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	
	St. Peter's Providers*	All Other Providers	All Providers	
Calendar Year Deductible Individual / Family	$0 Embedded	$1,500 / $3,000 Embedded	$3,000 / $6,000 Embedded	
Annual Out-of-Pocket Max Individual/Family	$4,000 / $8,000 Embedded		$7,000 / $14,000 Embedded	
Plan Services	St. Peter's Providers*	All Other Providers	All Providers, unless noted**	
Physician Office Visit	$10 copay	30% after deductible	30% after deductible	
Specialist Office Visit	$40 copay	30% after deductible	30% after deductible	
Preventive Care	Paid at 100%		Paid at 100%	
CT, MRI, PET scans	Paid at 100%	30% after deductible	30% after deductible	
Other lab and x-ray tests	Paid at 100%	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/St. Peter's**	30% after deductible
Durable Medical Equipment	Paid at 100%	30% after deductible	30% after deductible	
Chiropractic Care	Not Offered at St. Peter's	$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	

*St. Peter's Providers include St. Peter's Hospital, St. Peter's Hospital Professional Providers, and St. Peter's Hospital Urgent Care.

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.