, Standard and Dependent Life
- **Employee Assistance Program**
- **Retirement Plans** — ARRC Pension and 401(k) Savings Plan
- **Retiree Medical Plan** — Not available for retiree medical care: ARW-represented employees hired on or after Nov. 4, 2014; TCU-represented employees hired on or after April 2, 2015; and UTU-represented employees hired on or after March 4, 2016.
- **Paid time off —** Annual leave, sick leave, holidays
- **Free travel on Alaska Railroad**

Summary Plan Descriptions (SPDs), which provide more information and detail, are available on ARRC's inside track for:

- Health Plan (also see your Summary of Benefits and Coverage)
- Dental Plan
- Life Insurance Plan
- Pension Plan
- 401(k) Savings Plan
- Flexible Spending Accounts

You can access SPDs on the ARRC employee website, **insidetrack.akrr.com** > Benefits > Health Insurance > Medical Health Insurance. The Pension Plan SPD (Benefits > Retirement Plans > Pension Plans) is also available at **myatessa.com**; the Tax Deferred Savings Plan SPD (Benefits > Retirement Plans > Tax Deferred Savings) is also available at **empower.com**. You can view our Health Plan at **Premera.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 page 35).

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 to administer the Plan. 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	26		
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	11	✔	✔
Access to Premera mobile site, website, and tools	26, 27	✔	✔
Prior authorization for certain procedures	11	✔	✔
Health Care FSA	30		✔
Dependent Care FSA	30	✔	✔
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. 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 coming in 2022

If you need surgery, explore the **Surgery Plus** 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 Plan's deductible. In addition, ARRC will waive the coinsurance under both the **Gold** and **Blue** 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

For certain procedures, for all the plans, such as inpatient hospitalization and elective surgery, 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. However, preferred providers are required to get prior authorization for you; if they forget, they pay the penalty.

Usually, your provider will get prior authorization on your behalf, but you're responsible for making sure they do. Verify that your provider completes this process, or, you can get prior authorization for the procedure by contacting Premera by phone.

Virtual care options

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

Other features

Preventive drugs — The Blue and Blue Essentials plans cover preventive prescription drugs differently than the Gold and Gold Essentials plans.

Hearing — Hearing tests and hearing aids are covered under both Plans but the amount of coverage is different for each.

Dental — Dental coverage is not included in any Plan, but you may enroll in ARRC's Optional Dental Plan (see **page 28**).

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

You pay 15% of the biweekly premium; ARRC pays 85%.

	GOLD ESSENTIALS PLAN BIWEEKLY PREMIUMS		
PARTICIPANTS	You	You + 1	You + 2 or more
ARW, TCU and UTU	$50.75	$110.21	$137.37

	GOLD PLAN BIWEEKLY PREMIUMS		
PARTICIPANTS	You	You + 1	You + 2 or more
ARW, TCU and UTU	$62.69	$146.03	$191.10

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	$1,400	$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 prescription medications until you meet the annual in-network deductible. However, you can use funds in your Health Savings Account to help pay your annual deductible. 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.

To reach your deductible, you pay the full fee for doctor visits and most prescriptions. To help you pay these costs, you may open a Health Savings Account (HSA).

HEALTH SAVINGS ACCOUNT (HSA)

Because the Gold and Gold Essentials Plans have a higher deductible and no copays, you may enroll in a tax-free HSA to help pay those costs. You can put additional 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 the 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: $3,650
- You plus one or more (family): $7,300
- 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 $3,150	$3,650
You + 1 (family)	$1,000	Up to $6,300	$7,300
You + 2 or more (family)	$1,500	Up to $5,800	$7,300

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 53**).

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 AND VISION

Vision and hearing coverage is part of the Gold and Gold Essentials Plans. The plan pays for most of the customary cost of an exam, and provides an allowance for prescription glasses or contact lenses, and for hearing aids. There's no deductible. Benefit details include:

	DEDUCTIBLE	EXAMS	HARDWARE	FREQUENCY
Vision	None	90% Of UCR[1]	$200 Maximum	Every calendar year
Hearing	None	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.

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

You pay 20% of the biweekly premium; ARRC pays the other 80%. As each employee group adopted newer health care plans, ARRC has provided a premium adjustment, lowering your portion and increasing ARRC's portion of the premium cost. Adjustments gradually decrease each year during three-year transition periods. ARW, TCU and UTU transition is complete, and no adjustments remain.

	BLUE ESSENTIALS PLAN BIWEEKLY PREMIUMS		
PARTICIPANTS	You	You + 1	You + 2 or more
ARW, TCU and UTU	$77.84	$175.86	$223.89

	BLUE PLAN BIWEEKLY PREMIUMS		
PARTICIPANTS	You	You + 1	You + 2 or more
ARW, TCU and UTU	$89.77	$211.68	$277.62

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

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 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, an innovative prescriptions plan consisting of four tiers, or levels, of coverage. For details about coverage, see the separate section on the Essentials Pharmacy Plan, beginning on **page 19**.

