UKPEAĠVIK IÑUPIAT CORPORATION

2022 SCA EMPLOYEE BENEFITS GUIDE

Eligibility Information | Medical & Pharmacy | Dental & Vision | Life & Disability
Flexible Spending Account | 401(k) | Employee Assistance Program

CONTENT

OUR IÑUPIAT VALUES

As an Alaska Native Village Corporation, we incorporate the traditions of our ancestors into our daily practices. The traditional Iñupiat values are core to our business practices and guide our decisions.

- Compassion
- Resolution of Conflict
- Love & Respect for Elders
- Love & Respect One Another
- Cooperation
- Humor
- Sharing
- Family & Kinship
- Knowledge of Language
- Hunting Traditions
- Respect for Nature
- Humility
- Spirituality

Medicare Part D Notice: 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. Please see the Annual Notices for more details.

WELCOME TO YOUR BENEFITS

In a world where "we offer competitive pay and benefits" is a common expression, UIC believes our employees deserve better and strives for superior design, quality, and delivery to differentiate us from the pack. Our benefits are designed to not only be competitive, but to help you be your best at work and in your personal life.

Your health benefits focus on wellness to help you and your loved ones maintain good health, but when accidents or ailments strike, they provide excellent financial protection. Our life and disability insurance benefits help secure income for you and your family in the event of disability or worse. For those of you who don't want to work forever, our 401(k) plan, which provides a dollar-for-dollar match (up to 3%), is a powerful vehicle for helping you achieve your wealth goals at retirement.

We recognize that one size rarely fits all, and you will find "choice" a prevalent theme in our benefit offerings. Employees have the opportunity to choose from three medical plans, two dental plans, a vision plan, supplemental life insurance, and a choice between a traditional and a Roth 401(k) savings plan. These are just a few of the many choices you have to tailor your UIC benefits to your needs.

The providers we use to deliver our benefit plans are widely recognized and have met UIC's high standards for performance and value. We expect the very best from the providers we have selected to deliver your benefits.

If at any time you need assistance with your benefits, your company's Human Resources benefits representative is here to help.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

You are eligible for most UIC benefits on the first of the month following your date of hire, or on your hire date if it coincides with the first day of the month, and you are a full-time employee scheduled to work a minimum of 30 hours per week. Benefits eligibility can vary somewhat from benefit to benefit, and we encourage you to consult the summary plan description (SPD) for a particular benefit for more detailed information. In order to comply with the Affordable Care Act (ACA), UIC determines your eligibility for benefits using the Look Back Measurement Method. Refer to the Look Back Measurement Method section of this guide for additional information on how your eligibility is determined.

DEPENDENT ELIGIBILITY

You have the option of enrolling your eligible dependents in the same plans you choose for yourself. You may enroll your dependents in benefits as a newly hired employee, or during the annual open enrollment period. Otherwise, the only time you may add or drop a dependent from coverage is within 30 days of a qualified life event. Eligible dependents include your legal spouse, your children, your step-children, and/or legally adopted children up to age 26. It is also your responsibility to ensure that ONLY eligible dependents are enrolled to control plan costs and to comply with company policy; and will be subject to verification.

WHEN TO ENROLL

You can enroll in coverage within 30 days of your date of hire (first day worked) or during the annual Open Enrollment period. Benefit elections will take effect on the first of the month following your date of hire. If you do not enroll in benefits within 30 days from your hire date, you will not receive coverage during this plan year and will not have the opportunity to enroll until the next open enrollment, unless you experience a qualified change in family status (see “Mid-Year Changes” for details).

HOW TO ENROLL

To enroll in benefits, you will log into the Human Capital Management (UKG) system. Directions on how to login to the UKG are sent to every newly hired employee in an email in the first few days of employment.

Additionally, your local HR Representative will review how to login to the UKG during your new hire orientation. If you are unable to use a computer, please contact your local HR Representative for assistance in benefit enrollment.

MID-YEAR CHANGES

The choices you make when you first become eligible as a newly hired employee remain in effect for the remainder of the plan year, which begins on January 1, 2022 and ends on December 31, 2022.

Once you are enrolled, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents unless you have a qualified change in family status as defined by the IRS. Examples of a qualifying life event include, but are not limited to, the following:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Change in your workplace (if your benefit options change)
- Loss of other health coverage
- Change in your dependent’s eligibility status because of marriage, age, etc.

You have 30 days from your qualifying life event to make changes to your coverage. Note: Any change you make to your coverage must be consistent with the change in status.

Please note: Any missed benefit deductions may be caught up on a later pay date to recover the full premium amount

LOOK BACK MEASUREMENT METHOD

You and your dependents are eligible for the medical plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. ACA full-time status can affect or determine medical benefits eligibility but is not a guarantee of benefits eligibility. UIC uses the Look-Back Measurement Method to determine whether an employee meets this eligibility threshold.

NEW EMPLOYEES

If you are a new employee hired to work at least 30 hours a week/130 hours a month, you will be offered medical benefits on the first of the month following your date of hire, or on your hire date if it coincides with the first day of the month.

If—as of your date of hire—UIC is unable to determine that you are a full-time employee, you will not be offered medical benefits immediately. Instead, you will be placed into an Initial Measurement Period; a 12-month period to determine whether you are a full-time employee and eligible for benefits. Employees hired with the following schedules will be placed into an Initial Measurement Period, including those hired into a:

- Part-time position
- Position where hours vary and UIC is unable to determine whether you will work on average 130 or more hours a month
- Seasonal position where you are expected to work for six (6) consecutive months or less (regardless of monthly hours worked)

Your 12-month Initial Measurement Period will begin on the first of the month following your date of hire and will last for 12 months. If, during your Initial Measurement Period, you average 130 or more hours a month over that 12 months period, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your Initial Measurement Period ends. Your full-time status will remain in effect during an associated stability period that will last 12 months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES

UIC uses the look-back measurement method to determine medical plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire Standard Measurement Period. A Standard Measurement Period is the 12-month period of time over which UIC counts employee hours to determine which employees work full-time.

An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full-time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period, which is the same as our plan year.

Full-time status will be in effect for the 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered coverage under COBRA. UIC uses the Standard Measurement Period and associated Stability Period annual cycle outlined below.

Measurement Period Time to determine if you work 130+ hours per month on average – used to establish if you are “full-time” or “part-time” for medical eligibility	Nov 1 – Oct 31
Stability Period Time during which you will be considered “full-time” or “part-time” for medical plan eligibility - based on hours worked during preceding Measurement Period	Jan 1 – Dec 31

MEDICAL COVERAGE

PREMERA BLUE CROSS BLUE SHIELD

Nothing is more important than the health of you and your family, which is why UIC offers you three comprehensive medical plan choices through Premera Blue Cross Blue Shield of Alaska that are designed to help you get the care you need at a price that works with your budget. All three plans are Consumer-Driven Health Plans (CDHP) which give you, the consumer, the means to manage your own health care.

Employees are equipped to make informed medical decisions under these plans while continuing to enjoy access to the preferred provider network of medical providers. From finding a doctor, reviewing cost estimates, to managing claim balances, Premera Blue Cross Blue Shield provides the means to be an informed consumer. Premera Blue Cross Blue Shield is a leading healthcare provider and offers robust tools to aid in making decisions that empower you to actively manage your health.

All three plans include a Consumer-Driven Health Plan (CDHP) component through either a Health Reimbursement Account (HRA) or a Health Savings Account (HSA).

A Consumer-Driven Health Plan (CDHP) is the combination of a High Deductible Health Plan (HDHP) paired with a healthcare account (Health Savings Account or a Health Reimbursement Account). A CDHP has a healthcare account (HSA or HRA) that encourages more informed choices; without a healthcare account a high-deductible health plan is just an HDHP.

HOW THE CDHP WORKS

The Consumer-Driven Health Plans arm employees to select medical services based on best value. A central feature of Consumer-Driven Health Plans is that participants are provided with a funding tool (a Health Reimbursement Account (HRA) or a Health Savings Account (HSA)- more on these later) that they decide how to apply toward medical expenses. The deductibles under a Consumer-Driven Health Plan are higher than a traditional plan because of these funding options. Once the deductible is met, a Consumer-Driven Health Plan works like a traditional PPO plan, with a participant coinsurance share up to the out-of-pocket maximum which provides participants with financial protection in the event of large claims.

Because Consumer-Driven Health Plans provide participants with the means and benefits of making wise health care choices, costs go down while receiving the same or even higher quality of health care. That means we are able to offer these plans with much lower premiums than traditional plans.

If your HRA/HSA has money left over at the end of the plan year, it rolls over into the next year and is added to any UIC contribution for that year. There is no limit on the amount that can accumulate in your account.

If you use all the money in your HRA/HSA, you are responsible for the remaining portion of the deductible before the plan's coinsurance begins paying benefits. If you leave the company, the money in your HRA stays with UIC unless you elect COBRA; however, the money in your HSA will remain in the account, which you take with you.

Please note, if you move from the CDHP + HRA Plan to one of the HSA qualified plans, your HRA funds will not rollover into an HSA. Similarly, if you switch from the CDHP + HSA Plan to the HRA plan, your HSA funds will not rollover into your HRA account but your HSA account will remain active and could be used for future claims.

