

CBJ Benefit Comparison Plan Year July 2024—June 2025

BENEFIT	High Deductible Health Plan (HDHP)	Economy	Standard
Medical 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) (50% Out-of-Network)	80% of the allowable amount in-network (after deductible) 100% of the allowable amount in-network (after out-of-pocket max) (50% Out-of-Network)	80% of the allowable amount in-network (after deductible) 100% of the allowable amount in-network (after out-of-pocket max) (60% Out-of-Network)
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
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 <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 &
Emp Cont. Biweekly	\$0.00	\$53.40	\$104.40
Healthy Rewards EE	\$0.00	\$3.40	\$54.40
EE/ Family Biweekly	\$79.00	\$158.00	\$230.40
Healthy Rewards Family	\$29.00	\$108.00	\$180.40

City & Borough of Juneau Employer Contribution to Health, Rx, Dental & Vision per month per full time employee: \$1,722.00

Vision Premera BCBS of AK	100% of the allowable charges for Exam/lenses 1x PPY Frames/contacts: \$200 (Per Benefit Year)	Employee Only—\$3.50 Family—\$6.80
Dental Premera BCBS of AK Annual Deductible	\$50 / Individual \$150 / Family Preventive cleanings—100% of the allowable amount per member per plan year	
Basic Coverage (No employee contribution for basic dental coverage)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	Employee Only—\$21.00 Family—\$34.50

CBJ Plan Year 2024-2025 PART-TIME Rates

Hours of work per pay period (Based on 75hour pay period)		30	45	60
High Deductible Health Plan	Employee	\$ 440.75	\$ 293.83	\$ 146.92
	Family	\$ 516.30	\$ 370.53	\$ 224.77
Economy Plan	Employee	\$ 494.15	\$ 347.23	\$ 200.32
	Family	\$ 595.30	\$ 449.53	\$ 303.77
Standard Plan	Employee	\$ 545.15	\$ 398.23	\$ 251.32
	Family	\$ 667.70	\$ 521.93	\$ 376.17
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

Hours of work per pay period (Based on 80 hour pay period)		32	48	64
High Deductible Health Plan	Employee	\$ 440.75	\$ 293.83	\$ 146.92
	Family	\$ 516.30	\$ 370.53	\$ 224.77
Economy Plan	Employee	\$ 494.15	\$ 347.23	\$ 200.32
	Family	\$ 595.30	\$ 449.53	\$ 303.77
Standard Plan	Employee	\$ 545.15	\$ 398.23	\$ 288.05
	Family	\$ 667.70	\$ 521.93	\$ 376.17
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
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	Family	\$ 15.56	\$ 12.64	\$ 9.72