HEARING AND VISION

Vision and hearing coverage is part of the Blue Plan. The plan pays for most of the customary cost of an exam, and provides an allowance for prescription glasses or contact lenses, and for hearing aids. There's no deductible. Benefit details include:

	DEDUCTIBLE	EXAMS	HARDWARE	FREQUENCY
Vision	None	90% Of UCR[1]	$200 Maximum	Every calendar year
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.

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. You may only fill up to a 30-day supply at non-specialty retail pharmacies twice. 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 **Rx Search** under the **Pharmacy** tab. On the drop down menu, select **E1/E4** for either Essentials Plan.

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 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. 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

	GOLD AND GOLD ESSENTIALS PLANS	BLUE AND BLUE ESSENTIALS PLANS
BENEFIT		
Preventive care from Preferred and Participating Providers	Plan covers 100%	Plan covers 100%
Preventive maintenance prescriptions	Plan covers 100% of 192 preventive medications	Costs and coverage vary
Deductible	Higher	Lower
Biweekly premiums	Lower	Higher
Hearing coverage	$1,500 allowance every 3 years for hearing aids and maintenance	$800 allowance every 3 years for hearing aids and maintenance
Vision coverage	90% UCR for Exams and $200 annual maximum hardware	90% UCR for Exams and $200 annual maximum hardware
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
Includes dental coverage	No	No

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 James — You only

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

- get an annual physical
- visit his family doctor once
- need two generic prescriptions

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

	GOLD PLAN	BLUE PLAN
Annual medical Plan premium (includes Blue Plan premium adjustment)	$1,320	$2,023
Participant's HSA contributions	$500	N/A
Out-of-pocket costs:		
• Annual exam – preventive (estimated cost: $200)	$0	$0
• Family doctor visit (estimated cost: $165)	$165	$165
• Prescriptions – 2 monthly generic retail; 1 preventive, 1 not (estimated cost: $720)	$360	$360
HSA account reimbursement of participant contributions	-$500	N/A
ARRC HSA contributions	-$500	N/A
TOTAL ANNUAL COST	**$1,345**	**$2,548**

Meet Marshall and Mia — You + 1 dependent

Marshall and Mia are in their early 50s. They both get annual physical exams. Marshall will have a diagnostic colonoscopy (not preventive) and Mia, a preventive mammogram. In May, Marshall will suffer a heart attack requiring bypass surgery.

Marshall takes generic cholesterol medication. Mia takes medication for her thyroid.

Under each medical Plan option using Preferred Providers, Marshall and Mia will pay:

	GOLD PLAN	BLUE PLAN
Annual medical Plan premium (not including any premium adjustment)	$2,865	$4,572
Participant's HSA contributions	$3,150	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: $4,200)	$3,900	$1,640
• Heart attack, bypass surgery – 4 days inpatient stay and inpatient surgery (estimated cost: $82,400)	$1,400	$1,860
• Prescriptions – 1 monthly generic retail (cholesterol), 1 monthly brand formulary retail (thyroid RBF, not preventive) (estimated cost: $744)	$205	$152
HSA account reimbursement of participant contributions	-$3,150	N/A
ARRC HSA contribution	-$1,000	N/A
TOTAL ANNUAL COST	**$7,370**	**$8,224**

Meet the Smiths — You + 2 or more dependents

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

Each person gets an annual checkup. The youngest child will have two urgent care visits for ear infections. The family will need four prescriptions this year, which they'll fill through mail-order service.

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

	GOLD PLAN	BLUE PLAN
Annual medical Plan premium (includes Blue Plan premium adjustment)	$3,572	$5,821
Participant's HSA contributions	$2,000	N/A
Out-of-pocket costs:		
• Annual exams – 4 preventive (estimated cost: $800)	$0	$0
• Prenatal care – 6 doctor visits (estimated cost per visit: $180)	$1,080	$1,016
• Urgent care – 2 visits (estimated cost: $419)	$419	$419
• Hospital stays – 2 days (estimated cost: $27,000)	$3,500	$2,004
• Prescriptions – 4 monthly generic mail order; 2 preventive, 2 not (estimated cost: $1,440)	$720	$480
HSA account reimbursement of participant contributions	-$2,000	N/A
ARRC HSA contribution	-$1,500	N/A
TOTAL ANNUAL COST	**$7,791**	**$9,740**

IMPORTANT TAX FORMS

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

If you're enrolled in one of the Gold Plans and have a Health Savings Account (HSA), ConnectYourCare (CYC), the HSA administrator, will send you one or two additional forms. You must file HSA-related Form 8889 with your tax return.

