BRH Benefit Comparison Plan Year July 2023—June 2024

BENEFIT	High Deductible Health Plan (HDHP)	Economy	Standard
Medical **Premera BCBS of AK** Annual Deductible	$2000 / Individual $4000 / Family *if enrolled on family plan, you must meet the family deductible prior to plan paying 80% of allowable	$700 / Individual $1400 / Family *if enrolled on family plan, the plan starts to pay after an individual meets the deductible required	$350 / Individual $700 / Family *if enrolled on family plan, the plan starts to pay after an individual meets the deductible level required
Plan Pays	80% of the allowable amount in-network (after deductible) 100% of the allowable amount in-network (after out-of-pocket max)	80% of the allowable amount in-network (after deductible) 100% of the allowable amount in-network (after out-of-pocket max)	80% of the allowable amount in-network (after deductible) 100% of the allowable amount in-network (after out-of-pocket max)
Out of Pocket Limit (including Deductible)	**$4000** (Individual) **$8000** (Family) *if enrolled on family plan, you must meet the family Out-of-Pocket max prior to plan paying 100% of allowable	**$3000** (Individual) **$6000** (2 member Family) **$8000** (3+ member Family) *if enrolled on family plan, the plan starts to pay after an individual meets the Out-of-Pocket level required	**$1850** (Individual) **$3700** (2 member Family) **$5200** (3+ member Family) *if enrolled on family plan, the plan starts to pay after an individual meets the Out-of-Pocket level required
Emergency Room Visit	Deductible/Coinsurance	$150 Co-pay	$150 Co-pay
Annual/Lifetime Maximum	None	None	None
Prescription Drugs **Premera BCBS of AK** **30 = Retail Pharmacy Fill** **90 = Mail Order Pharmacy Fill**	Deductible/Coinsurance Preferred Generic Ded/Coins Preferred Brand Ded/Coins Preferred Specialty Ded/Coins Non-preferred (Generic, Brand Ded/Coins *Some preventive drugs have deductible waived	$150 deductible/Max OOP $2000 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	$75 deductible/Max OOP $1450 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
BRH Contribution Emp Cont. Biweekly Healthy Rewards EE EE/ Family Biweekly Healthy Rewards Family	**$770.48 Employee Only Bi-Weekly** **$764.80 Family Bi-Weekly** **$0.00** **$0.00** **$73.85** **$23.85**	**$770.48 Employee Only Bi-Weekly** **$764.80 Family Bi-Weekly** **$50.00** **$0** **$147.90** **$97.90**	**$770.48 Employee Only Bi-Weekly** **$764.80 Family Bi-Weekly** **$97.45** **$47.45** **$215.20** **$165.20**

<u>Vision</u> **Premera BCBS of AK**	100% of the allowable charges for Exam/lenses 1x PPY Frames/contacts: $200 (Per Benefit Year)	**Bi-weekly Contributions:** **Employee Only—$3.17 Family—$6.34** **Bi-weekly CBJ Employer Contribution:** **Employee Only—$15.68 Family—$15.06**
<u>Dental</u> **Premera BCBS of AK** Annual Deductible	$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	**Bi-weekly Employee Contributions:** **Employee Only—$0.00 Family—$0.00** **Bi-weekly CBJ Employer Contribution:** **Employee Only—$43.45 Family—$49.76**
Dental Buy-Up Plan	• Deductible & Preventive same as above • Preventive cleanings—100% of the allowable amount per member per plan year • 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 Employee Contributions:** **Employee Only—$19.61 Family—$32.22** **Bi-weekly CBJ Employer Contribution:** **Employee Only—$43.45 Family—$49.76**

BRH Plan Year 2023-2024 PART-TIME Rates

Hours of work per pay period (Based on 72 hour pay period)		32	48	64
High Deductible Health Plan	Employee	$0.00	$0.00	$0.00
	Family	$ 498.74	$ 328.78	$ 158.83
Economy Plan	Employee	$ 478.05	$ 306.83	$ 135.61
	Family	$ 572.79	$ 402.83	$ 232.88
Standard Plan	Employee	$ 525.50	$ 354.28	$ 183.06
	Family	$ 640.09	$ 470.13	$ 300.18
Basic Dental Plan	Employee	$ 24.14	$ 14.48	$ 4.83
	Family	$ 27.64	$ 16.59	$ 5.53
Buy-up Dental Plan	Employee	$ 43.75	$ 34.09	$ 24.44
	Family	$ 59.86	$ 48.81	$ 37.75
Vision Plan	Employee	$ 11.88	$ 8.40	$ 4.91
	Family	$ 14.70	$ 11.36	$ 8.01

Hours of work per pay period (Based on 80 hour pay period)		32	48	64
High Deductible Health Plan	Employee	$ 0.00	$ 0.00	$ 0.00
	Family	$ 532.73	$ 379.77	$ 226.81
Economy Plan	Employee	$ 512.29	$ 358.19	$ 204.10
	Family	$ 606.78	$ 453.82	$ 300.86
Standard Plan	Employee	$ 559.74	$ 405.64	$ 251.55
	Family	$ 674.08	$ 521.12	$ 368.16
Basic Dental Plan	Employee	$ 26.07	$ 17.38	$ 8.69
	Family	$ 29.86	$ 19.90	$ 9.95
Buy-up Dental Plan	Employee	$ 45.68	$ 36.99	$ 28.30
	Family	$ 62.08	$ 52.12	$ 42.17
Vision Plan	Employee	$ 12.58	$ 9.44	$ 6.31
	Family	$ 15.37	$ 12.36	$ 9.35