Unlike a traditional PPO plan, you will not pay anything at the time of service. Once your claim has been processed, you will receive an explanation of benefits that will list your payment responsibility.

MEDICAL COVERAGE

PREMERA BLUE CROSS BLUE SHIELD

ANNUAL UIC CONTRIBUTIONS

Annual UIC Contribution To The CDHP + HRA Plan:	
Employee Only Coverage	$750
Employee and Dependent(s)	$1,500

PHASE 1: 50% of your annual contribution will be made available beginning January 1, 2022 or upon entry in the plan.

PHASE 2: An additional 50% of your annual contribution will be made available within 60 days of completing the wellness initiatives.

Note: If you enroll in the plan after the plan year begins, your HRA allocation will be prorated.

- HRA funds are used before you pay anything out-of-pocket and counts toward the deductible.
- If you are covering one or more dependents, the entire UIC contribution is available to any family member with covered expenses.
- You do not need to do anything special when you receive medical care. Simply present your ID card and your provider will bill your insurance. The plan will automatically use funds from your HRA to pay for any covered expense until those funds are exhausted. If your HRA funds are exhausted you will receive a bill for the balance you owe.
- Unused amounts carry forward and are added to the annual UIC contribution to your HRA.

Annual UIC Contribution To The CDHP + HSA Plan:	
Employee Only Coverage	$750
Employee and Dependent(s)	$1,500

PHASE 1: 50% of your annual contribution will be incrementally funded during the remainder of the plan year through payroll.

PHASE 2: An additional 50% of your annual contribution will be deposited within 60 days of completing the wellness initiatives.

INCENTIVE FUNDS

Current employees are eligible to receive a $375/$750 contribution towards their HSA or HRA. The health of our employees is extremely important to UIC and maintaining an active lifestyle is imperative; therefore, UIC is offering a monetary incentive to get moving and to complete an online health assessment OR receive a preventive service in 2022. In order to receive funding, you and your spouse will need to complete a minimum level of physical activity or receive a preventative service along with completing the health assessment questionnaire. Please contact your HR representative with any questions. The program begins on January 1, 2022 and will be open to eligible employees at that time.

HIGH DEDUCTIBLE BASIC PLAN

In order to provide the most affordable comprehensive health plan for you and your family, we are offering you the opportunity to enroll on the High Deductible Basic Plan. While this plan does not include an employer contribution to an HSA, you have the option of taking advantage of tax savings by contributing to an HSA Bank account via pretax payroll deductions.

HEALTH SAVINGS ACCOUNT

If you enroll in the tax-qualified CDHP + HSA plan or High Deductible Basic plan, you may be eligible to open and contribute pre-tax dollars into a personal Health Savings Account (HSA) through HSA Bank. Any funds you don't use accumulate for the next year and will grow the account for future medical expenses. There is no "use it or lose it" rule. The money is yours to take with you should you change your health plan or terminate your employment.

USING YOUR HSA

You have the choice to use HSA funds to immediately pay for claims or leave the HSA funds in the account and pay out of pocket for claims.

If you are covering one or more dependents, the entire HSA balance is available to any dependent as eligible under IRS regulations.

You can contribute your own funds to the HSA on a pre-tax basis through payroll deductions or on a post-tax basis outside of payroll deductions.

The total HSA contributions are subject to IRS limits, which for 2022 are $3,650 for employee only coverage and $7,300 for employee and dependent coverage. For members over age 55, you may contribute an additional $1,000.

Unused amounts carry forward and if you were to leave the company, you take the balance with you.

You do not need to do anything special when you receive medical care. Simply present your ID card and your provider will bill your insurance. You will be responsible for your share of the negotiated fees (i.e. coinsurance, or any remaining portion of the deductible). You will receive an Explanation of Benefits (EOB) informing you of your balance to be paid and you have the choice to use your HSA funds to pay for any covered expense until those funds are exhausted.

Note: Your HSA account is through HSA Bank. If you enroll in the plan after the plan year begins, your HSA allocation will be prorated.

HSA BANK MOBILE APP

To get started, follow these three simple steps:

1. Create your username and password to register on the member Website
2. Download HSA Bank Mobile at Google Play or the App Store
3. Log in to HSA Bank Mobile to start managing your account on the go

2022 IRS Maximums

The 2022 IRS maximum HSA annual contribution amounts:

$3,650 for individual coverage only
$7,300 for family coverage

If you are over age 55 or if you turn 55 during 2022, you are eligible to contribute an additional annual catch-up contribution in the amount of $1,000.

HEALTH SAVINGS ACCOUNT

REASONS TO ENROLL IN THE CDHP + HSA PLAN OR THE HIGH DEDUCTIBLE BASIC PLAN:

- Your contributions are automatically deducted from your paycheck on a pre-tax basis each month and deposited in your HSA at HSA Bank
- You can change the amount you are contributing to your HSA at anytime
- You will pay much lower monthly premiums for these plans than you pay for the CDHP + HRA plan
- You can use the money in your HSA to pay for qualified medical expenses, such as amounts that apply toward your deductibles and coinsurance percentages for medical and dental care
- These plans offer comprehensive preventive care benefits, covered in full, with no deductible for in-network providers

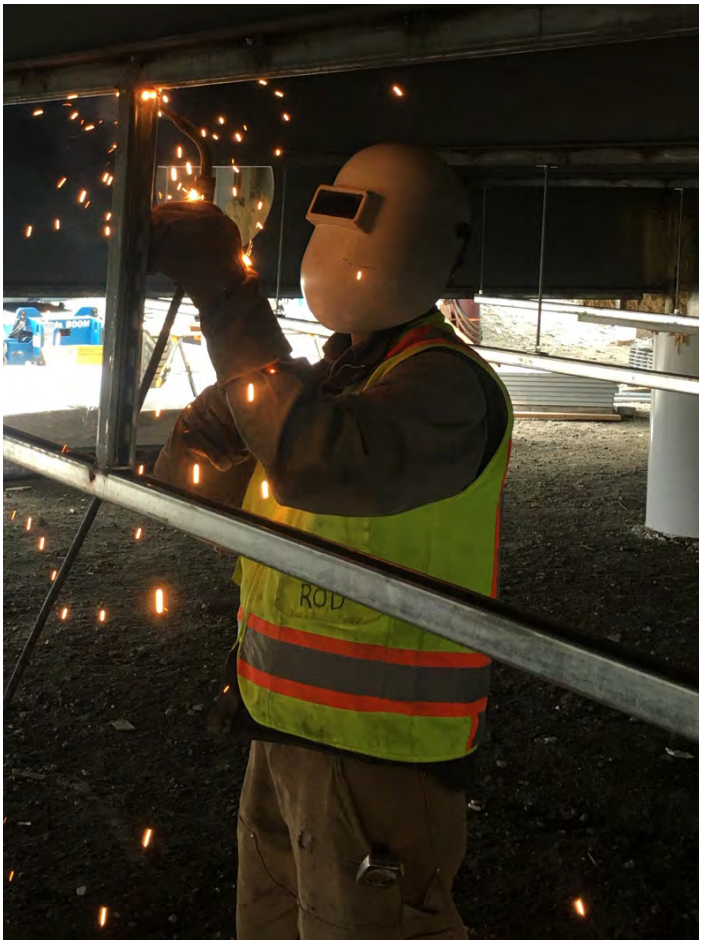
Once you have determined if one of these plans is right for you, you will need to determine if you are eligible to contribute to an HSA account. You are eligible to open an HSA if you meet the requirements defined by the IRS below:

- You are enrolled in a qualified High Deductible Health Plan (HDHP) that meets IRS requirements (our CDHP + HSA and High Deductible Plan meet these requirements)
- You are not covered under any other first dollar medical coverage including your spouse's full purpose Health Flexible Spending Account
- You are not claimed as a dependent on another individual's tax return
- You are not enrolled in Medicare
- You haven't utilized Indian Health Services (IHS) benefits within the last three months

TAKE AN ACTIVE ROLE IN YOUR HEALTH & CONTROL YOUR HEALTHCARE COSTS

Shop around. Talk with others. As someone involved in making the best healthcare choices for yourself and your loved ones, it pays to become a more engaged healthcare consumer. Here are some tips to help you take full advantage of your plan benefits:

- Know how to use the plan and find in-network providers that not only save you money, but also help control the overall costs of your medical plan.
- Be selective in using the appropriate network facilities; emergency room visits for non-critical situations such as sinus infections, colds and headaches are very costly.
- Talk to your doctor about the prescription drugs he/she is prescribing and ask if you can use a lower cost alternative. It is up to you to talk to your doctor about which prescriptions would work best for you.



CDHP AT A GLANCE

PART 1: ANNUAL UIC CONTRIBUTION

UIC contributes money to your HRA or HSA each year you participate in the Consumer-Driven Health Plan. This money is used first to pay for eligible, non-preventive medical expenses during the year. Please note, those who enroll in the High Deductible Basic medical plan are not eligible for any company contributions to their HSA.

CDHP + HRA:	CDHP + HSA:	High Deductible Basic:
$750/individual $1,500/family	$750/individual $1,500/family	$0/individual $0/family

PART 2: YOUR CONTRIBUTION

You may take advantage of tax savings by contributing to your HSA.