FEDERAL TAX FORM	WHAT IT'S FOR	FILE IT?	GOLD PLANS	BLUE PLANS
1095-C	ARRC will send to you; shows you worked full time during the year, and were offered medical insurance.	No	✔	✔
5498-SA	CYC will send to you; shows all contributions made to your HSA during the year.	No	✔	
1099-SA	CYC will send to you; shows how much HSA money you spent during the year.	No	✔	
8889	**You must prepare and file** this form with information from forms 5498-SA and 1099-SA.	Yes	✔	

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 and more	Behavioral health	
		Infants under 3 months old with high fever or need immediate care	Fungal infections	Children over the age of 5	
AVERAGE COST PER VISIT					
$200	$200	$2,500	Blue/Blue Ess. $0 Gold/Gold Ess: $60	Blue/Blue Essentials $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 or Blue Essentials plan can use the Coalition Health Center, 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 and Fairbanks just a few miles from the rail yards, 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 and 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

What you will pay

The following Coalition Health Center costs apply to Anchorage and Fairbanks locations, and to both active and retired employees.

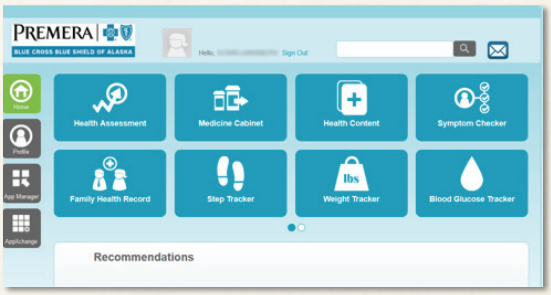
SERVICE	COST
Office visit	$20*
Generic drugs, labs and X-rays	$0
No-Show fee	$75*

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

ALL ABOARD PREMERA.COM

Register on Premera's website — **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 under Member Services



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. There are links to member discounts on products and services, and wellness tools and support.

Premera.com's many user-friendly features make staying up on your health and wellness easier than ever.

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.

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 YOUR COST	RAILROAD EMPLOYEES' NATIONAL DENTAL PLAN
You only	$5.84	$34.62
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 ARW-represented and UTU-represented • $2,850 TCU-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]	Employee	Twice (2 x) your basic annual pay, up to a maximum of $75,000.
AD&D[1]		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, 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	ARW	TCU	UTU
ARRC Pension Plan	Hire date	Hire date	Hire date
401(k) Tax Deferred Savings Plan	Hire date	After 182 cumulative calendar days of service	After 520 Subject-to-Retirement cumulative hours

RETIREMENT PLAN CONTRIBUTIONS

PLAN	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
	• **ARRC match:**
	  • ARW – 70% up to the first 5% of participant pay period compensation (equals 3.5% match)
	  • TCU – 66% up to the first 9% of participant pay period compensation (equals 5.94% match)
	  • UTU – No ARRC match
	• Vest in employer match at 10,400 STR[1] hours

1 STR = Subject-to-retirement hours.

ALASKA RAILROAD PENSION PLAN (ALL EMPLOYEES)

You must participate in and contribute to this Plan. The table above shows the eligibility dates for represented employees.

Employees that will participate in Tier 2 of the Pension Plan include:

- ARW and TCU employees hired for the first time on or after July 1, 2015
- UTU employees hired for the first time on or after March 4, 2016.

The Plan is a defined benefit Pension Plan that helps provide you with financial security in your retirement. If vested, you may receive a pension at retirement age.

Normal retirement age is 62 for Tier 1, and age 65 for Tier 2 participants; however, Tier 1 participants may retire at age 58 with early unreduced benefits. Tier 1 participants may retire at age 55 and Tier 2 participants at age 60 with reduced early retirement benefits.

Participants vest with five years of eligible vesting service. Survivor and disability benefits are available after you're vested.

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.

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 (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: RMD is 70½, if you turn 70½ on or before Dec. 31, 2019. RMD is 72 if you turn 70½ after Dec. 31, 2019.

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:

Atéssa Benefits, Inc.
ATTN: ARRC Pension Plan Administration
16959 Bernardo Center Drive, Suite 200
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 the annual IRS limits.

ARRC provides match contributions for ARW- and TCU- represented employees (UTU, no match).

There is a vesting period for the company match of 10,400 subject-to-retirement hours.

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 Plans.

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 services.

