

Your 2025/2026 benefits
at Anchorage School District

BENEFITS

ANCHORAGE SCHOOL DISTRICT



BENEFITING YOU EVERY DAY





This overview is a summary of your benefits as an eligible Anchorage School District employee. We have worked closely with our benefits consultant, Alliant, to provide you with a comprehensive, cost-effective benefits package. Alliant has created this overview to help you better understand your plans and choices. Each section contains important information, so please read this overview carefully.

Your Benefits at Anchorage School District

- Medical Insurance & Prescription Drugs Coverage
- Health Savings Account (HSA)
- Health Reimbursement Arrangement (HRA)
- Teladoc Health for Hypertension and Diabetes
- Hinge Health Virtual PT
- Dental and Vision Insurance
- Basic Life/AD&D / Supplemental Life/AD&D - Dependent Life Insurance
- Flexible Spending Account (FSA)
- Employee Assistance Program
- Near Site Health Clinics
- State of Alaska Retirement Plans
- Voluntary Benefits
- Mandatory Retirement Plans
- ASD 403(B)/457(B) Supplemental Retirement Plans

The benefits in this summary are effective: July 1, 2025 – June 30, 2026

Please note that this overview is a summary of benefits. For a complete description of benefit provisions, refer to your summary plan description (SPD). In the event of a discrepancy between this overview and the SPD, benefits will be paid as outlined in the SPD.

A copy of the SPD is available in the Benefits Department.

YOUR BENEFITS PORTAL

BENEFITSPOT

BenefitSpot

All ASD employees will manage benefits through BenefitSpot, the ASD benefits administration portal - this includes new elections, qualifying life events (QLE) entries, beneficiary designations and Open Enrollment. Kiosks are available in the Benefits Department for employees who need assistance or access to a computer. All communications regarding employee benefits will be sent to the employee's ASD email unless indicated differently.

New Hires/Bargaining Unit Change/Newly Benefits Eligible:

Newly hired employees or newly benefits eligible employees will receive a welcome email to their ASD email within 10-15 business days after their date of hire/eligibility. **Employees must log into BenefitSpot and submit elections within 45 calendar days from their date of hire/change.** Enrollment is time sensitive and should be addressed as soon as possible. If no election is entered employees will automatically default to a "waived" election.

1. **Check your ASD email** (*For assistance with ASD emails, contact the ASD Help Desk at 907.742.4615*)
An email invitation to enroll in eligible benefits will be sent to your ASD email account from asdk12benefits@tri-ad.com. ACTION IS REQUIRED! Make your benefit elections within 45 days from your date of hire/eligibility. If you have not received your invitation to enroll in benefits within 15 business days, please contact the Benefits Department as soon as possible.

How to access BenefitSpot:

Single sign-on (SSO) when connected to the Anchorage School District network:

1. Go to "My Apps", click on the BenefitSpot™ icon;
2. Select the "Benefits Enrollment" tile. You will be pre-authenticated and will not be required to enter a username and password.

Access the Anchorage Benefits Portal Directly:

1. Go to <https://asdk12.benefitspot.com>. The first time you visit the website, you will need to register to create your personal username and password. Thereafter, use the login credentials you established when you registered for the website.
2. Select the "Benefits Enrollment" tile on the home screen and choose the "Start Here" button to begin your enrollment.

Finalize Your Enrollment: Even though your elections are saved as you go, they DO NOT become finalized until you click on "Approve" and "I Agree" at the end of the election process. Be sure to print and save a copy of your benefits summary.

Need help? Contact the ASD Benefits Department.

WHO CAN YOU COVER?

Who is Eligible?

Employees working a 0.75 FTE or more are eligible for the medical, dental and vision benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), Anchorage School District 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.

You can enroll the following family members in our medical, dental, or vision plans:

Your legal spouse

- To be eligible for medical coverage, your spouse must elect their employer's medical plan, if it is available to them. A Spousal Insurance Affidavit must be completed for enrollment.
- ASD Spouses may be double covered under the ASD medical plan. Employees are responsible for ensuring dual medical plan coverage eligibility for HSA/HRA.

Your children:

- Under the age of 26 are eligible to enroll in medical, dental, or vision coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
- Dependent Children include:
 - Natural children
 - Step children
 - Adopted child including those placed with you for adoption
 - Foster children
 - Grandchildren in your legal custody
 - Children you are responsible for under a Qualified Medical Support Order (QMCSO) or court order
- Over age 26 ONLY if they are incapacitated due to a disability and dependent on you for support.

Who is Not Eligible?

The following are not eligible for coverage:

- Domestic partners
- Parents, grandparents, and siblings
- Employees who work less than a 0.75 FTE, contract employees, or employees residing outside the United States.

When Can I Enroll?

Coverage for new employees begins on the 1st of the month following 60 days of employment. Employees who don't make an election will not be covered and will have to wait until the next open enrollment unless they experience a qualifying life event. Open enrollment for current employees is held annually and is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Eligible employees must make benefit changes within 45 calendar days from date of hire through the benefits portal, BenefitSpot. All communication is sent to the employee's ASD email address until changed.

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.



QUALIFYING LIFE EVENTS (QLE)

What is a Qualifying Life Event (QLE)?

A qualifying life event is a change in your situation such as getting married, having a baby or losing/gaining health coverage. These types of events can make you eligible for a special enrollment period, allowing you to enroll or make changes to your health plan coverage outside of the annual Open Enrollment Period. Enrollment is time sensitive and must be completed in BenefitSpot. Employees should enter a QLE as soon as possible but no later than the timing noted below regardless of whether supporting documentation is available at the time of entry. All events are subject to review and approval.

Adding New Dependents/Removing Dependents

A QLE entry must be completed not more than 31 days after the event date through BenefitSpot for the events noted below. Supporting documentation is required.

- Birth
- Adoption or placement for adoption
- Marriage
- Legal Guardianship
- Court or administrative order
- Death
- Divorce/ Dissolution

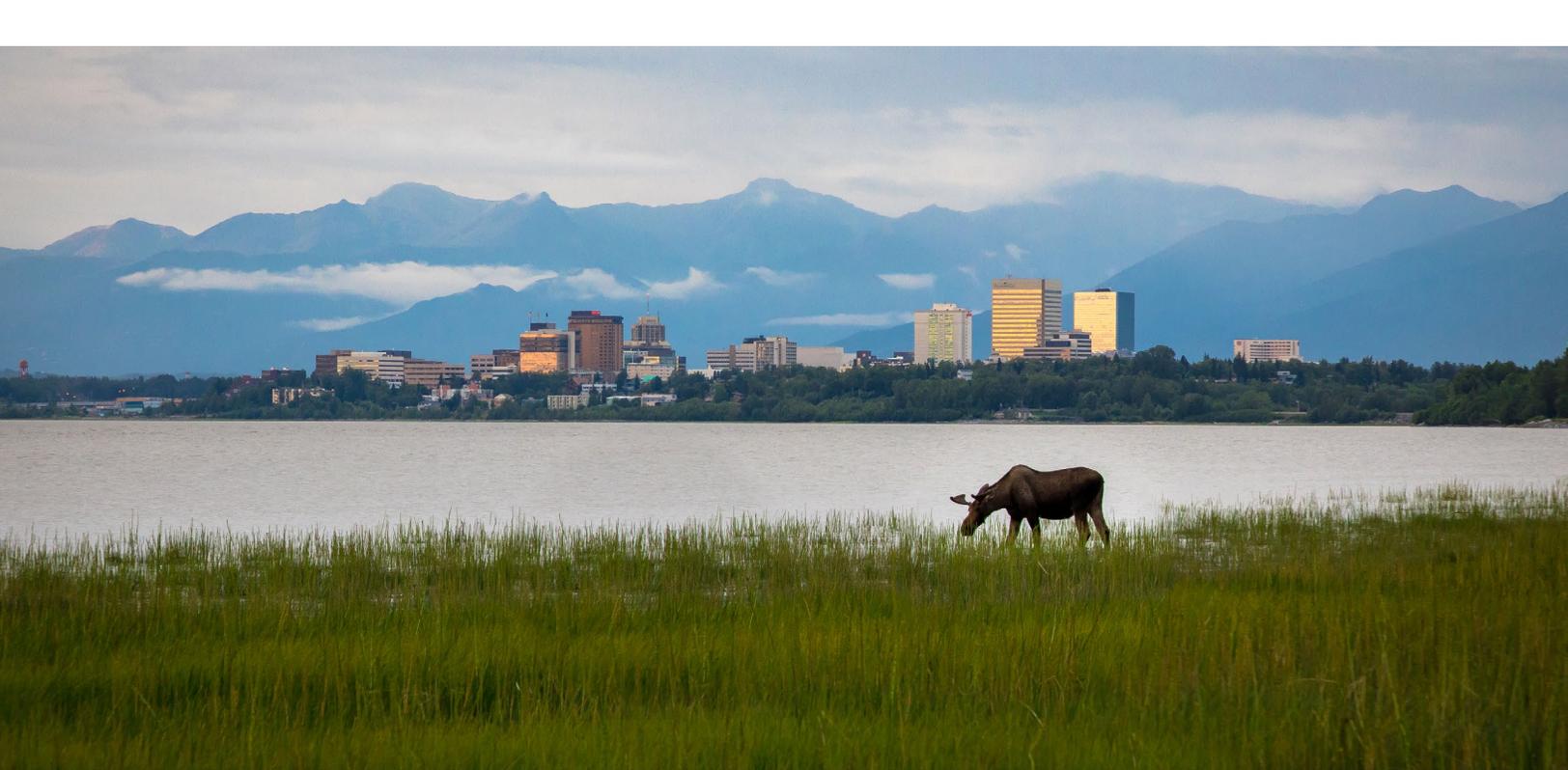
Special Times you can join the plan:

A QLE entry must be completed not more than 31 days from of the date when coverage ends through BenefitSpot

- You did not enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended

A QLE entry must be completed within 60 days of the date when coverage ends through BenefitSpot

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are not eligible for state fee assistance under Medicaid or S-CHIP which will pay your contribution under the plan



COST OF COVERAGE PER PAY PERIOD

Premium for employees paid monthly (September - June; 10 pay periods)

	AETNA MEDICAL CDHP WITH HSA OR HRA	AETNA MEDICAL PPO	DENTAL	VISION
Employee Only	\$82.00	\$247.00	\$23.00	\$6.00
Employee + Spouse	\$164.00	\$324.00	\$45.00	\$12.00
Employee + Child(ren)	\$118.00	\$286.00	\$47.00	\$12.00
Employee + Family	\$200.00	\$356.00	\$70.00	\$18.00

Premium for employees paid bi-weekly (September - May; 20 pay periods)

	AETNA MEDICAL CDHP WITH HSA OR HRA	AETNA MEDICAL PPO	DENTAL	VISION
Employee Only	\$41.00	\$123.50	\$11.50	\$3.00
Employee + Spouse	\$82.00	\$162.00	\$22.50	\$6.00
Employee + Child(ren)	\$59.00	\$143.00	\$23.50	\$6.00
Employee + Family	\$100.00	\$178.00	\$35.00	\$9.00

Elections

You may elect medical, dental and vision independently of each other. You may also choose to waive coverage.

