

**Helena School District #1**  
**Employee Health Benefit Summary**  
**October 1, 2023 – September 30, 2024**

BENEFIT DOLLARS AWARDED PER YEAR (IF PART-TIME, CONTACT HR BENEFITS MANAGER) –\$11,632.80 (1,163.28 X **10** MO)

PREMIUM PLAN	STANDARD PLAN																				
Benefit includes medical, dental, vision (employee and spouse only), and prescription coverage.	Benefit includes medical, preventive dental, and prescription coverage.																				
Monthly Premiums for 2023-2024 Plan Year	Monthly Premiums for 2023-2024 Plan Year																				
<table><tr><th>Coverage</th><th>Premium</th></tr><tr><td>Single</td><td>\$1,306.48</td></tr><tr><td>Single + Spouse</td><td>\$2,471.13</td></tr><tr><td>Single + Dependent(s)</td><td>\$1,506.71</td></tr><tr><td>Single + Spouse + Dependent(s)</td><td>\$2,668.03</td></tr></table>	Coverage	Premium	Single	\$1,306.48	Single + Spouse	\$2,471.13	Single + Dependent(s)	\$1,506.71	Single + Spouse + Dependent(s)	\$2,668.03	<table><tr><th>Coverage</th><th>Premium</th></tr><tr><td>Single</td><td>\$892.68</td></tr><tr><td>Single + Spouse</td><td>\$1,688.58</td></tr><tr><td>Single + Dependent(s)</td><td>\$1,052.86</td></tr><tr><td>Single + Spouse + Dependent(s)</td><td>\$1,843.75</td></tr></table>	Coverage	Premium	Single	\$892.68	Single + Spouse	\$1,688.58	Single + Dependent(s)	\$1,052.86	Single + Spouse + Dependent(s)	\$1,843.75
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Medical coverage:	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 with exception where max benefit applies.	\$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 with exception where max benefit applies.																				
Dental coverage: Reimbursed on a schedule	Dental coverage: Reimbursement according to 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.	Preventive dental coverage only. No deductible applies. The annual benefit includes the following preventive services: <ul style="list-style-type: none"><li>two periodic oral exams</li><li>one comprehensive oral evaluation (a one-time evaluation for new patients);</li><li>two cleanings (prophylaxis),</li><li>one set of x-rays - bitewing single film; bitewings two films; bitewings four films.</li></ul>																				
Prescription Coverage:	Prescription Coverage:																				
Each participant must meet a \$100 deductible. Participant co-payments per prescription (after deductible) will be:																					
Pharmacy Benefit:																					
<table><tr><td>Supply</td><td>Generic</td><td>Preferred Brand</td><td>Non-Preferred Brand</td></tr><tr><td>34-day</td><td>\$12</td><td>\$40 + 40%</td><td>\$50 + 50%</td></tr></table>	Supply	Generic	Preferred Brand	Non-Preferred Brand	34-day	\$12	\$40 + 40%	\$50 + 50%													
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Mail Order Benefit:																					
<table><tr><td>Supply</td><td>Generic</td><td>Preferred Brand</td><td>Non-Preferred Brand</td></tr><tr><td>34-day</td><td>\$12</td><td>\$40</td><td>\$50</td></tr><tr><td>3-month</td><td>\$24</td><td>\$104</td><td>\$120</td></tr></table>	Supply	Generic	Preferred Brand	Non-Preferred Brand	34-day	\$12	\$40	\$50	3-month	\$24	\$104	\$120	(Same as Premium Plan Prescription Benefit.)								
Supply	Generic	Preferred Brand	Non-Preferred Brand																		
34-day	\$12	\$40	\$50																		
3-month	\$24	\$104	\$120																		
Vision Coverage:	Vision Coverage:																				
Vision claims are based on a reimbursement schedule stated in your plan document. Vision coverage is an employee and spouse only benefit.	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](mailto:rfranco@helenaschools.org) to determine if an allowable change has occurred.