

CBJ Benefit Comparison Plan Year July 2023—June 2024

BENEFIT	High Deductible Health Plan (HDHP)	Economy	Standard
<u>Medical</u> Premera BCBS of AK Annual Deductible	\$2000 / Individual \$4000 / Family <small>*if enrolled on family plan, you must meet the family deductible prior to plan paying 80% of allowable</small>	\$700 / Individual \$1400 / Family <small>*if enrolled on family plan, the plan starts to pay after an individual meets the deductible required</small>	\$350 / Individual \$700 / Family <small>*if enrolled on family plan, the plan starts to pay after an individual meets the deductible level required</small>
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) <small>*if enrolled on family plan, you must meet the family Out-of-Pocket max prior to plan paying 100% of allowable</small>	\$3000 (Individual) \$6000 (2 member Family) \$8000 (3+ member Family) <small>*if enrolled on family plan, the plan starts to pay after an individual meets the Out-of-Pocket level required</small>	\$1850 (Individual) \$3700 (2 member Family) \$5200 (3+ member Family) <small>*if enrolled on family plan, the plan starts to pay after an individual meets the Out-of-Pocket level required</small>
Emergency Room Visit	Deductible/Coinsurance	\$150 Co-pay	\$150 Co-pay
Annual/Lifetime Maximum	None	None	None
<u>Prescription Drugs</u> 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 <small>*Some preventive drugs have deductible waived</small>	\$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 \$150 copay 30/90 (Generic, Brand &	\$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 \$100 copay 30/90 (Generic, Brand &
CBJ Contribution	\$697.79 Employee Only Bi-Weekly \$692.11 Family Bi-Weekly	\$697.79 Employee Only Bi-Weekly \$692.11 Family Bi-Weekly	\$697.79 Employee Only Bi-Weekly \$692.11 Family Bi-Weekly
Emp Cont. Biweekly	\$0.00	\$50.00	\$97.45
Healthy Rewards EE	\$0.00	\$0	\$47.45
EE/ Family Biweekly	\$73.85	\$147.90	\$215.20
Healthy Rewards Family	\$23.85	\$97.90	\$165.20

<p><u>Vision</u> Premera BCBS of AK</p>	<p>100% of the allowable charges for Exam/lenses 1x PPY Frames/contacts: \$200 (Per Benefit Year)</p>	<p>Bi-weekly Contributions: Employee Only—\$3.17 Family—\$6.34</p> <p>Bi-weekly CBJ Employer Contribution: Employee Only—\$15.68 Family—\$15.06</p>
<p><u>Dental</u> Premera BCBS of AK Annual Deductible</p>	<p>\$50 / Individual \$150 / Family</p>	
<p><u>Basic Coverage</u> (No employee contribution for basic dental coverage)</p>	<ul style="list-style-type: none"> • 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 	<p>Bi-weekly Employee Contributions: Employee Only—\$0.00 Family—\$0.00</p> <p>Bi-weekly CBJ Employer Contribution: Employee Only—\$43.45 Family—\$49.76</p>
<p><u>Dental Buy-Up Plan</u></p>	<ul style="list-style-type: none"> • 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 	<p>Bi-weekly Employee Contributions: Employee Only—\$19.61 Family—\$32.22</p> <p>Bi-weekly CBJ Employer Contribution: Employee Only—\$43.45 Family—\$49.76</p>

CBJ Plan Year 2022-2023 PART-TIME Rates

Hours of work per pay period (Based on 75 hour pay period)		30	45	60
High Deductible Health Plan	Employee	\$ 418.67	\$ 279.12	\$ 139.56
	Family	\$ 489.12	\$ 350.69	\$ 212.27
Economy Plan	Employee	\$ 468.67	\$ 329.12	\$ 189.56
	Family	\$ 563.17	\$ 424.74	\$ 286.32
Standard Plan	Employee	\$ 516.12	\$ 376.57	\$ 237.01
	Family	\$ 630.47	\$ 492.04	\$ 353.62
Basic Dental Plan	Employee	\$ 26.07	\$ 17.38	\$ 8.69
	Family	\$ 29.86	\$ 19.90	\$ 9.95
Buy-up Dental Plan	Employee	\$ 45.68	\$ 39.89	\$ 28.30
	Family	\$ 62.08	\$ 55.44	\$ 42.17
Vision Plan	Employee	\$ 12.58	\$ 9.44	\$ 6.31
	Family	\$ 15.37	\$ 12.36	\$ 9.35
Hours of work per pay period (Based on 80 hour pay period)		32	48	64
High Deductible Health Plan	Employee	\$ 418.67	\$ 279.12	\$ 139.56
	Family	\$ 489.12	\$ 350.69	\$ 212.27
Economy Plan	Employee	\$ 468.67	\$ 329.12	\$ 189.56
	Family	\$ 563.17	\$ 424.74	\$ 286.32
Standard Plan	Employee	\$ 516.12	\$ 376.57	\$ 237.01
	Family	\$ 630.47	\$ 492.04	\$ 353.62
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