CDHP + HRA:	CDHP + HSA:	High Deductible Basic:
No employee contributions are allowable	You may contribute up to IRS limit, less employer contribution.	You may contribute up to IRS limit (UIC does not contribute).

PART 3: ANNUAL DEDUCTIBLE

When HRA/HSA funds are depleted, you pay out-of-pocket for medical expenses until you satisfy the in-network deductible. Expenses reimbursed by the HRA /HSA count toward the deductible as well. This deductible is a family aggregate, which means that the deductible can be met by a single enrolled member, or more than one enrolled member in combination. Benefits aren't provided for any family member until the family enrollment deductible has been reached. Once the family enrollment amount is reached, the deductible will be met for all enrolled family members

CDHP + HRA:	CDHP + HSA:	High Deductible Basic:
$2,000/individual $4,000/family	$1,500/individual $3,000/family	$5,000/individual $10,000/family

PART 4: COINSURANCE/OUT-OF-POCKET MAX

Once the deductible has been met, the plan then works like a traditional plan.

CDHP + HRA:	CDHP + HSA:	High Deductible Basic:
You pay 20% Plan pays 80% in-network	You pay 20% Plan pays 80% in-network	You pay 30% Plan pays 70% in-network

The plan pays 100% for eligible expenses after you reach your out-of-pocket maximum. The deductible is included in the out-of-pocket maximum.

CDHP + HRA:	CDHP + HSA:	High Deductible Basic:
$3,000/individual $6,000/family	$3,000/individual $6,000/family	$6,000/individual $12,000/family

Note: Your decisions and choices will affect how far your HRA and HSA dollars will go, so it's important that you compare cost, quality, and value each time you shop for health care. Choose wisely.

MEDICAL PLAN FEATURES

The table below shows a comparison of the three Consumer Driven Health Plan options to help you choose which is best for you and your family. Preventive care services such as routine physical exams, mammograms, and flu shots are covered at no cost to you under all medical plans. These expenses are not charged against your HRA or HSA.

	CDHP + HRA		CDHP + HSA		High Deductible Basic	
	Preferred	Out-of-Network	Preferred	Out-of-Network	Preferred	Out-of-Network
Annual Deductible	$2,000/ind. $4,000/family	$4,000/ind. $8,000/family	$1,500/ind. $3,000/family	$3,000/ind. $6,000/family	$5,000/individual $10,000/family	
Out-of-Pocket Maximum (includes deductible)	$3,000/ind. $6,000/family	$6,000/ind. $12,000/family	$3,000/ind. $6,000/family	$6,000/ind. $12,000/family	$6,000/individual $12,000/family	
Company-Funded HRA/HSA Deposit	$750/individual $1,500/family		$750/individual $1,500/family		$0/individual $0/family	
Coinsurance	80%	60%	80%	60%	70%	50%
Preventive Care & Immunization	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 50% after deductible
Office Visit	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Emergency Room	Plan pays 80% after deductible		Plan pays 80% after deductible		Plan pays 80% after deductible	
Hospital Services Inpatient and Outpatient	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Prescription Drug Retail	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply	30-day supply
Preferred Generic	$10 copay after deductible	Plan pays 60% after deductible	$10 copay after deductible	Plan pays 60% after deductible	$10 copay after deductible	Plan pays 60% after deductible
Preferred Brand	$30 copay after deductible		$30 copay after deductible		$30 copay after deductible	
Preferred Specialty	$50 copay after deductible		$50 copay after deductible		$50 copay after deductible	
Non-preferred	30% after deductible		30% after deductible		30% after deductible	
Prescription Drug Mail Order	90-day supply 2x retail copay	Not covered	90-day supply 2x retail copay	Not covered	90-day supply 2x retail copay	Not covered

Until you've met your deductible, you will pay 100% of the cost of your prescription drugs, with the exception of preventive drugs, which are covered at 100%. All copays are applicable after deductible.

BARROW MEMBERS: Out-of-Network services are paid the same as In-Network services.

Participating Providers: There is a third network level for all three medical plans called Participating. The plan will pay 70% for services rendered at these providers, after your applicable deductible. Please contact Premera for a list of these

Note: The percentages in the above chart are the amounts the plan covers; you will be responsible for the additional amounts. For a detailed summary of plan features, please contact your local Human Resources Department.

Curbing the impact of rising drug costs: Generic Prescription Medications are FDA approved and contain the same Active Pharmaceutical Ingredient than brand name counterparts. Generics are also a better cost savings for you and can cost you 20%- 60% less.

THINGS TO CONSIDER WHEN CHOOSING YOUR UIC MEDICAL PLAN

Total Cost (Payroll Deduction/ Premium, Out-of-Pocket Costs)
Look at the TOTAL cost of each option based on your expected utilization. Take into account not only the deductibles and account funding under each option, but also the premium you will be paying each month out of your paycheck.

Coverage Level
All three plans cover the same services (e.g., office visits, inpatient care, prescription drugs), but the level and type of coverage varies by plan for certain services - see the comparison chart on previous page. Exception: All plans offer 100% coverage for in-network preventive care.

Other Coverage
If you have coverage under another plan or system, such as a spouse's coverage or you make use of IHS benefits, there are significant restrictions on employee and employer contributions into an HSA. An HRA may be a better choice in these scenarios.

Whose Money Is It?
Although participants control both the HRA and HSA funds, any unused funds rollover from year to year, there is one major difference: HRA funds are UIC assets, and forfeit to UIC should you leave the company and decline COBRA coverage. HSA funds are the participant's money, and should you leave UIC you would take the funds with you.

MEDICAL PLAN FAQS

HRA	HSA
Who contributes?	
Employer	Employer and/or employee
Who owns the account?	
Employer	Individual/employee
Balances for terminated employees?	
Return to employer unless COBRA is elected	Stay with employee
Do funds rollover year to year?	
Yes	Yes
What expenses are eligible?	
Medical only	All IRS code 213d expenses
When are the funds available?	
$375 for employee only coverage or $750 for employees enrolled with dependents available January 1st, then an additional $375 for employee only coverage or $750 for employees enrolled with dependents available within 60 days of completion of the wellness initiatives.	$375 for employee only coverage or $750 for employees enrolled with dependents available upon completion of the wellness initiatives, additional $375 for employee only coverage or $750 for employees enrolled with dependents funded incrementally per pay period.
Can my spouse have an FSA?	
Yes	Only a limited-purpose FSA (dental/vision)
Can I be covered under another medical plan?	
Yes	If you are covered under Medicare Part A or B, TRICARE, or any other non-high-deductible medical or pharmacy plan you are not eligible to participate in the HSA. If you are eligible for IHS or veterans services, there are restrictions on HSA accounts that you need to consider before electing an HSA plan. Please consult with your HR Department.

MEDICAL PLAN FAQS

CDHP FAQS

WILL PROVIDERS BE LESS INCLINED TO ACCEPT MY INSURANCE IF I HAVE AN HRA OR HSA?

No. Medical payments made with funds from an HRA or HSA are in no way worse or more inconvenient for your medical providers.

WILL I HAVE TO PAY OUT-OF-POCKET EVERY TIME I GO TO THE DOCTOR?

When you obtain care from a network provider, your medical expenses are billed directly to Premera Blue Cross Blue Shield for you without the need for you to file a claim.

- If you choose the HRA plan, your health insurance plan will automatically withdraw the money out of your HRA. Once the funds in your HRA are emptied, the remainder of your claim will be applied to your deductible. You will receive an Explanation of Benefits (EOB) from your health insurance plan informing you what amount (if any) you are responsible for up to the out-of-pocket maximum. If your provider is not in the network, you may have to pay up front and submit a claim for reimbursement.
- With an HSA, you can pay for expenses with your HSA debit card or pay out of pocket and submit a claim for reimbursement. When you obtain care from a network provider, your medical expenses are billed directly to Premera Blue Cross Blue Shield for you without the need for you to file a claim. You will receive an Explanation of Benefits showing you the balance left to be paid. You have the choice of paying the balance with your HSA funds or out of pocket.

HOW DOES AN HRA OR HSA WORK WITH A SPOUSE'S FLEXIBLE SPENDING ACCOUNT (FSA)?

If you enroll in the HRA plan and your spouse's FSA, you may submit your expenses to be reimbursed once your HRA funds are exhausted. You are not eligible to contribute or receive HSA dollars if your spouse has a full-purpose FSA.

IF I HAVE LARGE CLAIMS, WILL AN HRA OR HSA PLAN PROVIDE ME WITH ADEQUATE COVERAGE?

With all three plans, once you meet your out-of-pocket limit, there is no out-of-pocket expense for covered in-network services. For this plan year, in-network out-of-pocket costs on the CDHP + HRA and CDHP + HSA plans for an individual is $3,000 and $6,000 for families. On the High Deductible Basic Plan the in-network out-of-pocket maximums for an individual is $6,000 and $12,000 for families.

ARE DISTRIBUTIONS FROM THE HRA OR HSA TAXABLE TO ME?

