BOZEMAN SCHOOL DISTRICT #7 HEALTH PLAN

MONTHLY HEALTH INSURANCE & DENTAL PRICE TAGS

RETIREES & SELF PAYER RATES

Benefit Year 2026-2027

BASIC PLAN ($2,000 deductible) - plan pays 70% of covered charges after deductible has been satisfied

Employee Only	$1,744.00
Employee/Spouse	$2,820.00
Employee/Children	$2,368.00
Employee/Family	$3,265.00

$5,000 deductible HDHP - plan pays 100% of covered charges after deductible has been satisfied

Employee Only	$1,188.00
Employee/Spouse	$1,920.00
Employee/Children	$1,619.00
Employee/Family	$2,230.00

$8,050 deductible- HDHP - plan pays **100%** of covered charges after deductible has been satisfied

Employee Only	$920.00
Employee/Spouse	$1,600.00
Employee/Children	$1,342.00
Employee/Family	$1,856.00

DENTAL REIMBURSEMENT PLAN

Employee Only	$41.00
Employee/Spouse	$52.00
Employee/Children	$54.00
Employee/Family	$61.00

NOTES

- The plan year is September 1, 2026 through August 31, 2027.
- Maximum Out of Pocket are as follows:

	Individual		Family	
Plan	**Deductible**	**Maximum Out of Pocket**	**Deductible**	**Maximum Out of Pocket**
$2,000	$2,000	$4,000	$4,000	$8,000
$5,000	$5,000	$5,000	$10,000	$10,000
$8,050	$8,050	$8,050	$16,100	$16,100

- Use your BCBS card when filling prescriptions at the pharmacies and most national chains nationwide with negotiated discounts. Covered generic medications have a $0 co-pay at the point of service under the Basic plan ONLY. Preventative generic medications have a $0 co-pay under all plans. Plan information, including preventive drug lists, forms, claim information and plan documents can be found on our website by going to:
  http://www.bsd7.org > Our District > Department > Benefits

- Preventative benefits such as annual wellness physicals, vaccinations, well-child check-ups, etc. are included in the premium. These preventive services are not subject to the deductible.

- The Vision Reimbursement Plan is included in the medical premium. All paid claims including charges and receipts should be sent to the Benefits Specialist for reimbursement. The plan reimbursement has increased and now pays 75% of covered vision claims with an annual maximum of $250.00 per covered family member. Any charges covered by the BSD7 Medical Plan will not be covered by the Vision Plan.

- The Dental Reimbursement Plan pays 100% of the first $200.00 and 50% of the remaining claims until you have been reimbursed $800.00 per covered family member per year. Paid bills including charges and receipts should be sent to the Bozeman School District #7 Benefits Specialist for reimbursement. Any charges covered by the BSD7 Medical Plan, such as the surgical removal of impacted wisdom teeth, are not covered by the Dental Plan.

If you have any questions regarding the benefit choices, please contact the Benefits Specialist at (406) 522-6046