Medical Plans with Rates

Benefit Dollars Awarded Per Year for Full-Time EE (Part-time pro-rated): $12,832.80

Benefits	Option 1		Option 2	
	Tier 1	Tier 2	Tier 1	Tier 2
Calendar Year Deductible Individual / Family	$0 Embedded	$1,500 / $3,000 Embedded	N/A	$3,000 / $6,000 Embedded
Annual Out-of-Pocket Max Individual/Family	$4,000 / $8,000 Embedded		$7,000 / $14,000 Embedded	
Plan Services	**Tier 1**	**Tier 2**	**Tier 1**	**Tier 2**
Physician Office Visit	$10 copay	30% after deductible	30% after deductible	
Specialist Office Visit	$40 copay	30% after deductible	30% after deductible	
Preventive Care	No Charge			
CT, MRI, PET scans	No Charge	30% after deductible	30% after deductible	
Other lab and x-ray tests	No Charge	30% after deductible	30% after deductible	
Inpatient Hospital	30% after deductible	30% after deductible	30% after deductible	
Oupatient Hospital	$10 copay	30% after deductible	30% after deductible	
Emergency Room	$250 copay	30% after deductible	30% after deductible	
Urgent Care	$25 copay	30% after deductible	$25 copay	30% after deductible
Durable Medical Equipment	No Charge	30% after deductible	30% after deductible	
Chiropractic Care	Not Covered	$25 copay, deductible waived	$25 copay, deductible waived	
Pharmacy Services	**Generic/Preferred/Non-Preferred**		**Generic/Preferred/Non-Preferred**	
Rx Co-Pay Out-of-Pocket Max	$700 Individual / $1,300 Family		$700 Individual / $1,300 Family	
Rx Benefit Deductible Per Year	$100		$100	
Retail 34-day supply	$12 / $40 + 40% / $50 + 50%		$12 / $40 + 40% / $50 + 50%	
Mail Order - 90-day supply	$24 / $104 / $120		$24 / $104 / $120	
12 Month EE Rates	**Option 1**		**Option 2**	
Employee Only	$1,155.31		$955.06	
Employee + Spouse	$2,216.17		$1,824.19	
Employee + Child	$1,450.38		$1,193.84	
Employee + Children	$1,566.39		$1,289.35	
Employee + Family (1 child)	$2,506.24		$2,062.95	
Employee + Family (2+ child)	$2,622.28		$2,158.47	
10 Month EE Rates	**Option 1**		**Option 2**	
Employee Only	$1,386.37		$1,146.07	
Employee + Spouse	$2,659.40		$2,189.03	
Employee + Child	$1,740.46		$1,432.60	
Employee + Children	$1,879.67		$1,547.22	
Employee + Family (1 child)	$3,007.49		$2,475.54	
Employee + Family (2+ child)	$3,146.74		$2,590.16	

Dental Plan Premiums

12 Month EE Rates		10 Month EE Rates	
Coverage Type	**Premium Cost**	**Coverage Type**	**Premium Cost**
Employee Only	$53.29	Employee Only	$63.95
Employee + Spouse	$101.78	Employee + Spouse	$122.14
Employee + Child	$66.61	Employee + Child	$79.93
Employee + Children	$71.94	Employee + Children	$86.33
Employee + Family (1 child)	$115.10	Employee + Family (1 child)	$138.12
Employee + Family (2+ child)	$120.43	Employee + Family (2+ child)	$144.52

Dental Coverage is based on a reimbursement schedule. This schedule and SPD can be found on the District Insurance Website.

Our TPA for your Dental benefits is Delta Dental. Please visit the Helena School District Insurance Website for more information such as their Network and other options.

Vision Plan Premiums

12 Month EE Rates		10 Month EE Rates	
Coverage Type	**Premium Cost**	**Coverage Type**	**Premium Cost**
Employee Only	$13.55	Employee Only	$16.26
Employee + Spouse	$25.88	Employee + Spouse	$31.06

Vision Coverage is based on a reimbursement schedule. This schedule and SPD can be found on the District Insurance Website. Vision Coverage is an Employee and Spouse only benefit.

Our TPA for your Vision benefits is Ameritas. Please visit the Helena School District Insurance Website for more information.ns.