No. HRA and HSA funds are not considered income, so distributions are not taxable. HSA funds become taxable if used towards non IRS Code 213d expenses; HRA funds can only be used for medical expenses covered by the medical plan.

DO I LOSE MY HRA OR HSA FUNDS IF I DO NOT USE THEM BY THE END OF THE YEAR?

No. Any unused funds will automatically roll over from year to year as long as you continue to participate in the same Consumer Driven Plan.

WHAT IF I'M CURRENTLY ENROLLED IN THE HRA?

If you choose to re-enroll into the HRA plan, any unused monies will roll into your new HRA. If you choose to elect the HSA plan any unused HRA monies will be forfeited.

WHAT HAPPENS TO MY HRA/HSA IF MY EMPLOYMENT TERMINATES?

Any unused HRA balance is forfeited unless COBRA coverage is elected. If you have an HSA, any unused funds are available to you even if you leave UIC.

PREMERA RESOUCES

PREMERA PULSE

Premera Pulse is a digital resource designed to deliver you personalized health information in the moments you need it. Receive timely messages that help you make informed decisions about your care. Your account is already set up – all you have to do is activate it. **Text "Blue" to 24248 to activate your account.**

About Premera Pulse

1. **Get care notifications:** Take advantage of your health plan benefits and stay on top of recommended care.
2. **See a list of your medications:** Your medication history is all in one place. Share with your doctors and pharmacists to easily coordinate your care.
3. **Find doctors in your network:** Easily find doctors that meet your specific care needs. Read reviews from patients to gather more information

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Create your account today. By creating your account today, you'll immediately have access to the following:

- Find a doctor
- Check your coverage
- Track a claim
- Access your explanation of benefits (EOB) following a claim,an explanation of benefits is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.
- and more by accessing your account

PREMERA MOBILE APP

Keep your health plan info right in your pocket

Now available for iOS, Android, and Windows

Why download the app?

The mobile app puts your Premera healthcare info into your own hands. Get the peace of mind that comes with easy and convenient access to the health plan info you need while on the go.

View your claims: Use the app to view detailed claims information from anywhere. You'll see when Premera receives a claim, when we pay it, and what the provider may bill you. Know more about what's going on with your claims, and where we are with processing them.

Show (off) your Premera ID card: Forgot your card while you're out and about? Impossible if you've got the Premera app. You'll never forget your card again. We've got you covered with your Premera ID card—right here on your phone. You can even save it to your photo gallery so you can send it over to your doctor's office if you need to.

Find care: Are you a weekend warrior sporting a sprained ankle? Suffering from stomachache? Or just want to find a new doctor? Use the app to find care options in your neighborhood or online through Teladoc. Find nearby, in-network doctors, hospitals, urgent care facilities, and more. You can have a Teladoc video or phone consultation with a board-certified doctor right from the Premera app, without having to download a separate app or visit another web site.

Deductible met, or not yet?: Don't guess. Be in the know. Use the app to check to see how much of your deductible is met for the year. By knowing how much you have left to pay each plan year before Premera starts paying, you can make smarter decisions. With the app, you can view your individual and family deductibles for medical and dental at any time, from anywhere.

TELEMEDICINE
THROUGH PREMERA

MYCARE ALASKA

With Premer Blue Cross Blue Shield of Alaska, supporting health, happiness, and productivity is simple! MyCare Alaska offers a chat-first virtual care platform that allows your employees to securely text with a dedicated doctor on their time.

- Connect to an in-network doctor in <60 seconds
- Ask general or urgent medical questions from your desk- no need for you to go into a medical office
- Access care from your phone anywhere you have internet access
- Get answers to questions 24 hours a day, 7 days a week
- Increase team productivity by spending more time focusing on your work and not having to hassle with receiving care

Access to care 7 days a week from a smartphone or computer means that you can get care when it's most convenient for you. When there are no appointments or time limits. From more information about mycare Alaska visit **mycarealaska.com**.

TALKSPACE

Talkspace Virtual Therapy For Behavioral Health

With Talkspace, you can easily connect to therapists and psychiatrists by video and text for about the same cost as an in-person visit. When you need Talkspace- regardless of the time of day or where you are- you can reach your dedicated therapist.

Here's how to get started:

- Sign up for Talkspace at blue.premera.com/bhsupport/
- Get matched with the best therapist for you
- Start messaging your therapist right away

You can also visit the Premera behavioral health digital resource center at **blue.premera.com/bhsupport** to find useful resources, information on starting conversations, and more.

BOULDER CARE

Boulder Care is a comprehensive approach to addiction therapy in the form a digital treatment program for Opioid Use Disorder (OUD) that focuses on long-term, sustainable solutions focused on the individual patient's needs.

Proven Treatment

- Licensed addiction specialists
- Customized care plans
- MAT therapy using buprenorphine

Dedicated Care Teams

- Expert care providers work together to ensure patients have the right resources at the right time
- Dedicated Care Teams consist of Clinicians, Care Advocates, and Peer Coaches

Digital Platform

- Easy-to-access secured private digital platform
- 24/7 access to Boulder's Care Team
- Secure video and text messaging all from their phone

Cost Effective Treatment

- Provides care to patients who may struggle with access, thus avoiding unnecessary ED visits and hospitalizations
- Care is provided on a per month basis

DR. ON DEMAND

A doctor who is with you always - every day.

Connect with our board-certified doctors and licensed psychologists via live video right from your phone, tablet or computer on demand 24/7 or by appointment.

We can help with:

- Colds & Allergies
- Migraines & Headaches
- Urinary Tract Infections
- Acne & Skin Conditions
- Anxiety & Depression
- Heart Health
- Labs & Screenings
- Prescription Refills

To learn more, downlaod the app or visit **Doctorondemand.com**.

LIVONGO

CHRONIC CONDITION MANAGEMENT

Premera is excited to announce Livongo, a new health benefit being offered at no cost to you. Livongo empowers you with tools, insights, and expert support to help you reach your health goals. Livongo offers a comprehensive chronic condition support program. This program supports those at risk of developing diabetes, those who are working daily to manage their condition, and those who are managing hypertension. The program provides solutions to make healthcare simple and easy.

DIABETES PREVENTION

The diabetes prevention program helps those at risk of developing diabetes create new healthy lifestyle behaviors. Through this 12-month digital program, you will be coached by experts on how to make everyday changes to your current lifestyle behaviors and work toward reversing your risk of diabetes long-term.

TOOLS INCLUDED IN THIS PROGRAM

- Messaging and live one-on-one expert coaching
- An app that logs and tracks results
- Health summaries to help educate and offer positive reinforcement
- Community support from other participants
- Five-day challenges that promote long-term lifestyle habit changes

HYPERTENSION MANAGEMENT

This program makes monitoring blood pressure easy. You can compare your blood-pressure readings over time, schedule a call with a health coach, and share your results with family, friends, and healthcare providers.

EACH PARTICIPANT GETS A CELLULAR-CONNECTED BLOOD PRESSURE MONITOR

- Members all have access to unlimited live, one-on-one expert coaching
- Through the app, you can get high blood-pressure alerts and access real-time insights and interpret trends
- The monitor allows blood pressure readings to be taken anywhere and automatically uploads the data.

DIABETES MANAGEMENT

Premera understands how hard managing diabetes can be. That is why the diabetes management program focuses on taking away the daily stress and hassle of managing the chronic condition.

DIABETES MANAGEMENT WORKS BETTER FOR YOU THROUGH:

- **Cellular-enabled blood glucose meter:** These bright and accessible touchscreen meters make it easy to see health data in one convenient place. Receive real-time analytics and feedback based on the current readings.
- **Real-time analytics:** The program's analytic tools capture all readings and make it easy to track or share data with providers. They also help share trends over specific periods of time and create immediate insights for long-term planning.
- **Expert coaching available:** Expert coaches are available 24/7. You can customize your notification levels. When your blood glucose reading is out of range, the coaches will contact you within three minutes to help them manage their blood sugar back into target range. Friends and family can also play a key role by opting in to receive a text or email when blood glucose reading are out of target range.
- **Free unlimited supply of test strips:** Test strips are automatically shipped when supplies are running low. Based on your testing pattern, the cellular-enabled meter knows when you are down to a 20-day supply. Once that happens, the member is prompted on their meter to have supplies sent directly to your door.

For Assistance

If you have any questions about these programs, please visit the Livongo Website at **go.livongo.com/PREMERAAK/now** or call Livongo Member Support at **(800) 945-4355** and mention registration code **PREMERAAK**.

AETNA DENTAL COVERAGE

The Core and Buy-Up dental plans offered through Aetna are designed to help you maintain a healthy smile through regular preventive dental care and to fix any problems as soon as they occur. Because preventive care is so important, both plans cover these services in full with no deductible or copay.

You have the freedom to visit in-network or out-of-network providers for your dental care; however, you will save money when you visit in-network providers. Please see the table below for a comparison of the dental plans.

