Helena Public Schools

2026-2027 Benefit Guide

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Digital Access

Access this booklet, required notices, Summary of Benefits and Coverage (SBC) and other resources for our plan by clicking the bookshelf image below or scanning the QR code.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Welcome to 2026-27 Open Enrollment

As we get ready to welcome another exciting school year, it's time to review and choose your health benefits for the 2026–27 plan year. **Open Enrollment begins August 14 and ends September 4**.

We know the work you do each day makes a difference for our students, and we are committed to providing benefits that support you and your family. This year also marks the beginning of our participation in the Bridged Health Alliance, an exciting step that brings several advantages, including greater collaboration, enhanced resources, and a continued focus on delivering high-quality, cost-effective benefits for employees.

This packet contains everything you need to complete your enrollment through the Employee Portal. Please take a few minutes to review this information, especially the section outlining changes for the upcoming plan year. Even if you don't plan to make changes, it's important to understand any updates to benefits, costs, and wellness incentives before making elections. Employees who do not complete the enrollment process by the deadline may experience a lapse in coverage. Before submitting your enrollment, be sure to complete the items on this checklist:

- ☐ Review the benefit changes for the 2026–27 plan year.
- ☐ Review your current medical, dental, and vision coverage.
- ☐ Decide whether to keep your current coverage or make changes.
- ☐ Verify that your dependent information is accurate and up to date.
- ☐ Review available wellness incentives and program information.
- ☐ Log into the Employee Portal and complete your enrollment.
- ☐ Review your elections carefully before submitting by September 4, 2026.

We know benefits can feel overwhelming, and we're here to help. Please feel free to contact me by phone at (406) 324-2014 or email. Thank you for everything you do for our students and schools.

Sincerely,
Keri Mizell
Human Resources Director

JOIN US AT THE BENEFITS FAIR ON AUGUST 14!

We encourage you to attend the Benefits Fair from **10 a.m. to 2 p.m. August 14** at the Lincoln Center. Representatives from benefit partners, Human Resources, and Bridged Health Alliance will be available to help you better understand your options. Lunch will be provided from 11:30 a.m. to 1:00 p.m.

Getting Started

2026-27 Benefits

Effective: October 1, 2026

Medicare Part D Notice

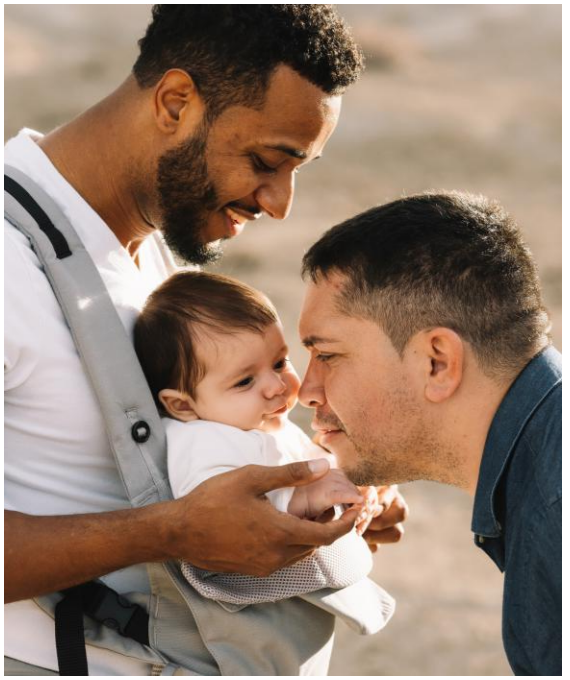
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

No matter where you are in your career, Helena Public Schools supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare benefits, as well as life and disability coverage.

You'll find tips to help you understand your medical coverage. Take a look at what's available to make the most of your benefits package.

Who's eligible for benefits?



Domestic partner notice

Please note that domestic partner coverage can differ from spouse coverage when Medicare eligibility is a factor.

Medicare is the primary payer for domestic partners with large employer group health plan coverage if a domestic partner can get Medicare due to their age and has group health plan coverage through their partner's current employer.

Employees

You are eligible if you are in a regular FTE position.

Eligible Dependents

- Legally married spouse or domestic partner
- Biological, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

Changing your benefits

Click to play video

Life happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit any changes within 90 days after the event.

Important Plan Information

Know your plan

In this section, you'll find important plan information including:

- Your medical, dental and vision benefit costs for 2026/27
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

What's Changing for the 2026-27 Plan Year?

Benefit Dollars: Benefit Dollars will remain $1,069.40 per month for a full-time (1.00 FTE) 12-month employee. Part-time employees will be pro-rated accordingly.

Plan options: There will continue to be two plan options for Medical. Dental and Vision can still be elected separately. There was an 8.5% increase to premiums for each medical plan as shared in prior communications. Please refer to the **District Insurance website** for detailed information.

- **Our Pharmacy Benefit Manager (PBM) is now Judi Rx** (formerly Capital Rx), a full service PBM known for its transparent, pass-through pricing model. More information on page 13.
- **Our telemedicine partner is now First Stop Health**, where you can access primary care, urgent care, mental health care and health coaching at no cost to you! More on page 20.
- **Medical/Rx Option 1** (has the Tier 1 program with co-pays)
- **Medical/Rx Option 2** (does not have the Tier 1 program but does still have $25 Urgent Care visits and Accident/Injury Benefit).
- There is one Dental option that will provide preventative, basic, and major restorative care.
- Vision is available for Employee or Employee/Spouse only through Ameritas.
- An employee may elect Dental and/or Vision coverage for self and/or eligible dependents with no out-of-pocket cost if waiving Medical/Rx coverage.

Online Enrollment: All Active District Health Benefit Plan members must log into the Employee Portal between August 14 and September 4 to make elections, even if you are not looking to make any changes. **Failure to take action by September 4 may result in a lapse in coverage.** Please visit **Human Resources/Health Care and Cafeteria Benefits webpage** for a comprehensive overview of the Health Insurance Plan Description, Health Plan Document, Summary of Benefits and Coverage, as well as legal notices regarding the requirements of The Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act of 2010 (HCERA).

Important Health Plan Election Information: A change in dependents coverage is only allowed during open enrollment period or if a Qualifying Event occurs during the plan year. Email humanresources@helenaschools.org to determine if an allowable change has occurred.

Wellness Program: The District Wellness Program encourages healthy habits and preventive care. Employees and enrolled spouses who participate in wellness screenings, complete required health activities, and meet program criteria may qualify for wellness incentives. Employees and enrolled spouses have until **June 30 of each year** to complete any required activities and meet eligibility requirements for incentives in the following plan year. For specific wellness requirements, incentive amounts, and program details, please visit the **District Insurance website**.

