Helena Public Schools
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Insurance Office
1325 Poplar St.
Helena, MT 59601

8/4/2025

Dear Member,

With the start of another school year upon us, your election of Health Benefits for the 2025-2026 school year will need to be completed. In this packet, you will find the necessary information to help you enroll *online* via the Employee Portal for your health benefits. Please note the following:

- **Open Enrollment is four weeks,** beginning 8/20/2025 and ending 9/17/2025. You **MUST** complete the online enrollment no later than September 17th, or you may lose your Health Benefit coverage!
- Carefully read, "Changes in Health Benefits for 2025-26 Plan Year" for crucial information as you make decisions for the 2025-2026 school year.
- Please read both sides of the paper of the Insurance Open Enrollment Packet.
- As you are completing the online enrollment via the Employee Portal, please be sure to review each page carefully.
- You may elect to change your insurance plan from last year. There is ***no*** mandatory two-year commitment for your plan selection.

We know there will be many questions. Please consider attending the Benefits Fair at Lincoln Center on August 18th between 9:30 am to 2:00 pm. You will be able to ask questions to vendors, HR and myself along with a covered lunch between 11:30 – 1:00. You may also contact me via phone or email and allow adequate time for a response due to the high volume. ***Please enroll as soon as possible to avoid any last-minute struggles or issues that may arise*!** We look forward to another great year and servicing your needs.

Thanks,

Richard Franco
HR Benefits Manager
Helena School District #1
406-324-2008
rfranco@helenaschools.org

HSD#1 HEALTH BENEFITS PLAN PREMIUMS
BENEFIT CHANGES FOR THE *2025-2026 PLAN YEAR*

Benefit Dollars – Benefit Dollars increased from $1031.90 per month to $1069.40 per month for a full-time (1.00 FTE) 12-month employee. Part-time employees will be pro-rated accordingly.

Plan Changes – There will continue to be two options for Medical and Dental and Vision can still be elected separately.

- 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 coverage. We have a new TPA this year with Delta Dental.
- Vision is available for Employee or Employee/Spouse only. We have a new TPA this year with Ameritas.
- There were minor increases to the deductibles and maximum out of pocket for each plan.
- There were minor decreases to the premiums for each plan.
- An employee may elect Dental and/or Vision coverage for self only with no out-of-pocket cost if waiving Medical/Rx coverage.

Please refer to the District Insurance website for more detailed information.

Wellness Program – The Wellness Screening criteria is focused on health risk and the fall and spring Health Clinics are administered by St. Peter's *Well Now!* Staff. Participating members may be eligible for the following:

- Premium Reduction Incentive paid out in full on the September 25, 2025, payroll for those who qualified for the 2025-2026 Plan Year from the 2024-2025 fall and spring screenings.
- Qualifying members and spouses who attended the 2024-2025 screenings, completed an Annual Well Visit with their primary physician and filled out the Primacy Care Provider Form, will receive $200.

- Qualifying active members and qualifying spouses who passed all criteria will receive $400. Wellness screening criteria includes:
    - Waist measurement: <35 Women and <40 Men
    - Cholesterol: < 200 or Ratio of <4.3 Women and <5 Men
    - Blood Pressure: < 130/85
    - Blood Sugar: < 110
    - Tobacco: no use in previous 3 months
- Members and enrolled spouses have until **June 30th**, of each year to meet any criteria required to receive the Incentive for the next plan year.

Online Enrollment– All Active District Health Benefit Plan members must log into the Employee Portal between August 18 and September 12, 2025, to make insurance selections, even if you are not looking to make any changes for the 2025-2026 school year. **Failure to take action by September 12, 2025 will result in a lapse in insurance 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).

