

## BRH Benefit Comparison Plan Year July 2025—June 2026

BENEFIT	High Deductible Health Plan (HDHP)	Economy	Standard
<b>Medical</b> <b>Premera BCBS of AK</b> 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>
<b>Plan Pays</b>	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)	<b>\$4000</b> (Individual) <b>\$8000</b> (Family) <small>*if enrolled on family plan, you must meet the family Out-of-Pocket max prior to plan paying 100% of allowable</small>	<b>\$3000</b> (Individual) <b>\$6000</b> (2 member Family) <b>\$8000</b> (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>	<b>\$1850</b> (Individual) <b>\$3700</b> (2 member Family) <b>\$5200</b> (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>
<b>Emergency Room Visit</b>	Deductible/Coinsurance	\$150 Co-pay	\$150 Co-pay
<b>Annual/Lifetime Maximum</b>	None	None	None
<b>Prescription Drugs</b> <b>Premera BCBS of AK</b> <b>30 = Retail Pharmacy Fill</b> <b>90 = Mail Order Pharmacy Fill</b>	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 & 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)
Emp Cont. Biweekly	<b>\$0.00</b>	<b>\$53.40</b>	<b>\$104.40</b>
Healthy Rewards EE	<b>\$0.00</b>	<b>\$3.40</b>	<b>\$54.40</b>
EE/ Family Biweekly	<b>\$79.00</b>	<b>\$158.00</b>	<b>\$230.40</b>
Healthy Rewards Family	<b>\$29.00</b>	<b>\$108.00</b>	<b>\$180.40</b>

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

<b>Vision</b> <b>Premera BCBS of AK</b>	100% of the allowable charges for Exam/lenses 1x PPY Frames/contacts: \$200 (Per Benefit Year)	<b>Employee Only—\$3.50</b> <b>Family—\$6.80</b>
<b>Dental</b> <b>Premera BCBS of AK</b> Annual Deductible	\$50 / Individual \$150 / Family Preventive cleanings—100% of the allowable amount per member per plan year	
<b>Basic Coverage</b> (No employee contribution for basic dental coverage)	<ul style="list-style-type: none"> <li>• General Services—80% of the allowable charges</li> <li>• Major Services—50% of the allowable charges</li> <li>• \$2000.00 Maximum coverage limit per member per plan year</li> </ul>	
<b>Dental Buy-Up Plan</b>	<ul style="list-style-type: none"> <li>• General Services—80% of allowable charges</li> <li>• Major Services—80% of allowable charges</li> <li>• \$3000.00 Maximum coverage limit per member per plan year</li> <li>• \$2500.00 Lifetime coverage for orthodontia per member</li> </ul>	<b>Employee Only—\$21.00</b> <b>Family—\$34.50</b>

### BRH Plan Year 2025-2026 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