Helena School District #1
Employee Health Benefit Summary
October 1, 2020 – September 30, 2021

BENEFIT DOLLARS AWARDED PER YEAR (IF PART-TIME, CONTACT HR BENEFITS MANAGER) –$9,840.00 (984.00 X 10 MO)

PREMIUM PLAN

Benefit includes medical, dental, vision (employee only), and prescription coverage.

Monthly Premiums for 2020-2021 Plan Year

Coverage	Premium
Single	$939.60
Single + Spouse	$1,777.20
Single + Dependent(s)	$1,083.60
Single + Spouse + Dependent(s)	$1,918.80

Medical coverage:

$500 deductible for individual and $1,000 deductible for family. Participants incur a 20% co-pay on applicable expenses until they reach a maximum out-of-pocket limit. The maximum out-of-pocket cost for an individual is $2,000 and $3,000 for family.

Dental coverage: Reimbursed on a schedule

Preventive, basic restorative and major restorative coverage. Non-preventive services are subject to a $100 annual deductible applied per covered person. Maximum allowable per benefit plan year per covered person is $2,000.00.

Prescription Coverage:

Each participant must meet a $100 deductible. Participant co-payments per prescription (after deductible) will be:

Pharmacy Benefit:

Supply	Generic	Preferred Brand	Non-Preferred Brand
34-day	$12	$40 + 40%	$50 + 50%

Mail Order Benefit:

Supply	Generic	Preferred Brand	Non-Preferred Brand
34-day	$12	$40	$50
3-month	$24	$104	$120

Vision Coverage:

Vision claims are based on a reimbursement schedule stated in your plan document. Vision coverage is an employee and spouse only benefit.

STANDARD PLAN

Benefit includes medical, preventive dental, and prescription coverage.

Monthly Premiums for 2020-2021 Plan Year

Coverage	Premium
Single	$642.00
Single + Spouse	$1,214.40
Single + Dependent(s)	$757.20
Single + Spouse + Dependent(s)	$1,326.00

Medical coverage:

$1,000 deductible for individual and $2,000 deductible for family. Participants incur a 30% co-pay on applicable expenses until they reach a maximum out-of-pocket limit. The maximum out-of-pocket cost for an individual is $5,000 and $10,000 for family.

Dental coverage: Reimbursement according to schedule

Preventive dental coverage only. No deductible applies. The annual benefit includes the following preventive services:

- two periodic oral exams
- one comprehensive oral evaluation (a one-time evaluation for new patients);
- two cleanings (prophylaxis),
- one set of x-rays - bitewing single film; bitewings two films; bitewings four films.

Prescription Coverage:

(Same as Premium Plan Prescription Benefit.)

Vision Coverage:

There will be no vision coverage under the Standard Plan.

Important Health Plan Election Information:

Employees may change their health benefit plan election to the Standard Plan, however, the Plan requires a **two year** minimum commitment to remain on the Standard Plan. A change in dependents coverage is only allowed during open enrollment period or if a change in family status occurs anytime during the plan year. Contact the Human Resource Benefits Manager, Richard Franco at 324-2008 or rfranco@helenaschools.org to determine if an allowable change has occurred.