Helena Public Schools
A great place to learn

Human Resource Benefits Office
1325 Poplar St
Helena, MT 59601

8/15/25

Dear Retiree,

With the start of another Health Insurance Plan Year upon us, this Insurance packet will provide you with the necessary information to help you with your Helena School District #1 Benefits. Here are some particularly important notes to help:

- **Open Enrollment**:
  - **<u>You must complete the forms in this envelope</u>**. The plans were unbundled last year, and you can still elect Medical, Dental and Vision **separately**. Please fill out the form and return it to the Benefits office by 9/16/2025.

- The Insurance Website will have the necessary documents and information for you to view: http://helenaschools.org (Departments – Human Resources – Health Care and Cafeteria Benefits)

- **Please read** both sides of the paper(s) of the Welcome to School Packet when applicable. As there is **necessary information** for you to retain.

We know there may be many questions, therefore I request you contact me through phone or email and allow adequate time for a response due to high volume.

Thanks,

Richard Franco
HR Health Benefits Manager
Helena Public School District #1
Ph: 406-324-2008

MEMO

To: Helena Public School District #1 Retirees

From: Rich Franco/Health Benefits Manager

Date: August 15, 2025

RE: Annual Benefits Required Notices

This memo gives you the information to view the following notices as required by law:

1) **HSD1 Summaries of Benefits and Coverage (SBC) for Premium and Standard Plans**
2) **Health Plan Document**
3) **Health Benefit Plan Description**
4) **Appeals Process and Rights for Members**
5) **Changes for the Health Plan Year 25-26**
6) **Mid-Year Changes**
7) **CHIPRA – notice informs employees of possible assistance (Medicaid, CHIP, etc.)**
8) **COBRA – Continuation of health coverage option**
9) **Health Insurance Marketplaces**

To view these notices and information, please visit the HSD Insurance Website. You can find the insurance website by going to: **www.helenaschools.org** – Departments – Human Resources – Health Care and Cafeteria Benefits.

If you have any questions, please do not hesitate to contact your Health Benefits Manager.

Thanks,

Richard Franco
Helena School District 1
HR Health Benefits Manager
rfranco@helenaschools.org
Ph: (406) 324-2008

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.

Helena School District #1
Retiree Health Benefit Summary
October 1, 2025 – September 30, 2026

OPTION 1 PLAN

Benefit Option includes medical and prescription coverage.

Monthly Premiums for 2025-2026 Plan Year

Coverage	Premium
Retired Single	$1,064.80
Retired Single + Spouse	$2,042.55
Retired Single + 1 Child	$1,336.76
Retired Single + Children	$1,443.68
Retired Single + Family (1 Child)	$2,309.90
Retired Single + Family (Children)	$2,416.85
Medicare Eligible Retiree **	$585.00

*****EFFECTIVE JANUARY 1, 2011 MEDICARE RATE DOES NOT COVER PHARMACY. RETIREES WILL NEED TO ENROLL IN MEDICARE PART D OR OTHER COVERAGE FOR PHARMACY***

Medical coverage:

$1,500 deductible for individual and $3,000 deductible for family. Participants incur a 30% co-pay on applicable expenses until they reach a maximum out-of-pocket limit. The maximum out-of-pocket cost for an individual is $4,000 and $8,000 for family. There is Narrow Network Program on Option 2 (Tier 1)

Prescription Coverage:

Each participant must meet a $100 deductible. Participant co-payments per prescription will be:

Pharmacy Benefit:

Supply	Generic	Preferred Brand	Non-Preferred Brand
34-day	$12	$40 + 40%	$50+50%

Mail Order Benefit:

Supply	Generic	Preferred Brand	Non-Preferred Brand
34-day	$12	$40	$50
3-month	$24	$104	$120

OPTION 2 PLAN

Benefit Option includes medical and prescription coverage.

Monthly Premiums for 2025-2026 Plan Year

Coverage	Premium
Retired Single	$880.24
Retired Single + Spouse	$1,681.28
Retired Single + 1 Child	$1,100.31
Retired Single + Children	$1,188.34
Retired Single + Family (1 Child)	$1,901.34
Retired Single + Family (Children)	$1,989.37
Medicare Eligible Retiree **	$395.00

*****EFFECTIVE JANUARY 1, 2011 MEDICARE RATE DOES NOT COVER PHARMACY. RETIREES WILL NEED TO ENROLL IN MEDICARE PART D OR OTHER COVERAGE FOR PHARMACY***

Medical coverage:

$3,000 deductible for individual and $6,000 deductible for family. Participants incur a 30% co-pay on applicable expenses until they reach a maximum out-of-pocket limit. The maximum out-of-pocket cost for an individual is $7,000 and $14,000 for family. There is ***no*** Narrow Network Program on Option 2.

Prescription Coverage:

(Same as Option 1 Plan Prescription Benefit.)

Important Health Plan Election Information:

Retirees may change their health benefit plan election during the open enrollment period. Dependents may remain on the plan but may not be added after retirement. Also, please note that once a Retiree turns 65 they must go onto Medicare and cannot have the District Insurance as a Primary. Contact the Human Resource Benefits Manager, Richard Franco at 324-2008 or rfranco@helenaschool.org if you have any questions.

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DENTAL PLAN

Monthly Dental Premiums for the 2025-2026 Plan Year – **Retiree**

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.

VISION PLAN

Monthly Vision Premiums for the 2025-2026 Plan Year – **Retiree**

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

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

Vision Coverage is based on a reimbursement schedule and network through Ameritas. Vision Coverage is an Employee and Spouse only benefit.

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.

HELENA SCHOOL DISTRICT #1

CAFETERIA BENEFITS SELECTION FORM FOR RETIREES SUMMARY - PLAN YEAR 2025-26

Health Insurance

Choose One ONLY

from **"Option 1"** or **"Option 2" Plan**

		Option 1 Plan w/ RX				*Option 2 Plan w/ Rx*	
Single Only		**$1,064.80**	**per month**	Single Only		**$880.24**	**per month**
Single + Spouse		**$2,042.55**	**per month**	Single + Spouse		**$1,681.28**	**per month**
Single + Child		**$1,336.76**	**per month**	Single + Child		**$1,100.31**	**per month**
Single + Children		**$1,443.68**	**per month**	Single + Children		**$1,188.34**	**per month**
Single + Family (1 Child)		**$2,309.90**	**per month**	Single + Family (1 Child)		**$1,901.34**	**per month**
Single + Family Children		**$2,416.85**	**per month**	Single + Family Children		**$1,989.37**	**per month**
Medicare Eligible Retiree		**$585.00**	**per month**	Medicare Eligible Retiree		**$395.00**	**per month**

> **NAME (Please print)** _____

> **YOUR ADDRESS** >>>>>>>> _____

> **City, State Zip** >>>>>>>> _____

> >>>>>>>> _____

> **YOUR SIGNATURE (REQUIRED) >>>>>>>** _____

> **INSURANCE MANAGER (VERIFIED) >>>>** _____ **Upon Receipt of Form*

> **DATE >>>>** _____ **PHONE # >>>>>>** **(406) 324-2008**

**** The Plan Year begins October 1, 2025 and runs through September 30, 2026***