Medical

Words To Know

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

Deductible: The total healthcare costs you pay for with your own money before your plan will start to pay a portion.

Out-of-pocket maximum: Once you've spent this amount on covered medical services, your insurance pays 100% of most eligible expenses for the rest of the plan year.

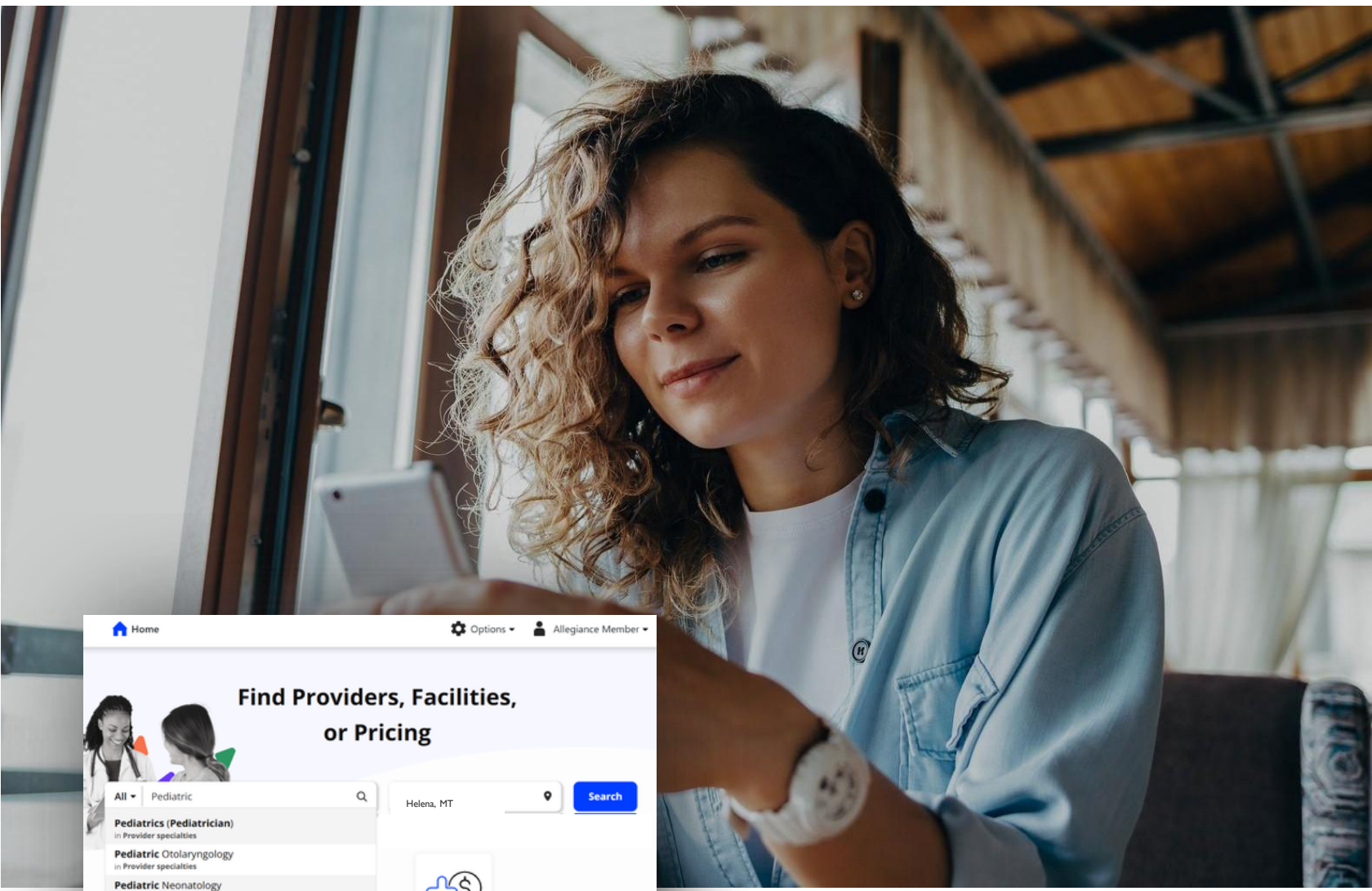
Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your share of the cost (your coinsurance) is 20%. You are billed for your coinsurance after your visit.

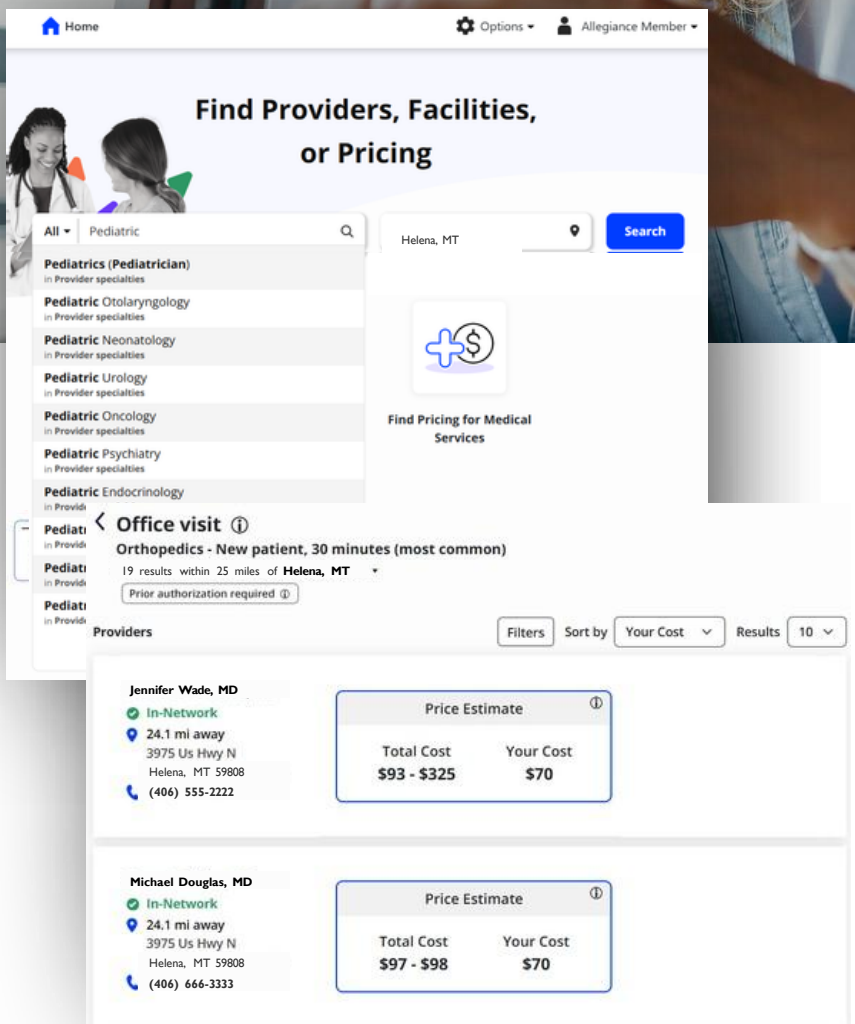
Copay: A set fee (rather than coinsurance) for certain healthcare services—for example, a doctor's office visit. You pay the copay at the time you receive care.

