# UA Choice Plan
## July 1, 2015

## Medical Benefits

<table>
<thead>
<tr>
<th>Deductible</th>
<th>750 Plan</th>
<th>High Deductible Health Plan (HDHP)</th>
<th>Consumer-Directed Health Plan (CDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$750 Individual</td>
<td>$1,250 Individual</td>
<td>$1,300 Individual OR $2,600 Family (note: if more than one person covered, family deductible applies)</td>
<td></td>
</tr>
<tr>
<td>$2,250 Family</td>
<td>$3,000 Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Coinsurance

(all benefits are subject to allowable charges)

- **In network:** 80% of allowable charges after deductible, and charges accrue toward maximum out-of-pocket
- **Out of network:** 60% of allowable charges after deductible, and charges do not accrue toward the maximum out-of-pocket; member is responsible for all amounts over the allowable charge

Network applies to Anchorage, Fairbanks, Juneau and all locations outside of Alaska

<table>
<thead>
<tr>
<th>Annual Out-of-Pocket (OOP) Maximum (Includes Deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,250/Individual</td>
</tr>
<tr>
<td>$9,250/Family</td>
</tr>
</tbody>
</table>

### Lifetime Maximum Benefit

- **The lifetime maximum benefit is unlimited.**

### Hospital Admissions (Inpatient)

- **In-network:** 80% of allowable charges, after deductible
- **Out-of-network:** 60% of allowable charge after deductible; your 40% coinsurance does not accrue toward maximum out-of-pocket and member is responsible for any amount over the allowable charge

### Emergency Room Co-Payment

- 80% of allowable charges, after deductible, whether in-network or out-of-network; member is responsible for any amount over the allowable charge for out-of-network services

### Physician Visits, Outpatient Surgery, Second Surgical Opinions, Diagnostic Lab and X-Ray

- **In-network:** 80% of allowable charges, after deductible
- **Out-of-network:** 60% of allowable charge after deductible; your 40% coinsurance does not accrue toward maximum out-of-pocket and member is responsible for any amount over the allowable charge

### Mental Health and Chemical Dependency

- **In-network:** 80% of allowable charges, after deductible
- **Out-of-network:** 60% of allowable charge after deductible; your 40% coinsurance does not accrue toward maximum out-of-pocket and member is responsible for any amount over the allowable charge

### Chiropractic Treatment

- **In-network:** 80% of allowable charges, after deductible
- **Out-of-network:** 60% of allowable charge after deductible; your 40% coinsurance does not accrue toward maximum out-of-pocket and member is responsible for any amount over the allowable charge

### Massage Therapy

- Maximum of 26 visits per year unless additional visits are pre-certified

### Physical Therapy, Rehabilitation

- **In-network:** 80% of allowable charges, after deductible
- **Out-of-network:** 60% of allowable charge after deductible; your 40% coinsurance does not accrue toward maximum out-of-pocket and member is responsible for any amount over the allowable charge

### Morbid Obesity and Bariatric Surgery

- Non-surgical benefit: covered as any other medical condition; covered services include behavioral health, nutritionist/dietician visits, physician visits, related lab and diagnostic services.

Surgical Benefit: member must meet morbid obesity criteria; coverage for bariatric procedures must be medically necessary and considered only after non-surgical measures have proven ineffective. Subject to a $25,000 maximum lifetime benefit.

A Benefit Advisory is recommended for members considering this approach to weight loss.
## Medical Benefits:
**Preventive / Wellness**

<table>
<thead>
<tr>
<th>Plan</th>
<th>750 Plan</th>
<th>High Deductible Health Plan HDHP</th>
<th>Consumer-Directed Health Plan CDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Baby and Well Child Checkups</td>
<td></td>
<td>Covered under the General Preventive Benefit (see below)</td>
<td></td>
</tr>
<tr>
<td>General Preventive Benefit (Physical Benefit) Including Adult Immunizations</td>
<td></td>
<td>The health plan will cover at 100% of the allowable charge with no deductible, all preventive services given an &quot;A&quot; or &quot;B&quot; recommendation by the U.S. Preventive Services Task Force, as well as preventive services recommended by the Advisory Committee on Immunization Practices. See the list of recommended services at <a href="http://www.alaska.edu/files/benefits/preventivelist.pdf">http://www.alaska.edu/files/benefits/preventivelist.pdf</a></td>
<td></td>
</tr>
</tbody>
</table>

### Pharmacy Benefits

- **The 750 Plan and HDHP have the same pharmacy benefit.**
  Go to [www.premera.com](http://www.premera.com) to register and get more information on mail order and other plan features.