The above premiums reflect the cost of 12 months of coverage to you. For mid-year hires, the employee premiums are adjusted for the remaining pay periods. Coverage changes may result in deductions adjustments on paychecks.

MEDICAL HIGHLIGHTS (CDHP)



When you enroll in the Consumer Driven Health Plan (CDHP), you may be eligible to open and contribute pre-tax dollars into a Health Savings Account (HSA) through TRI-AD. **If you are not eligible for the HSA, you will be provided with a Health Reimbursement Arrangement (HRA) with Aetna. See page 8 for additional details and important information about HSA eligibility.**

It is important to note that both the PPO and Consumer Driven Health Plan (CDHP) offer the Alaska Value Network. If you voluntarily see an out-of-network provider for care, you will pay more than if you choose to see an in-network provider. Visit aetnadocfind.com/asd/ to find a participating provider.

Benefit Features	AETNA CONSUMER DRIVEN HEALTH PLAN (CDHP)	
	In-Network	Out-of-Network
Calendar Year Annual Deductible	\$3,000/individual; \$6,000/family (aggregate)	\$3,000/individual; \$6,000/family (aggregate)
HSA/HRA Funding (offsets deductible)	\$1,000/individual; \$2,000/family	
Calendar Year Out-of-Pocket Maximum	\$5,800/individual; \$11,600/family (aggregate) \$6,850/embedded individual maximum	\$5,800/individual; \$11,600/family (aggregate) \$6,850/embedded individual maximum
Lifetime Max Benefit	Unlimited	
	Plan Pays	
Preventive Services	100%	100%
Office Visit	80% after deductible	50% of allowed amount after deductible
Specialist Visit	80% after deductible	50% of allowed amount after deductible
Urgent Care	80% after deductible	50% of allowed amount after deductible
Chiropractic Service	80% after deductible	50% of allowed amount after deductible (up to 30 visits per year)
Diagnostic X-Ray & Lab	80% after deductible	50% of allowed amount after deductible
Emergency Room	80% after deductible	
Non-Emergency Care in an ER	80% after deductible	80% of allowed amount after deductible
Inpatient Hospital Services	80% after deductible	50% of allowed amount after deductible
Outpatient Surgery	80% after deductible	50% of allowed amount after deductible
Mental Health, Inpatient or Outpatient	80% after deductible	50% of allowed amount after deductible
Massage Therapy	80% after deductible	50% of allowed amount after deductible
Physical Therapy	80% after deductible	50% of allowed amount after deductible
Occupational Therapy	80% after deductible	50% of allowed amount after deductible

*Physical therapy, massage therapy covered as physical therapy, and occupational therapy have a combined annual 30 visit limit.

Important Note About Anchorage Hospitals: Alaska Regional Hospital is the preferred in-network hospital. Enrolled employees and dependents have access to the Vera Whole Health Clinic and Coalition Health Clinic.

Important Note About the CDHP Deductible and Out-of-Pocket Maximum: The family deductible and family out-of-pocket limit are aggregate. This means the plan will not begin paying coinsurance until the family deductible has been met in full by one or a combination of family members. Similarly, the plan will not pay 100% coverage until the family out-of-pocket limit has been met. This can be met by a combination of family members; however, no individual will pay more than the individual embedded maximum of \$6,850.

MEDICAL HIGHLIGHTS (PPO)



It is important to note that both the PPO and Consumer Driven Health Plan (CDHP) offer the Alaska Value Network. If you voluntarily see an out-of-network provider for care, you will pay more than if you choose to see an in-network provider. Visit aetnadocfind.com/asd/ to find a participating provider.

Benefit Features	AETNA PPO PLAN (PPO) CLOSED TO NEW ENROLLMENT	
	In-Network	Out-of-Network
Calendar Year Annual Deductible	\$3,000/individual; \$9,000/family	\$3,000/individual; \$9,000/family
Calendar Year Out-of-Pocket Maximum	\$5,800/individual; \$14,400/family	\$5,800/individual; \$14,400/family
Lifetime Max Benefit	Unlimited	
	Plan Pays	
Preventive Services	100%	100%
Office Visit	80% after deductible	50% of allowed amount after deductible
Specialist Visit	80% after deductible	50% of allowed amount after deductible
Urgent Care	80% after deductible	50% of allowed amount after deductible
Chiropractic Service	80% after deductible	50% of allowed amount after deductible (up to 30 visits per year)
Diagnostic X-Ray & Lab	80% after deductible	50% of allowed amount after deductible
Emergency Room	90% after \$300 copay (copay waived if admitted)	
Non-Emergency Care in an ER	80% after deductible	80% of allowed amount after deductible
Inpatient Hospital Services	80% after deductible	50% of allowed amount after deductible
Outpatient Surgery	80% after deductible	50% of allowed amount after deductible
Mental Health, Inpatient or Outpatient	80% after deductible	50% of allowed amount after deductible
Massage Therapy	80% after deductible	50% of allowed amount after deductible
Physical Therapy	80% after deductible	50% of allowed amount after deductible
Occupational Therapy	80% after deductible	50% of allowed amount after deductible

*Physical therapy, massage therapy covered as physical therapy, and occupational therapy have a combined annual 30 visit limit.

Important Note About Anchorage Hospitals: Alaska Regional Hospital is the in-network hospital in Anchorage for both medical plans. Enrolled employees and dependents have access to the Vera Whole Health Clinic and the Coalition Health Clinic.

Providence Hospital in Anchorage is out-of-network so your cost sharing will be 50% of the allowed amount after deductible and you may be balance billed.

Services received at Providence that are not available at Alaska Regional Hospital will be covered at the higher in-network level. Services not currently provided at Alaska Regional Hospital include:

- NICU III & IV
- Pediatric neurology
- Pediatric ICU
- Pediatric hematology

PRESCRIPTION DRUG HIGHLIGHTS



We know that prescription drug coverage is important to you and your family. Our tiered plan is based on Aetna's Standard Prescription Drug Formulary and designed to give you options to fit your prescription needs.

Benefit Features	AETNA PPO PLAN		AETNA CONSUMER DRIVEN HEALTH PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	N/A		Subject to medical plan deductible	
Retail Pharmacy	You Pay		You Pay	
Generic	\$15 copay	\$15 copay then 50%	\$15 copay	\$15 copay then 50%
Preferred Brand	20% (up to \$120 cap)	20% (up to \$120 cap) then 50%	20% (up to \$120 cap)	20% (up to \$120 cap) then 50%
Non-preferred Brand	20% (up to \$240 cap)	20% (up to \$240 cap) then 50%	20% (up to \$240 cap)	20% (up to \$240 cap) then 50%
Supply Limit	Up to 30 days	Up to 30 days	Up to 30 days	Up to 30 days
Mail Order	You Pay		You Pay	
Generic	\$30 copay	Not covered	\$30 copay	Not covered
Preferred Brand	20% (up to \$80 cap)		20% (up to \$80 cap)	
Non-preferred Brand	20% (up to \$160 cap)		20% (up to \$160 cap)	
Supply Limit	31-90 days		31-90 days	

Mail Order Program: The mail order option allows you to buy qualified prescriptions in 90-day quantities. Mail order saves you time in trips to the pharmacy because prescriptions are delivered right to your door.

Prescription Out-of-Pocket: The applicable medical plan out-of-pocket maximum also applies to all prescription drugs. Once you have met the out-of-pocket maximum, Aetna will pay 100% of the cost of your prescriptions for the remainder of the calendar year.

Vaccines: Seasonal, preventive and travel vaccines are covered 100% at Aetna's participating network pharmacies for patients 18 years and older.

Step Therapy: Certain prescriptions may require step therapy. With step therapy, the plan requires that you try one or more prerequisite drugs before the step therapy drug is covered. If you don't try the appropriate alternative drug first, you may need to pay the full cost for the brand name version.

Note: Some prescriptions have dispensing limits or may require preauthorization. Specialty prescriptions (e.g. injectibles) may need to be purchased from a specific provider. Over-the-counter drugs will not be covered even with a prescription.

Generic Drugs: Generic drugs can often help you reduce your out-of-pocket costs. If a generic drug is available and you choose to get the brand name drug instead, you'll pay the difference in cost between the brand and generic and the applicable copay. If you want to try a generic version of your drug, talk to your doctor about changing your prescription. If you can't tolerate the generic or have had an adverse reaction, talk to your doctor about requesting an exception.

Aetna Mandatory Maintenance Choice Program: If you are enrolled in the Aetna medical plan, you will also be automatically enrolled in the Aetna Maintenance Choice Program. Maintenance Choice is a CVS/Caremark program that lets you easily fill your long-term (maintenance) medications. These are medications you take for chronic conditions such as high blood pressure, asthma, diabetes and high cholesterol. In this program, you have the choice to pick up a 90-day supply of your medication at a CVS, Costco, or Kroger/Fred Meyer pharmacy, or have your medication mailed through the CVS Mail Service Pharmacy. If you have questions or if you would like to opt out of this program, you can call Aetna Customer care at 1-888.792.3862.

HEALTH SAVINGS ACCOUNTS (HSA)

If you enroll in the Aetna Consumer Driven Health Plan (CDHP), you may be eligible to open and contribute pre-tax dollars into a personal Health Savings Account (HSA) through TRI-AD. You may also receive contributions from ASD even if you choose not to contribute. An HSA is a tax-exempt account that allows you to pay for qualified out of pocket health care expenses such as deductibles, coinsurance, copays, prescription drugs and more with tax-free dollars.

Eligibility

To determine if you are eligible for the Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA), are YOU:

- claimed as someone else's tax dependent (other than a spouse); or
- enrolled in a non-qualified healthplan (including a spouse's plan) or Medicare Parts A and B, C or D; or
- eligible to receive benefits from a general purpose FSA or HRA (including a spouse's plan), Medicaid or TRICARE; or
- receiving Veterans or Indian Health Services benefits (within the past 90 days) or do you intend to use them this plan year

If you answered no to all, you are eligible for the CDHP with HSA. If you answered yes to any, you are eligible for the CDHP with HRA. Employees are responsible for determining their eligibility to participate in an HSA. For further guidance on eligibility, please speak with a tax advisor. Ineligible participation may have tax consequences.

Account Contributions

The Anchorage School District will make a contribution to your HSA unless you opt out. You may elect to have an additional pre-tax amount deducted from your paycheck. Contributions to your HSA are subject to IRS limits. Money that you don't spend will accumulate and grow to be used for future healthcare expenses. If you're over 55, the IRS allows you to make an additional \$1,000 Catch Up Contribution. Both the Anchorage School District contribution and employee contributions may take 7 - 10 business days to appear in your account after each payroll.

