



PO Box 21548  
Eagan, MN 67530  
Questions? Call 1-888-277-9133

November 2024

## **ACTION REQUIRED**

### **IMPORTANT NOTICE ABOUT YOUR 2025 PREMIUM RATES & COVERAGE OPTIONS (Medicare Plans)**

Dear Enrollee,

This letter contains important information about your premium rate change effective January 1, 2025, and Eligibility Verification Form that must be returned by December 30, 2024, to renew your ACHIA coverage. You may also change ACHIA plans (some restrictions apply).

#### **2025 ACHIA PREMIUM RATES**

Your ACHIA monthly premium rate will change effective January 1, 2025. By law, rates are based upon what other insurance carriers in the state charge for similar benefits. Please consult the enclosed premium rate chart to find your new rate.

#### **PREMIUM INVOICES**

Premiums must be paid on or before the due date or during a 31-day grace period that follows. If your premium is not received before the end of the grace period, your coverage ends at the end of the period for which your premium was paid.

#### **ELIGIBILITY VERIFICATION FORM – ACTION REQUIRED**

ACHIA requires enrollees to verify their eligibility every year. Please return the enclosed Eligibility Verification Form by December 30. A return envelope is enclosed.

**ACHIA Plans.** To renew your ACHIA plan, fill out and return the enclosed Eligibility Verification Form by December 30. If you want to cancel your ACHIA coverage, please contact Customer Service at 1-888-277-9133 for assistance. If you do not request a plan change or cancel your ACHIA coverage, your current plan will be renewed pending receipt of your Eligibility Verification Form.

#### **QUESTIONS?**

If you have questions or need assistance, please call ACHIA Customer Service at **1-888-277-9133**.

#### **Enclosures:**

- 2025 ACHIA Premium Rates
- 2025 ACHIA Plan Comparison Chart
- Eligibility Verification Form
- Return Envelope

#### **IMPORTANT DEADLINES**

**December 30th** is the deadline to return your ACHIA Eligibility Verification Form to continue coverage with ACHIA.

MEDICARE SUPPLEMENT - PREMIUM RATES				
2025 MONTHLY PREMIUM RATES				
Attained Age	Plan A	Plan F	Plan G	Plan I
0-64	\$373	\$594	\$437	\$484
65	\$185	\$295	\$217	\$251
66	\$190	\$303	\$226	\$257
67	\$198	\$317	\$235	\$270
68	\$206	\$330	\$248	\$280
69	\$215	\$343	\$263	\$292
70	\$225	\$358	\$267	\$306
71	\$231	\$370	\$276	\$316
72	\$239	\$384	\$285	\$326
73	\$248	\$395	\$295	\$340
74	\$255	\$407	\$306	\$346
75	\$263	\$419	\$317	\$358
76	\$272	\$432	\$330	\$369
77	\$278	\$445	\$342	\$380
78	\$288	\$457	\$354	\$389
79	\$296	\$469	\$365	\$400
80+	\$315	\$501	\$400	\$428

MEDICARE CARVE-OUT PLAN - PREMIUM RATES		
2025 Monthly Premium Rates		
	Attained Age	Rates
	0-18	\$156
	19+	\$442



**ACHIA**  
A L A S K A  
COMPREHENSIVE  
HEALTH INSURANCE  
ASSOCIATION

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**Plan Change & Eligibility Verification Form is  
Due December 30, 2024**

1. Are you currently a resident of the State of Alaska? Yes / No (circle one)
2. Have you become eligible to participate in Medicare, Medicaid, Denali Kid Care or Indian Health Services?

Yes / No (circle one) If yes, please enter effective date: \_\_\_\_\_

Medicare Part A effective date: \_\_\_\_\_

Medicare Part B effective date: \_\_\_\_\_

3. Have you enrolled or do you plan to enroll in Medicare Part D?

Yes / No (circle one) If yes, please enter effective date: \_\_\_\_\_

4. Have you been declared disabled by social security?

Yes / No (circle one) If yes, please enter eligibility date: \_\_\_\_\_

5. Are you currently eligible for employer group insurance or any other health insurance?

Yes / No (circle one) If yes, please enter eligibility date: \_\_\_\_\_

6. Please provide your Social Security Number: \_\_\_\_\_



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7. Please verify your physical address and your mailing address below.

