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

BENEFIT DOLLARS AWARDED EFFECTIVE 4/25/2024 (IF PART-TIME, CONTACT HR BENEFITS MANAGER) –$1,119.40 FOR 12 MO EE'S

PREMIUM PLAN

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

Monthly Premiums for 2023-2024 Plan Year

Coverage	Premium
Single	$1,088.73
Single + Spouse	$2,059.28
Single + Dependent(s)	$1,255.59
Single + Spouse + Dependent(s)	$2,223.35

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.

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 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 2023-2024 Plan Year

Coverage	Premium
Single	$743.90
Single + Spouse	$1,407.16
Single + Dependent(s)	$877.39
Single + Spouse + Dependent(s)	$1,536.46

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 with exception where max benefit applies.

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 is no vision coverage under the Standard Plan.

Important Health Plan Election Information:

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 (Qualifying Event). Contact the Human Resource Benefits Manager, Richard Franco at 324-2008 or rfranco@helenaschools.org to determine if an allowable change has occurred.

Helena Public Schools
A great place to learn