	ANCHORAGE SCHOOL DISTRICT CONTRIBUTES	YOU MAY CONTRIBUTE
Individual	\$100 per month September – June (\$1,000 per year - prorated for mid-year hires)	Up to \$4,300 per year (less employer contribution)
Family	\$200 per month September – June (\$2,000 per year - prorated for mid-year hires)	Up to \$8,550 per year (less employer contribution)

Beneficiaries

Be sure to log into BenefitSpot after your account is established and designate a beneficiary to your HSA account.

Health Savings Account Investments

Participants with sufficient account balances may elect to invest HSA dollars through a self-directed investment account. Minimum account balances are required. Investments in securities through the HSA investment account are not FDIC insurance, may lose value and are not bank guaranteed. Employees should review all relevant information and understand the risks and fees involved with investing in securities before establishing an account. Further information is found through the BenefitSpot portal.

HEALTH SAVINGS ACCOUNTS (HSA)

Opening and using your HSA

When you sign up for the CDHP and HSA, an account will be set-up for you. The HSA is a bank account, and you may be asked for personal information needed to comply with the provision of the USA Patriot act. This information is confidential. If you fail to provide the necessary information to establish an HSA account, you will be automatically moved to the health reimbursement arrangement.

Once an account is established, you will be issued a debit card, and contributions will be made to your account starting in September (if a continuing employee) or as soon as administrative possible after coverage begins (if a mid-year hire). Remember, you can only spend what has been deposited into the account. You can also submit for a reimbursement from the HSA for expenses. You can use your HSA to pay for qualified expenses for you or an eligible dependent. Log into your HSA portal through BenefitSpot for additional details on health savings accounts and eligible purchases.

Participants of the CDHP with HSA may not participate in a medical FSA account.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRA)

Health Reimbursement Arrangement (HRA)

If you are ineligible for an HSA, you can still enroll in the CDHP and receive HRA contributions comparable to the HSA. An HRA is an employer owned and funded account so employees may not make contributions.

Employees who fail verification for the health savings account will automatically be enrolled in the HRA.

Anchorage School District contributes \$1,000/individual or \$2,000/family per calendar year. For new enrollees, half of the employer contribution (\$500/individual or \$1,000/family) will be available July 1st. For all others, the full employer contribution will be available January 1st. Because the employer owns the account, when you leave employment or are no longer enrolled in this plan, the money in the HRA stays with the employer.

HRA funds are used before you pay anything out-of-pocket and count towards the deductible. You do not need to do anything special when you receive medical care. Simply present your ID card and your provider will bill Aetna who will automatically use the HRA funds to pay your claims.

If you use all the funds in your HRA, you will be responsible for the remaining portion of the deductible before the plan's coinsurance begins paying benefits. Any HRA funds not used will roll over to the next calendar year up to the maximum limit of \$3,000 individual/\$6,000 family. HRA funds are not eligible to be used for dental or vision expenses.

Employees who wish to save additional funds for qualified medical expenses may elect to participate in a medical FSA in addition to the HRA. See the section on "Healthcare FSA" for more information

ADDITIONAL AETNA PROGRAMS



Aetna 24 Hour Nurseline

When your health question can't wait, you can call Aetna's 24 hour Nurseline at 1-800.556.1555. With the Nurseline, you can speak to a registered nurse about health issues at any time. The call is toll-free and you can call as many times as you need to — at no extra cost. You can turn to the Nurseline for helpful health information. You can also get information on a wide range of health and wellness topics, make smarter health care decisions, find out more about a medical test or procedure and get help preparing for a doctor's visit.

Aetna Member Website - [Aetna.com](https://www.aetna.com)

Aetna's self-service website provides you with online health and benefits information 24/7. Go to aetnaresource.com/p/Anchorage-School-District and register your information to view or print a digital ID card, contact Aetna directly, and access your claims and benefits status.

To find participating Aetna providers, go to aetnadocfind.com/asd/. The Anchorage School District Plans are part of the 'Alaska Value Network'.

Aetna Health App

Download the free Aetna mobile app for your Android or iPhone mobile devices. If you use a different mobile device, just visit [aetna.com](https://www.aetna.com) and use the mobile web version of the site. From the app you can search for providers, view your claims, access your ID card, review your coverage and much more.

Aetna Transform Oncology Program

The Aetna Transform Oncology program assists you with the resources and support you may need to manage your cancer diagnosis and care, understand your benefits and locate the right providers. In this program, you will have access to a dedicated care navigation advocate and additional Aetna programs such as the Guided Genetic Health program and the Aetna Cancer Support Center. For more information, please visit the Aetna Cancer Support Center at [aetna.com/cancersupport](https://www.aetna.com/cancersupport) or text "cancercare" to 66902 to receive a link to log into the support center.

MDLive Televideo Counseling Services

MDLive provides you with access to behavioral health televideo counseling services from anywhere. With televideo services, you have another way to get help from psychiatrists, social workers, marriage counselors and more when it's convenient for you. You can see the same provider each time so you can build comfort and keep your care on track.

To access this televideo counseling, you will need to be able to receive an email link, have high speed internet access and have a webcam. No referral or precertification is required. A behavioral health televideo session will cost and be billed the same as a face-to-face office visit.

To get started, call 855.824.2170 or go to [mdlive.com/BHCOMM](https://www.mdlive.com/BHCOMM).

Telemedicine through Aetna

Telemedicine is a convenient and low-cost way to get the care you need when you need it. Get help with:

- General Medicine: cold/flu symptoms, infections, tummy trouble
- Chronic Conditions: allergy symptoms, chronic disease
- Mental Health: anxiety, depression, stress management

Flat dollar amounts based on the type of service:

- Flat \$55 for general medicine
- Flat \$85 for talk therapy visit; less for ongoing visits with same provider

Access anywhere, anytime 24/7 using the Aetna Mobile App!

ADDITIONAL AETNA PROGRAMS



Aetna Medical Travel

The Aetna medical plans include a medical travel reimbursement benefit for those who may need to travel within Alaska or to the Lower 48 to receive care. Travel will be covered only if the cost of travel plus services received is less costly than local surgery or you have a condition that cannot be treated locally.

Travel benefits apply only to the conditions covered under the Aetna medical plan. Air travel within Alaska will be considered for reimbursement only if this is the only mode of transportation available.

To use the benefit, you must first call Aetna's Alaska Medical Travel pre-certification line at 559.241.1035 for authorization. Be prepared to leave your name, phone number, Aetna ID number, appointment date, name and location of the doctor doing the procedure and the name of your local doctor. A letter will be sent to you within 7 days of leaving a message on the pre-certification line.

If approved, you will need to provide Aetna with the required travel information (boarding pass or receipts) along with the medical benefit request claim form for reimbursement. Reimbursement will take 17-24 days from the date the complete claim is received.

HINGE HEALTH BACK AND JOINT PAIN

Hinge Health is an exercise therapy program designed to address back and joint pain. It's convenient and fits in with your schedule – it can be done anywhere, at any time. Employees and dependents age 18+ enrolled in the ASD PPO or CDHP are eligible to use Hinge Health at no additional cost.

What does the program include?

- Personalized exercise therapy to improve strength and mobility in short, 15-minute sessions.
- 1-on-1 health coaching to provide motivation and support via text, email, or call.
- Interactive Education to teach you how to manage your specific condition, treatment options, and more.
- Hinge Health Kit which includes a tablet and wearable motion sensors that give you live feedback during exercises.

What is a health coach?

A health coach is an accountability partner. They will work with you throughout the program to help you create and stick with your goals.

To learn more: If you have any questions about this program, call 855.902.2777 or visit hingehealth.com/asd

TELADOC HEALTH

VIRTUAL HEALTHCARE PROGRAMS

The Teledoc Health Program helps make living with diabetes, high blood pressure, Mental Health and/or Weight Management easier. When you register with Teladoc, you will be provided with the tools to manage your healthcare program.:

This program is offered at no cost to you and your family members who are enrolled in an ASD Sponsored Aetna medical plan.

Diabetes Management

A personalized way to help manage diabetes. Receive:

- A connected blood glucose meter
- Unlimited strips and lancets
- Tips, action plans and one-on-one coaching
- Real-time Support for out-of-range readings

Hypertension Management

Take control of heart health and make managing blood pressure easier. Receive:

- A connected blood pressure monitor
- Step-by-step action plans based on goals
- Tips on nutrition and activity
- One-on-one support from expert coaches

Diabetes Prevention Program

Reduce risk of type 2 diabetes. Receive help from:

- A team of expert coaches for support
- A smart scale that syncs to the app and web
- An all-in-one program that tracks weight, activity and food

Mental Health

Connect with a licensed therapist

- Connect with a licensed therapist 7 days a week from home
- Personalized plan tailored to your needs
- * Activities and content designed for you.

Weight Management

Reach goals with our interactive weight management program.

- A smart scale that syncs to the app and web portal
- An app to log food and set goals
- One-on-one support from a team of expert coaches and the ability to share progress with doctor

For Assistance

If you have any questions about these programs, please call Teledoc Member Support at (800) 835-2362 or visit the Teledoc Website at TeladocHealth.com/Go/ANCHORAGE-SHOOLDISTRICT (code: ANCHORAGE-SHOOLDISTRICT).

VERA WHOLE HEALTH CARE CENTER



Vera Whole Health is an independent primary care health clinic, and an additional benefit available to Anchorage School District employees and their families on the District sponsored health plan*.

Vera provides in-person visits at their Anchorage locations. Services provided include, but are not limited to:

Preventive Care

- Annual Whole Health Evaluation which includes: Biometric screening, provider visit and health coaching. **An incentive of \$200 each is provided for employees and enrolled spouses who complete the Annual Whole Health Evaluation.**
- Immunizations; screenings; well women exams; family planning

Chronic Disease Management

- Diabetes; hypertension; depression

Acute Care

- Coughs/colds; wound care; sprains and strains; rashes; urinary tract infections; back pain

Bonus Support Services

- Health coaching; on-site labs; provider-dispensed medications; specialty care coordination and advocacy

Costs

Preventive visits are always free. If you are on the Consumer Driven Health Plan (CDHP) you will pay \$25 for each non-preventive care visit. Cost share does not apply once you have met your deductible. If you are on the PPO plan, all visits are free.

Appointments

You can schedule an appointment at either of the two Vera Whole Health Anchorage locations via:

Phone: 907.302.4950 (Midtown) or 907.313.7550 (Eastside)

Web: patients.verawholehealth.com

App: visit the app store on any iOS device to download the [Vera Whole Health app](#)

In addition to scheduling or canceling appointments, you can also schedule health coaching sessions, access your chart and medical information, and see your Vera benefits through the patient website and mobile app. Register with your birthdate and employer name to set up your access.

Saturday appointments are available at the Eastside location.

Midtown Anchorage

582 E 36th Ave, Suite 203
Anchorage, AK 99503
907.302.4950

Eastside Anchorage

1450 Muldoon Road, Suite 100
Anchorage, AK 99504
907.313.7550

*Employees on the District sponsored health plan include:

ACE, APA, Exempt, Food Services, Maintenance, Non-Represented and TOTEM.