Physical Address of your current residence - Required		Mailing Address <i>if different</i> than physical address	
Name		Name	
Address		Address	
City		City	
State & Zip		State & Zip	
Telephone Number:		Email Address:	
Cell Number: (      )			

### Plan Change Request

If you wish to change your deductible effective January 1, 2025, please indicate below your choice of plan. If you wish to remain on your current plan, please write "No Change".

I hereby request a change to plan \_\_\_\_\_ Effective January 1, 2025

This form must be returned PRIOR TO December 30, 2024 to the above address. For your convenience we have enclosed a return envelope.

Signature \_\_\_\_\_

Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

# Alaska Comprehensive Health Insurance Association

## Health Insurance Policy Highlights and Comparison

The following table is NOT a complete summary or explanation of policy benefits.

Please refer to your policy for complete details of benefits.

Service/Benefit	Carveout (under 65 only)	Supplement PLAN A	Supplement PLAN F	Supplement PLAN G
<b>ACHIA Deductible</b>	\$1,000 per calendar year with 4th quarter carryover.	Not applicable	Not applicable	Not applicable
<b>ACHIA Out of Pocket</b>	Out of pocket Max- \$2,500 including Deductible	Not applicable	Not applicable	Not applicable
<b>ACHIA Coinsurance</b>	We pay 80% after Medicare pays on most eligible expenses after deductible and 100% after out of pocket has been met.	Not applicable	Not applicable	Not applicable
<b>ACHIA Lifetime Max</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Routine Expenses</b>	We pay for certain Mammograms, Pap Smears & Prostate Exams. Refer to Policy.	Not Covered unless M/C pays Primary	Not Covered unless M/C pays Primary	Not Covered unless M/C pays Primary
<b>Mental &amp; Nervous</b>	Outpatient pays at 50%, \$4,000 calendar year max. In patient pays at 50%, no out of pocket max. Payments made by you do not count toward out of pocket max & no out of pocket max applies to inpatient. Subject to deductible.	Not Covered unless M/C pays Primary	Not Covered unless M/C pays Primary	Not Covered unless M/C pays Primary
<b>Outpatient Drug Abuse &amp; Alcoholism</b>	Limit of \$16,380 in 2 consecutive calendar years. Lifetime Limit is \$32,750.	Not Covered unless M/C pays Primary	Not Covered unless M/C pays Primary	Not Covered unless M/C pays Primary
<b>Drugs</b>	Not Covered	Not Covered	Covered only if covered by M/C Part B.	Covered only if covered by M/C Part B.
<b>Foreign Travel Medical Emergency Care</b>	Covered at 80% after ACHIA \$1,000 deductible, and 100% after ACHIA out of pocket maximum of \$2,500 has been met. Other limitations & rules apply.	No coverage	We will pay 80% of the billed charges not covered by M/C incurred for medically necessary emergency care subject to limitations & \$50,000 lifetime max.	We will pay 80% of the billed charges not covered by M/C incurred for medically necessary emergency care subject to limitations & \$50,000 lifetime max.
<b>Medicare Part A Inpatient Hospital, days 1-60</b>	Covered at 80% after ACHIA \$1,000 annual deductible, and 100% after ACHIA out of pocket maximum of \$2,500 has been met.	No coverage for Part A or Part B deductible. No Benefit.	We will pay the M/C Part A deductible amount per M/C Benefit period.	We will pay the M/C Part A deductible amount per M/C Benefit period.
<b>Medicare Part A Inpatient Hospital, days 61 - 90</b>	Covered at 80% after ACHIA \$1,000 deductible, and 100% after ACHIA out of pocket maximum of \$2,500 has been met.	We pay Part A M/C Eligible Expenses to the extent not covered by M/C.	We pay Part A M/C Eligible Expenses to the extent not covered by M/C.	We pay Part A M/C Eligible Expenses to the extent not covered by M/C.
<b><sup>1</sup>Medicare Lifetime Reserve days used</b>	We pay hospitalization to the extent not covered by M/C for each Lifetime Reserve Day used.			
<b>Exhausted hospital inpatient coverage including Lifetime Reserve Days Used</b>	Covered at 80% after ACHIA \$1,000 deductible, and 100% after ACHIA out of pocket maximum of \$2,500 has been met.	Paid at the Diagnostic Related Group (DRG) outlier per diem or other appropriate standard of payment, subject to a lifetime payment, subject to a lifetime maximum benefit of an additional 365 days.		