In-network/out-of-network: In-network services will always be the lowest-cost option. Out-of-network services will cost more or may not even be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

Find in-network providers and pricing estimates for healthcare services

Allegiance℠ by Cigna Healthcare





Get started at AskAllegiance.com

1. Login to the Allegiance online member portal at **www.AskAllegiance.com**.
2. Select the links for **Provider Search** or **Cost Transparency.**
3. Verify your location and begin your search.

Medical Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	OPTION #1		OPTION #2	
	Tier 1	Tier 2	Tier 1	Tier 2
Annual Deductible Individual/Family	$0 Embedded	$1,500 / $3,000 Embedded	N/A	$3,000 / $6,000 Embedded
Annual Out-of-Pocket Maximum Individual/Family	$4,000 / $8,000 Embedded		$7,000 / $14,000 Embedded	
Benefit Period	Plan Year		Plan Year	
Exams				
Office Visit	$10 copay	30% after deductible	30% after deductible	
Specialist Visit	$40 copay	30% after deductible	30% after deductible	
Preventive Care	Covered in full		Covered in full	
Diagnostic Services				
Labs & X-Ray	Covered in full	30% after deductible	30% after deductible	
Complex Imaging	Covered in full	30% after deductible	30% after deductible	
Therapeutic Services				
Chiropractic *(up to 25 visits per yr)*	Not covered	$25 copay	$25 copay	
Facility Services				
Urgent Care	$25 copay	30% after deductible	$25 copay	30% after deductible
Emergency Room	$250 copay *(copay waived if admitted)*	30% after deductible	30% after deductible *(copay waived if admitted)*	
Hospitalization	30%	30% after deductible	30% after deductible	
Outpatient Surgery	$10 copay	30% after deductible	30% after deductible	
Prescription Drugs	In-Network - Retail	In-Network - Mail	In-Network - Retail	In-Network - Mail
Rx Copay Out-of-Pocket Max	$700 Individual / $1,300 Family Rx Benefit Deductible Per Year: $100		$700 Individual / $1,300 Family Rx Benefit Deductible Per Year: $100	
Generic	$12 copay	$24 copay	$12 copay	$24 copay
Preferred Brand	$40 copay + 40%	$104 copay	$40 copay + 40%	$104 copay
Non-Preferred Brand	$50 copay + 50%	$120 copay	$50 copay + 50%	$120 copay
Specialty	$24 copay / $104 copay / $120 copay		$24 copay / $104 copay / $120 copay	
# of Days Supply	34 days	90 days	34 days	90 days

Medical Cost Comparison

Helena Public Schools 12 Month Premiums			
	2025-26 Plan Year Monthly Premiums	2026-27 Plan Year Monthly Premiums (8.5% increase)	Projected Monthly Premium Increase
OPTION 1: 12 Month Premiums			
Employee Only	$1,064.80	$1,155.31	$90.51
Employee + Spouse	$2,042.55	$2,216.17	$173.62
Employee + Child	$1,333.76	$1,450.38	$113.62
Employee + Children	$1,443.68	$1,566.39	$122.71
Employee + Family (1 child)	$2,309.90	$2,506.24	$196.34
Employee + Family (2+ child)	$2,416.85	$2,622.28	$205.43
OPTION 2: 12 Month Premiums			
Employee Only	$880.24	$955.06	$74.82
Employee + Spouse	$1,681.28	$1,824.19	$142.91
Employee + Child	$1,100.31	$1,193.84	$93.53
Employee + Children	$1,188.34	$1,289.35	$101.01
Employee + Family (1 child)	$1,901.34	$2,062.95	$161.61
Employee + Family (2+ child)	$1,989.37	$2,158.47	$169.10

Helena Public Schools 10 Month Premiums			
	2025-26 Plan Year Monthly Premiums	2026-27 Plan Year Monthly Premiums (8.5% increase)	Projected Monthly Premium Increase
OPTION 1: 10 Month Premiums			
Employee Only	$1,277.76	$1,386.37	$108.61
Employee + Spouse	$2,451.06	$2,659.40	$208.34
Employee + Child	$1,604.11	$1,740.46	$136.35
Employee + Children	$1,732.42	$1,879.67	$147.26
Employee + Family (1 child)	$2,771.88	$3,007.49	$235.61
Employee + Family (2+ child)	$2,900.22	$3,146.74	$246.52
OPTION 2: 10 Month Premiums			
Employee Only	$1,056.29	$1,146.07	$89.78
Employee + Spouse	$2,017.54	$2,189.03	$171.49
Employee + Child	$1,320.37	$1,432.60	$112.23
Employee + Children	$1,426.01	$1,547.22	$121.21
Employee + Family (1 child)	$2,281.61	$2,475.54	$193.94
Employee + Family (2+ child)	$2,387.24	$2,590.16	$202.92

Your Monthly Medical Costs

The total amount you pay for your benefits coverage depends on the plans you choose and how many dependents you cover. Benefit Dollars will remain at $1,069.40 per month for a full-time (1.00 FTE) 12 month employee. Part time employees will be pro-rated accordingly. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

Medical Plans

Medical Plan Rates (12 Month EE)		
	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

Medical Plan Rates (10 Month EE)		
	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

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Helena Public Schools if your domestic partner is your tax dependent.

Are prescription drugs breaking your budget?

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

2026 Judi Rx Formulary.

RxFlex Formulary Drug Search for Plan - LIBERTY FOR WEB

Judi Rx Network Pharmacies

Are you taking a specialty – High-Dollar medication?

Judi Rx can help you navigate alternative sources and hold your hand through locating the most cost-efficient source for your medication.

Understanding the formulary can save you money

- If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

- A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

The formulary drug tiers determine your cost

$	Generic drugs
$$	Preferred Brand-name drugs
$$$	Non-preferred Brand-name drugs
$$$$	Specialty drugs

FORMULARY 411

Simply put, a formulary is another name for a drug list. A formulary is a list of generic and brand-name drugs typically covered by your pharmacy benefit plan. The primary purpose of a formulary is to promote the most safe and effective use of medications while delivering value.

At Judi Rx, your health is our top priority. We prepare formularies to ensure that you have access to a robust offering that meets your needs and lowers your overall prescription drug cost.

Your pharmacy benefit covers many prescription drugs, but some exclusions may apply. If a drug is not covered, an alternative covered drug will be available.

