Highlights of your Health Care Coverage

University of Alaska
Group Number: 1000033

Effective Date: 07/01/2024

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	**2024 RX ESSENTIALS, a University of Alaska**
PRESCRIPTION DRUGS	
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PPY	$0
Family Deductible PPY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	In-Network: $1,000 PPY Individual / $1,700 PPY Family. OON: Shared with In-Network
Enhanced Preventive Drug List	PV Core Plus (Buy-Up)
Retail Cost Shares	$10/$30/$100/30%
Mail Cost Shares	$20/$60$100/30%
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

This plan is self-funded by University of Alaska, which means that University of Alaska is financially responsible for the payment of plan benefits. University of Alaska has the final discretionary authority to determine eligibility for benefits and construe the terms used in this plan.

University of Alaska has contracted with Premera Blue Cross Blue Shield of Alaska, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this plan.

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PPY = Per Plan Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

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