Preferred Gold and One Gold Plans

Available on HealthCare.gov

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association

Monthly rates for individuals and families

Start date: **Jan. 1, 2025**

Area 2

These rates apply if you live in a ZIP code that begins with 996 or 997.

Rates will be adjusted if you apply through the exchange and are eligible for a subsidy.

Determine your monthly rate

Step 1: **Choose a plan and a deductible amount from the chart.** The chart shows the deductible for an individual. The deductible for a family is 2 times the individual deductible. A deductible is the amount you pay each year before the health plan starts to pay for certain services. Copayments do not count toward meeting your deductible.

Step 2: **Find your age and circle the rate that applies to your use or non-use of tobacco.** Tobacco use means use of any tobacco product on average 4 or more times per week within the past 6 months. Tobacco use does not include religious or ceremonial use. E-cigarettes are not considered tobacco.

Step 3: **Repeat step 2 for each eligible family member you wish to add to your health care plan.** Eligible family members include you, your spouse or domestic partner, and your legal dependents and children under age 26. Monthly rates are charged for all dependents and children age 21 and older and for the first 3 oldest dependents and children under age 21. Additional dependents and children age 20 and younger are not charged.

Step 4: **Add up the circled amounts.** The total will be the dollar amount of your monthly health plan bill.

You	$
+ Spouse/Domestic partner	$
+ Dependent	$
+ Dependent	$
+ Dependent	$
Total monthly rate	$

	Preferred Gold		One Gold	
Deductible	$1,500		$1,500	
AGE	Non-tobacco	Tobacco	Non-tobacco	Tobacco
0-14	595.39	595.39	594.92	594.92
15	648.31	648.31	647.80	647.80
16	668.55	668.55	668.02	668.02
17	688.78	688.78	688.24	688.24
18	710.57	710.57	710.02	710.02
19	732.37	732.37	731.79	731.79
20	754.94	754.94	754.35	754.35
21	778.28	836.66	777.68	836.00
22	778.28	836.66	777.68	836.00
23	778.28	836.66	777.68	836.00
24	778.28	836.66	777.68	836.00
25	781.40	840.00	780.79	839.35
26	796.96	856.74	796.34	856.07
27	815.64	876.81	815.00	876.13
28	845.99	909.44	845.33	908.73
29	870.90	936.22	870.22	935.49
30	883.35	949.60	882.66	948.86
31	902.03	969.68	901.33	968.93
32	920.71	989.76	919.99	988.99
33	932.38	1002.31	931.66	1001.53
34	944.84	1015.70	944.10	1014.91
35	951.06	1022.39	950.32	1021.59
36	957.29	1029.09	956.54	1028.28
37	963.52	1035.78	962.76	1034.97
38	969.74	1042.47	968.98	1041.66
39	982.19	1055.86	981.43	1055.03
40	994.65	1069.25	993.87	1068.41
41	1013.33	1089.33	1012.53	1088.47
42	1031.23	1108.57	1030.42	1107.70
43	1056.13	1135.34	1055.31	1134.45
44	1087.26	1168.81	1086.41	1167.89
45	1123.84	1208.13	1122.96	1207.19
46	1167.43	1254.98	1166.51	1254.00
47	1216.46	1307.69	1215.51	1306.67
48	1272.49	1367.93	1271.50	1366.86
49	1327.75	1427.33	1326.71	1426.22
50	1390.02	1494.27	1388.93	1493.10
51	1451.50	1560.36	1450.36	1559.14
52	1519.21	1633.15	1518.02	1631.87
53	1587.70	1706.78	1586.46	1705.44
54	1661.64	1786.26	1660.34	1784.86
55	1735.57	1865.74	1734.22	1864.28
56	1815.74	1951.92	1814.32	1950.39
57	1896.68	2038.93	1895.20	2037.34
58	1983.07	2131.80	1981.52	2130.13
59	2025.87	2177.81	2024.29	2176.11
60	2112.26	2270.68	2110.61	2268.91
61	2186.98	2351.00	2185.27	2349.16
62	2236.01	2403.71	2234.26	2401.83
63	2297.49	2469.81	2295.70	2467.88
64+	2334.84	2509.97	2333.03	2508.00

We want to make it simple and easy for you to understand your health plan.

Important notes

- Individual health plans are available to permanent Alaska residents who are not enrolled in Medicare Part A or Part B.
- Rates are based on your current age. When your age changes during the year, your rate will not change until the next time you enroll in a health plan.
- The deductible amount listed for each rate category is the individual deductible. The family deductible is 2 times the individual deductible.

Contact us

For enrollment information or if you have questions about Premera Blue Cross Blue Shield of Alaska:

- Visit premera.com
- Call 844-961-9847.
- Talk to a producer, a licensed professional also known as an agent.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.