WHAT ARE TERMS COMMONLY USED WHEN TALKING ABOUT FORMULARY?

Tier: Formularies are organized into categories called tiers. Each prescription drug is placed in a tier depending on the type of drug. Formularies are commonly divided into three tiers. Some plans may have more or less than three tiers, but how tiers are managed is the same.

Please note: *Drugs that are newly approved by the Food and Drug Administration (FDA) may not be covered until they have been fully evaluated.*

What is a Prior Authorization (PA): Approval may be required before your pharmacy benefit plan will cover certain drugs. This process ensures you receive a prescription that is safe and the most cost effective. Once notified by the pharmacy, your healthcare provider will work with Judi Rx to complete paperwork to submit a prior authorization.

What is a Quantity Limit (QL): There is a limit on the maximum dosage or quantity for certain medications that are covered per prescription, or within a specific time frame. If you require a dose or quantity beyond what the limit allows, please work with your healthcare provider to submit a prior authorization for approval.

What is Step Therapy (ST): You may be required to try another medication (usually a generic) prior to starting the medication your healthcare provider prescribed (usually a brand). If a medication you are prescribed has a step therapy program in place, please discuss your options with your healthcare provider.

FORMULARY RESOURCES FOR YOU AND YOUR HEALTHCARE PROVIDER

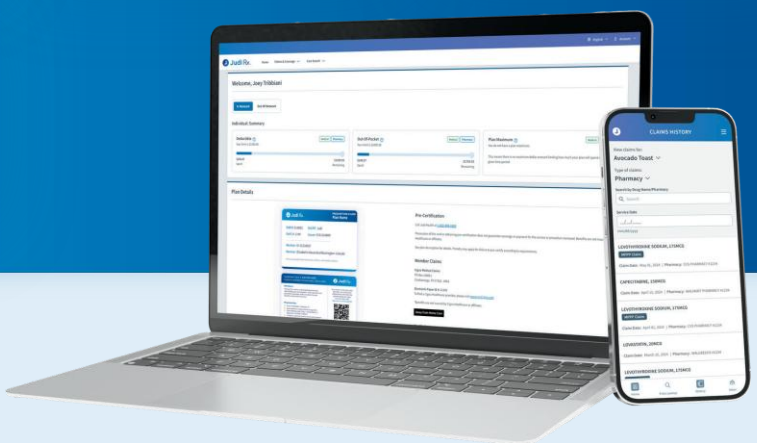
To review if your medications have prior authorization, step therapy, and/or quantity limit requirements, log into the member portal and use the 'Lookup Formulary' tool.

Your healthcare provider can work with Judi Rx to complete paperwork needed for prior authorization requests. They can refer to http s://www.judi.health /capital-rx-prescribers to download a fillable form and more.

OUR DIGITAL APP HAS ALL OF THE INFORMATION YOU WOULD EXPECT WITH ADDED FEATURES!

The Judi Rx suite of digital tools includes an online member portal and mobile app, giving you a personal advisor for your prescriptions in the palm of your hand.

- Find low cost medications at a pharmacy near you
- Find a pharmacy
- View your claims history
- Download a digital pharmacy ID card
- View which medications are covered under your plan
- Track how much money you have paid towards your out-of-pocket obligations
- View and download member documents and platforms



HOW TO REGISTER:

1. Visit http s://ap p.cap -rx.com/register
2. Fill in your personal information and click **VALIDATE**
3. Complete credentials form and click **CREATE ACCOUNT**
4. Check your email and locate the verification code sent from Judi Rx
5. Enter the code provided to validate your email address

Registration is complete! *You can now log in using the credentials established during registration!*

SCAN THE QR CODE TO DOWNLOAD THE MOBILE APP.

GET IT ON Google Play

Available on the App Store

SAVING TIME AND MONEY ON YOUR PRESCRIPTIONS HAS NEVER BEEN EASIER.

Judi Rx and Bridged Health Alliance are working together to offer you affordable prescription medications delivered right to your home.

If you are prescribed a 90-day prescription for maintenance medications, you can fill at Ridgeway Mail Order Pharmacy or with Costco Mail Order. Please reach out to your prescriber and update your mail order pharmacy provider to Ridgeway Pharmacy or Costco Mail Order.

Ridgeway Mail Order Pharmacy
2824 US Hwy 93 N
Victor, MT 59875
Phone: 800-630-3214
Fax: 406-642-6050
Hours: Monday-Friday 9:00am to 5:00pm MT
Online: https://www.ridgewayrx.com/

Getting started with Costco Mail Order:

Please reach out to your healthcare provider and update your mail order pharmacy provider to Costco.

Online: Go to rx.costco.com and create a patient profile.

Phone: Call Judi Rx and follow the prompts for medications delivered to your home to provide patient and payment information.

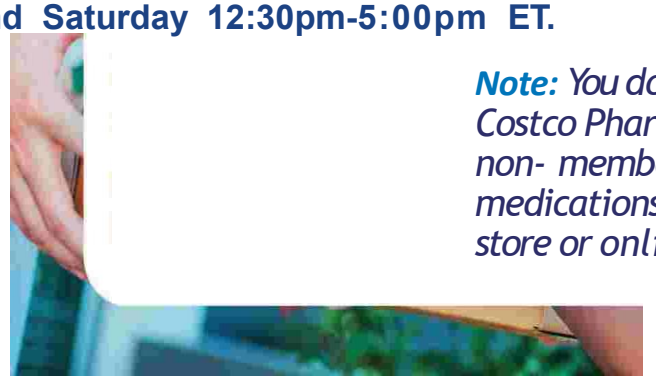
Choose one of the following options to request refills of current prescriptions or send new prescriptions to Costco Mail Order:

Mail: Go to rx.costco.com and access your patient account. Select refill prescriptions or new prescriptions. Follow the prompts to complete the request and mail your paper prescription to Costco Pharmacy, 6801 Seaway Blvd., Suite A-2, Everett, WA 98203.

E-prescribe: Have your prescriber electronically send your prescription to Costco Pharmacy, #1748, Zip Code 98203.

Fax: Have your healthcare provider fax your prescription to 1-877- 258-9584. Faxed prescriptions may only be sent by a healthcare provider's office and must include patient information.

Costco Mail Order Customer Support is available Monday-Friday 8:00am to 10:00pm ET and Saturday 12:30pm-5:00pm ET.



Note: *You do not need a Costco membership to use Costco Pharmacy Services. Both members and non- members can purchase prescription medications at Costco pharmacies, whether in-store or online.*

MEET YOUR NEW SPECIALTY PHARMACY TEAM!

Costco Specialty Pharmacy provides a patient-centric model that drives improved clinical outcomes, positive experiences, and saves money. Our personalized and caring approach is designed to empower and inspire patients to choose healthy behaviors and live better.