COALITION HEALTH CLINIC

Coalition Health Clinic managed by Beacon is an independent health clinic with experienced healthcare providers, and an additional benefit available to Anchorage School District employees and enrolled dependents on the District sponsored health plan*. Services provided by the clinic are billed directly to the District and are not subject to health plan deductibles. The Coalition Health Clinics offer services to eligible employees and dependents at three different locations throughout the state. Services provided include, but are not limited to:

Preventive Care

- Immunizations; screenings; wellness visits, physicals

Chronic Disease Management

- Diabetes; hypertension; depression, migraines, asthma, depression and anxiety

Acute Care

- Coughs/colds; wound care; sprains and strains; rashes; urinary tract infections; back pain

Bonus Support Services

- on-site labs; provider-dispensed medications; x-rays

Costs

Preventive visits are always no cost to the employee. If you are on the Consumer Driven Health Plan (CDHP) you will pay \$25 for each non- preventive care visit . If you are on the PPO plan, all visits are free.

Appointments

You can schedule an appointment to fit your schedule or visit during walk-in hours. Clinic contact information and hours are below. **A fee of \$75 is assessed for cancellations or no-show with less than 24 hour advance notice.**

Anchorage

701 East Tudor Suite 120
907.264.1370

Appointments

Monday – Friday:
7:30 AM – 6:30 PM

Walk-Ins Available

Monday – Friday
8:30 am – 5:00 pm

Mat-Su

1700 East Bogard Road
Building A, Suite 103
907.313.7550

Call to verify hours

Appointments

Monday – Friday:
7:30 AM – 6:30 PM

Walk-Ins Available

Monday – Friday
8:30 am – 5:00 pm

Fairbanks

570 Riverstone Way, Unit 3
907.450.3300

Appointments

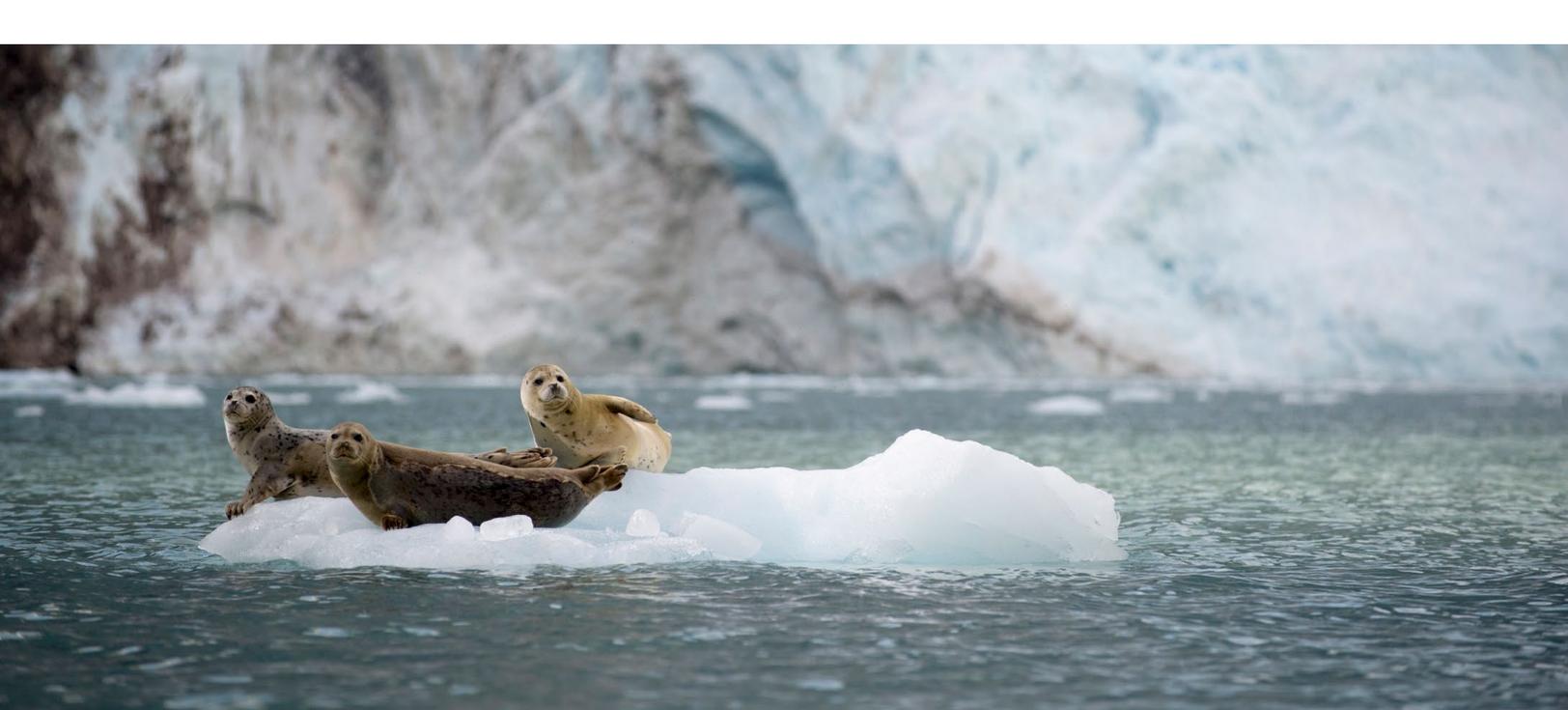
Monday – Friday:
7:30 AM – 6:30 PM

Walk-Ins Available

Monday – Friday
8:30 am – 5:00 pm

*Employees on the District sponsored health plan include:

ACE, APA, Exempt, Food Services, Maintenance, Non-Represented and TOTEM.



DENTAL HIGHLIGHTS

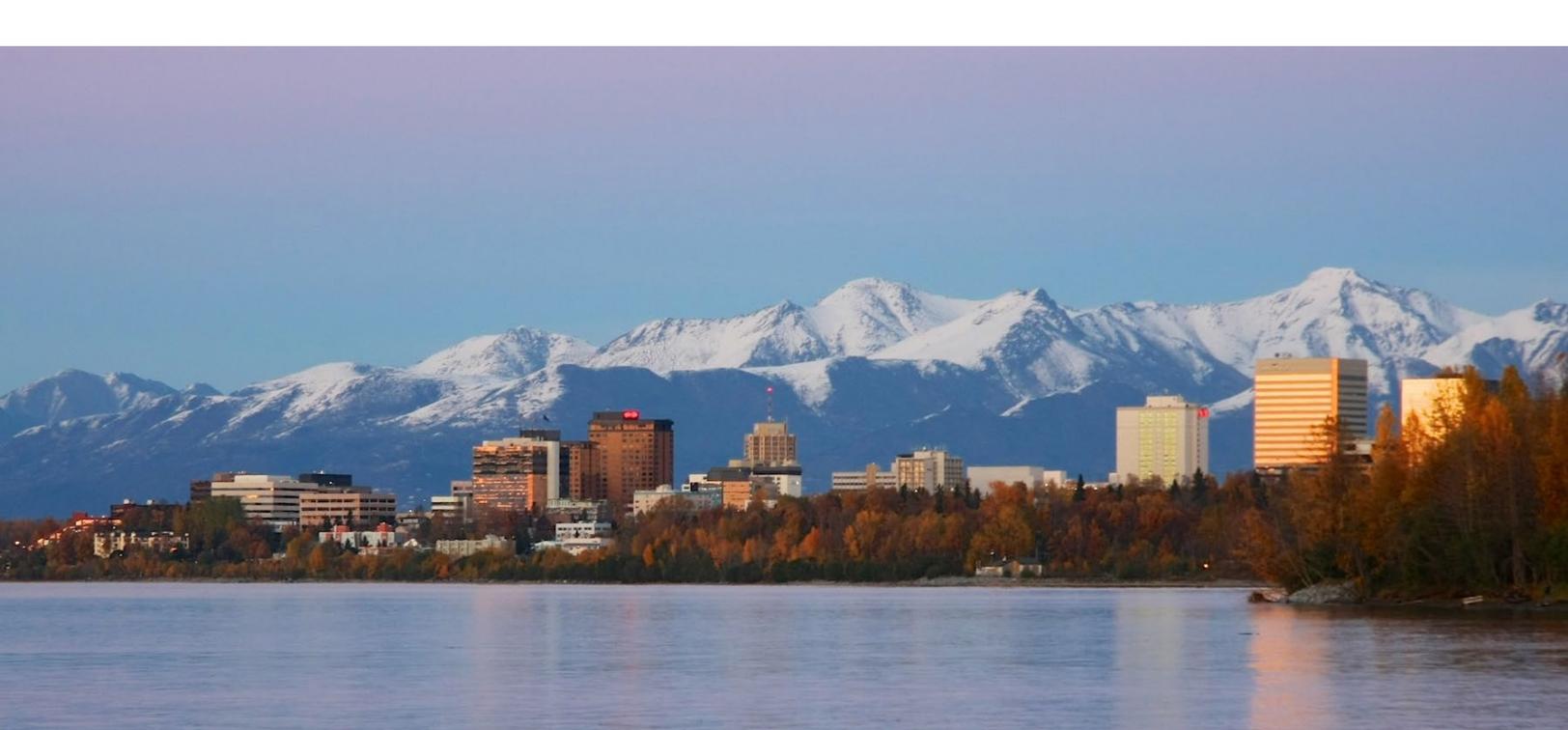


We are pleased to offer you a dental plan through Aetna. You may choose to seek care from any licensed dental provider; however, when you visit a participating dentist, you maximize your benefit with lower out-of-pocket expenses. If you visit an out-of-network dentist, you may be responsible for additional costs if the provider's charges exceed the plan's usual & customary levels. You can search for participating dentists in the Dental PPO/PDN w/PPO II network at aetnadocfind.com/asd/.

Benefit Features	AETNA DENTAL PLAN	
	In-Network	Out-of-Network
Calendar Year Deductible	\$50/individual; \$150/family	
Annual Plan Maximum	\$2,000	
Reimbursement Level	Negotiated Fee	90th Percentile of Reasonable and Customary
Diagnostic and Preventive Services	Plan Pays	Plan Pays
Exams, Cleanings, X-rays	100%	100%
Basic Services	Plan Pays	Plan Pays
Fillings, Periodontics, Endodontics	80% after deductible	80% after deductible
Major Services	Plan Pays	Plan Pays
Crowns, Bridges, Dentures	50% after deductible	50% after deductible

Pre-Treatment Estimate: Before beginning extensive dental work, it is STRONGLY recommended that you have your dentist obtain a pre-treatment estimate from Aetna. A pre-treatment estimate ensures that you are aware of expected out-of-pocket costs before beginning treatment.

ID Card: New enrollees will receive a paper ID card in your dental welcome letter from Aetna. You can also access your card digitally on the Aetna Member Website or Aetna Health App. If you are enrolled in an Aetna medical plan, you will use your same ID card for dental coverage.