# Alaska Comprehensive Health Insurance Association

## Health Insurance Policy Highlights and Comparison

The following table is NOT a complete summary or explanation of policy benefits.

Please refer to your policy for complete details of benefits.

Service/Benefit	Carveout (under 65 only)	Supplement PLAN A	Supplement PLAN F	Supplement PLAN G
<sup>2</sup> Part B Deductible	N/A	No coverage	We pay deductible amount per calendar year regardless of hospital confinement.	No coverage
<b>Part B Medicare - Only Medicare Eligible expenses</b>	We will pay coinsurance amount for eligible expenses under Part B regardless of hospitalization. M/C generally pays 80%; ACHIA's Carveout Plan Pays 80% of the 20% patient responsibility. ACHIA's Supplement Plans A & F usually pay 100% of the remaining 20% patient responsibility. Services may include physician services, inpatient or outpatient medical and surgical services and supplies, physical or speech therapy, diagnostic tests and durable medical equipment.			
<b>Part B Excess Charges</b>	Covered at 80% after ACHIA \$1,000 deductible, and 100% after ACHIA out of pocket maximum of \$2500 which includes deductible has been met.	No coverage	We will pay the difference between the actual M/C Part B charge as legally billed, not to exceed any charge limitation established by M/C or state law, and the M/C approved Part B charge.	We will pay the difference between the actual M/C Part B charge as legally billed, not to exceed any charge limitation established by M/C or state law, and the M/C approved Part B charge.
<b>Blood</b>	We will pay benefits under M/C Parts A & B for the reasonable cost of the first 3 pints of blood for equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.			
<b>Home Health</b>	Covered at 80% after ACHIA \$1,000 deductible, and 100% after ACHIA out of pocket maximum of \$2,500 has been met. Max of 270 visits per calendar year. Other limitations & rules apply.	No coverage unless Medicare Pays as Primary	No coverage unless Medicare Pays as Primary	No coverage unless Medicare Pays as Primary
<b>Skilled Nursing Facility</b>	Covered at 80% after ACHIA \$1,000 deductible, and 100% after ACHIA out of pocket maximum of \$2,500 has been met. Pays up to 120 days per calendar year.	No coverage unless Medicare Pays as Primary	We pay coinsurance amount from 21st - 100th day, for post-hospital stay. Hospital & skilled nursing facility stay must begin after ACHIA policy is effective unless it occurs within 6 months of initial Part B eligibility.	We pay coinsurance amount from 21st - 100th day, for post-hospital stay. Hospital & skilled nursing facility stay must begin after ACHIA policy is effective unless it occurs within 6 months of initial Part B eligibility.

<sup>1</sup> You have a lifetime reserve of 60 days for Medicare Part A inpatient hospital care. These days may be used whenever more than 90 days of hospitalization occurs in a M/C Benefit period.

<sup>2</sup> This is the amount you pay each Calendar year before Part B of Medicare pays benefits for Part B Medicare eligible expenses.

**Please note: This comparison chart is for reference only. In situations where this comparison and the Policy differ the Policy is the governing legal document. Benefits will be paid by ACHIA subject to all terms and conditions of the Plan.**