UA Choice

R/V Sikuliaq Employees Only

Health Plan Enrollment Form for FY25

www.alaska.edu/benefits

UNIVERSITY of ALASKA
Many Traditions One Alaska

☐ I am a New Hire

☐ I have experienced a Life Event
Date of Life Event: _____

Employee ID	Campus	Work Phone
Last Name First M.		

Use this form to elect plan options. Review the FY25 Enrollment Guide and the Summary of Benefits and Coverage (SBC) online at alaska.edu/benefits for each plan to help you make your decision. If unsure which plan to use, call TouchCare at 1-866-486-8242. Use the Dependent Enrollment Form to add or drop dependents. Be sure to read and understand the coverage effective date information on the back of this form.

I wish to enroll in the following medical plan

- ☐ **Premium Health Plan** Office Use Only: [H60]
- ☐ **Basic Health Plan** Office Use Only: [H70]
- ☐ **High Deductible Health Plan (HDHP)** Office Use Only: [H80]
  Note: This HDHP works differently than the other plans. Please read the Enrollment Guide for details. This plan qualifies for the Health Savings Account (HSA) (other eligibility requirements may apply).
- ☐ **I am opting out of health care** Office Use Only: [H00]

I wish to enroll in the following dental plan

- ☐ **Premium Dental Plan** Office Use Only: [H40]
- ☐ **Basic Dental Plan** Office Use Only: [H30]
- ☐ **I am opting out of dental care** Office Use Only: [H04]

I wish to enroll in the vision plan

- ☐ **Yes** Office Use Only: [H20]
- ☐ **No** Office Use Only: [H02]

I elect to cover enroll the following people: *(Do not complete if you are opting out of medical, dental, AND vision)*

☐ Employee only coverage

☐ Dependent coverage (Spouse/Partner and/or children): Complete page 2

I authorize the University of Alaska to reduce my salary in an amount equal to the cost of the applicable plan, in this and future years. I understand that this election cannot be revoked or changed until the next open enrollment, unless there is a loss of eligibility or life event. The change must be made within 30 days from the date of the life event. If there are questions, please contact UA Benefits at ua-benefits@alaska.edu or (907) 450-8242 to discuss.

Employee Signature	Date	Email Address

Please return the completed form to UA HR

Dependent Enrollment Form: Yes _____ No _____

Entered By: _____ Date: _____ DEDN Eff. Date: _____ BCOV Eff. Date: _____ Rev. 6/25/2024

Important Information Concerning Health Plan Enrollment

All newly hired University of Alaska employees have a 30-day election period in which to choose their preferred health care plan and dependent coverage options. Coverage for R/V Sikuliaq employees is effective the date of hire or life event.

If you are a benefit eligible employee, this form must be submitted even if opting out of coverage, within your 30 days of employment. If this form is not submitted by the deadline, employees will automatically be enrolled in the **Basic Health Plan, Basic Dental Plan, and Vision Plan for employee-only**.

If you are a temporary employee and do not submit an enrollment form, you will automatically waive your right to coverage.

Dependents can only be enrolled in the same plan an employee is enrolled in. Please provide backup documentation (i.e. birth or marriage certificate) for each of the dependents you are enrolling.

Name	Relationship	DOB	SSN

MEDICAL BENEFITS

Medical benefits are provided through Premera Blue Cross Blue Shield of Alaska. Choose the plan that works best for your lifestyle. Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire FY25 Plan Year, unless you have a Qualifying Life Event. Contributions are deducted from your paycheck on a pre-tax basis.

Medical Plan Summary

This chart summarizes the FY25 medical coverage provided by Premera Blue Cross Blue Shield. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PREMIUM PLAN		BASIC PLAN		HDHP W HSA	
BI-WEEKLY CONTRIBUTIONS						
EMPLOYEE ONLY	$137.85		$81.24		$64.39	
EMPLOYEE + SPOUSE	$297.82		$173.32		$135.82	
EMPLOYEE + CHILD(REN)	$213.05		$120.01		$91.93	
EMPLOYEE + FAMILY	$385.01		$218.51		$166.43	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$800		$1,325		$1,600	
FAMILY	$2,400		$3,200		$3,200	
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	60%*	80%*	60%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$4,250	N/A	$5,000	N/A	$5,000	N/A
FAMILY	$9,250	N/A	$11,000	N/A	$6,850	N/A
COPAYS/COINSURANCE - % OF COINSURANCE PAID BY THE MEMBER						
PREVENTIVE CARE	100% Covered	100% Covered	100% Covered	100% Covered	100% Covered	100% Covered
PRIMARY CARE	20%*	40%*	20%*	40%*	20%*	40%*
SPECIALIST SERVICES	20%*	40%*	20%*	40%*	20%*	40%*
TELEMEDICINE	20%*	40%*	20%*	40%*	20%*	40%*
URGENT CARE	20%*	Hospital-based: 20%* / Freestanding Center: 40%*	20%*	Hospital-based: 20%* / Freestanding Center: 40%*	20%*	Hospital-based: 20%* / Freestanding Center: 40%*
DIAGNOSTIC CARE	20%*	40%*	20%*	40%*	20%*	40%*
EMERGENCY ROOM	20%*	20%*	20%*	20%*	20%*	20%*

*After Deductible

For the Premium and Basic Plans, the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

For the HDHP, each covered individual is not required to meet the individual deductible. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.