# JSD Benefit Comparison Plan Year July 2025—June 2026

| 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 (after deductible)<br>100% of the allowable amount in-network (after out-of-pocket max) | 80% of the allowable amount in-network (after deductible)<br>100% of the allowable amount in-network (after out-of-pocket max) | 80% of the allowable amount in-network (after deductible)<br>100% of the allowable amount in-network (after out-of-pocket max) |
| 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 |
| EO Cont. Biweekly<br>Healthy Rewards EE<br><br>EE/ Family Biweekly<br>Healthy Rewards Family | **$93.23**<br>**$43.23**<br><br>**$172.23**<br>**$122.23** | **$146.63**<br>**$96.63**<br><br>**$251.23**<br>**$201.23** | **$197.63**<br>**$147.63**<br><br>**$323.63**<br>**$273.63** |

**Juneau School District Employer Contribution to Health, Rx, Dental & Vision per month per full time employee: $1634.00**

| | | |
|---|---|---|
| **Vision**<br>**Premera BCBS of AK** | 100% of the allowable charges for Exam/lenses 1x PPY<br>Frames/contacts: $200 (Per Benefit Year) | **Bi-weekly Employee Contributions:**<br><br>**Employee Only—$3.50** **Family—$6.80** |
| **Dental**<br>**Premera BCBS of AK**<br>Annual Deductible | $50 / Individual<br>$150 / Family | |
| **Basic Coverage**<br>(No employee contribution for basic dental coverage) | Preventive cleanings—100% of the allowable amount per member per plan year<br>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** | **Buy-up option:**<br>• Deductible & Preventive same as above<br>• 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 | **Bi-weekly Employee Contributions:**<br><br>**Employee Only—$21.00** **Family—$34.50** |