VISION HIGHLIGHTS



We are pleased to offer you a vision benefit through Guardian using the VSP Signature network.

Benefit Features	GUARDIAN VISION PLAN	
	In-Network	Out-of-Network
Vision Benefits	Plan Pays	Plan Pays
Eye Exam Once every 12 months	100%	100% up to \$50
Materials	100%	100% up to benefit limits listed below
Contact Lens Fitting/Exam	100% after up to \$60 copay	See Contact Lenses Below
Eyeglass Lenses Once every 12 months		
Single Vision Lens	100% for basic lens	100% up to \$50
Bifocal Lens	100% for basic lens	100% up to \$65
Trifocal Lens	100% for basic lens	100% up to \$100
Frames Once every 24 months	100% up to \$180	100% up to \$70
Contact Lenses (in lieu of eyeglasses) Once every 12 months	100% up to \$170	100% up to \$105

Note: The vision hardware benefit may not cover all costs including lens coatings and taxes. If you choose to use an out-of-network provider, you may have to pay your provider at the time of service and you may be required to submit your own claim to the insurance company.

ID Card: You will receive an ID card from Guardian for your vision coverage. If you lose your card or need additional cards, you can request a new card by contacting Guardian.

To search for a VSP provider, go to vsp.com and select 'Signature' in the 'Doctor Network' field.

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSAs) allow you to save by setting aside money pre-tax to pay for qualified out-of-pocket expenses. We offer both a Healthcare and Dependent Care Flexible Spending Account through TRI-AD.

You can enroll in the FSA during your initial enrollment period and during the annual open enrollment. You must re-enroll each year and you can designate an amount, up to the annual account maximums. This amount will be deducted from your paycheck on a pre-tax basis throughout the plan year. You can use your FSA debit card to pay for qualified healthcare and dependent care expenses. Make sure you keep your receipts and explanation of benefits in the event that TRI-AD or the IRS requests additional information on a transaction. You can use your FSA debit card to pay for qualified healthcare and dependent care expenses.

Healthcare FSA

This plan allows you to pay for qualified out-of-pocket healthcare expenses with pre-tax dollars. You may access your entire annual election from the first day of the plan year.

Qualified expenses include medical, dental or vision costs including plan deductibles, copays, coinsurance amounts and non-covered healthcare costs for you and your tax dependents.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Annual Minimum: \$300

Annual Maximum: \$3,300

Dependent Care FSA

This plan allows you to pay for qualified out-of-pocket dependent care expenses with pre-tax dollars. It is important to note that you can access money only after it is placed into your dependent care FSA.

Qualified expenses may include daycare centers, in-home child care and before or after school care for your dependent children under age 13 while both you and your spouse (if applicable) work or go to school full time. Other individuals may qualify if they are considered your tax dependents and are incapable of self-care. All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Annual Minimum: \$300

Annual Maximum \$5,000 (\$2,500 if married and filing separately)

Important Considerations

- Expenses must be incurred between 7/1/2025 and 6/30/2026 and submitted for reimbursement no later than 9/30/2026.
- Employees separating from employment may only claim expenses incurred between their benefit start date and their last day of work. Reimbursements must be submitted no later than 90 days from the last day of employment.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status.
- Unused amounts will be forfeited at the end of the plan year, so it is important that you plan carefully.
- FSA funds can be used for you and your tax dependents only.
- You can obtain reimbursement for qualified expenses incurred by your spouse or tax dependent children, even if they are not covered on the Anchorage School District health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents. Consult your tax advisor about the tax status of your dependents.
- Your coverage and debit card access will terminate on your last day of work.
- Qualified expenses incurred after your last day of employment are not eligible for reimbursement. Claims filed after 90 days from the last day of employment will be denied.
- Any unclaimed funds are forfeited at the end of each plan year.



LIFE/AD&D INSURANCE

Basic Life/AD&D Highlights

Life insurance is provided for all regular full-time and part-time employees. If you have loved ones who depend on your income for financial support, you are probably aware of the importance of Life and AD&D (Accidental Death & Dismemberment) protection. Life insurance pays your beneficiary a benefit, should you die and AD&D insurance pays a benefit, should your death result from an accident OR if you are severely injured in an accident. Age may affect coverage levels.

We are offering you Basic Life/AD&D insurance through The Hartford. Enrollment is automatic and Anchorage School District pays the full cost for your coverage based on your applicable employee group. You only need to designate a beneficiary. For more information about your specific life/AD&D benefit, see the chart on page 21 or contact the Benefits Department at BenefitsDept@asdk12.org.

Dependent Life Highlights

You are eligible to purchase \$10,000 of life insurance for your eligible spouse and dependent children through an after-tax payroll deduction. The annual employee premium is \$24 and is deducted on your paycheck during the months of September - May/June. The employee premium is prorated for mid-year hires. Employees may not be covered under their own policy and as dependent under another employees policy

Supplemental Life/AD&D Highlights

You may be eligible to enroll in supplemental Life/AD&D insurance through The Hartford. If you need additional life insurance to meet your financial needs, you can purchase voluntary life insurance through after-tax payroll deductions. Should you leave Anchorage School District, you can elect to continue this coverage.

Evidence of Insurability: If you enroll when you are first eligible, you can request up to the guaranteed issue amount for yourself without providing proof of good health. If you request coverage after you are first eligible, you will need to submit proof of good health for all amounts of coverage requested.

LIFE/AD&D INSURANCE

Life/AD&D Insurance coverage by Employee Group

For information about the employee Supplemental Life/AD&D eligibility, coverage and cost, contact the Benefits Department at BenefitsDept@asdk12.org.

EMPLOYEE GROUP	DISTRICT PROVIDED LIFE/AD&D COVERAGE	EMPLOYEE SUPPLEMENTAL LIFE/AD&D COVERAGE	DEPENDENT LIFE COVERAGE
ACE Class B	3 x Annual Salary Maximum \$300,000	Not Available	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
AEA Class D	3 x Annual Salary Maximum \$100,000	Can purchase supplemental coverage in increments of \$10,000 up to the lesser of 5x annual salary or \$500,000.	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
APA Class C	3 x Annual Salary Maximum \$300,000	Can purchase supplemental coverage in increments of \$10,000 up to the lesser of 5x annual salary or \$500,000.	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Exempt Class A	3 x Annual Salary Maximum \$600,000	Not Available	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Local 71 Class H	3 x Annual Salary Maximum \$50,000	Can purchase supplemental coverage in increments of \$10,000 up to the lesser of 5x annual salary or \$500,000.	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Non-Represented Class L	3 x Annual Salary Maximum \$300,000	Not Available	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Teamsters Bus Class I	3 x Annual Salary Maximum \$300,000	Not Available	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Teamsters Food Service Class F	3 x Annual Salary Maximum \$300,000	Not Available	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Teamsters Maintenance Class G	3 x Annual Salary Maximum \$300,000	Can purchase supplemental coverage in increments of \$10,000 up to the lesser of 5x annual salary or \$500,000.	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried
Totem Class E	3 x Annual Salary Maximum \$50,000	Can purchase supplemental coverage in increments of \$10,000 up to the lesser of 5x annual salary or \$500,000.	Spouse: \$10,000 Child(ren): \$10,000 each, birth-age 26, if unmarried

Note: Coverage is subject to change based on collective bargaining unit agreements.

Example for 30,000:

- $\$30,000 \times .000217 = \6.50 monthly $\times 12 = \$78.12$ per year
- $\$78.12$ annual premium $\div 10 = \$7.81$ per month, September through June
- $\$78.12$ annual premium $\div 20 = \$3.91$ per biweekly paycheck September through June

Any deaths should be reported to the Benefits Department as soon as possible.

VOLUNTARY BENEFITS

Anchorage School District has partnered with The Hartford to offer employees a suite of income protection options.

The Hartford is proud to be an industry leader in Group Benefits. As part of The Hartford's Culture of Caring, the solution-oriented claims process is made up of over 400 compassionate medical professionals, ready to assist you and your family with personalized, considerate care when you need it most. They are committed to helping protect you and those you love.

Eligible employees may elect benefits that fit their personal situation. Cost is deducted from employee paychecks. Employees are encouraged to discuss coverage options with The Hartford prior to election.

Additional information and assistance is available by contacting The Hartford Benefits Support Team at 1-888.212.8484.

Disability Flex[®] Insurance

Income Protection Benefits, tailored to your needs

You can choose how soon benefit payments begin after an injury or illness, the benefit amount that is right for you, and how long payments continue if you remain disabled

This benefit allows elections in \$100 increments up to \$1,500 for a weekly benefit payout.

Accident Insurance

Accidental Injury Benefits for you and your family

Some of the benefits include:

- Ground ambulance benefit
- Medical appliance benefit
- Physical therapy benefit
- Diagnostic exam benefit
- X-ray benefit

This benefit provides a cash benefit for incidents related to a qualifying accident.

Critical Illness Insurance

Critical Illness Benefits for you and your family

Enroll in \$10,000, \$20,000, or \$30,000 of coverage for yourself.

Some of the benefits include:

- Cancer
- Heart Attack
- Stroke

Critical Illness insurance offers benefits for 34 serious illness and related expenses.



EMPLOYEE ASSISTANCE PROGRAM (EAP)

Each person's life includes its own unique set of challenges. To help you cope with these challenges, we offer the School Employee Guidance Program through Aetna's Resources for Living. Enrollment is automatic and Anchorage School District pays the full cost for your coverage. This program is available to you and your household members beginning on your date of hire.

Benefits include confidential access to trained counselors any time, day or night, for assistance with:

- Marital and family issues
- Depression and anxiety
- Problems with substance abuse
- Financial, Legal and ID Theft issues
- Balancing work and home
- Child and elder care referrals

Simply call 1-888.866.4827 and a counselor will assist you. The EAP provides up to 6 free visits per issue for you and your family members, with a Licensed Mental Health Provider who is skilled in assessing your concerns. Counseling sessions are available via phone, televideo or face-to-face.

You can also visit resourcesforliving.com (Username: AnchorageSD, Password: ARFL) for a range of tools and resources on behavioral health and worklife balance topics.

MANDATORY PARTICIPATION SOA RETIREMENT PLANS

State of Alaska Retirement

The Anchorage School District (ASD) participates in the retirement programs sponsored by the State of Alaska. Participation is mandatory for eligible ASD employees.