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

Medical Plans

Medical Plan Benefits	Option 1		Option 2	
	Tier 1	Tier 2	Tier 1	Tier 2
Calendar Year Deductible				
Individual / Family	$0	$1,500 / $3,000	N/A	$3,000 / $6,000
Embedded / Aggregate	Embedded		Embedded	
Annual Out-of-Pocket Maximum				
Individual / Family	$4,000 / $8,000		$7,000 / $14,000	
Embedded / Aggregate	Embedded		Embedded	
Physician Office Visit	$10	30% (after deductible)	30% (after deductible)	
Specialist Copay	$40	30% (after deductible)	30% (after deductible)	
Preventative Care	No Charge		No Charge	
Lab and X-Ray				
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)	
Hospitalization				
Inpatient	30%	30% (after deductible)	30% (after deductible)	
Outpatient	$10	30% (after deductible)	30% (after deductible)	
Emergency Room	$250	30% (after deductible)	30% (after deductible)	
Urgent Care Services	$25	30% (after deductible)	$25	30% (after deductible)
Durable Medical Equipment	No Charge	30% (after deductible)	30% (after deductible)	
Chiropractic Care	Not Covered	$25 co-pay deductible waived	$25 co-pay deductible waived	
Acupuncture Care	Not Covered		Not Covered	
PRESCRIPTION DRUGS	Generic / Preferred Brand / Non-Preferred Brand		Generic / Preferred Brand / Non-Preferred Brand	
Rx Copay Out-of-Pocket Maximum (Individual / Family)	$700 / $1,300		$700 / $1,300	
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 MO EE - MONTHLY RATES	Current	Current
EE Only	$1,064.80	$880.24
EE + Spouse	$2,042.55	$1,681.28
EE + Child	$1,336.76	$1,100.31
EE + Children	$1,443.68	$1,188.34
EE + Family (1 Child)	$2,309.90	$1,901.34
EE + Family (Children)	$2,416.85	$1,989.37

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

Medical Plans

Medical Plan Benefits	Option 1		Option 2	
	Tier 1	Tier 2	Tier 1	Tier 2
Calendar Year Deductible				
Individual / Family	$0	$1,500 / $3,000	N/A	$3,000 / $6,000
Embedded / Aggregate	Embedded		Embedded	
Annual Out-of-Pocket Maximum				
Individual / Family	$4,000 / $8,000		$7,000 / $14,000	
Embedded / Aggregate	Embedded		Embedded	
Physician Office Visit	$10	30% (after deductible)	30% (after deductible)	
Specialist Copay	$40	30% (after deductible)	30% (after deductible)	
Preventative Care	No Charge		No Charge	
Lab and X-Ray				
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)	
Hospitalization				
Inpatient	30%	30% (after deductible)	30% (after deductible)	
Outpatient	$10	30% (after deductible)	30% (after deductible)	
Emergency Room	$250	30% (after deductible)	30% (after deductible)	
Urgent Care Services	$25	30% (after deductible)	$25	30% (after deductible)
Durable Medical Equipment	No Charge	30% (after deductible)	30% (after deductible)	
Chiropractic Care	Not Covered	$25 co-pay deductible waived	$25 co-pay deductible waived	
Acupuncture Care	Not Covered		Not Covered	
PRESCRIPTION DRUGS	Generic / Preferred Brand / Non-Preferred Brand		Generic / Preferred Brand / Non-Preferred Brand	
Rx Copay Out-of-Pocket Maximum (Individual / Family)	$700 / $1,300		$700 / $1,300	
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	

10- MO EE - MONTHLY RATES	Current	Current
EE Only	$1,277.76	$1,056.29
EE + Spouse	$2,451.06	$2,017.54
EE + Child	$1,604.11	$1,320.37
EE + Children	$1,732.42	$1,426.01
EE + Family (1 Child)	$2,771.88	$2,281.61
EE + Family (Children)	$2,900.22	$2,387.24

DENTAL PLAN

*Monthly Dental Premiums for the 2025-2026 Plan Year – **12 MO EE***

Coverage Type:	Premium Cost
Single	$53.29
Single + Spouse	$101.78
Single + Child	$66.61
Single + Children	$71.94
Single + Family (1 Child)	$115.10
Single + Family (Children)	$120.43

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.

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

DENTAL PLAN

*Monthly Dental Premiums for the 2025-2026 Plan Year – **10 Mo EE***

Coverage Type:	Premium Cost
Single	$63.95
Single + Spouse	$122.14
Single + Child	$79.93
Single + Children	$86.33
Single + Family (1 Child)	$138.12
Single + Family (Children)	$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.

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

VISION PLAN

Monthly Vision Premiums for the 2025-2026 Plan Year – ***12 MO EE***

Coverage Type:	Premium Cost
Single	$13.55
Single + Spouse	$25.88

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.