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

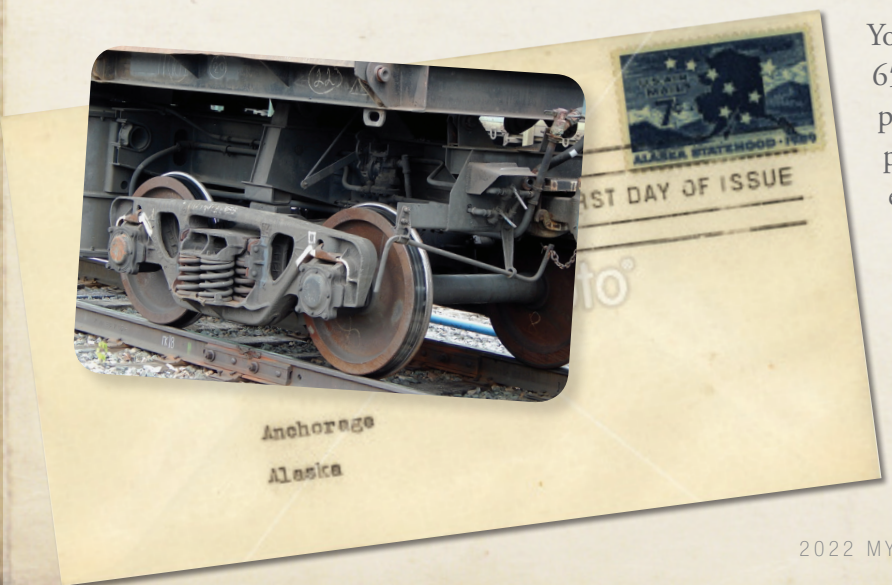
Retiree Medical Plan

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 ARW-represented employees hired before Nov. 4, 2014; to TCU-represented employees hired before April 2, 2015; and 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, or the date disability benefits start, to enroll in the Plan. Your election to decline retiree medical coverage is irrevocable.

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 if you chose a Gold Plan, but you can use any funds remaining in your HSA for medical expenses after you retire.

ARRC pays 40% of an ARW or TCU retiree's premium cost, starting at age 62. ARRC pays 40% of an UTU 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. 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. The Alaska Railroad has determined that the 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	**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	ARW and TCU - 240 hours UTU - 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.

LEGAL NOTICES

Alaska Railroad is required by federal law to provide benefit plan participants with certain legal notices each year. This document fulfills that obligation and does not require you to act, unless you wish to exercise one or more of the rights explained in this document. Please read this notice carefully and keep it where you can find it. If you have any questions regarding these legal notices, please contact Human Resources at 907-265-2220. This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year. Be sure you are reviewing an updated version of this important notices document. *This section was updated in October 2021.*

MID-YEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this Open Enrollment Window is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents outside of the annual Open Enrollment Window period, unless you have a Special Enrollment Event or a Mid-Year Change in Status Event as outlined below:

- ***Special Enrollment Event:***

  Loss of Other Coverage Event: 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 enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must **request enrollment within 31 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

  Marriage, Birth, Adoption Event: 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 31 days** after the marriage, birth, adoption, or placement for adoption.

  Medicaid/CHIP Event You and your eligible dependents may also enroll in this plan if you (or your dependents):

  - Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
  - Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within **60 days** after you (or your dependents) are determined to be eligible for such assistance.

  To request special enrollment or obtain more information, contact the ARRC Human Resources office at 907-265-2220.

- ***Mid-Year Change in Status Event:***

  Because you are paying for your benefits on a pre-tax basis we are required to follow Internal Revenue Service (IRS) regulations regarding when benefits can be changed in the middle of a plan year. The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

  - Change in legal marital status (e.g. marriage, divorce/legal separation, death).
  - Change in number or status of dependents (e.g. birth, adoption, death).
  - Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
  - Coverage of a child due to a QMCSO.
  - Entitlement or loss of entitlement to Medicare or Medicaid.
  - Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
  - Changes consistent with Special Enrollment rights.

  You must notify the plan in writing **within 31 days** of the mid-year change in status event by contacting the ARRC Human Resources office at 907-265-2220. The plan will determine if your change request is permitted and if so, changes become effective prospectively, on the first day of the pay period, following the approved change in status event (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

REMINDER: PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH HEALTH PLAN ENROLLEE

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: **http://www.socialsecurity.gov/online/ss-5.pdf**. Applying for a social security number is free. The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare and Medicaid (CMS) for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the ARRC Human Resources office at 907-265-2220.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

The plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this notice when you enroll in the plan. You can get another copy of this notice from the ARRC Human Resources office at 907-265-2220. It is also included with this document.

AVAILABILITY OF SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a **Summary of Benefits and Coverage (SBC)** to help you understand and compare medical plan benefits. The SBC summarizes and compares important information including, what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to benefits information displayed on an SBC.

To get a free copy of the most current SBC documents for our medical plan options, contact the ARRC Human Resources office at 907-265-2220 or you can find them at **https://insidetrack.akrr.com/benefits/health-insurance/medical-health-insurance**.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents 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.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayment and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by Alaska Railroad Corporation. For more information on WHCRA benefits, contact the ARRC Human Resources office at 907-265-2220.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP) and Direct Access to OB/GYN Providers:

The Blue Medical Plan and the Gold Medical Plan offered by ARRC do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any in-network (or non-network) health care provider; however, payment by the Plan may be less for the use of a non-network provider. To locate an in-network provider in the Alaska Heritage Network, visit **www.premera.com**.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional specializing in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology (OB/GYN), contact Premera at 800-508-4722. For other questions contact the ARRC Human Resources office at 907-265-2220.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan may pay for a shorter stay if the attending physician (e.g., physician, or health care practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the plan may not, under federal law, require that a physician or other health care practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Premera at 800-508-4722 to precertify the extended stay. If you have questions about this Notice, contact the ARRC Human Resources office at 907-265-2220.

KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

You or your Dependents must promptly furnish to the ARRC Human Resources office at 907-265-2220, information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan of any of these changes within 31 days. Note that for certain changes, like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Failure to give the ARRC Human Resources office at 907-265-2220 a timely notice of the above noted events may:

a. cause you, your spouse and/or dependent child(ren) to lose the right to obtain COBRA Continuation Coverage.
b. cause the coverage of a dependent child to end when it otherwise might continue because of a disability.
c. cause claims to not be considered for payment until eligibility issues have been resolved.
d. result in your liability to repay the Plan if any benefits are paid on behalf of, or to, an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical dental, and/or vision benefits

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility for benefits, contact the ARRC Human Resources office at 907-265-2220

ADDITIONAL IMPORTANT NOTICES INCLUDED IN THIS SECTION

The following pages include important notices for you and your family:

- Health Insurance Marketplace Notice
- Medicare Part D Notice
- HIPAA Privacy Notice
- Notice about Premium Assistance with Medicaid and CHIP
- Paperwork Reduction Act Statement
- COBRA Continuation Coverage Rights

EMPLOYER NOTICE ABOUT THE HEALTH INSURANCE MARKETPLACE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there were new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, **you will not be eligible** for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **ARRC Human Resources at 907-265-2220 or Premera's Customer Service at 800-508-4722**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] *An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.*

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: **Alaska Railroad Corporation**		4. Employer Identification Number (EIN): **92-0020624**
5. Employer address: **327 West Ship Creek Avenue**		6. Employer phone number: **907-265-2220**
7. City: **Anchorage**	8. State: **AK**	9. ZIP code: **99501**
10. Who can we contact about employee health coverage at this job?: **Michael Humphrey**		
11. Phone number (if different from above): **907-265-2220**		12. Email address: **humphreym@akrr.com**

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs. 5705338v1/14128.007

MEDICARE PART D NOTICE

MEDICARE CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by ARRC are creditable, you should review the Plan's Medicare Part D Notice of Creditable Coverage available from ARRC and located within this enrollment notice document (below).

THIS INFORMATION DOES NOT APPLY TO RETIREES AND DEPENDENTS WHO ARE COVERED UNDER A MEDICARE ADVANTAGE PLAN

IMPORTANT NOTICE FROM ARRC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

This notice is for people with Medicare. Please read this notice carefully and keep it where you can find it.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. You should read this Notice. It is your responsibility to share this notice with any dependents who may qualify for Medicare.

This notice has information about your current prescription drug coverage with Alaska Railroad Corporation 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. **Alaska Railroad Corporation has determined that the prescription drug coverage is "creditable" in these medical plans: Blue Medical Plan, Gold Medical Plan and the Alaska Heritage Select Medical Plans, sponsored by the Alaska Railroad Corporation.** "Creditable" means that the value of the Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay. Because ARRC medical plan 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.
   IMPORTANT NOTE: If enrolled in a High Deductible Health (HDHP) Plan with a Health Savings Account (HSA), **contributions may not be made to a health savings account** once you are enrolled in Medicare, including being enrolled in a Medicare Part D drug plan.

When Can You Join a Medicare Drug Plan?

The enrollment window for Medicare Part D runs from October 15 to December 7. 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 Alaska Railroad Corporation coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. However, if you enroll in Part D coverage, the Alaska Railroad Corporation will not receive a subsidy toward the cost of your prescription drug costs.

If you do decide to join a Medicare drug plan and drop your current Alaska Railroad Corporation coverage, be aware that you and your dependents will not be able to get this coverage back. Note that you would have to drop your entire ARRC medical plan coverage, which pays for other health expenses, in order to drop ARRC prescription drug coverage.

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 Alaska Railroad Corporation 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 below 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 Alaska Railroad Corporation 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 **800-MEDICARE (800-633-4227)**. TTY users should call **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 **800-772-1213 (TTY 800-325-0778)**.

Remember: Keep this Creditable Coverage 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).

For more information about this notice or your current prescription drug coverage contact:

Contact – Position: **Michael Humphrey** ***Manage of Benefits & Records*** **Alaska Railroad Corporation** 327 W. Ship Creek Avenue PO Box 107500 Anchorage, AK 99510-7500 Phone Number: 907-265-2220 Email: **humphreym@akrr.com**	**Alternative Contact – Position:** **Theresa MacLeod** ***Manager of Retirement Plans*** **Alaska Railroad Corporation** 327 W. Ship Creek Avenue PO Box 107500 Anchorage, AK 99510-7500 Phone Number: 907-265-2220 Email: **macleodt@akrr.com**

As in all cases, ARRC reserves the right to modify benefits at any time, in accordance with applicable law. This document is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

NOTICE OF PRIVACY PRACTICES—ARRC GROUP HEALTH PLAN BENEFITS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to the Group Health Plan benefits provided under:

- The Alaska Railroad Corporation Welfare Benefits Plan
- The Alaska Railroad Corporation Retiree Benefits Plan

These benefits currently include medical and prescription drug benefits for active employees and retirees; dental, vision, employee assistance, COBRA administration, Health Savings Account administration and health care flexible spending account benefits for active employees.