Public Employees' Retirement System (PERS)

Classified employees who work at least 15 hours per week are covered for retirement benefits as outlined in the applicable statutes related to PERS. Both ASD and the employee make contributions to PERS. The following employee groups are covered:

- Totem
- ACE (classified)
- Local 71 (custodians)
- Exempt (classified)
- Teamster Local 959 (student nutrition, bus, maintenance/warehouse)
- Non-Represented (classified)
- Certificated employees working an FTE of 0.40 to 0.49

Teachers' Retirement System (TRS)

Certificated employees working an FTE of .50 to 1.0 are covered for retirement benefits as outlined in the applicable statutes related to TRS. Both ASD and the employee make contributions to TRS. Participants of the TRS do not participate in Social Security. The following employee groups are covered:

- AEA
- APA
- ACE (certificated)
- Exempt (certificated)
- Non-Represented (certificated)

Defined Benefit Plan (DB)

doa.alaska.gov/drb/programs/help.html

For employees who first entered PERS or TRS prior to July 1, 2006:

The defined benefit plan is designed to offer a lifetime monthly benefit once retirement eligibility is reached. Retirement eligibility is based on the DB tier by either age or by years of service. Benefits from the plan will be determined by a formula defined in statute unless a refund is requested. The formula comprises of a multiplier times the average monthly salary (AMS) times the total years of service at retirement. The multiplier increases at certain key points the longer an employee remains in service.

Defined Contribution Plan (DCR)

doa.alaska.gov/drb/programs/help.html

For employees who first entered PERS or TRS on or after July 1, 2006:

The Alaska PERS/TRS Defined Contribution Retirement Plan is a defined contribution plan governed by section 401(a) of the Internal Revenue Code. A portion of the employee's wages and an employer contribution are made to this plan pre-tax. The contributions, plus any changes in value (interest, gains and losses), minus any plan administrative fees or other charges are payable to the employee or their beneficiary at a future date. The PERS/TRS DCR Plan is a participant-directed plan with investment options offered by the plan. The providers of the investment options were selected by the Alaska Retirement Management (ARM) Board. The DCR Plan provides the option of selecting an investment management style based on the employee's comfort level of selecting investments. The plan is record-kept by Empower Retirement and an account is automatically established for the employee.

SUPPLEMENTAL RETIREMENT PLANS

Anchorage School District 403(B) and 457(B) Retirement Plans

All regular ASD employees, substitute teachers and temporary employees have the option to contribute to two supplemental retirement accounts. They are the 403(b) Defined Contribution Plan and the 457(b) Deferred Compensation Plan. These plans can be used to help employees save more for retirement or even lower their taxable income. The 403(b) and 457 have some similar features such as contribution limits, the type of money you can save: pre-tax and/or Roth, investments and loan options. Where they differ is when you can take out your money when the time comes. These plans are sponsored by the Anchorage School District and serviced by Empower Retirement. Learn more at retire.asdk12.org.

Enrollment

You may enroll online using a plan enrollment code (PEC) or by paper enrollment form. A PEC or enrollment form can be obtained by emailing the ASD Benefits department at benefitsdept@asdk12.org or contacting Empower Retirement at 800.232.0859.

Employees may participate in both the 403(b) and 457(b) plan.

Employee Contributions

Participants may contribute 1% to 70% or \$10 up to the IRS limit for the calendar year. You may not contribute more than 70% per pay period.

Contributions can be made in before-tax or Roth (after-tax) dollars or a combination of the two money types.

Participants turning age 50 or older may contribute additional amounts as defined by the IRS.

Contribution limits are separate for each plan. Participants may contribute the maximum to each plan.

457(B) 3-year Special Catch-Up: Participants within 3 years of normal retirement age may contribute up to double the regular IRS maximum. Contact Empower for details.

Roth

The Roth option will give you the flexibility to designate all or part of your elective deferrals as Roth contributions. Roth contributions are made with after-tax dollars, as opposed to the pre-tax dollars you contribute to a traditional account. In other words, with the Roth option, you've already paid taxes on money you contribute. With the traditional invest account, your contribution is made on a pre-tax basis and you pay taxes only when you take a distribution.

Investment Options

A wide array of core investment options is available through the plans. Investment options are the same for both plans.

Each option is explained in further detail in your Plan's fund sheets. Investment option information is also available at empowermyretirement.com (Plan Number 93399-01 or 93399-02) or you can call the Voice Response System toll-free at 1-800.232.0859. The Web site and the Voice Response System are available to you 24 hours a day, 7 days a week.

Transfers and Allocation Changes

Use your Username and password to access empowermyretirement.com or you can use your Social Security number and password to access the Voice Response System. You can move all or a portion of your existing balances between investment options (subject to Plan rules) and change how your payroll contributions are invested.

Plan Fees

There is an asset based fee of 0.01083 that is calculated and deducted from your account monthly.

Distribution Fees

The benefit disbursement fee is \$0.

Investment Option Fees

Each investment option has an investment management fee that varies by investment option. These fees are deducted by each investment option's management company before the daily price or performance is calculated. Fees pay for trading of securities within the investment option and other management expenses.

Funds may impose redemption fees on certain transfers, redemptions or exchanges.

SUPPLEMENTAL RETIREMENT PLANS

Loans

Your Plan allows you to borrow the lesser of \$50,000 or 50% of your eligible total vested account balance. The minimum loan amount is \$1,000 and you have up to 60 months to repay your general purpose loan or up to 180 months if the money is used to purchase your primary residence.

There is also a \$50 origination fee for each loan, plus an ongoing annual \$25 fee deducted from your account at \$6.25/quarterly.

You may have one active 403(b) loan and one active 457(b) loan at any time. Loan balances are aggregated across all loans (403(b) and 457(b)) that are available through ASD retirement plans.

Rollovers

403(b) Defined Contribution Retirement Plan

Only Plan Administrator approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the Plan.

457(b) Deferred Compensation Plan

Approved balances from eligible governmental 457(b) plans only may roll over

As with any financial decision, you are encouraged to discuss moving money between accounts, including rollovers, with a financial advisor and to consider costs, risks, investment options and limitations prior to investing.

Withdrawals

Qualifying distribution events are as follows:

- Retirement
- Permanent disability
- Financial hardship (as defined by the Internal Revenue Code and your Plan's provisions)
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Attainment of age 59½
- Death (your beneficiary receives your benefits)
- Transfer for purchase of service credit

When you qualify for a withdrawal (also known as a distribution, you have the following options available:

- Deferred payment until you reach the age for a required minimum distribution
- Lump-sum payment (full or partial)
- Periodic payment
- 5, 10, and 15-year period-certain annuity
- Single life annuity
- Single life annuity with 10 or 15-year period certain
- 50% or 100% joint/survivor annuity
- Direct Rollover to another qualified or eligible plan

Ordinary income tax will apply to each distribution. Distributions from the 403(b) received prior to age 59½ may also be assessed a 10% early withdrawal federal tax penalty. Qualified Roth distributions are not subject to ordinary income tax provided the distribution occurs after you have reached age 59½ (or been disabled or died) and at least five years have passed since your first Roth contribution.

How do I get more information?

Contact the service provider, Empower Retirement at 1-800.232.0859 to schedule an appointment with a local representative.

Appointments may also be available at the Benefits Department with an Empower representative periodically. Contact ASD Benefits for more information.

FMLA/AFLA & LEAVE

The Anchorage School District is committed to providing employees with leave in compliance with the policies, bargaining agreements and laws that govern the Anchorage School District. This includes the Federal Family Medical Leave Act and the Alaska Family Leave Act, as applicable. Both laws provide employer options for implementation of leave.

THE FAMILY AND MEDICAL LEAVE ACT (FMLA) requires the District to provide up to 12 weeks of unpaid leave in a 12-month period to eligible employees for qualifying family and medical reasons. Employees are eligible if they have worked for the District for at least one year, and for 1,250 hours over the previous 12 months. For purposes of total leave availability, the Anchorage School District utilizes a rolling 12-month period measured backward from the date an employee uses any FMLA/AFLA leave. Unused FMLA/AFLA leave does not accumulate from year to year.

THE ALASKA FAMILY LEAVE ACT (AFLA) requires the District to provide up to 18 weeks of unpaid leave during a 24-month period to eligible employees because of a serious health condition of the employee or qualifying family member. AFLA provides a total of 18 weeks of unpaid leave during a 12-month period because of pregnancy, childbirth, or adoption. Employees are eligible if they have worked for the District for at least 35 hours a week in the last six consecutive months, or for at least 17.5 hours a week for the last 12 consecutive months immediately preceding the leave. In the event an employee is eligible for leave under AFLA only, and AFLA does not contain specific requirements for implementation of that leave, the District adopts and utilizes the procedures, rights, and responsibilities set forth in FMLA.

FML and AFL will run concurrently for employees eligible for both types of leave.

When to Apply

Employees who expect to be absent for more than 5 consecutive calendar days or require an intermittent or reduced schedule for the foreseeable future for one of the following reasons listed below should submit a request.

- To care for the employee's infant during the first 12 months following birth;
- To care for a child during the first 12 months following the employee's adoption of the child or foster care placement of the child with the employee;
- To care for a spouse, child, or parent with a serious health condition;
- Because of the employee's own serious health condition;
- For an employee whose family member is a military member who has a qualifying exigency or a serious illness or injury.

How to Apply

Requests for FML/AFL should be submitted through EmpCenter at least 30 days in advance or as soon as possible. Kiosks are available in the Benefits department for employees who need support or access to a computer. Employees will receive a case number upon submission. All requests are review by a representative of the benefits department and communication will be sent to the employee.

Leave taken under these provisions provide job protection, continued benefits and cannot be used against employees.

More information can be found on <https://www.dol.gov/agencies/whd/fmla>

MEASUREMENT METHOD

You and your dependents are eligible for the 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 major medical benefits eligibility but is not a guarantee of benefits eligibility. Anchorage School District uses the look-back measurement method to determine whether an employee meets this eligibility threshold.

New Employees

If you are hired as a new full-time employee (.75 FTE), you and your dependents are generally eligible for the medical plan as of the first of the month following 60 days.

If you are hired into a part-time position, a position where your hours vary and Anchorage School District is unable to determine — as of your date of hire — whether you will be a full-time employee (.75 FTE), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee.

Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average .75 FTE over that 12 month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing Employees

Anchorage School District uses the look-back measurement method to determine group health 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 Anchorage School District counts employee hours to determine which employees work full-time.

An employee is deemed full-time if he or she averages .75 FTE over the 12-month standard measurement period. Those employees who average .75 FTE or more 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. Full-time status will be in effect for a 12-month stability period. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Measurement Period Time to determine if you work .75 FTE on average – used to establish if you are “full-time” or “part-time” for medical eligibility	May 1 – April 30
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	July 1 – June 30

IMPORTANT PLAN NOTICES AND DOCUMENTS

Current Health Plan Notices

Notices must be provided to plan participants on an annual basis and are available in the Annual Notices packet and on our benefits website. The notices 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.

HIPAA Notice of Privacy Practices

Describes how medical information about you may be used and disclosed and how you can get access to this information.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Describes availability of premium assistance for Medicaid eligible dependents.

Nondiscrimination and Accessibility Requirements Notice

Describes organization's compliance with Federal non-discrimination laws along with communication and language assistance services.

Current Plan Documents

Important documents for our benefit plans are available on our benefits website 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.

Cobra Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

Note on Dependent Eligibility

Knowingly enrolling an ineligible dependent or intentionally keeping a dependent on the plan when they have lost eligibility constitutes insurance fraud and is a material misrepresentation of fact. When the plan discovers any such ineligible dependent it will terminate coverage retroactively and reprocess any claims, making them payable by such an individual.