	Aetna Core Plan	Aetna Buy-Up Plan
Annual Deductible (waived for Preventive Services)	$50/person $150/family	$50/person $150/family
Class I: Diagnostic and Preventive Services (e.g., x-rays, cleanings, exams)	Plan pays 100%	Plan pays 100%
Class II: Basic and Restorative Services (e.g., fillings, extraction, root canals)	Plan pays 80% after deductible	Plan pays 80% after deductible
Class III: Major Services (e.g., dentures, crowns, bridges)	Plan pay 50% after deductible	Plan pays 50% after deductible
Annual Maximum	$1,500	$2,500
Orthodontia Lifetime Maximum	N/A	Plan pays 50% up to $5,000

Note: When you visit out-of-network dental providers, you are responsible for charges above usual, reasonable and customary rates, also known as balance billing.

VSP VISON COVERAGE

The vision plan includes benefits for eye exams, eyeglasses, and contact lenses through VSP. You may visit a doctor within the VSP network and take advantage of higher benefits coverage, or visit an out-of-network provider of your choice for a reduced benefit.

	VSP Vision Plan		Barrow Members VSP Vision Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exam (every 12 months)	$20 copay	Plan pays up to $50	$20 copay	Plan pays up to $50
Lenses (every 12 months)				
Single Vision	$0 copay	Plan pays up to $50	$0 copay	Plan pays up to $100
Lined Bifocal	$0 copay	Plan pays up to $75	$0 copay	Plan pays up to $140
Lined Trifocal	$0 copay	Plan pays up to $100	$0 copay	Plan pays up to $155
Standard Progressive	$50 copay	Plan pays up to $75	$50 copay	Plan pays up to $140
Premium Progressive	$80-$90 copay	N/A	$80-$90 copay	N/A
Custom Progressives	$120-$160 copay	N/A	$120-$160 copay	N/A
Frames (every 24 months)	Plan pays up to $200 allowance	Plan pays up to $70	Plan pays up to $200 allowance	Plan pays up to $90
Contacts (every 12 months)	Plan pays up to $200 allowance ($60 copay for contact lens exam)	Plan pays up to $105 (for lenses and exam)	Plan pays up to $200 allowance ($60 copay for contact lens exam)	Plan pays up to $115 (for lenses and exam)

BARROW MEMBERS: Due to the limited network availability in your area, your benefits will vary.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Employees now will be offered the following through HSA Bank:

- Flexible Spending Account (FSA)
- Limited Flexible Spending Account
- Dependent Care FSA
- Commuter / Parking Benefit

Flexible Spending Accounts

- Set aside up to **$2,850** before taxes for qualified healthcare expenses
- Access entire amount on 1st day of plan year
- Use money for eligible out-of-pocket medical expenses such as deductibles and copays
- If you are enrolled in the HDHP with HSA, sign up for the Limited FSA (Dental & Vision only)

HELATHCARE FSA

Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You contribute before-tax dollars to your FSA to reimburse yourself for eligible out-of-pocket medical expenses. That means you can enjoy tax savings and increased take-home pay. And that makes real sense.

An FSA is a tax-advantaged financial account that can be set up through your employer's cafeteria plan. An FSA allows you to designate a portion of your pre-tax earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for qualified medical expenses, but also for dependent care. Since the money deducted from your paycheck for the FSA is not subject to Federal or state taxes, you can benefit from tax savings.

HOW A HEALTHCARE FSA WORKS:

You determine an annual election amount to contribute to your FSA via payroll deduction, in equal installments, on a tax-free basis.

- You can pay for qualified expenses with your Health Benefits Debit Card directly to your medical provider, or pay out-of-pocket and submit a claim to HSA Bank for reimbursement.
- When submitting a claim, scan and upload your bill(s), Explanation of Benefits or prescription(s), and receipt(s) through HSA Bank's mobile app or your computer.
- Once your claim is approved based on eligibility and availability of funds, reimbursement will be sent to you.
- Check your balances and account information via HSA Bank's Member Website or mobile device 24/7.

ARE YOU ELIGIBLE FOR A HEALTHCARE FSA?

Generally, to be eligible for an FSA, you just have to be an employee of an employer who offers an FSA. Unlike an HSA, you do not have to be covered by a High Deductible Health Plan (HDHP). You can have several insurance plans or none. You're not required to have health coverage to be eligible for a health FSA. If you are enrolled in the HDHP with HSA, you are eligible to sign up for the Limited FSA (Dental and Vision only).

WHAT ARE THE ANNUAL IRS CONTRIBUTION LIMITS?

The IRS sets limits each year for maximum contributions to an FSA. The 2022 IRS maximum FSA annual contribution amount is $2,850 before taxes for qualified healthcare expenses.

Visit **hsabank.com/irs-guidelines** for the current limits.

You must submit reimbursements by March 31st for expenses incurred between January 1st and March 15th of the following year. Funds that are not spent by the end of the plan year are forfeited, use it or lose it!

FLEXIBLE SPENDING ACCOUNTS (FSA)

LIMITED FSA

Using a Limited Purpose Flexible Spending Account (LPFSA) is a great way to stretch your benefit dollars. You contribute before-tax dollars to your LPFSA to reimburse yourself for eligible out-of-pocket vision and dental expenses. That means you can enjoy tax savings and increased take-home pay. And that makes real sense.

An LPFSA is a tax-advantaged financial account that can be set up through your employer's cafeteria plan. An LPFSA allows you to designate a portion of your pre-tax earnings to pay for qualified expenses as established in the cafeteria plan for dental and vision expenses. Since the money deducted from your paycheck for the LPFSA is not subject to Federal or most state taxes, you can benefit from tax savings.

HOW A LIMITED PURPOSE FSA WORKS:

- You determine an annual election amount to contribute to your LPFSA via payroll deduction, in equal installments, on a tax-free basis.
- You can pay for vision and dental expenses with your Health Benefits Debit Card directly to your provider, or pay out-of-pocket and submit a claim to HSA Bank for reimbursement.
- When submitting a claim, scan and upload your receipt(s) or Explanation of Benefits through HSA Bank's mobile app or your computer.
- Once your claim is approved based on eligibility and availability of funds, reimbursement will be sent to you.
- Check your balances and account information via HSA Bank's Member Website or mobile device 24/7.

ARE YOU ELIGIBLE FOR A LIMITED PURPOSE FSA?

Limited Purpose FSAs are established by your employer; therefore self-employed persons are not eligible for an LPFSA. An LPFSA may be offered together with other employer-provided benefits as part of your employer's cafeteria plan. You do not have to be covered under any other healthcare plan to participate, but your employer must generally sponsor a group health plan for its eligible employees.

The 2022 IRS maximum Limited FSA annual contribution amount is $2,850 before taxes for qualified healthcare expenses.

Visit **hsabank.com/irs-guidelines** for the current limits. You must submit reimbursements by March 31st for expenses incurred between January 1st and March 15th of the following year. Funds that are not spent by the end of the plan year are forfeited, use it or lose it!

FLEXIBLE SPENDING ACCOUNTS (FSA)

DEPENDENT CARE FSA

UIC offers employees the opportunity to enroll in a Dependent Care Flexible Spending Account (FSA). FSAs are a tax-saving way to pay dependent care expenses that you would typically pay out-of-pocket. Expenses for dependent day care or elder care expenses can be very expensive. The FSA lets you pay these expenses with pre-tax dollars, which means that the funds you set aside in an FSA are not taxed, so you save money. Each year that you would like to participate in the FSA, you must re-enroll and elect the amount you want to contribute. Your contributions will be deducted from your paychecks in equal installments throughout the year and deposited into your account.

You may contribute up to $5,000 ($2,500 if you are married and file your taxes separately) to the Dependent Care FSA. When you have eligible expenses, you submit a claim to HSA Bank for reimbursement.

ELIGIBLE EXPENSES

Eligible dependent care expenses for the Dependent Care FSA are those that allow you and your spouse (if you are married) to work or attend school full time. These services generally include day care, babysitters, most day camps, and caregivers for disabled dependents.

Please be sure to check current IRS limits, as they are subject to change. For a complete list of eligible expenses, go to **irs.gov**.

IMPORTANT RULES TO KEEP IN MIND

FSAs offer sizable tax advantages. The trade-off is that these accounts are subject to strict IRS regulations, including the following:

- The IRS has a strict "use it or lose it" rule: If you do not use the full amount in your FSAs by the end of the plan year, you will lose any remaining funds.
- You have 90 days from the end of the plan year to submit all reimbursement requests. Failure to submit requests within this window will result in the loss of any remaining funds.
- Once you enroll in the FSAs, you cannot change your contribution amount during the year unless you experience a qualified life event.

If you are unable to estimate your dependent care costs accurately, it is better to be conservative and underestimate rather than overestimate your expenses.

COMMUTER / PARKING BENEFIT

With Commuter Benefits through UIC, you can make tax-free payroll deductions (up to the IRS limits) and in certain circumstances, post-tax deductions, to cover various modes of mass transit or parking expenses. There are two primary Commuter Benefit account types: Mass Transit accounts and Parking accounts.

MASS TRANSIT ACCOUNTS:

Mass Transit accounts cover eligible workplace mass transit expenses such as the price of tickets, vouchers, and passes to ride a subway, train, city bus, or ferry. Qualified expenses also encompass costs of transportation in a commuter highway vehicle (e.g., vanpool), if such transportation is in connection with travel between a residence and place of employment. Funds only available via debit card.