You are receiving this Notice from the Group Health Plan Benefits of the Plan described above, which is sponsored by Alaska Railroad Corporation (ARRC).

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. HIPAA gives you significant rights to understand and control how your health information is used, and provides penalties for covered entities that misuse personal health information. As required by regulations under HIPAA (the "HIPAA Privacy Rule"), we have prepared this explanation of how we will maintain the privacy of your health information and how we may use and disclose your health information. This Notice pertains to you and your covered dependents. Please share it with them.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Group Health Plan protects and holds confidential information that relates (1) to your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for your health care. For example, we create a record of the health care claims reimbursed under the Group Health Plan for Plan administration purposes. This Notice applies to all of the medical records we create, maintain, receive, use, transmit, or disclose. Such information is PHI during your lifetime and remains PHI for a period of 50 years after your death. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

The HIPAA Privacy Rule requires that we protect the privacy of medical information that identifies a participant, or where there is a reasonable basis to believe the information can be used to identify a participant. This information is called "protected health information" or "PHI." This Notice describes your rights as a Group Health Plan participant and our obligations regarding the use and disclosure of PHI. We are required by law to:

- maintain the privacy of your PHI;
- provide you with certain rights with respect to your PHI;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that is in effect.

In some situations, federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose specially protected PHI. In these situations, we will contact you for the necessary authorization.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you as well as any information we receive in the future. If and when a significant change is made, we will provide you with the new Notice either (1) within 60 days from the change; or (2) by prominently posting the new Privacy Notice on the ARRC Intranet at insidetrack.akrr.com and then providing a hard copy of the new Privacy Notice in our next annual mailing to you.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

Under the law, we may use or disclose your PHI without your specific authorization for the purposes described below. All other uses and disclosures of PHI about you will only be made with your written permission (an "Authorization"). If you have given us written permission to use or disclose your PHI, you may take back ("revoke") your written permission at any time, except to the extent that we have already acted based on your permission. The examples that may be included in each category do not list every type of use or disclosure that fall within that category.

USES AND DISCLOSURES NOT REQUIRING AN AUTHORIZATION FROM YOU:

For Payment. We may use or disclose your PHI for payment purposes, including to determine eligibility for Group Health Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Group Health Plan, or to coordinate Group Health Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Group Health Plan will cover the treatment. We may also share medical information with a utilization review or pre- certification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your PHI for other Group Health Plan operations. These uses and disclosures are necessary to run the Group Health Plan. For example, we may use medical information in connection with:

- conducting quality assessment and improvement activities;
- underwriting, premium rating, and other activities relating to Group Health Plan coverage;
- submitting claims for stop-loss (or excess loss) coverage;
- conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs;
- business planning and development such as cost management; and
- business management and general plan administrative activities, including customer service and the resolution of internal grievances.

However, the Group Health Plan will never use or disclose your genetic information for underwriting purposes.

To Business Associates. We may contract with third parties known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Subcontractors of these third parties also may be our Business Associates in certain cases. Business Associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. In addition, Business Associates are directly subject to many of the provisions of HIPAA which protect the privacy and security of protected health information.

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

Disclosure to the Plan Sponsor. For the purpose of administering the Plan, we may disclose your PHI to certain employees of Alaska Railroad Corporation. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific Authorization.

Organ and Tissue Donation. If you are an organ donor, we may use or disclose PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate an organ, eye, or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may disclose PHI about you as required by military command authorities.

Workers' Compensation. We may disclose PHI about you for workers' compensation or similar programs. These programs **provide benefits for work-related injuries or illnesses.**

Public Health Risks. We may use and disclose PHI about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births or deaths;
- to report child, abuse or neglect;
- to report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
- to locate and notify persons of recalls of products they may be using;
- to notify a person who may have been exposed to a communicable disease in order to control whom may be at risk of contracting or spreading the disease; or
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

We will only make this disclosure if you agree or when required or authorized by law.

Health Research. We are allowed to use or share your PHI in ways that contribute to the public good, such as health research.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government health care programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may use and disclose your PHI if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime, the location of a crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are under the custody of a law enforcement official, we may disclose your PHI to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Where Required by the HIPAA Privacy Rule. We are required to disclose PHI to the Secretary of the Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.

Minimum Necessary Standard. To the extent possible, when using or disclosing your PHI or when requesting your PHI from another organization subject to HIPAA, we will not use, disclose, or request more than the minimum amount of your PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply to:

- disclosures to or requests by a health care provider for treatment;
- uses by you or disclosures to you of your own protected health information;
- disclosures made to the Secretary of the Department of Health and Human Services;
- uses or disclosures that may be required by law;
- uses or disclosures that are required by the Plan's compliance with legal regulations; and
- uses and disclosures for which the Plan has obtained your authorization.