Statement Of Material Modifications: This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Anchorage School District 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.

ANNUAL NOTICES

Medicare Part D Notice

Important Notice from Anchorage School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Anchorage School District 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. Anchorage School District has determined that the prescription drug coverage offered by the Aetna Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Anchorage School District coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Aetna Medical Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing 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 Anchorage School District 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.

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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 Anchorage School District changes. You also may request a copy of this notice at any time.

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 Anchorage School District 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 [medicare.gov](https://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 [socialsecurity.gov](https://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).

Date:	May 15, 2025
Name of Entity/Sender:	Anchorage School District
Contact-Position/Office:	Benefits Department
Address:	5530 Northern Lights Blvd. Anchorage, AK 99504
Phone Number:	907.742.4200

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator 907.742.4200.

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Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 907.742.4200.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Anchorage School District's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Anchorage School District's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Anchorage School District's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

HIPAA Notice of Privacy Practices

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.

Effective August 14, 2024

This is the Notice of Privacy Practices (the "Notice") that is described in the Health Insurance Portability and Accountability Act of 1996 and the corresponding federal regulations (commonly known as "HIPAA"). It is required to be published and distributed by those responsible for maintaining the Anchorage School District Health Plans (the "Plan"). HIPAA requires those benefit programs within the Plan that are subject to HIPAA (medical, prescription, dental, vision, health reimbursement arrangement (HRA), health care flexible spending account (Health Care FSA), employee assistance program (EAP), and retiree medical, dental, and vision) to protect the privacy of your personal health information, to provide you with notice of the Plan's legal duties and privacy practices, as they pertain to your personal health information, and to notify you following a breach of unsecured protected health information. The Plan is required by law to abide by the terms of this Notice, as currently in effect.

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You may have additional privacy rights under state law. An applicable state law that provides for greater privacy protection or privacy rights will continue to apply.

Your Personal Health Information

The Plan collects personal health information from or about you through the application and enrollment process, utilization and review activities, claims management, and/or other activities in connection with the general management of the Plan. Your personal health information that is protected by law broadly includes any information, whether verbal, written or recorded, that is created or received by certain healthcare entities, including healthcare providers, such as physicians and hospitals, as well as health insurance companies or health plans. The law specifically protects health information that contains data such as your name, address and social security number that could be used to identify you as the individual who is associated with that health information.

Uses and Disclosures of Your Personal Health Information

Generally, the Plan may not use or disclose your protected health information ("PHI") without your permission. Further, once your permission has been obtained, the Plan must use or disclose your PHI in accordance with the specific terms of that permission.

Uses and Disclosures without Authorization

The following are the circumstances under which the Plan is permitted by law to use or disclose your PHI without your permission:

- For payment purposes, such as, but not limited to, billing, claims management, collection activities, and related healthcare data processing. For example, the Plan may disclose your PHI to a health care provider so that it can make authorization decisions;
- For healthcare operations purposes, such as, but not limited to, quality assessment and improvement activities, underwriting, conducting or arranging for medical review, legal services, audit services, fraud and abuse detection programs, and other activities necessary or appropriate for the maintenance of the Plan. For example, the Plan may use the information to provide disease management programs for covered persons with specific conditions such as diabetes, asthma or heart failure; and
- For treatment purposes, such as, but not limited to, disclosures to a healthcare provider. For example, the Plan may disclose to a treating orthodontist the name of the treating dentist so that the orthodontist may request dental records from the treating dentist.

The Plan may also disclose PHI without your permission as follows:

To Anchorage School District ("ASD"). The Plan may disclose your PHI to designated ASD employees so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to individuals involved in Plan-related administration. These individuals will protect the privacy of your health information and ensure it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your health information may not be disclosed by the Plan to any other ASD employee or department and will not be used by ASD for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by ASD.

To Business Associates. Certain services are provided to the Plan by third parties known as "business associates." For example, the Plan may input information about your healthcare treatment into an electronic claims processing system maintained by the Plan's business associate so your claim can be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

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With Regard to Treatment Alternatives and Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you. Also, the Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

To Individuals Involved in Your Care or Payment of Your Care. In certain circumstances, the Plan may disclose PHI to a close friend or family member involved in or who helps pay for your healthcare. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Otherwise Permitted By Law. The Plan may also use or disclose your PHI without your permission in the following situations, subject to applicable requirements under HIPAA:

As required by law;

- For public health activities;
- For health oversight activities, such as for government benefit programs;
- In judicial and administrative proceedings;
- For law enforcement purposes;
- With respect to decedents, such as disclosures to coroners and funeral directors;
- To proper authorities with regard to victims of abuse, neglect or domestic violence;
- For organ or tissue donation purposes;
- To avert a serious threat to health or safety;
- To military authorities, if you are a member of the armed forces;
- To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by federal law;
- To correctional institutions or law enforcement officials, if you are an inmate of a correctional institution or are in the custody of a law enforcement official;
- To health information researchers when the individual identifiers within the PHI have been removed or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research; and
- For workers' compensation.

The Plan is required to disclose PHI to:

- you, in accordance with your rights with respect to your PHI, as discussed below; and
- The Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA.

Uses And Disclosures That Require Your Authorization

The Plan must obtain your written authorization for the following uses and disclosures:

- a use or disclosure of psychotherapy notes in accordance with 45 C.F.R. § 164.508 (a)(2);
- a use or disclosure of PHI for marketing unless the communication is in the form of:
 - a face-to-face communication made by the Plan to an individual; or
 - a promotional gift of nominal value provided by the Plan.

If the marketing involves financial remuneration to the Plan from a third party, your authorization must state that such remuneration is involved:

- a disclosure of PHI which constitutes a sale of PHI. Any authorization permitting a sale of your PHI must state that the disclosure will result in financial remuneration to the Plan.

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All Other Situations Require Your Written Authorization

Other Plan uses and disclosures not described in this Notice will be made only with your authorization. Further, the Plan is required to use or disclose your PHI in a manner consistent with the terms of your authorization. You may revoke your authorization to use or disclose your PHI at any time, except to the extent that either the Plan has taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Certain Prohibited Uses And Disclosures

If the Plan uses PHI for underwriting purposes, the Plan will not use or disclose PHI that is genetic information of an individual for such purposes.

Your Rights with Respect to Your PHI

Under HIPAA, you have certain rights with respect to your PHI. The following is a brief overview of your rights and the Plan's duties with respect to enforcing those rights.

Right To Request Restrictions On Uses And Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI. You may request restrictions on the following uses or disclosures:

- To obtain payment or treatment or with respect to healthcare operations of the Plan;
- Disclosures to your family members, relatives, or close personal friends of your PHI directly relevant to your care or payment related to your healthcare or your location, general condition, or death;
- Instances in which you are not present or when your permission cannot practicably be obtained due to your incapacity or an emergency circumstance;
- Disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts; or
- If you become deceased, disclosures to a family member, other relative, or a close personal friend who was involved in your care or payment for your care prior to your death. Such disclosures must be relevant to such person's involvement; however, no such disclosures will be made if doing so is inconsistent with any prior expressed preference you have made known to the Plan.

The Plan is not required to agree to your request. However, if the Plan does agree to the request, it will honor the restriction until you revoke it or we notify you.

Your request should be submitted in writing on the form available from the Privacy Officer. If the Plan agrees to a restriction, the Plan is bound not to use or disclose your PHI in violation of such restriction, except in certain emergency situations. You cannot request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to request confidential communications of your PHI. Your written request for confidential communications must include an alternative address or method of contact and be sent to the Privacy Officer. The Plan is required by law to accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you clearly state in your written request for confidential communications that disclosure of all or part of the information could endanger you.

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Right To Inspect And Copy Your PHI

You have the right to inspect and copy your PHI maintained in a designated record set. This includes information about your Plan eligibility, claims and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the Plan, submit your request in writing on the form available from the Privacy Officer. The Plan may charge a fee for the cost of labor for copying the PHI, supplies for creating the copy, mailing your request and/or other permitted costs. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial from the Privacy Officer of the Plan at the contact information listed below.

Right To Amend Your PHI

If you feel that the Plan's health information about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment as long as the information is kept by or for the Plan. To request an amendment, submit a request in writing using the form available from the Privacy Officer. You must provide the reason(s) to support your request. The Plan may deny your request if your request is not in writing or if you ask the Plan to amend health information that was:

- Accurate and complete;
- Not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Not part of the health information kept by or for the Plan; or
- Not information that you would be permitted to inspect and copy.

Right To Receive An Accounting Of Disclosures Of Your PHI

You have the right to receive a written accounting of all disclosures of your PHI that the Plan has made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such accountings will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure. The Plan is not required to provide accountings of disclosures for certain purposes, including, but not limited to, the following:

- Payment, treatment, and healthcare operations;
- Disclosures pursuant to your authorization;
- Disclosures to you;
- Disclosures made to friends or family in your presence or because of an emergency;
- Disclosures for national security purposes; or
- Disclosures incidental to otherwise permissible disclosures.

If the Plan uses or maintains an electronic health record ("EHR") with respect to PHI, you have the right to receive an accounting of disclosures of PHI within a designated record set, which includes all disclosures for purposes of payment, health care operations, or treatment over the past three (3) years, in accordance with the laws and regulations currently in effect. The Plan reserves the right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law.

The Plan will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. The Plan 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.

All requests for an accounting should be submitted in writing on the form available from the Privacy Officer.

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Right To Notice Of A Breach Of Your PHI

You have the right to be notified in the event that the Plan (or a business associate) discovers a breach of unsecured PHI. The Plan and its business associates will take appropriate steps to ensure that PHI is secure and will notify you upon a breach of any unsecured PHI. The notice must be made within sixty (60) days of the Plan becoming aware of the breach and will include, to the extent possible: (a) a brief description of the breach, including the date of breach and discovery; (b) a description of the types of unsecured PHI disclosed or used during the breach; (c) the steps you can take to protect yourself from potential harm; (d) a description of the Plan's or business associate's actions to investigate the breach and mitigate harm and prevent further breaches; and (e) contact procedures for affected individuals to find additional information.

Complaints

You may file a complaint with the Plan or with the U.S. Department of Health and Human Services, Office of Civil Rights, if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to the Privacy Officer at the contact information identified below. For information regarding filing a complaint with the Department of Health and Human Services, you may access the following website at <https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html>. Alternatively, you may file a complaint with the regional office in the state or jurisdiction where the Plan is located. A list of regional offices may be obtained through the Benefits Department. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Notice. A complaint must be received by the Plan or filed with the U.S. Department of Health and Human Services, Office of Civil Rights, within one hundred eighty (180) days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendment to This Privacy Notice

The Plan reserves the right to revise or amend this Notice at any time. Revisions or amendments may be made effective for all PHI the Plan maintains even if created or received prior to the effective date of the revision or amendment. The Plan will provide you with notice of any revisions or amendments to this Notice, or changes in the law affecting this Notice. If there is a material change to the Notice, the Plan will prominently post the change or its revised Notice at <https://asdk12ak.sharepoint.com/sites/share/support/Benefits/default.aspx> (internal link) and <https://www.asdk12.org/site/Default.aspx?PageID=1372> (external link) by the effective date of the material change and will provide the revised Notice or information about the material change and how to obtain the revised Notice in its next annual mailing to individuals covered by the Plan.

