# BRH Benefit Comparison Plan Year July 2024—June 2025

| BENEFIT | High Deductible Health Plan (HDHP) | Economy | Standard |
|---|---|---|---|
| **Medical**<br>**Premera BCBS of AK**<br>Annual Deductible | $2000 / Individual<br>$4000 / Family<br>*if enrolled on family plan, you must meet the family deductible prior to plan paying 80% of allowable | $700 / Individual<br>$1400 / Family<br>*if enrolled on family plan, the plan starts to pay after an individual meets the deductible required | $350 / Individual<br>$700 / Family<br>*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<br>(after deductible)<br>100% of the allowable amount in-network<br>(after out-of-pocket max)<br>(50% Out-of-Network) | 80% of the allowable amount in-network<br>(after deductible)<br>100% of the allowable amount in-network<br>(after out-of-pocket max)<br>(50% Out-of-Network) | 80% of the allowable amount in-network<br>(after deductible)<br>100% of the allowable amount in-network<br>(after out-of-pocket max)<br>(60% Out-of-Network) |
| Out of Pocket Limit<br>(including Deductible) | **$4000** (Individual)<br>**$8000** (Family)<br>*if enrolled on family plan, you must meet the family Out-of-Pocket max prior to plan paying 100% of allowable | **$3000** (Individual)<br>**$6000** (2 member Family)<br>**$8000** (3+ member Family)<br>*if enrolled on family plan, the plan starts to pay after an individual meets the Out-of-Pocket level required | **$1850** (Individual)<br>**$3700** (2 member Family)<br>**$5200** (3+ member Family)<br>*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**<br>**Premera BCBS of AK**<br>**30 = Retail Pharmacy Fill**<br>**90 = Mail Order Pharmacy Fill** | Deductible/Coinsurance<br>Preferred Generic Ded/Coins<br>Preferred Brand Ded/Coins<br>Preferred Specialty Ded/Coins<br>Non-preferred (Generic, Brand & Specialty Ded/Coins<br>*Some preventive drugs have deductible waived | $150 deductible/Max OOP $2000<br>Preferred Generic $10 copay 30/90<br>Preferred Brand $35 copay 30/90<br>Preferred Specialty $55 copay 30 day mail<br>Non-preferred (Generic, Brand & Specialty $150 copay 30/90 | $75 deductible/Max OOP $1450<br>Preferred Generic $10 copay 30/90<br>Preferred Brand $25 copay 30/90<br>Preferred Specialty $45 copay 30 day mail<br>Non-preferred (Generic, Brand & Specialty $100 copay 30/90 |
| Emp Cont. Biweekly<br>Healthy Rewards EE<br><br>EE/ Family Biweekly<br>Healthy Rewards Family | **$0.00**<br>**$0.00**<br><br>**$79.00**<br>**$29.00** | **$53.40**<br>**$3.40**<br><br>**$158.00**<br>**$108.00** | **$104.40**<br>**$54.40**<br><br>**$230.40**<br>**$180.40** |

**Bartlett Employer Contribution to Health, Rx, Dental & Vision per month per full time employee: $1,815.50**

| | | |
|---|---|---|
| **Vision**<br>**Premera BCBS of AK** | 100% of the allowable charges for Exam/lenses 1x PPY<br>Frames/contacts: $200 (Per Benefit Year) | **Employee Only—$3.50** **Family—$6.80** |
| **Dental**<br>**Premera BCBS of AK**<br>Annual Deductible | $50 / Individual<br>$150 / Family<br>Preventive cleanings—100% of the allowable amount per member per plan year | |
| **Basic Coverage**<br>(No employee contribution for basic dental coverage) | • General Services—80% of the allowable charges<br>• Major Services—50% of the allowable charges<br>• $2000.00 Maximum coverage limit per member per plan year | |
| **Dental Buy-Up Plan** | • General Services—80% of allowable charges<br>• Major Services—80% of allowable charges<br>• $3000.00 Maximum coverage limit per member per plan year<br>• $2500.00 Lifetime coverage for orthodontia per member | **Employee Only—$21.00** **Family—$34.50** |

## BRH Plan Year 2024-2025 PART-TIME Rates

| Hours of work per pay period (Based on 72 hour pay period) | | 36 | 48 | 60 |
|---|---|---|---|---|
| High Deductible Health Plan | Employee | $388.87 | $259.25 | $129.62 |
| | Family | $464.99 | $336.33 | $207.66 |
| Economy Plan | Employee | $442.27 | $312.65 | $183.02 |
| | Family | $543.99 | $415.33 | $286.66 |
| Standard Plan | Employee | $493.27 | $363.65 | $234.02 |
| | Family | $616.39 | $487.73 | $359.06 |
| Basic Dental Plan | Employee | $22.41 | $14.94 | $7.47 |
| | Family | $25.67 | $17.11 | $8.56 |
| Buy-up Dental Plan | Employee | $43.41 | $35.94 | $28.47 |
| | Family | $60.17 | $51.61 | $43.06 |
| Vision Plan | Employee | $11.18 | $8.62 | $6.06 |
| | Family | $14.10 | $11.67 | $9.23 |

| Hours of work per pay period (Based on 80 hour pay period) | | 32 | 48 | 64 |
|---|---|---|---|---|
| High Deductible Health Plan | Employee | $466.64 | $311.10 | $155.55 |
| | Family | $542.19 | $387.80 | $233.40 |
| Economy Plan | Employee | $520.04 | $364.50 | $208.95 |
| | Family | $621.19 | $466.80 | $233.40 |
| Standard Plan | Employee | $571.04 | $415.50 | $259.95 |
| | Family | $693.59 | $539.20 | $384.80 |
| Basic Dental Plan | Employee | $26.89 | $17.93 | $8.96 |
| | Family | $30.80 | $20.53 | 10.27 |
| Buy-up Dental Plan | Employee | $47.89 | $38.93 | $29.96 |
| | Family | $65.30 | $55.03 | $44.77 |
| Vision Plan | Employee | $12.72 | $9.64 | $6.57 |
| | Family | $15.56 | $12.64 | $9.72 |