Personal Representatives and Family Members

Personal Representatives. The Group Health Plan will disclose your PHI to individuals who are your personal representatives under state law. For example, the Group Health Plan will disclose PHI of minor children to the parents of such children. The Group Health Plan will also disclose your PHI to other persons authorized by you in writing to receive your PHI, such as your representative under a medical power of attorney, as long as we are provided with a written notice/ authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA Privacy Rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse, or neglect by such person;
- treating such person as your personal representative could endanger you; or
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Family Members. Unless otherwise allowed by the HIPAA rules, the Group Health Plan will not orally disclose your PHI to your spouse or to your parent (if you are an adult child), unless you have agreed to such disclosure. However, with only limited exceptions, the Group Health Plan will send all mail to the employee. This includes mail relating to the employee's family members (spouse and children (including adult children)) who are covered under the Group Health Plan, and includes mail with information on the use of the Group Health Plan's benefits by the employee's family members and information on the denial of any of the Group Health Plan benefits to the employee's family members. If a person covered under the Group Health Plan requests restrictions on uses / disclosures of PHI (see Right to Request Restrictions below under "Your Rights Regarding Your PHI"), and if the Group Health Plan has agreed to the request, the Group Health Plan will send mail as provided by the request.

Upon your death, the Group Health Plan may disclose your PHI to a family member (or other relative or close friend) involved in your health care or payment for your health care prior to your death, to the extent the PHI is relevant to such person's involvement, unless such disclosure is inconsistent with your prior expressed preference that is known to the Group Health Plan.

YOUR RIGHTS REGARDING YOUR PHI Under federal law, you have the following rights regarding PHI about you:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your health care benefits. To inspect and copy your PHI, you must submit your request in writing to the individual identified in the Contact Information section below. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for the copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual identified in the Contact Information section below.

If the information you request is maintained electronically, and you request an electronic copy, the Group Health Plan will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that electronic form and format, we will work with you to come to an agreement on another electronic form and format. If we cannot agree on an electronic form and format, the Group Health Plan will provide you with a paper copy.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Group Health Plan. To request an amendment, your request must be made in writing and submitted to the individual identified in the Contact Information section below. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment, but we will provide a written explanation within 60 days. For example, we may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Group Health Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to Receive an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures that we have made of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your Authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the individual identified in the Contact Information section below. Your request must state a time period which may not be longer than six years prior to the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we may use for payment and health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request except in limited circumstances. We will agree to your request if the PHI pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full. In other instances, such as where your care would be affected, we are not required to agree to your request.

If we do agree to your request, we are required to comply with our agreement, except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to the individual identified in the Contact Information section below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Receive Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the individual identified in the Contact Information section below. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Share Certain Health Information. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the following situations, tell us what you want us to do and we will follow your instructions:

- share information with your family, close friends, or others involved in payment for your care;
- share information in a disaster relief situation.

We will never share your PHI for marketing purposes or sell your PHI unless you give us written permission.

Breach Notification. If and when required by HIPAA, we will notify you of a breach of the HIPAA privacy rules which involves your PHI considered to be "unsecure" under applicable HIPAA regulations. If HIPAA requires us to send you a notice, the notice will contain:

- a description of the breach;
- the type of PHI that was breached;
- what steps you could take to protect yourself from potential harm;
- what steps we are taking to investigate the breach, mitigate harm, and protect from further breaches; and
- who to contact for additional information.

Right to a Paper Copy of this Notice. You have a right to receive a paper copy of this Notice. You may ask us for a copy of this Notice at any time. Even if you agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice on the ARRC Intranet at **http://insidetrack.akrr.com/web/HR/Benefits/ARRC_Required_Notices_vF_10242016.pdf**. To obtain a paper copy of this Notice, contact the individual identified in the Contact Information section below.

COMPLAINTS

If you believe your privacy rights have been violated, or if you disagree with a decision we made about a request, you may file a written complaint with the Group Health Plan or with the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Group Health Plan, please direct your complaint to the individual identified in the Contact Information section below. All complaints must be submitted in writing. Alternatively, you may file a complaint with the Office for Civil Rights, by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20211, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized, or in any other way retaliated against, for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written Authorization. However, we are unable to take back any disclosures we have already made with your permission.

PRIVACY OFFICIAL CONTACT INFORMATION

If you have any questions about this Notice or wish to exercise the rights described in this Notice, please contact the **Privacy Official** at the address and telephone number listed below. The Privacy Official may require that any request be made in writing.