Getting started with Costco Specialty:

Please reach out to your prescriber and update your specialty pharmacy provider to Costco Specialty Pharmacy.

1. Have your prescriber e-prescribe to Costco Specialty Pharmacy #1710, Zip Code 53717 or fax your prescription to 1-855-213-0125. Make sure your prescriber includes your contact information. If prior authorization is required, your prescriber may need to take extra steps to submit your prescription. To review more information related to prior authorizations, visit mycapitalrx.judi.health/ or call Judi Rx Customer Care.

2. A representative from Costco Specialty Pharmacy will call you to obtain more information and schedule your first delivery. Additionally, you may call Judi Rx Customer Care to confirm receipt of the prescription from the prescriber. When calling, please follow the prompts for specialty pharmacy.

3. Your prescription will arrive when and where you've requested.

Costco Specialty Pharmacy offers specialty services and programs to support your needs.

- Education and support programs to help manage your condition.
- Delivery to your home or another address within two days of ordering at no cost.
- Highly trained pharmacists and nurses available to answer any questions.
- Insurance specialists to help you get the most out of your benefits.
- Therapy-related ancillary medical supplies provided at no additional cost.

Note: *You do not need a Costco membership to use Costco Pharmacy Services. Both members and non-members can purchase prescription medications at Costco pharmacies, whether in-store or online.*

Specialty Pharmacy Customer Support is available Monday - Thursday 9:00am to 8:00pm ET and Friday 9:00am - 7:00pm ET. If you have an urgent request, support is available 24 hours a day, 7 days a week.

JUDI RX IS HERE TO SUPPORT YOU

Our customer care representatives are available 24 hours a day, 7 days a week to answer any questions you may have about your prescription drug benefit plan.

Toll Free Number: 1-833-395-7211

Rx Bin: 610852
Rx PCN: CHM
Rx Group: JD383

If you don't know your member ID, please call Customer Care for support.

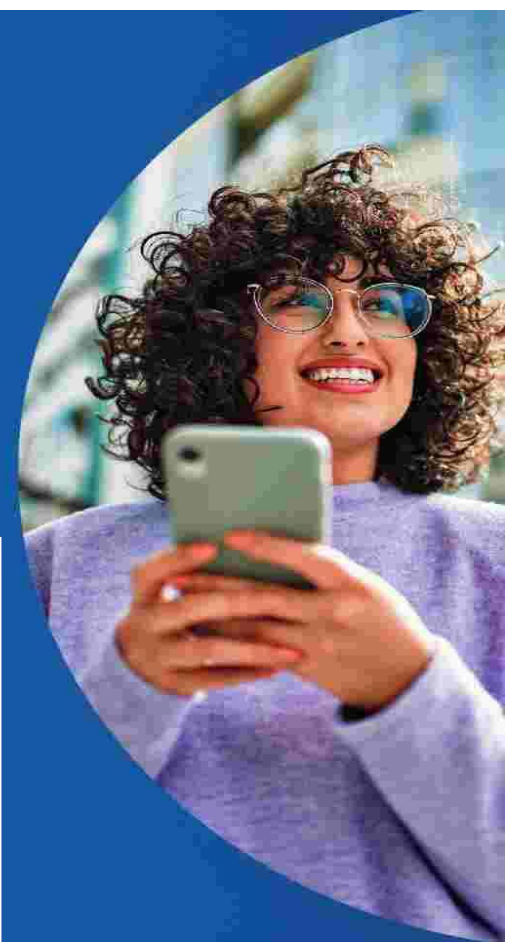
JUDI RX'S MEMBER PORTAL IS THE QUICKEST AND EASIEST WAY TO:

Manage/View Your Benefit Information

Access Your Prescription History

Track Out-Of-Pocket Spend

SCAN HERE TO VISIT OUR WEBSITE AND ACCESS A FULL SUITE OF MEMBER RESOURCES



ACCESS TO DIGITAL FORMS

- Download Digital Prescription Drug Claim Form
- Complete Authorized Representative Form
- View Patient Rights and Responsibilities
- Learn More with Frequently Asked Questions

NEW Telemedicine Provider: First Stop Health

If you choose a medical plan, you will automatically be enrolled in First Stop Health, a new virtual healthcare benefit designed to make it easier to care for your physical and mental wellbeing without any additional cost to you.

Through convenient phone or video visits, First Stop Health provides 24/7 access to urgent care providers, virtual primary care, health coaching, therapy, and mental health support. Best of all, you can do it all from the comfort of home or wherever you are.

Whether you need treatment for a minor illness, help managing an ongoing health condition, support reaching wellness goals, or someone to talk to during a challenging time, First Stop Health connects you with experienced, compassionate professionals who put your needs first. This benefit helps save time, reduces barriers to care, and gives you and your family access to confidential support when it matters most.

We encourage you to take advantage of this valuable new benefit and experience the convenience, quality, and personalized care that First Stop Health has to offer.

Virtual Urgent Care

By providing you with on-demand, 24/7 urgent care provider access, First Stop Health will save you time and money. We truly believe you will love this benefit.

- 24/7 access to board-certified urgent care providers
- Convenient visits via phone or video so you can get care where you are
- Learn more by watching this video or reading more here

Virtual Primary Care

Connect with experienced providers who will listen, understand, and truly care about your health. Schedule a visit as soon as tomorrow!

- 24/7 access to board-certified primary care providers for all ages
- Expert support from board-certified primary care providers for those over 18
- Visits for well checks, ongoing health management, referrals, screenings, lab orders, and more
- Learn more by watching this video or reading more here

First Stop Health Services offered at $0 member cost-share!!

Virtual Health Coaching

Reach your health goals, no matter how big or small, with expert guidance and support.

- Well-being support from registered dietitians, board-certified health coaches, and certified diabetes educators for those over 18
- Work with a wellness specialist to reach your goals like eating better, weight management, quitting tobacco, managing diabetes, and more
- Learn more by watching this video or reading more here

Virtual Therapy

Need to talk? Whether you're feeling down, anxious or overwhelmed, First Stop Health therapists are here to listen, and they're here to help.

- Compassionate support from licensed therapists
- Solution-focused care for major life changes, social anxiety, conflict, work/life stress, grief, and more
- Learn more by watching this video or reading more here

Virtual Mental Healthcare

Your mental health matters. Confidentially talk with a mental health provider who is here to listen and provide support.

- Compassionate support from licensed therapists, board-certified health coaches, and primary care providers
- Schedule a visit for individual therapy or coaching, couples and family therapy, or medication management for anxiety and depression
- Learn more by watching this video or reading more here

Here's how to get started:

Log in on the First Stop Health mobile app or at firststophealth.com. If it's your first time logging in, select "Find My Account" to claim your account with the last 4 digits of your [SSN/employee ID.]

