UA Choice Plan
July 1, 2021

Medical Benefits	750 Plan	High Deductible Health Plan HDHP	Consumer-Directed Health Plan CDHP
Deductible	$750 Individual $2,250 Family	$1,250 Individual $3,000 Family	$1,500 Individual OR $3,000 Family (note: if more than one person covered, family deductible applies)
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. **NOTE: Allowable charge for out-of-network providers is 200% of Medicare.** Network differential applies to all locations in and outside of Alaska		
Annual **Out-of-Pocket (OOP) Maximum** **(Includes Deductible)**	$4,250/Individual $9,250/Family	$5,000/Individual $11,000/Family	$5,000/Individual OR $6,850/Family (note: if more than one person covered, family OOP max applies)
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	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 Maximum of 26 visits per year unless additional visits are pre-certified		
Massage Therapy	80% of allowable charges, after deductible. Massage therapists are not subject to the lower out-of-network coinsurance, but the member is responsible for any amount over the allowable charge. Limited to 26 visits per year unless additional visits are pre-certified. Massage therapy must be billed and supervised by a medical doctor, chiropractor or physical therapist to be covered.		
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 Maximum of 45 visits per year unless additional visits are pre-certified		
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.		

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Medical Benefits: Preventive / Wellness	750 Plan	High Deductible Health Plan HDHP	Consumer-Directed Health Plan CDHP
Well Baby and Well Child Checkups	Covered under the General Preventive Benefit (see below)		
General Preventive Benefit (Physical Benefit) Including Adult Immunizations	The health plan will cover at 100% of the allowable charge with no deductible, all preventive services given an "A" or "B" 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 http://www.alaska.edu/files/benefits/preventivelist.pdf		

Pharmacy Benefits	The 750 Plan and HDHP have the same pharmacy benefit. **Go to 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.	CDHP pharmacy benefits are subject to the medical plan deductible and coinsurance
Network Retail Pharmacy - 30-day supply	$10 copay for preferred generic $30 copay for preferred brand name 30% coinsurance for non-preferred drugs (generic, brand, specialty)	subject to the medical plan deductible, then 20% coinsurance
Network Retail Pharmacy - 90-day supply	up to $30 copay for preferred generic ($10 per 30 day supply) (Brand-name and non-preferred drugs are not eligible for the 90 days at retail benefit.)	subject to the medical plan deductible, then 20% coinsurance
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 Preferred generic drugs are exempt from this program, some preventive drugs at no cost. Current list is at the benefits web site (www.alaska.edu/benefits) or at Premera.com	This plan provides a preventive medication benefit for certain medications at zero copay. 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 for preferred specialty	subject to the medical plan deductible, then 20% coinsurance
Mail Order - 90-day supply	$20 copay for preferred generic $60 copay for preferred brand name 30% coinsurance for non-preferred drugs (generic or brand)	subject to the medical plan deductible, then 20% coinsurance
Maintenance Medications - Mail Order (90 day supply)	Same as the regular Mail Order benefit shown above.	See above information on preventive generic medications
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.

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Dental Benefits	750 Plan	High Deductible Health Plan HDHP	Consumer-Directed Health Plan CDHP
Annual Deductibles*			
Preventive	$0	$0	$0
Restorative	$25	$50	$50
Prosthetic	$25 (combined with restorative)	$50 (combined with restorative)	$50 (combined with restorative)
*Per person, paid once per plan year			
Coinsurance			
Preventive	100%	100%	100%
Restorative	80%	80%	80%
Prosthetic	50%	50%	50%
Annual Maximum Benefit	$2,000	$2,000	$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
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 yo ua $150 alloawance 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/specialoffers to learn about discounts on non-covered lens options, additional prescription glasses and sunglasses and laser vision corrections through a VSP network doctor.