Ongoing Access to Privacy Notice

The Plan will provide you with a copy of the most recent version of this Notice at any time upon your written request directed to the Privacy Officer. Also, the most current version of the Notice may be obtained from this website at <https://asdk12ak.sharepoint.com/sites/share/support/Benefits/default.aspx> (internal link) and <https://www.asdk12.org/site/Default.aspx?PageID=1372> (external link). For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint with the Plan, please contact the Privacy Officer.

Contact Information

Any inquiry to the Privacy Officer should be directed to:

Thai Walty, Privacy Officer

Anchorage School District, ASD Education Center

5530 E. Northern Lights Blvd., Anchorage, Alaska 99504

Phone: 907.742.4200

Email: privacyofficer@asdk12.org

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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 January 31, 2024. Contact your State for more information on eligibility—

ALABAMA – Medicaid

Website: myalhipp.com/

Phone: 1-855.692.5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com/

Phone: 1-866.251.4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:

health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: myarhipp.com/

Phone: 1-855-MyARHIPP 855.692.7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

website: dhcs.ca.gov/hipp

Phone: 916.445.8322

Fax: 916.440.5676

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: healthfirstcolorado.com/

Health First Colorado Member Contact Center:

1-800.221.3943 | State Relay 711

CHP+: colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800.359.1991

State Relay 711

Health Insurance Buy-In Program (HIBI): mycohibi.com/

HIBI Customer Service: 1-855.692.6442

FLORIDA – Medicaid

Website: flmedicaidprecovery.com/

flmedicaidprecovery.com/hipp/index.html

Phone: 1-877.357.3268

GEORGIA – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678.564.1162, press 1

GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: 678.564.1162, press 2

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INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: in.gov/fssa/hip/
Phone: 1-877.438.4479
All other Medicaid Website: in.gov/medicaid/
Phone 1-800.457.4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: dhs.iowa.gov/ime/members
Medicaid Phone: 1-800.338.8366
Hawki Website: dhs.iowa.gov/Hawki
Hawki Phone: 1-800.257.8563
HIPP Website:
dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888.346.9562

KANSAS – Medicaid

Website: kancare.ks.gov/
Phone: 1-800.792.4884
HIPP Phone: 1-800.967.4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877.524.4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: 1-888.342.6207 (Medicaid hotline)
or 1-855.618.5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: 1-800.862.4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800.657.3739

MISSOURI – Medicaid

Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid

Website:
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800.694.3084
Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: ACCESSNebraska.ne.gov
Phone: 1-855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid

Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800.992.0900

NEW HAMPSHIRE – Medicaid

Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603.271.5218
Toll-free number for the HIPP program:
1-800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 609.631.2392
CHIP Website: njfamilycare.org/index.html
Phone: 1-800.701.0710

NEW YORK – Medicaid

Website: health.ny.gov/health_care/medicaid/
Phone: 1-800.541.2831

NORTH CAROLINA – Medicaid

Website: medicaid.ncdhhs.gov/
Phone: 919.855.4100

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NORTH DAKOTA – Medicaid

Website: hhs.nd.gov/healthcare
Phone: 1-844.854.4825

OKLAHOMA – Medicaid and CHIP

Website: insureoklahoma.org
Phone: 1-888.365.3742

OREGON – Medicaid

Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800.699.9075

PENNSYLVANIA – Medicaid and CHIP

Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800.692.7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: eohhs.ri.gov/
Phone: 1-855.697.4347 or 401.462.0311
(Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: scdhhs.gov
Phone: 1-888.549.0820

SOUTH DAKOTA – Medicaid

Website: dss.sd.gov
Phone: 1-888.828.0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services

Phone: 1-800.440.0493

UTAH – Medicaid and CHIP

Medicaid Website: medicaid.utah.gov/
CHIP Website: health.utah.gov/chip
Phone: 1-877.543.7669

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800.250.8427

VIRGINIA – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800.432.5924

WASHINGTON – Medicaid

Website: hca.wa.gov/
Phone: 1-800.562.3022

WEST VIRGINIA – Medicaid and CHIP

Website: dhr.wv.gov/bms/ or mywvhipp.com/
Medicaid Phone: 304.558.1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855.699.8447)

WISCONSIN – Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800.362.3002

WYOMING – Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800.251.1269

To see if any other states have added a premium assistance program since January 31, 2024, 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

ANNUAL NOTICES

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2025 of your modified adjusted household income.

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

ANCHORAGE SCHOOL DISTRICT HEALTH PLANS

SUPPLEMENT TO HIPAA PRIVACY POLICIES, PROCEDURES, & FORMS EFFECTIVE DATE: DECEMBER 23, 2024

The Anchorage School District Health Plans (the "Plan") maintains HIPAA Privacy Policies, Procedures & Forms (the "HIPAA Privacy Policies"). The documents in this Supplement are incorporated into the Plan's HIPAA Privacy Policies.

Capitalized terms in this Supplement have the meanings assigned in this Supplement, or if not defined, the meanings assigned them in the HIPAA Privacy Policies. The documents in this Supplement are intended to update the HIPAA Privacy Policies to comply with the HIPAA Privacy Rule to Support Reproductive Health Care Privacy, published on April 2, 2024, which rule made various changes to HIPAA's privacy standards. As of the effective date identified above, the Plan's HIPAA Privacy Policies will be administered in accordance with that rule.

Documents in this Supplement, which are incorporated into the Plan's HIPAA Privacy Policies:

1. Amendment to HIPAA Privacy Policies, Procedures & Forms
2. Policy & Procedure on the "Prohibition on the Disclosure of Protected Health Information for Certain Impermissible Purposes Related to Reproductive Health Care"
3. Policy & Procedure on "Attestations Related to Requests for Protected Health Information Potentially Related to Reproductive Health Care"

Questions concerning this Supplement should be directed to the Plan's Privacy Officer.

ANNUAL NOTICES

TITLE: AMENDMENT TO THE POLICIES & PROCEDURES ON:

(1) THE “USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABSENT AUTHORIZATION,” AND (2) THE “DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WHICH AN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED”

EFFECTIVE DATE: December 23, 2024

The Anchorage School District Health Plans (the “Plan”) maintains HIPAA Privacy Policies, Procedures & Forms (the “HIPAA Privacy Policies”). Capitalized terms in this Amendment have the meanings assigned in this Amendment, or if not defined, the meanings assigned them in the Plan’s HIPAA Privacy Policies.

1. Effective as of the date above, the header of the Policy & Procedure on the “Use and Disclosure of Protected Health Information Absent Authorization” now includes a citation to 45 C.F.R. § 164.509.
2. Effective as of the date above, the Policy & Procedure on the “Disclosure of Protected Health Information for Which an Authorization or Opportunity to Agree or Object Is Not Required” is amended as follows:
 - a. The header of the Policy & Procedure now includes a citation to 45 C.F.R. § 164.509.
 - b. For purposes of disclosures of PHI for public health reasons, as described in Section 1.B, “public health” has the following meaning:

“Public health,” as used in the terms “public health surveillance,” “public health investigation,” and “public health intervention,” means population-level activities to prevent disease in and promote the health of populations. Such activities include identifying, monitoring, preventing, or mitigating ongoing or prospective threats to the health or safety of a population, which may involve the collection of protected health information. But such activities do not include those with any of the following purposes:

 - To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating health care; 2
 - To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating health care; or
 - To identify any person for any of the activities described in the two bullets above.
 - c. For purposes of disclosures of PHI related to victims of abuse, neglect, or domestic violence, as described in Section 1.D, the following applies: Nothing in Section 1.D shall be construed to permit disclosures prohibited by the Policy & Procedure on the “Prohibition On The Disclosure Of Protected Health Information For Certain Impermissible Purposes Related To Reproductive Health Care” when the sole basis of the report of abuse, neglect, or domestic violence is the provision or facilitation of Reproductive Health Care (as defined in that Policy & Procedure).
 - d. For purposes of the disclosures of PHI for law enforcement purposes, as described in Section 1.H, “administrative request” means an administrative request for which response is required by law.

NOTES

FOR ASSISTANCE

Alliant Benefit Advocate

If you have a benefits question or claims issue, your Benefit Advocate at Alliant is available to help you and your covered family members. Benefit Advocates are benefits professionals who are available to help you understand your benefits and assist you with complex issues including claims appeals.

- **Phone:** 800.489.1390
- **Website:** benefitsupport@alliant.com
- **Hours:** 4:00 a.m. – 4:00 p.m. Alaska Time, Monday – Friday

You can call Alliant toll-free from anywhere in the U.S. or Canada. All calls are confidential. Your Benefit Advocate will track your issue and make sure that it is resolved.

Due to HIPAA privacy regulations, a written authorization may be required in order to assist with certain issues. Your Benefit Advocate will provide you with an authorization form, if needed.

You can also contact our providers directly:

BENEFIT	PROVIDER	TELEPHONE	WEBSITE	GROUP NUMBER
BenefitSpot Website Support	TRI-AD	877.874.3213	asdk12.benefitspot.com/Contact	ASD
Medical/HRA/Rx	Aetna	800.245.0618	aetna.com	658742
Health Savings Account	TRI-AD	877.874.3213	asdk12.benefitspot.com	ASD
Dental	Aetna	877.238.6200	aetna.com	658742
Vision	Guardian	877.814.8970	guardianlife.com	538822
Flexible Spending Account	TRI-AD	877.874.3213	asdk12.benefitspot.com	ASD
Employee Assistance Program	Aetna Resources for Living	888.866.4827	resourcesforliving.com Username: AnchorageSD Password: ARFL	737480
Mandatory Retirement - PERS/TRS	State of AK Division of Retirement & Benefits Member Services	800.821.2251	doa.alaska.gov/dr/	PERS/TRS
Voluntary Benefits	The Hartford	888.212.8484		DGL-805780
DCR Retirement Plans & Supplemental 403b/457b Plans	Empower Retirement	800.232.0859	retire.asdk12.org	PERS: 98214-04 TRS: 98214-05 403(b): 93399-01 457(b): 93399-02

ASD Benefits Office

- **Website:** share.asdk12.org/support/Benefits/
- **Email:** benefitsdept@asdk12.org
- **Phone:** 907.742.4200

TRI-AD (BenefitSpot Administrators)

- Contact for:
 - BenefitSpot access & registration issues
 - HSA/FSA reimbursement or issues with cards
 - COBRA questions
- **Email:** asdk12benefits@tri-ad.com
- **Phone:** 877.874.3213
- **Hours:** Monday-Friday, 4:00AM-5:00PM