We hope that you'll take advantage of this new benefit.

First Stop Health Services offered at $0 member cost-share!!

Introducing Visana.

A comprehensive virtual women's health clinic.

Women often face barriers to care with 30-day+ wait times to be seen by a provider[1] only to leave them feeling dismissed or dissatisfied with their treatments. As a result, women today are looking for a better health care experience that meets their unique needs during the various stages of life.

Starting 1/1/25, Visana Health, a virtual women's health clinic, will be in-network for Cigna Healthcare℠ clients and customers.

Visana provides **whole-person, listening-based clinical care** from OB/GYNs and Nurse Practitioners available in all 50 states. Visana treats a wide range of women's health conditions – from puberty through menopause – including:

- Preventive care (e.g., well-woman care, breast health & mammograms)
- Sexual and reproductive health (e.g., fertility & preconception, postpartum)
- Complex gynecology (e.g., PCOS, endometriosis)
- Menopause and perimenopause

Customers are able to:

- Book a virtual appointment in days, not weeks
- Meet with a clinician for up to one hour
- Get referrals to in-network care including prescriptions, labs and imaging – when in-person care is needed.

Visana offers virtual in-network provider access for the spectrum of women's services!!

cigna healthcare

1. Kharraz, Oliver. Stat News, "Long waits to see a doctor are a public health crisis." May 2023.

Meet Oshi Health.

An in-network virtual care clinic for digestive issues, without the wait.

Offered as part of your Cigna Healthcare® medical plan. **Simply schedule a convenient virtual visit and pay your in-network cost-share.***

Access to next-day virtual visits with a team of gastrointestinal (GI) providers, registered dietitians, and gut-brain specialists. Find lasting relief for symptoms and conditions, including:

- **Abdominal pain and bloating**
- **Acid reflux and gastroesophageal reflux disease (GERD)**
- **Crohn's disease and ulcerative colitis**
- **Irritable bowel syndrome (IBS)**
- **Undiagnosed GI symptoms**
- **And hundreds of other GI issues**

Already working with a GI doctor? Oshi Health's multidisciplinary experts are available to provide medical, dietary, and gut-brain support between in-person visits.

A different approach to GI care:

Care for the whole you.
GI experts treat the root cause of gut health issues, delivering personalized care plans to provide relief.

Clinically proven approach.
Evidence-based methodology helps identify triggers for digestive care issues, for proven relief.

Quick, convenient access.
A team of GI experts, there when you need them, including evenings and weekends.

To get started, scan the QR code or visit: oshihealth.com/cigna

OSHI HEALTH™

Oshi offers virtual, in-network provider access for GI related issues!!

Meet Heartbeat Health.

An in-network virtual care clinic, offering cardiovascular care from anywhere.

Offered as part of your Cigna Healthcare® medical plan. **Simply schedule a convenient virtual visit and pay your in-network cost-share.***

Introducing heart care that's easy and convenient, so you can prevent, manage and treat heart conditions from the comfort of home. Day and evening appointments available with a team of cardiologists, nurse practitioners, physician assistants and registered nurses.

When necessary, Heartbeat Health™ will coordinate any necessary testing, manage medications, and work closely with local providers for advanced care.

Examples of conditions commonly treated:

- **Atrial fibrillation**
- **Heart failure**
- **Vascular disease**
- **Post-acute care**

A faster path to specialized care.
Virtual appointments typically scheduled within five days.

Evidence-based approach.
Clinically guided treatment, medication management and recommendations.

Convenient care is one click away.
No apps to download – just click on a link to connect to your virtual care.

Heartbeat Health ***is available as an extension of your care team, available to provide support in between visits and to collaborate with your doctor to ensure care is coordinated.***

To get started, scan the QR code or visit: heartbeat.health/cigna

cigna healthcare

989638 02/25

Heartbeat health offers virtual in-network provider access for the cardiac related conditions!!

Heartbeat™

Dental

Our Plan

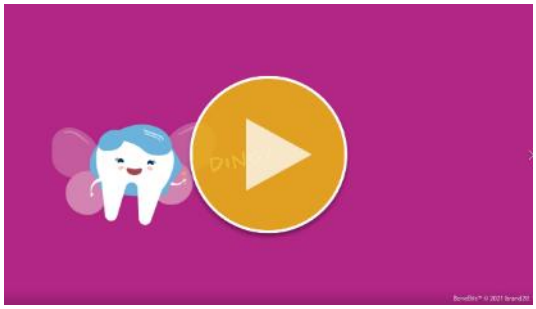
Delta Dental PPO Plan

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



DELTA DENTAL®

Find an in-network dentist

Follow these easy steps to find an in-network Delta Dentist in your area.

Step 1
Go to **deltadentalins.com** and choose "Find a dentist".

Step 2
Enter your location. This could be your home address or even your office address—choose the location that's most convenient for you.

Step 3
Select your network. Choose the Delta Dental PPO™ network from the options provided.

Step 4
Tap on "Find a dentist".

Step 5
Review, pick and call a dentist from the list provided.

If you would like to refine your search results, go to the "Refine your search" field.

- **Update your location** using your preferred city, state or zip code and apply keywords like a specific dentist's or practice's name.
- **To further filter your results,** choose "Filter" from the right side of the screen. Review the list of filter options including Language, Distance, Specialized Care and more. Tap on "Apply".
- **Didn't find a PPO dentist that fit your needs?** Try selecting the Delta Dental Premier® network. You'll save the most by visiting a Delta Dental PPO dentist but your next best bet is the Delta Dental Premier network.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT. West Virginia: Learn about our commitment to providing access to a quality dentist network at **deltadentalins.com/about/legal/index-enrollee.html**.

Scan to find a dentist

deltadentalins.com/members

Delta Dental PPO

With the Table of Allowance Plan, you know in advance exactly how much the plan covers for each dental service. Delta Dental will pay the share specified on your table of allowance; you are responsible for the share of the dentist's fee not covered by the allowance.

Annual Deductible	$100 per person each plan year
Annual Benefit Maximum	$2,000 per person each plan year
Accumulation Period	Plan year
Dental Services	**Table Allowance (amount Delta Dental will pay)**
Sample Benefits and Covered Services**	**Table Allowance***** (Amount Delta Dental Will Pay)
Diagnostic & Preventive Services (D & P)	D0120 Periodic oral exam – established patient: $41 D0272 Bitewings (two diagnostic images): $39 D1110 Prophylaxis (cleaning): $84
Basic Services	D2150 Amalgam fillings, two surfaces – primary or permanent: $111 D2160 Amalgam fillings, three surfaces – primary or permanent: $129
Endodontics	D3310 Root canal, (anterior – excluding final restoration): $359
Periodontics	D4341 Periodontal scaling and root planing - four or more teeth per quadrant: $184
Oral Surgery	D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal): $105
Major Services	D2750 Crown; porcelain fused to high noble metal: $541
Prosthodontics	D5110 Complete denture – maxillary: $553
Implant Benefits	D6010 Surgical placement – endosteal implant: $898
Orthodontia Services	
Covered for	Not covered

** Limitations or waiting periods may apply for some benefits; some services may be excluded.
*** Allowances specified above represent only a few examples from your plan's table. Please refer to your Benefit Booklet for a full schedule of allowances and for any limitations and exclusions on these benefits.