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

VISION PLAN

Monthly Vision Premiums for the 2025-2026 Plan Year – ***10 Mo EE***

Coverage Type:	Premium Cost
Single	$16.26
Single + 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.

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

Request for Enrollment Change PY 25-26

Group Name: _Helena School District 1 **Group Number:** 3000684 **Effective Date of Change:**_____

Indicate Type of Change Below: ☐ RETIREE ☐ EMPLOYEE

☐ CHANGE COVERAGE FROM OPTION 1 TO OPTION 2 ☐ ADD/REMOVE DENTAL

☐ CHANGE COVERAGE FROM OPTION 2 TO OPTION 1 ☐ ADD/REMOVE VISION

☐ ADD DEPENDENT ☐ DROP COVERAGE (complete waiver on back) ☐ DROP DEPENDENT (complete waiver on back)

IF THIS WILL CHANGE CURRENT TYPE OF COVERAGE TO NEW TYPE OF COVERAGE CHECK NEW TYPE OF COVERAGE:

☐ SINGLE ☐ SINGLE + SPOUSE ☐ SINGLE + CHILD(REN) ☐ SINGLE + SPOUSE + CHILD(REN)

EMPLOYEE INFORMATION (*REQUIRED*):

Employee Last Name	Employee First Name	Social Security Number		Telephone Number(s)
Address	**City**	**State**	**Zip**	**E-mail Address**

CHANGE MY ENROLLMENT AS INDICATED BELOW:

Last Name, First Name, Middle Name	Sex M/F	Social Security # (required by law)	Date of Birth MM/DD/YY	Relationship Child/Spouse	Resides With Employee YES / NO		COVERAGE Add	COVERAGE Drop

REASON FOR ADD/CHANGE (indicate below)	DATE OF EVENT			REASON FOR DROP (indicate below)	DATE OF EVENT		
Newborn DOB				**Divorce or Legal Separation (circle one)**			
Adoption (attach Proof)				**In Anticipation of Divorce**			
Marriage (date of Marriage Required)				**Ineligible Dependent Max Age DATE**			
Court Order (attach Proof)				**Ineligible Dependent Other Reason:**			
Other Reason: Loss of Other Coverage: Reason for loss of coverage_____ (You must provide a Certificate of Creditable Coverage.)				**Waiving Coverage: (You must complete the waiver on the back of this form for every covered person, including the reason.)**			

Do you have Secondary Insurance? If so, please complete this form. Other Insurance Information & Creditable Coverage Information Required (Use additional paper if necessary.)

Please complete the fields below if you are going to continue to have coverage through another carrier in addition to this coverage:
Type of Coverage: Medical ___ Pharmacy ___ Dental ___Vision ____ Effective Date:_____ Date Coverage will end: _____
Family covered under the other health plan: Self ___ Spouse ___ Name(s) of Child(ren): _____ _____ _____
Name, Phone Number, and Address of other insurance company: _____
Policy Holder's Name: _____ Policy Number: _____ ID #:_____
Medicare Enrollee's Name: _____ Medicare ID#: _____
Medicare Coverage: Part A – Effective Date: _____ Part B – Effective Date: _____ Part D – Effective Date: _____
Medicaid Enrollee's Name: _____ Medicaid ID#: _____ Medicaid Effective Date: _____
Court Ordered coverage for a dependent child (if applicable): Name(s) of Child(ren) _____ _____ _____
Policy Holder's Name: _____ Policy Number: _____
Type of Coverage: Medical ___ Pharmacy ___ Dental ___Vision ____ Effective Date: _____
Name, Phone Number, and Address of other insurance company: _____
Please include a copy of a Certificate of Creditable Coverage from your prior carrier showing the effective date and termination date, if applicable. *

I UNDERSTAND that providing inaccurate or incorrect information to any of the answers above may be considered health care fraud.

_____ _____

Employee Signature (required) **Date** (required)

HEALTH COVERAGE WAIVER FORM

(Complete Waiver only if you are waiving coverage for yourself & / or any dependent)

GROUP / EMPLOYER NAME:	***GROUP NUMBER***
Helena School District #1	3000684
EMPLOYEE NAME: (LAST) , (FIRST) , (INITIAL)	**SOCIAL SECURITY NUMBER** – –

I *decline* to enroll in health coverage for:

□ Myself □ My Spouse ***Reason for waiver***: □ the existence of other coverage _____ (Plan Name)

□ My Dependent Child/Children (please list) □ other reason (explain)_____

1._____ 4._____

2._____ 5._____

3._____ 6._____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods".

