BRH Comparison Benefit Plan Year July 2020—June 2021

BENEFIT	Economy	Standard
Medical **Premera BCBS of AK** Annual Deductible	$550 / Individual $1100 / Family	$300 / Individual $600 / Family
Plan Pays Based on allowable amount	80% of the allowable amount	80% of the allowable amount
Out of Pocket Limit (including Deductible) **Individual** **Family (2 member)**	 **$2550** **$5100** **$7100**	 **$1800** **$3600** **$5100**
Emergency Room Visit	$150 Co-pay	$150 Co-pay
Annual/Lifetime Maximum	None	None
Prescription Drugs **Premera BCBS of AK** **30 = Retail Pharmacy Fill** **90 = Mail Order Pharmacy Fill**	$50 deductible/Max OOP $1750 Preferred Generic $10 copay 30/90 Preferred Brand $35 copay 30/90 Preferred Specialty $55 copay 30 day mail Non-preferred (Generic, Brand & Specialty $150 copay 30/90	$50 deductible/Max OOP $1250 Preferred Generic $10 copay 30/90 Preferred Brand $25 copay 30/90 Preferred Specialty $45 copay 30 day mail Non-preferred (Generic, Brand & Specialty $100 copay 30/90
Vision **Premera BCBS of AK** Plan Pays Frequency	**No benefit**	100% of the allowable charges Exam/lenses: 1x PPY Frames/contacts: $200 (Per Benefit Year)
CBJ Contribution (MONTHLY) Emp Cont. Biweekly Healthy Rewards EE EE/ Family Biweekly Healthy Rewards Family	**$1490.00** **$0** **$0** **$88.20** **$38.20**	**$1490.00** **$70.00** **$20.00** **$155.40** **$105.40**
Dental **Premera BCBS of AK**	$50 / Individual $150 / Family	
Basic Coverage (No employee contribution for basic dental coverage)	Preventive cleanings—100% of the allowable amount per member per plan year General Services—80% of the allowable charges Major Services—50% of the allowable charges $2000.00 Maximum coverage limit per member per plan year	
Dental Buy-Up Plan NEW	**Buy-up option:** Deductible & Preventive same as above General Services—80% of allowable charges Major Services—80% of allowable charges $3000.00 Maximum coverage limit per member per plan year **$2500.00 Lifetime coverage for orthodontia per member** **Bi-weekly Contributions: Employee Only—$12.46 Family—$24.00**	

BRH Plan Year 2020-2021 PART-TIME Rates

BENEFIT	Economy	Standard
Medical Annual Deductible	$550 / Individual $1100 / Family	$300 / Individual $600 / Family
Plan Pays Based on allowable amount	80% of the allowable amount	80% of the allowable amount
Out of Pocket Limit (including Deductible) **Individual** **Family (2 member)** **Family (3+ member)**	 **$2550** **$5100** **$7100**	 **$1800** **$3600** **$5100**
Emergency Room Visit	$150 Co-pay	$150 Co-pay
Annual/Lifetime Maximum	None	None
Prescription Drugs 30 = Retail Pharmacy Fill 90 = Mail Order Pharmacy Fill	$50 deductible/Max OOP $1750 Preferred Generic $10 copay 30/90 Preferred Brand $35 copay 30/90 Preferred Specialty $55 copay 30 day mail Non-preferred (Generic, Brand & Specialty $150 copay 30/90	$50 deductible/Max OOP $1250 Preferred Generic $10 copay 30/90 Preferred Brand $25 copay 30/90 Preferred Specialty $45 copay 30 day mail Non-preferred (Generic, Brand & Specialty $100 copay 30/90
Vision Plan Pays Frequency	**No benefit**	100% of the allowable charges Exam/lenses: 1x PPY Frames/contacts: $200 (Per Benefit Year)
Dental	See information on opposite side	
BRH Contribution (MONTHLY)	**Depends on Part-time hours worked**	

Hours of work per pay period	32	36	40	48	60	64
Economy	0.00	0.00	0.00	0.00	0.00	0.00
Standard	$455.11	$413.85	$372.58	$296.94	$186.91	$145.65
Employee & Family	**32**	**36**	**40**	**48**	**60**	**64**
Economy	$473.31	$432.05	$390.78	$315.14	$205.11	$163.85
Standard	$540.51	$499.25	$457.98	$382.34	$272.31	$231.05