PARKING ACCOUNTS:

Parking accounts enable you to pay for qualified parking. Funds can be accessed via debit card or claim submission. Qualified parking is defined as parking provided to an employee on or near the business premises of the employer or on or near a location from which the employee commutes to work by transportation for which a transit pass is used, in a commuter vehicle or by carpool. Such terms shall not include any parking on or near property used by the employee for residential purposes.

ANNUAL IRS LIMITS FOR COMMUTER BENEFITS

The IRS sets maximum monthly pre-tax deduction and spending amounts and may adjust them annually. These limits reflect the maximum allowed pre-tax contribution and reimbursement amounts per calendar month. The 2022 maximum monthly benefit is $280 for both the Transit account and the Parking Account.

DID YOU KNOW?

Contributions to either a Mass Transit or Parking account are deducted from your pay before taxes, which can mean tax savings. Unused Commuter Benefits will carry over to the following year. Election changes are not limited by a plan year and can be updated or stopped as your needs change. Reimbursement funds become available as they are deducted from your paycheck. You can change election amounts monthly.

All claims for qualified expenses must be received within 180 days after the service is provided in order for it to be considered for reimbursement.

TRICARE SUPPLEMENT

UIC offers a TRICARE Supplement Plan administered through Selman Co. This is a voluntary supplemental health benefit program available to employees and their dependents who are eligible for TRICARE, the military health program. Eligible employees and dependents cannot be eligible for Medicare and include the following:

- Retired military entitled to retired or retainer pay
- Retired Reservists between the ages of 60 and 65 entitled to retired pay
- Retired Reservists under age 60 but enrolled in TRICARE Retired Reserves (TRR)
- Spouses and Surviving spouse of the above
- Coverage for this plan ends at age 65

The plan deductible is $100 for individuals and $200 for families. The monthly premiums are paid through pre-tax payroll deductions.

TRICARE SUPPLEMENTAL PLAN ADMINISTERED THROUGH SELMAN CO.

- Plan Deductible of $100 per individual and $200 per family
- Premiums include membership to American Military Retirees Association (AMRA)
- Discounted services available through AMRA (hotels, moving services, car rental, etc.)

CARE REQUIRED	TRICARE Select Pays	THE SUPPLEMENT PLAN PAYS
INPATIENT FACILITY SERVICES in civilian hospitals for RETIREES and their dependent family members (room, board, supplies and staff services billed by the hospital).	The TRICARE Select Non-network DRG1 allowed amount (contracted rate for TRICARE Select Network minus your copay).	The lesser of $708 per day or 25% of the billed amount, not to exceed the TRICARE Select Non-network DRG1 amount (lesser of $250 per day or copay of the contracted rate of TRICARE Select Network).
INPATIENT PROFESSIONAL SERVICES in civilian hospitals for RETIREES and dependent family members (doctors, and other inpatient services not billed by the hospital).	75% of the TRICARE Select Non-network allowed amount (contracted rate for TRICARE Select Network minus your copay) for doctors and other professional services.	Your 25% Select Non-network cost share /Copay for Select Network PLUS 100% of Covered Excess Charges up to Legal Limit.
INPATIENT CARE in military hospitals.	The daily subsistence fee.	The daily subsistence fee.
OUTPATIENT CARE for RETIREES and their dependent family members (office visits, clinics, lab, etc).	75% of the TRICARE Non-network allowed amount (contracted rate for TRICARE Select Network minus your copay) after you pay the TRICARE Outpatient Deductible.	Your 25% Select Non-network cost share/ Copay for Select Network and 100% of the TRICARE Outpatient Deductible2 of $150 per person or $300 per family PLUS 100% of Covered Excess Charges up to Legal Limit.

***This voluntary program is available to employees and their dependents who are eligible for TriCare*

401(K) RETIREMENT PLAN

LOOKING TO BE COMFORTABLE IN YOUR RETIREMENT?
ALL THE EXPERTS AGREE: START EARLY, KEEP SAVING AS MUCH AS YOU CAN AFFORD,
You can save pre-tax with a traditional contribution, or post-tax with a Roth 401(k) contribution.

ELIGIBILITY

Most employees are eligible to participate in the plan. The following employees are not eligible:

- Employees covered by collective bargaining agreements (unless negotiated in by the CBA)
- Leased or reclassified employees
- Non-resident aliens
- Employees under age 18

You are eligible to enroll and participate in the plan as soon as administratively feasible.

PLAN CONTRIBUTIONS*

You may make contributions ranging from 1% to 100% of your salary through payroll deductions. The limit for 2022 is $20,500 for anyone under age 50. If you are over age 50, you may contribute an additional $6,500.

**2022 limit indexed each year and subject to change. Please be sure to check current IRS limits, as they are subject to change.*

ROTH VS. TRADITIONAL

The main difference between the Roth and Traditional plans is when you pay income taxes on the money put into the plan. Traditional 401(k) plan contributions are tax-deferred; you pay the taxes when you withdraw the money. Just the opposite is true with a Roth plan; you put your contributions in after taxes, but you don't pay taxes when you take the money out at retirement. We give employees the choice because we know retirement savings needs vary. Talk to your financial advisor about which option is right for you.

ROLLOVER

You are able to rollover 401(k) balances from other qualified plans into your UIC account at any time.

VESTING

Vesting refers to your "ownership" of the money contributed to your account. All contributions to the plan are 100% vested, including the UIC match.

Note: There is no waiting period for vesting.

LIFE AND AD&D INSURANCE

BASIC LIFE AND AD&D

Providing economic security for your family if you die, become disabled, or experience an injury or illness is a major consideration in personal financial planning. UIC provides you with employee life and AD&D insurance coverage at no cost to you. You automatically receive life and AD&D coverage in the amount of twice your annual earnings, up to $200,000. You must choose a beneficiary to receive benefits in the event of your death. The basic life and AD&D cost comes out of employer provided Health & Welfare Funds. Log in to UKG to update your beneficiary today.

VOLUNTARY LIFE AND AD&D

We are offering you the opportunity to enroll in voluntary life and accidental death and dismemberment insurance through Cigna. If you need additional life insurance to meet your financial needs, you can purchase voluntary life/ AD&D insurance through after- tax payroll deductions for yourself and your dependents.

IMPORTANT

As a new hire, if you enroll within 30 days of your hire date, you may apply for any amount of life insurance coverage up to $140,000 for yourself and any amount of coverage up to $25,000 for your spouse without having to complete Evidence of Insurability. Any life insurance coverage over the Guarantee Issue amount(s) will be subject to Evidence of Insurability being submitted and approved. Voluntary life coverage elected over the Guaranteed Issue Amount will not be in force until your submitted Evidence of Insurability form has been approved by Cigna.

If you and your eligible dependents do not enroll within 30 days of your initial hire date, you will be required to furnish Evidence of Insurability for the entire amount of coverage. However, existing employees who are currently enrolled in the voluntary life plan with a coverage amount that is less than the guaranteed issue amount, can elect up to the guaranteed issue amount at a later date without submitting evidence of insurability.

EMPLOYEE

You can purchase additional life and AD&D insurance coverage for yourself if you choose. Consider costs such as funeral expenses, legal expenses, and general living expenses for your surviving family members when determining an appropriate amount of additional coverage. You can choose amounts from $10,000 up to five times your annual earnings, to a maximum of $500,000. ***Note:** You may purchase life insurance coverage even if you do not purchase AD&D coverage. You may also purchase AD&D insurance even if you do not purchase life coverage.

If you enroll in additional life and/or AD&D coverage for yourself, you may choose to elect additional coverage for your spouse and/or your child(ren) in the following amounts:

SPOUSE:

Up to 100% of employee amount, in increments of $5,000, up to a maximum of $500,000.

CHILD(REN)

Up to 100% of employee amount or a maximum of $10,000, whichever is less, in increments of $2,000 (The maximum death benefit for a child between the ages of live birth and 6 months is $1,000).

**Your Unmarried, Dependent Children under age 19 (or under age 26 if they are full-time students), as long as you apply for and are approved for coverage for yourself, in order to be covered under the Cigna supplemental plans.*

LIFE AND AD&D INSURANCE

VOLUNTARY LIFE AND AD&D

EVIDENCE OF INSURABILITY

If you enroll when you and/ or your spouse are first eligible, you can request up to $140,000 for yourself and $25,000 for your spouse without providing proof of good health. If you request coverage for yourself or spouse after you are first eligible, you will need to submit proof of good health for all amounts of coverage requested.