EMPLOYEE'S SIGNATURE_____DATE SIGNED _____

SPOUSE'S SIGNATURE_____DATE SIGNED_____

(Spouse must sign if waiving coverage)

Statement of HIPAA Portability Rights

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment according to the Special Enrollment provisions of your plan (usually within 30 or 60 days). (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

You or your eligible dependents may also have special enrollment rights in this Plan as a result of:

- The loss of eligibility for coverage under Medicaid or a state sponsored Children's Health Insurance Program (CHIP) if request for enrollment is made within 60 days after loss of such coverage: or,
- Becoming eligible for a premium subsidy from either Medicaid or CHIP for coverage under this Plan, if request for enrollment is made within 60 days after the date of the Determination Letter advising of the eligibility for the premium subsidy, issued by either Medicaid or CHIP. You should consult with your local Medicaid or CHIP office regarding rights to the premium subsidy.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Whether you are a member that is brand new to the District's Health Benefits Plan or has been on it a while, here are some definitions of insurance terms commonly used:

Allowed Amount: This is the maximum payment your plan will pay for a covered healthcare service. May also be called "eligible expense," "payment allowance," or "negotiated rate".

Coinsurance: The percentage of costs you pay for a covered healthcare service after you've met your deductible. For example, if your coinsurance is 20%, and you have a $100 medical bill after meeting your deductible, you would pay $20, and your insurance would pay the remaining $80.

Copayment (Copay): A fixed amount you pay for a covered healthcare service, typically when you receive the service. For example, a doctor's visit might have a $20 copay. This is separate from your deductible and is due at the time of the service.

Deductible: The amount of money you must pay out-of-pocket for healthcare services before your insurance begins to pay. For example, if your deductible is $1,000, you pay that amount for services before your insurance starts covering costs. The deductible does not apply to preventative care and certain other services.

Explanation of Benefits (EOB): An EOB is a summary of the health insurance plan that shows the total cost of the healthcare service(s) a member received, how much the plan paid, and how much a member may owe. It may be sent by mail or available online.
Important: This is *not* a bill.

Narrow Network (Tier 1): A narrow network is a type of health insurance plan that offers access to a limited group of healthcare providers, such as doctors, hospitals, and specialists, who have contracted with the insurer to provide services at lower costs and co-pays.

Out-of-Network Provider: A provider who doesn't have a contract with the plan to provide services.

Out-of-Pocket Maximum: The most you'll have to pay for covered healthcare services in a plan-year. Once you reach this amount, your insurance covers 100% of the services covered for the remainder of the year.

Premium: The amount you pay for your health insurance every month, whether you use the insurance or not. Think of the premium as a subscription fee.

Provider: A provider is a person or place that gives healthcare services. This can include doctors, nurses, chiropractors, physician assistants, hospitals, surgery centers, nursing homes, or rehab centers.

Flexible Spending Account (FSA)

A **Flexible Spending Account (FSA)** is a tax-advantaged account offered by HPS to help employees cover eligible out-of-pocket healthcare costs, including medical, dental, and vision expenses. Medical FSA can be used for anyone in the household even if they are not on the health plan.

How It Works:

- **Pre-tax contributions**: You choose an annual amount to contribute, up to $3,300, deducted from your paycheck before taxes.
- **Tax savings**: Reduces your **taxable income**.
- **Eligible expenses**: Funds can be used for qualified medical costs such as copays, prescriptions, medical devices, and more.
- Funds must be used within the plan year and cannot be rolled over.

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HSD HEALTH FAIR!

- **When: 8/18/25 from 9:30am – 2pm**
- **Where: The Lincoln Center Backyard**
- **Who: Allegiance, St. Peter's Health, Delta Dental, Insurance Manager and HR**

Come meet your Insurance folks and ask questions!

Allegiance® a Cigna Company

https://www.askallegiance.com/hsd1

St. Peter's Health

https://www.sphealth.org/

DELTA DENTAL

https://www.deltadental.com/us/en/login.html