Vision

Our Plans

Ameritas VSP Network Plan

Ameritas EyeMed Network Plan

Click to play video

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like LASIK and PRK, and rebates on contact lenses.

Vision Plans

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible. In-network benefits are outlined below. Additional lens enhancement options available at a member copay when utilizing an in-network provider.

Benefit Details	VSP Network	EyeMed Network
Exam	$0 copay	$0 copay
Materials	$0 copay	$0 copay
Lenses		
Single Vision	Covered in full	Covered in full
Bifocal	Covered in full	Covered in full
Trifocal	Covered in full	Covered in full
Frequency	1 x every 12 months	
Frames		
Coverage	Up to $150 allowance	Up to $150 allowance
Frequency	1 x every 12 months	
Contacts *(in-lieu of frames & lenses)*		
Fit & Evaluation	Up to $60 copay	Up to $40 copay
Elective	Up to $150 allowance	Up to $150 allowance
Frequency	1 x every 12 months	

Your Monthly Dental & Vision Costs

Dental Plans

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

Vision Plans

Vision Plan Rates		
	12 Month EE	10 Month EE
Employee Only	$13.55	$16.26
Employee + Spouse	$25.88	$31.06

Healthcare flexible spending account (FSA)

Click to play video

Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan you can only participate in the limited-purpose FSA for dental and vision expenses.

Find out more

- www.askallegiance.com
- Eligible Expenses
- Ineligible Expenses

Set aside healthcare dollars for the year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Helena Public Schools FSA works

- You estimate what you and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- You can contribute up to $3,400 in 2026. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

You have until December 31, 2027 to incur expenses and until March 14, 2028 to submit claims for reimbursement. If you don't spend all the money in your account, you forfeit the leftover balance at the end of the grace period.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables, but here's an example using single-filer status and marginal federal income tax rates:

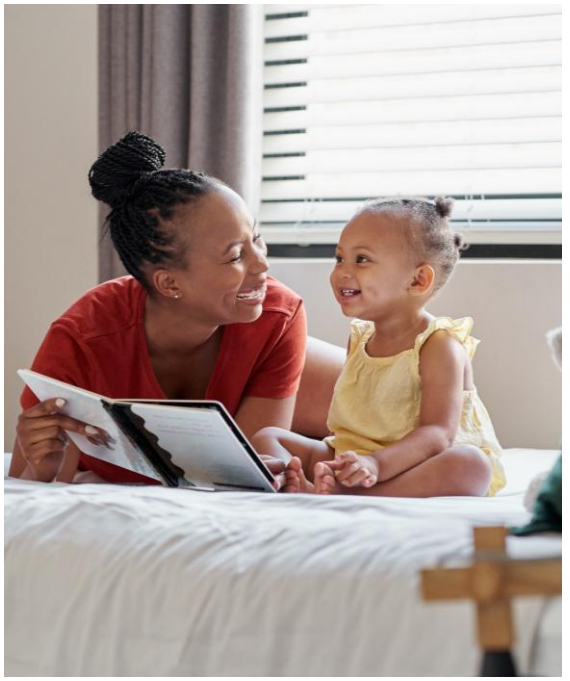
$60,000 annual pay, contributing $1,700 to FSA

$374	$130	$504
22% income tax savings	7.65% FICA tax savings	Total FSA tax savings

$120,000 annual pay, contributing $3,400 to FSA

$816	$260	$1,076
24% income tax savings	7.65% FICA tax savings	Total FSA tax savings

Paying for daycare? Make it tax-free!



Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent care FSA—up to $7,500 tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Allegiance Plan Management.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 in 2026. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

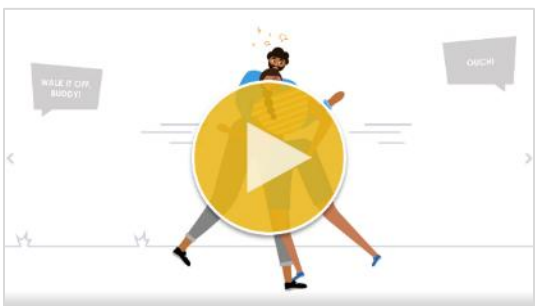
You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Know where to go

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for ...
Nurse line ($) Often available 24/7 at no cost	• quick answers from a trained nurse: – to determine if immediate care is needed – for home treatment options & advice
Online visit ($) Often available 24/7	• non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit ($$) Typically open during regular business hours	• routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care ($$$) Typically open with extended evening and weekend hours	• urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room ($$$) Open 24/7	• life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

Alternative facilities

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Procedure	Alternative	Features	Savings*
Surgery	Ambulatory surgical center	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% vs. a hospital stay
Physical therapy	Outpatient facility	• Most cases are suited for outpatient physical therapy • Same types of treatments and similarly skilled therapists as inpatient facilities	40 to 60% vs. a hospital setting
Sleep study	Home testing	• Diagnoses obstructive sleep apnea • Cost is often covered by insurance if considered medically necessary	Up to $4,500 vs. a lab
Infusion therapy	Home or outpatient infusion	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% vs. a hospital stay

**Savings estimates are based on in-network facilities and providers*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital.

You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance.

Some alternative facilities include a fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

Employee assistance program (EAP)

Contact the EAP

Phone: 888-238-6232

Website www.resourcesforliving.com

Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The AETNA Resources for Living EAP can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 6 sessions per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools.
- Legal services, including referrals to local attorneys
- Assistance preparing and filing a will and other end-of-life planning documents

Counseling

- Relationship challenges
- Emotional distress
- Job stress
- Communication issues
- Interpersonal conflict
- Alcohol or drug use
- Loss and grief

Elder care

- Help finding care resources for elderly or disabled relatives

Financial

- Money/debt management
- Identity theft resolution
- Tax issues
- Bankruptcy

Parenting & childcare

- Quality referrals
- Family day care centers
- Infant centers and preschools
- Before- and after-school care
- 24-hour care

Online resources

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics

Resources for Living
To access services:
1-888-238-6232, TTY: 711 / resourcesforliving.com
Username: Helena / Access Code: EAP

Life & Disability

Name Your Beneficiaries

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D, and disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Plans section for details.