  The Pharmacy benefit on these plans has a $1,000 annual out-of-pocket maximum per individual with a family maximum of $1,700. Please note this is separate from the medical out-of-pocket maximums in the medical plan.

  | Network Retail Pharmacy - 30-day supply | $10 copay for generic | $30 copay for brand name | $60 copay for non-preferred brand |
  | Network Retail Pharmacy - 90-day supply | Up to $30 copay for generic ($10 per 30 day supply) (Brand-name drugs are not eligible for the 90 days at retail benefit.) |                      |                                      |
  | Maintenance Medications - Retail (30 day) Supply | For preferred or non-preferred brand drugs that you take on an ongoing daily basis: Up to 2 refills at retail pharmacy with regular copays (see above) For the third and future refills at retail (On 3rd refill): $60 copay for brand name $120 copay for non-preferred brand Generic drugs are exempt from this program, some preventive drugs at no cost. Please see the current list at the benefits web site (www.alaska.edu/benefits) or at Premera.com |                      |                                      |
  | Specialty Medications - 30 day supply Must obtain from Accredo Health or Walgreens Specialty Pharmacy | $100 copay |                      |                                      |
  | Mail Order - 90-day supply | $20 copay for generic | $60 copay for brand name | $120 copay for non-preferred brand |
  | Maintenance Medications - Mail Order (90 day supply) | Same as the regular Mail Order benefit shown above. |                      |                                      |
  | Non-Network Pharmacy (charges do not apply to out-of-pocket maximums) | Pay retail price at time of purchase, and submit claim form to be reimbursed at negotiated price less appropriate co-payment. Please note that you will be reimbursed the negotiated (contracted) rate, less the copay. This will most likely always be less than the full price paid at an out-of-network pharmacy. |                      | Pay retail price at time of purchase, submit claim to have negotiated price applied to deductible or coinsurance benefits, as appropriate. Note that non-network pharmacy can charge more than negotiated price. |

- **CDHP pharmacy benefits are subject to the medical plan deductible and coinsurance**
### UA Choice Plan

**July 1, 2015**

#### Dental Benefits

<table>
<thead>
<tr>
<th>Annual Deductibles*</th>
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<th>High Deductible Health Plan (HDHP)</th>
<th>Consumer-Directed Health Plan (CDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Restorative</td>
<td>$25</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Prosthetic</td>
<td>$25 (combined with restorative)</td>
<td>$50 (combined with restorative)</td>
<td>$50 (combined with restorative)</td>
</tr>
</tbody>
</table>

*Per person, paid once per plan year

#### Coinsurance

<table>
<thead>
<tr>
<th></th>
<th>750 Plan</th>
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<th>CDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Restorative</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Prosthetic</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Annual Maximum Benefit

- 750 Plan: $2,000
- HDHP: $2,000
- CDHP: $2,000

#### Orthodontia

- Covered at 50%, with a $1,500 lifetime maximum
- Not Covered
- Not Covered

### Vision Benefits with VSP

All UA Choice Plans have the same vision benefit as described below.

For more information, visit [www.VSP.com](http://www.VSP.com)

**Copay**

- $10 copay for exam
- $25 copay for glasses (lenses and frame)
- No copay for contacts

**Exam — once every plan year**

- VSP Network Doctor: Covered in full after $10 copay
- Non-VSP Provider: Up to a $50 reimbursement after the $10 copay

**Lenses and frames — every other plan year**

- Lenses covered in full after $25 copay, frame of your choice up to $150, plus 20% off any out-of-pocket cost.

  - Non-VSP Provider: Reimbursement after the $25 copay as follows:
    - Single vision lenses Up to $50
    - Lined bifocal lenses Up to $75
    - Lined trifocal lenses Up to $100
    - Frames Up to $70

**OR Contacts — every other plan year**

- Contact Lens Care program gives you a $150 allowance with no copay every other plan year for the cost of your contacts and the contact lens exam/fitting

  - Non-VSP Provider: Reimbursement Up to $105

**Discounts & Savings**

- VSP offers other discounts and savings to plan members. Go to vsp.com to learn about discounts on non-covered lens options, additional prescription glasses and sunglasses and laser vision corrections through a VSP network doctor.