JSD 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 & Specialty) — 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
JSD Contribution	**$1634.00 Monthly**	**$1634.00 Monthly**	**$1634.00 Monthly**
EO Cont. Biweekly Healthy Rewards EE	**$93.23** **$43.23**	**$143.23** **$93.23**	**$190.68** **$140.68**
EE/ Family Biweekly Healthy Rewards Family	**$167.02** **$117.02**	**$241.13** **$191.13**	**$308.43** **$258.43**

<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 Employee Contributions:** **Employee Only—$3.17** **Family—$6.34**
<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	
Dental Buy-Up Plan	**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 Employee Contributions:** **Employee Only—$19.61** **Family—$32.22**