**Benefit reduction applies for ages 70+*

Schedule of Benefits	
Employee	Increments of $10,000 up to the lesser of 5 x covered annual earnings or $500,000
Spouse	Increments of $5,000 up to the lesser of 100% of the employee amount or $500,000
Children	Increments of $2,000 up to the lesser of 100% of the employee amount or $10,000

EXAMPLE:

Employee (age 24, non-smoker)	30 units x $.056 per unit ($300,000)	= $1.68
Spouse (age 29)	30 units x $.099 per unit ($150,000)	= $2.97
Children	5 units x $.262 per unit ($10,000)	= $1.31
Total Monthly Cost		**= $5.96**

Voluntary Life Step Monthly Cost Per $1,000			
Age	Non-Smoker Employee	Smoker Em-ployee	Spouse
<24	$0.056	$0.100	$0.099
25-29	$0.060	$0.100	$0.099
30-34	$0.080	$0.138	$0.109
35-39	$0.090	$0.195	$0.138
40-44	$0.118	$0.292	$0.217
45-49	$0.195	$0.487	$0.388
50-54	$0.328	$0.788	$0.636
55-59	$0.501	$1.099	$0.920
60-64	$0.677	$1.354	$1.410
65-69	$1.331	$2.388	$2.603
70-74	$2.484	$3.969	$4.532
75+	$4.920	$6.401	$8.703
Voluntary Life Child Rate			$0.262

Voluntary AD&D Monthly Cost Per $1,000	
Employee	$0.027
Spouse	$0.027
Child	$0.027

DISABILITY INSURANCE

SHORT-TERM DISABILITY

You are automatically provided with short-term disability (STD) coverage. The STD plan provides 60% of your weekly earnings, to a maximum of $1,500 per week for the first 13 weeks of a disability (after a seven-day waiting period for an illness, including pregnancy). There is no waiting period for an injury. All payments received are after-tax; the basic STD cost comes out of employer provided Health & Welfare Funds.

LONG-TERM DISABILITY

UIC believes that long-term disability (LTD) coverage is important because anyone at any age may become injured or ill for an extended period of time. You are automatically covered under the LTD plan. LTD coverage will replace 60% of your base earnings* to a monthly maximum of $7,500 if you are disabled for more than 90 days and are unable to work. LTD benefits are offset by other sources of income, such as Social Security and workers' compensation. All payments received are after-tax; the basic STD cost comes out of employer provided Health & Welfare Funds..

VOLUNTARY SHORT TERM DISABILITY:

As a full-time employee of UIC, you are provided with a base short term disability benefit. This benefit will pay you 60% of your covered weekly earnings up to $1,500 through your 13th week of disability in the event you are unable to work after 7 days for illness or on the first day for an accident. To provide you and your family with additional financial security, we are offering you the opportunity to purchase a buy-up short term disability plan.

With the supplemental buy-up plan, you will receive 70% of your covered weekly earnings, up to $2,000 through your 13th week of disability. The cost of the supplemental buy-up benefit is paid by you, and is based on the rates below per $10 of weekly covered earnings.

DEFINITION OF DISABILITY

Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

COVERED EARNINGS

Covered earnings means your wages or salary, including commissions and bonuses, but not including overtime pay or any other extra compensation.

EARNINGS WHILE DISABLED

Benefits will be reduced for any week that benefits plus income from employment exceeds 100% of weekly covered earnings.

Cost of Coverage Per $10 of benefit		
Age	Weekly	Bi-Weekly
<50	$0.0192	$0.0384
50-54	$0.0240	$0.0480
55-59	$0.0287	$0.0574
60-64	$0.0359	$0.0718
65+	$0.0383	$0.0766

**For life and AD&D insurance plans as well as disability plans, "earnings" means income actually received from commissions, bonuses and regularly scheduled overtime pay.*

VOLUNTARY CRITICAL ILLNESS

Critical Illness insurance pays a one-time, lump sum benefit amount upon the diagnosis of a covered disease or illness. You can use this money for any purpose you like- lost wages, child care, travel, home health care costs, or any of your regular household expenses. The Cigna Critical Illness plan includes a lump sum benefit for the following diseases and illnesses:

- Cancer
- Paralysis
- Heart Attack
- Amyotrophic Lateral Sclerosis (ALS)
- Stroke
- Blindness
- Renal (Kidney) Failure
- Coronary Artery Disease (Surgery- 25% benefit)
- Major Organ Transplant
- Carcinoma in Situ (25% benefit)

Covered Person	Weekly
Employee	$5,000, $10,000 or $20,000
Spouse	50% of employee benefit
Children	25% of employee benefit

Please note that benefits reduce by 50% at age 75.

PRE-EXISTING CONDITION LIMITATION

This plan will not pay benefits for a covered loss caused or contributed to by, or resulting from, a pre-existing condition. A pre-existing condition is any sickness or injury for which a covered person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a physician within 12 months before the effective date of coverage, and the most recent effective date of any added or increased amount of insurance.

HEALTH SCREENING BENEFIT

This Voluntary Critical Illness plan feature provides a benefit amount of $50 for a health screening test taken by each covered person per calendar year. The benefit waiting period is 30 days following the effective date of the policy.

Eligible health screening tests include:

- Mammography
- Pap Smear for women over age 18
- Flexible Sigmoidoscopy
- Hemocult Stool Specimen
- Colonoscopy
- Prostate Specific Antigen
- Fasting blood glucose test
- Stress test on a bicycle or treadmill
- Blood test for triglycerides
- Bone marrow testing
- Serum cholesterol test to determine levels of HDL and LDL
- Chest X-ray
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Serum Protein Electrophoresis
- Thermography

VOLUNTARY CRITICAL ILLNESS

WEEKLY COST OF COVERAGE

EMPLOYEE BENEFIT AMOUNT OF $5,000

	Non-Tobacco				Tobacco			
Issue Age	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
0-29	$0.84	$1.48	$0.89	$1.53	$1.08	$1.86	$1.14	$1.92
30-39	$1.26	$2.13	$1.31	$2.19	$1.96	$3.25	$2.02	$3.31
40-49	$2.19	$3.62	$2.24	$3.67	$3.79	$6.14	$3.85	$6.20
50-59	$4.05	$6.54	$4.10	$6.59	$7.05	$11.28	$7.11	$11.34
60-69	$6.98	$11.17	$7.03	$11.23	$11.44	$18.25	$11.50	$18.30
70-79	$8.42	$13.45	$8.47	$13.50	$12.04	$19.18	$12.10	$19.23
80+	$9.57	$15.28	$9.64	$15.33	$12.75	$20.30	$12.81	$20.37

EMPLOYEE BENEFIT AMOUNT OF $10,000

	Non-Tobacco				Tobacco			
Issue Age	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
0-29	$1.27	$2.14	$1.35	$2.23	$1.75	$2.90	$1.84	$2.99
30-39	$2.10	$3.43	$2.19	$3.54	$3.51	$5.67	$3.62	$5.78
40-49	$3.97	$6.41	$4.05	$6.50	$7.17	$11.46	$7.26	$11.55
50-59	$7.68	$12.25	$7.77	$12.33	$13.68	$21.73	$13.79	$21.84
60-69	$13.54	$21.52	$13.63	$21.61	$22.47	$35.67	$22.56	$35.76
70-79	$16.43	$26.07	$16.52	$26.16	$23.67	$37.54	$23.76	$37.63
80+	$18.74	$29.74	$18.85	$29.83	$25.08	$39.78	$25.19	$39.89

EMPLOYEE BENEFIT AMOUNT OF $20,000

	Non-Tobacco				Tobacco			
Issue Age	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
0-29	$2.12	$3.45	$2.28	$3.61	$3.09	$4.98	$3.25	$5.13
30-39	$3.78	$6.04	$3.94	$6.24	$6.60	$10.52	$6.80	$10.72
40-49	$7.52	$11.99	$7.68	$12.15	$13.94	$22.10	$14.09	$22.26
50-59	$14.95	$23.67	$15.11	$23.83	$26.95	$42.64	$27.15	$42.84
60-69	$26.67	$42.22	$26.83	$42.38	$44.54	$70.52	$44.69	$70.67
70-79	$32.44	$51.32	$32.60	$51.47	$46.94	$74.25	$47.09	$74.41
80+	$37.06	$58.65	$37.26	$58.81	$49.75	$78.73	$49.95	$78.93

VOLUNTARY CRITICAL ILLNESS

BI-WEEKLY COST OF COVERAGE

EMPLOYEE BENEFIT AMOUNT OF $5,000

	Non-Tobacco				Tobacco			
Issue Age	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
0-29	$1.68	$2.96	$1.79	$3.07	$2.16	$3.72	$2.27	$3.83
30-39	$2.51	$4.26	$2.62	$4.38	$3.92	$6.49	$4.05	$6.62
40-49	$4.38	$7.23	$4.49	$7.34	$7.59	$12.29	$7.69	$12.39
50-59	$8.10	$13.07	$8.20	$13.18	$14.10	$22.56	$14.22	$22.68
60-69	$13.96	$22.35	$14.06	$22.45	$22.89	$36.49	$22.99	$36.60
70-79	$16.84	$26.89	$16.95	$27.00	$24.09	$38.36	$24.19	$38.47
80+	$19.15	$30.56	$19.28	$30.67	$25.50	$40.60	$25.62	$40.73

EMPLOYEE BENEFIT AMOUNT OF $10,000

	Non-Tobacco				Tobacco			
Issue Age	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
0-29	$2.53	$4.28	$2.71	$4.45	$3.50	$5.80	$3.68	$5.98
30-39	$4.20	$6.86	$4.37	$7.08	$7.01	$11.34	$7.23	$11.56
40-49	$7.93	$12.82	$8.11	$12.99	$14.35	$22.92	$14.52	$23.10
50-59	$15.36	$24.49	$15.54	$24.67	$27.36	$43.46	$27.59	$43.68
60-69	$27.09	$43.05	$27.26	$43.22	$44.95	$71.34	$45.12	$71.52
70-79	$32.86	$52.14	$33.03	$52.32	$47.35	$75.08	$47.52	$75.25
80+	$37.47	$59.48	$37.69	$59.65	$50.16	$79.56	$50.39	$79.78

