



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

(Non-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) or enroll in plans available in the Marketplace or from an insurance company.

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.

COVERAGE OPTIONS & RENEWAL INSTRUCTIONS

You have the option to buy new coverage from the Marketplace or directly from an insurance company or agent, renew your current ACHIA plan or change to a new plan. ACHIA premiums are generally higher, so we encourage you to explore other coverage options by visiting HealthCare.gov or reaching out to an agent. December 15 is the deadline to enroll for coverage effective January 1, 2025.

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 15th is the deadline to enroll in new coverage for January 1, 2025 through the Marketplace or directly from an insurance company or agent. The last day to enroll in 2025 coverage is January 15, 2025.

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

Alaska Comprehensive Health Insurance Assocaion (ACHIA) 2025 PREMIUM RATES							
Plan Type	Traditional Non-PPO	PPO	PPO	Traditional Non-PPO	PPO	PPO	PPO
Deductible	\$1,000	\$1,000	\$2,500	\$5,000	\$5,000	\$10,000	\$15,000
Coinsurance - In-Network	80%	80%	80%	80%	80%	80%	80%
Out-of-Pocket Limit	\$2,500	\$2,500	\$5,000	\$10,000	\$10,000	\$15,000	\$20,000
Attained Age							
0-18	\$613	\$558	\$446	\$395	\$359	\$302	\$263
19	\$971	\$883	\$706	\$626	\$569	\$479	\$416
20	\$981	\$892	\$713	\$632	\$575	\$484	\$421
21	\$991	\$902	\$721	\$639	\$581	\$489	\$425
22	\$1002	\$911	\$728	\$646	\$587	\$494	\$430
23	\$1019	\$927	\$740	\$657	\$597	\$502	\$437
24	\$1036	\$942	\$753	\$668	\$607	\$511	\$444
25	\$1053	\$958	\$765	\$679	\$617	\$519	\$451
26	\$1070	\$973	\$778	\$690	\$627	\$527	\$459
27	\$1087	\$989	\$790	\$701	\$637	\$536	\$466
28	\$1111	\$1010	\$807	\$716	\$651	\$548	\$476
29	\$1135	\$1032	\$825	\$731	\$665	\$559	\$487
30	\$1160	\$1055	\$843	\$748	\$680	\$572	\$498
31	\$1186	\$1078	\$862	\$764	\$695	\$585	\$509
32	\$1211	\$1102	\$880	\$781	\$710	\$597	\$519
33	\$1249	\$1136	\$908	\$805	\$732	\$616	\$536
34	\$1288	\$1171	\$936	\$830	\$755	\$635	\$552
35	\$1329	\$1209	\$966	\$857	\$779	\$655	\$570
36	\$1372	\$1247	\$997	\$884	\$804	\$676	\$588
37	\$1414	\$1286	\$1028	\$912	\$829	\$697	\$607
38	\$1469	\$1336	\$1067	\$947	\$861	\$724	\$630
39	\$1523	\$1385	\$1107	\$982	\$893	\$751	\$653
40	\$1581	\$1438	\$1149	\$1019	\$927	\$780	\$678
41	\$1641	\$1492	\$1193	\$1058	\$962	\$809	\$704
42	\$1704	\$1550	\$1238	\$1098	\$999	\$840	\$731
43	\$1772	\$1612	\$1288	\$1142	\$1039	\$874	\$760
44	\$1844	\$1677	\$1340	\$1188	\$1081	\$909	\$791
45	\$1917	\$1744	\$1393	\$1236	\$1124	\$945	\$822
46	\$1994	\$1813	\$1449	\$1285	\$1169	\$983	\$855
47	\$2074	\$1886	\$1507	\$1337	\$1216	\$1023	\$890
48	\$2176	\$1979	\$1582	\$1403	\$1276	\$1073	\$933
49	\$2285	\$2078	\$1661	\$1473	\$1340	\$1127	\$980
50	\$2398	\$2181	\$1743	\$1546	\$1405	\$1182	\$1028
51	\$2517	\$2289	\$1829	\$1623	\$1475	\$1241	\$1080
52	\$2641	\$2402	\$1920	\$1703	\$1548	\$1303	\$1133
53	\$2755	\$2506	\$2003	\$1776	\$1615	\$1359	\$1182
54	\$2875	\$2615	\$2090	\$1853	\$1685	\$1418	\$1233
55	\$2999	\$2728	\$2180	\$1934	\$1758	\$1479	\$1287
56	\$3129	\$2846	\$2274	\$2017	\$1834	\$1543	\$1342
57	\$3263	\$2968	\$2372	\$2104	\$1913	\$1609	\$1400
58	\$3384	\$3078	\$2460	\$2182	\$1984	\$1669	\$1452
59	\$3509	\$3191	\$2551	\$2262	\$2057	\$1731	\$1505
60	\$3638	\$3309	\$2645	\$2346	\$2133	\$1794	\$1561
61	\$3771	\$3430	\$2741	\$2431	\$2211	\$1860	\$1618
62	\$3911	\$3557	\$2843	\$2521	\$2293	\$1929	\$1678
63	\$4035	\$3671	\$2933	\$2602	\$2366	\$1990	\$1731
64+	\$4134	\$3760	\$3005	\$2665	\$2424	\$2039	\$1774



ACHIA
A L A S K A
C O M P R E H E N S I V E
H E A L T H I N S U R A N C E
A S S O C I A T I O N

PO Box 21548
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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 been declared disabled by social security?

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

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

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

5. Please provide your Social Security Number: _____



ACHIA
 A L A S K A
 COMPREHENSIVE
 HEALTH INSURANCE
 ASSOCIATION

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6. 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.

Please note: *You may increase your deductible as high as you feel necessary, but you may only lower your deductible one (1) deductible level.*

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

Policy Highlights and Comparisons

The following table is not a complete summary or explanation of policy benefits.
Please refer to your policy for complete details of benefits.

Benefits	Non-PPO Traditional Plan \$1,000	Non-PPO Traditional Plan \$5,000	PPO Plan \$1,000	PPO Plan \$2,500	PPO Plan \$5,000	PPO Plan \$10,000	PPO Plan \$15,000
Deductible, per Calendar Year	\$1,000	\$5,000	\$1,000	\$2,500	\$5,000	\$10,000	\$15,000
In Network Co-Insurance	20%	20%	20%	20%	20%	20%	20%
Out of Pocket Max	\$2,500	\$6,500	\$2,500	\$5,000	\$10,000	\$15,000	\$25,000
Out of Network Co-Insurance	20%	20%	40%	40%	40%	40%	40%
Benefit % payable After Ded & Co-ins	100%	100%	100%	100%	100%	100%	100%
Individual lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Prescriptions	20% after Deductible 100% after OOP	20% after Deductible 100% after OOP	20% after Deductible 100% after OOP	20% after Deductible 100% after OOP			