Michael Humphrey Manager, Benefits & Records 907-265-2220
Alaska Railroad Corporation, 327 W. Ship Creek Avenue, Anchorage, AK 99510-7500

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or **call 1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility:

ALABAMA – Medicaid
http://myalhipp.com
1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program:
http://myakhipp.com
1-866-251-4861 or Email CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
http://myarhipp.com
1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurnce Premium Payment (HIPP) Program:
http://dhcs.ca.gov/hipp
916-445-8322 or Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado: **https://www.healthfirstcolorado.com**
1-800-221-3943 / State Relay 711
Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance- buy-program**
1-855-692-6442

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com
1-877-357-3268

GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19–64
http://www.in.gov/fssa/hip
1-877-438-4479
All other Medicaid: **http://www.indianamedicaid.com**
1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid: **https://dhs.iowa.gov/ime/members**
1-800-257-8563
Hawki: **http://dhs.iowa.gov/Hawki**
1-800-257-8563
HIPP: **https://dhs.iowa.gov/ime/members/medicaid-a- to-z/hipp**
1-888-346-9562

KANSAS – Medicaid
https://www.kancare.ks.gov/
1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1-855-459-6328 or Email KIHIPP.PROGRAM@ky.gov
KCHIP: **https://kidshealth.ky.gov/Pages/index.aspx**
1-877-524-4718
Kentucky Medicaid: **https://chfs.ky.gov**

LOUISIANA – Medicaid
https://www.medicaid.la.gov or www.ldh.la.gov/lahipp
Medicaid hotline: 1-888-342-6207 or *LaHIPP:* 1-855-618-5488)

MAINE – Medicaid and ME HIPP
https://www.maine.gov/dhhs/ofi/applications-forms
Medicaid: 1-800-442-6003 or TTY: Maine relay 711
HIPP: 1-800-977-6740 or TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium- assistance-pa
1-800-862-4840

MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
and
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other- insurance.jsp
1-800-657-3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
1-855-632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
https://dwss.nv.gov
1-800-992-0900

NEW HAMPSHIRE – Medicaid
Medicaid: **https://www.dhhs.nh.gov/oii/hipp.htm**
Medicaid: 603-271-5218
HIPP: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
609-631-2392
CHIP: **http://www.njfamilycare.org/index.html**
1-800-701-0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid
1-800-541-2831

NORTH CAROLINA – Medicaid
Medicaid: **https://medicaid.ncdhhs.gov/**
919-855-4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid
1-844-854-4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
1-888-365-3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
1-800-699-9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/
HIPP- Program.aspx
1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov
1-855-697-4347or *Direct RIte Share Line* 401-462-0311

SOUTH CAROLINA – Medicaid
https://www.scdhhs.gov
1-888-549-0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
1-888-828-0059

TEXAS – Medicaid
http://gethipptexas.com
1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid: **https://medicaid.utah.gov**
CHIP: **http://health.utah.gov/chip**
1-877-543-7669

VERMONT– Medicaid
http://www.greenmountaincare.org
1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid: **https://www.coverva.org/en/famis-select**
CHIP: **https://www.coverva.org/en/hipp**
1-800-432-5924

WASHINGTON – Medicaid
https://www.hca.wa.gov/
1-800-562-3022

WEST VIRGINIA – Medicaid
http://mywvhipp.com
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/
programs-and-eligibility/
1-800-251-1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ***ebsa.opr@dol.gov*** *and reference the OMB Control Number 1210-0137.*

OMB Control Number 1210-0137 (expires 1/31/2023

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

This notice pertains to those with coverage under a group health plan (the Plan) and has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice **explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

For more information about your coverage offered by your employer, please check your summary plan description or contact ARRC Human COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Employee. An employee becomes a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Spouse. An employee's spouse becomes a qualified beneficiary if you lose coverage under the Plan because of the following qualifying events::

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Dependents. Dependent children become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events::

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Alaska Railroad Corporation, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Alaska Railroad Human Resources Office.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage.

Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan)

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

What if I have more COBRA-related questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa** (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

For more information about the Marketplace, visit **www.HealthCare.gov**.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Direct your questions about the ARRC Plan to.

Michael Humphrey Manager, Benefits & Records
Alaska Railroad Corporation, 327 W. Ship Creek Avenue, Anchorage, AK 99510-7500
907-265-2220

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

How to Enroll

You may submit your Benefits Enrollment Information/Election Form and FSA Enrollment Form one of four ways:

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

Benefits Directory

SERVICE	ADMINISTRATOR	WEBSITE/EMAIL	PHONE
ARRC Health Plan, Group 1038789 (Medical; prescription drug, including mail order; dental; vision; and hearing)	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
National Dental Plan Group 12000 (represented employees)	Aetna for National Railway Labor Conference	**Aetnanavigator.com**	877-277-3368
Employee Assistance Program (EAP)	ComPsych	**GuidanceResources.com**	833-306-0101
Flexible Spending or Health Savings Accounts	Premera/CYC	**Premera.com**	800-941-6121
Life insurance	Hartford Life Insurance Co.	**HRBenefits@akrr.com**	907-265-2220
Pension Plan	Atéssa Benefits, Inc.	**Myatessa.com**	888-309-0041
401(k) Savings Plan 090587	Empower	**Empower.com**	800-232-0859
457 Deferred Compensation Plan 078043			
Customer service or any benefit enrollment for ARRC employees	ARRC Human Resources	**HRBenefits@akrr.com**	907-265-2220