

CBJ Benefit Comparison Plan Year July 2025—June 2026

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 & 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 (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		
Emp Cont. Biweekly Healthy Rewards EE	\$0.00 \$0.00	\$53.40 \$3.40			\$104.40 \$54.40		
EE/ Family Biweekly Healthy Rewards Family	\$79.00 \$29.00	\$158.00 \$108.00			\$230.40 \$180.40		

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

<u>Vision</u> 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
<u>Dental</u> 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 2025-2026 PART-TIME Rates

Hours of work per pay period (Based on 75 hour 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
Vision Plan	Employee	\$12.72	\$ 9.64	\$ 6.57
	Family	\$15.56	\$12.64	\$ 9.72