EMPLOYEE BENEFIT AMOUNT OF $20,000

	Non-Tobacco				Tobacco			
Issue Age	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family
0-29	$4.24	$6.91	$4.56	$7.22	$6.18	$9.96	$6.49	$10.27
30-39	$7.56	$12.08	$7.88	$12.48	$13.20	$21.03	$13.60	$21.44
40-49	$15.04	$23.99	$15.36	$24.30	$27.87	$44.20	$28.19	$44.52
50-59	$29.90	$47.34	$30.22	$47.65	$53.90	$85.28	$54.31	$85.68
60-69	$53.35	$84.45	$53.66	$84.76	$89.07	$141.03	$89.39	$141.35
70-79	$64.89	$102.63	$65.20	$102.95	$93.87	$148.51	$94.19	$148.82
80+	$74.12	$117.31	$74.52	$117.62	$99.50	$157.46	$99.91	$157.87

VIRGIN PULSE WELLNESS PLATFORM

EARN YOUR 2022 INCENTIVE FUNDING THROUGH VIRGIN PULSE

If you are enrolled in the Company HSA or HRA medical plan, you may choose to participate in UIC's 2022 wellness program.

Virgin Pulse is an award winning wellness platform that has been designed to cultivate good lifestyle habits. With Virgin Pulse, you can learn how to improve in areas that are important to your health. This new program will assist you in reaching your health goals and even work on those goals with friends, if you choose to do so. You can monitor your activity, sleep, mood, and more. Other features include coaching and ways to reduce stress and eat healthy.

UIC REWARDS

To earn your 2022 wellness incentive funding, you and your spouse (if applicable) must complete the two requirements below on the Virgin Pulse website by December 31, 2022. Please note that employees enrolled in the Basic medical plan do not qualify for wellness incentive funding.

WELLNESS INCENTIVE REQUIREMENTS

1. Complete the online Health Assessment
   AND
2. Complete a preventive service *this will be manually entered through the mobile app or the website in order to satisfy the requirement
   OR
3. Complete the 20 Day Triple Tracker:
   - 7,000 steps 20 days in a month (140K total) OR
   - 15 active minutes 20 days in a month (300 total) OR
   - 15 workout minutes 20 days in a month (300 minutes)

   **Activity needs to be recorded daily for 20 days within one month in order to receive credit towards the wellness incentive*

For the Health Assessment, log into the Virgin Pulse website, then navigate to Home > Rewards. The steps, workouts or activity for the triple tracker can be logged manually from the homepage or can be automatically tracked by syncing a device to the Virgin Pulse website or Virgin Pulse Mobile App (please see the resources below for syncing your device).

HOW TO REGISTER

Go to **www.join.virginpulse.com/UIC** to easily register. Upon registration and sign in you will be prompted to take a tour of the website. It is recommended that you take a few minutes to complete the tour in order to familiarize yourself with this new platform and how to navigate it. Please note that employees and spouses will register separately.

INCENTIVE FUNDING

You should see your incentive in your account within 90 days after you complete both requirements.

EMPLOYEE-ONLY

$375 contribution to your HSA or HRA

EMPLOYEE-PLUS-ONE OR MORE

$750 contribution to your HSA or HRA

QUESTIONS?

Your HR Benefits Representatives are always available to help answer your questions.

UIC GOVERNMENT SERVICES

Shelley Gouvisis
Shelley.Gouvisis@bowheadsupport.com | 540-709-2110

UIC CORPORATE AND COMMERCIAL

Selma Khan
Selma.Khan@UICAlaska.com | 907-677-5273

VIRGIN PULSE SUPPORT

You can chat with a representative on the Virgin Pulse website, submit a request through the website for assistance, or email them at **support@virginpulse.com**

MYBENEFITS.LIFE

THE EASY WAY TO GET BENEFITS INFO

ALL OF YOUR BENEFITS INFORMATION IN ONE PLACE

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life is both a website and a mobile app that give you access to the benefits information you need, when you need it.

WHAT YOU'LL FIND ON MYBENEFITS.LIFE

Benefits	See benefit details and costs for all plans you're eligible for, such as healthcare, disability, life insurance, and more
Search	Can't find it? Just search the site
Articles and Video Library	Have 2 minutes? Increase your benefits IQ with short explainer articles and videos
Financial Wellness	Want to understand your finances better? Learn how in the Digital Financial Wellness Center, powered by Prudential
Glossary	HDHP? EOB? Coinsurance? Get the definitions in plain English
Documents	Important benefit plan notices ("the fine print")
Contacts	Find HR, benefits, and carrier contacts
Get Help	Need help? Reach helpful resources

GET MYBENEFITS.LIFE

On the web; select the division that apples to you:

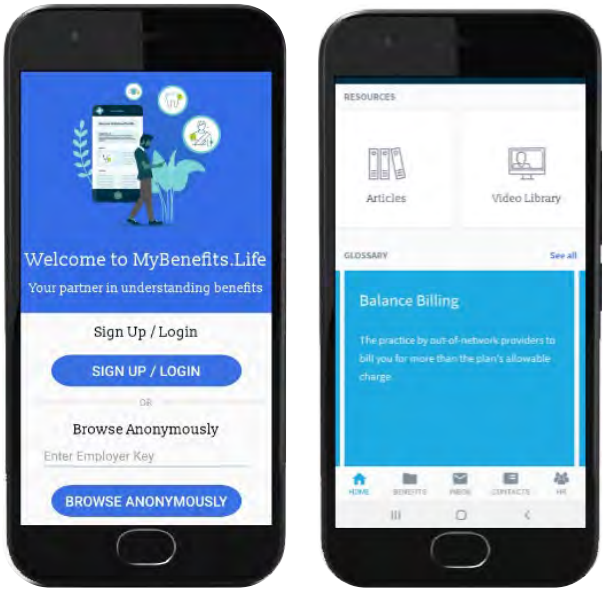
- uicalaska.mybenefits.life | **Employer Key:** uicalaska
- uicl48.mybenefits.life | **Employer Key:** uicl48
- uicsca.mybenefits.life | **Employer Key:** uicsca
- uiccba.mybenefits.life | **Employer Key:** uiccba

On your smartphone

Download from the App Store or Google Play.
Login With Employer Key above

Download on the App Store

GET IT ON Google Play



EMPLOYEE ASSISTANCE PROGRAM

Because unresolved personal issues can affect every aspect of one's life, including work performance, UIC automatically provides you and your family with an Employee Assistance Program (EAP) through Magellan Health Services at no cost to you.

You may call the EAP hotline 24 hours a day, 7 days a week at 800.478.2812 for unlimited confidential assistance by telephone with nearly any personal matter you may be experiencing. Licensed counselors can provide you with access to up to 6 face- to-face counseling sessions, legal advice, financial consultation, medical advice, dependent care referrals, other community referrals, and written information.

QUESTIONS?

BENEFIT	CONTACT	TELEPHONE	WEB ADDRESS
MyBenefits.Life	Alliant	N/A	uicalaska.mybenefits.life | **Employer Key:** uicalaska uicl48.mybenefits.life | **Passwor:** uicl48 uicsca.mybenefits.life | **Password:** uicsca uiccba.mybenefits.life | **Password:** uiccba
Health Advocate	Health Advocate	866.695.8622	HealthAdvocate.com/members
Medical	Premera Blue Cross Blue Shield	844.236.1842 (1UIC)	premera.com
Health Savings Account	HSA Bank	800.357.6246	hsabank.com
TRICARE Supplement	SelmanCo	800.735.6262	selmanco.com/tricare-supplement
Dental	Aetna	877.238.6200	aetna.com
Vision	VSP	800.877.7195	vsp.com
Flexible Spending Accounts Commuter / Parking	HSA Bank	800.357.6246	hsabank.com
Life/AD&D	Cigna	800.362.4462	cigna.com
Short- & Long-Term Disability	Cigna	800.362.4462	cigna.com
Employee Assistance Program	Magellan Health Services	800.478.2812	magellanhealth.com
401(k) Retirement Plan	Principal Financial	800.547.7754	principal.com
Chronic Condition Management	Livongo	800.945.4355	go.livongo.com/PREMERAAK/now

IMPORTANT PLAN NOTICES AND DOCUMENTS

CURRENT HEALTH PLAN NOTICES

The following notices must be provided to plan participants on an annual basis. They are available in the Annual Notices booklet and include:

Medicare Part D Notice

Describes options to access prescription drug coverage for Medicare eligible individuals.

Women's Health and Cancer Rights Act

Describes benefits available to those that will or have undergone a mastectomy.

Newborns' and Mothers' Health Protection Act

Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.

HIPAA Notice of Special Enrollment Rights

Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Describes availability of premium assistance for Medicaid eligible dependents.

CURRENT PLAN DOCUMENTS

Important documents for our health plan and retirement plan available and include:

Summary Plan Descriptions (SPDs)

A Summary Plan Description, or SPD, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of Benefits and Coverage (SBCs)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the UIC Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.