

BRH Non-PERS Benefit Comparison Plan Year July 2025—June 2026

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) Individual Family	\$4000 \$8000 <small>*if enrolled on family plan, you must meet the family Out-of-Pocket max prior to plan paying 100% of allowable</small>	\$3000 \$8000 <small>*if enrolled on family plan, the plan starts to pay after an individual meets the Out-of-Pocket level required</small>	\$1850 \$5200 <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 & Specialty) 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 & Specialty)	\$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 & Specialty)
Contribution from 30%	\$777.74 Employee Only Bi-Weekly \$781.22 Family Bi-Weekly		
Emp Cont. Biweekly Healthy Rewards EE EE/ Family Biweekly Healthy Rewards Family	\$0.00 \$0.00 \$79.00 \$29.00	\$53.40 \$3.40 \$158.00 \$108.00	\$104.40 \$54.40 \$230.40 \$180.40

<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—\$3.50 Family—\$6.80</p> <p>Bi-weekly Contribution from 30%: Employee Only—\$ 15.36 Family—\$ 14.60</p>
<p><u>Dental</u> Premera BCBS of AK Annual Deductible</p>	<p>\$50 / Individual \$150 / Family</p>	
<p>Basic Coverage (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 Contribution from 30%: Employee Only—\$ 44.83 Family—\$ 51.34</p>
<p>Dental Buy-Up Plan</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 	<p>Bi-weekly Employee Contributions: Employee Only—\$21.00 Family—\$34.50</p> <p>Bi-weekly Contribution from 30%: Employee Only—\$ 44.83 Family—\$ 51.34</p>