Helena Public Schools-Provided Life and AD&D Insurance

What's guaranteed issue?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status to qualify for the requested amount of coverage.

A note about taxes

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic life insurance pays your beneficiary a lump sum if you die. AD&D (accidental death & dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by Helena Public Schools.

Lincoln Financial Basic Life and AD&D

Employee $25,000 or $50,000*

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

*** Employee is responsible for additional Basic Life and AD&D premium if electing the $50,000 option. The $50,000 option is required should an employee want to purchase any Voluntary Life and AD&D.**

Voluntary Plans

Our Plans

Lincoln Voluntary Life and AD&D

SunLife Voluntary Long-Term Disability

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

Voluntary Life and AD&D Insurance

Guaranteed issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit evidence of insurability with additional information about your health for the insurance company to approve the amount of coverage.

Calculate your life and AD&D insurance cost

1. Desired coverage ($1,000 increments)

You:	Spouse:

2. Divide step 1 by $1,000 =

You:	Spouse:

3. Multiply step 2 by rate from table =

You:	Spouse:

4. Add you + spouse from step 3 =

Cost per month:

Protecting those you leave behind

Voluntary life and AD&D insurance allows you to purchase additional life insurance to protect your family's financial security. You pay the cost of this coverage. Coverage is available for your spouse and/or children if you purchase coverage for yourself. **Please note: In order to elect this benefit, you must opt into the $50,000 Basic Life Option.**

Lincoln Voluntary Life and AD&D	
Employee	
Benefit Amount	Increments of $10,000, up to $300,000
Guaranteed Issue	$150,000
Spouse	
Benefit Amount	Increments of $5,000, up to the lesser of 50% of employee benefit or $50,000
Guaranteed Issue	$50,000
Child(ren)	
Benefit Amount	$10,000
Guaranteed Issue	$10,000

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage.

Age	Employee Rate
(monthly rate per $1,000 of coverage)	
<24	$0.050
25-29	$0.060
30-34	$0.080
35-39	$0.100
40-44	$0.150
45-49	$0.250
50-54	$0.670
55-59	$0.840
60-64	$0.840
65-69	$1.460
70-74	$2.370
75+	$3.640

Long-term disability insurance

Things to know about LTD insurance

- It can protect you from having to tap into your retirement savings.
- You can use LTD benefits however you need, for housing, food, medical bills, etc.
- Benefits can last a long time—from weeks to even years—if you remain eligible.
- Benefits are tax-free, since you pay the premiums with after-tax dollars.

There is no medical underwriting to enroll in the voluntary long-term disability but there is a pre-existing condition look back and waiting period. If you become disabled within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, SunLife will not pay any benefit for any pre-existing condition.

LTD benefits cushion the financial impact of a disability

Long-term disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

You pay the cost of this coverage.

SunLife Voluntary Long Term Disability Benefits	
Employee	
Amount	60% of earnings, up to a monthly maximum of $5,000.
Begins	after 180 days of disability
Duration	Up to your Social Security Normal Retirement Age or longer, depending on your age at disability

Age	Employee Rate
(monthly rate per $100 of covered payroll)	
<25	$0.00190
25-29	$0.00228
30-34	$0.00342
35-39	$0.00552
40-44	$0.00873
45-49	$0.01290
50-54	$0.01750
55-59	$0.01975
60-64	$0.01860
65-69	$0.01860
70+	$0.08160

Plan contacts

Plan type	Provider	Phone Number	Website/Email
Medical and Pharmacy	Bridged Health Alliance	855.999.1528	support@BridgedMT.org
Medical	Allegiance	855-333-1005	www.askallegiance.com
Pharmacy	JudiRx	833.395.7211	https://enrollment.cap-rx.com/plans?client=bridgedhealthhelena
Bridged Health Alliance	Sean Thatcher	406.459.0936	sthatcher@bridgedmt.org
TeleHealth	First Stop Health	888.691.7867	Firststophealth.com
Dental	Delta Dental	800.521.2651	www.deltadentalins.com
Vision	Ameritas	800.659.2223	www.ameritas.com
Life/AD&D; Voluntary Life/AD&D	Lincoln	800.423.2765	www.lfg.com
Voluntary LTD	SunLife	800.247.6875	www.sunlife.com/us
EAP	AETNA	888.238.6232	www.resourcesforliving.com
HPS Benefits	Keri Mizell	406.324.2014	insurance@helenaschools.org
Alliant Insurance Services	Sarah Harne	406.438.3344	Sarah.Harne@alliant.com

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Glossary (A–E)

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Maximum
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Maximum
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as "ineligible," "not covered," or "not allowed."

Glossary (F–V)

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network
Also known as participating or preferred providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn't require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician's assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as "immunizations," vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, often through payroll deduction.

Important Plan Information

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at https://helenaschools.org/departments/human-resources/health-care-and-cafeteria-benefits/

Medicare Part D Notice: Describes options to access prescription drug coverage for Medicare eligible individuals

- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48–96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills.

COBRA continuation coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Plan documents

Important documents for our health plan and retirement plan are available at https://helenaschools.org/departments/human-resources/health-care-and-cafeteria-benefits/

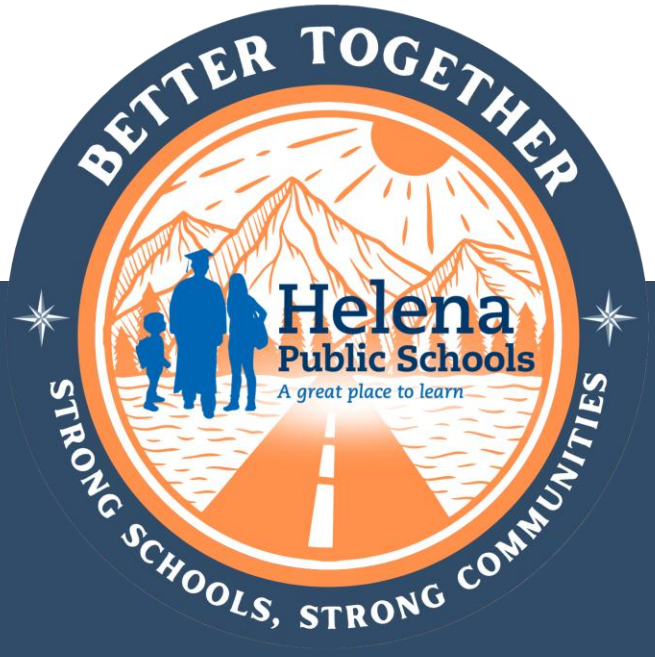
Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available at https://helenaschools.org/departments/human-resources/health-care-and-cafeteria-benefits/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