State of Montana Benefit Plan Legal Notices

Issued January 2026

This booklet contains notices the State of Montana Benefit Plan (State Plan) must provide benefit eligible members according to State and Federal law.

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Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **the State of Montana, Health Care & Benefits Division (HCBD) at (800) 287-8266 or email BenefitsQuetions@mt.gov**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name State of Montana	4. Employer Identification Number (EIN) 81-0302402	
5. Employer address 125 N Roberts St.	6. Employer phone number (800) 287-8266	
7. City Helena	8. State MT	9. ZIP code 59601
10. Who can we contact about employee health coverage at this job? State of Montana, Department of Administration, Health Care & Benefits Division		
11. Phone number (if different from above)	12. Email address BenefitsQuestions@mt.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

See Attachment 1: Employee Health Benefits Eligibility

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

See Attachment 2: Dependent Health Benefits Eligibility

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

ATTACHMENT 1: Employee Health Benefits Eligibility

EMPLOYEE ELIGIBILITY

Eligible Employees include the following:

1. Employees of a department or agency of the judicial, legislative and executive branches of the State;
2. Elected Officials;
3. Officers of the legislative branch;
4. Judges;
5. Employees of Montana State Fund; and
6. Members of the legislature.

An Employee becomes eligible under this Plan for each employment status and schedule as follows:

STATUS	SCHEDULE	INSURANCE
Seasonal < 6 months	Full-Time Part-Time Variable	No. Audit for employment > 6 months.
Short-Term Worker	Full-Time Part-Time	Yes.
Short-Term Worker	Variable	No. Audit for 90 days in a year.
Short-Term Recurring	Full-Time Part-Time Variable	No. Audit for 90 days in a year.
Regular Temporary Seasonal	Variable	No. Audit for average hours > 20 hours per week.
Regular Temporary Seasonal	Full-Time Part-Time	Yes.

An Employee is eligible while on active military duty or in a leave of absence status.

WAIVER OF COVERAGE AND RE-ENROLLMENT

If an eligible Employee waives coverage under this Plan, the State Employer contribution continues to accrue to the benefit plan for the group benefit cost (§ 2-18-703, MCA).

An eligible Employee may enroll for Employee only coverage under this Plan at anytime.

STATUS DEFINITIONS

1. "Temporary" means an Employee who is hired on a temporary basis, and will not work in that position more than twelve (12) months. If the Employee is in a Temporary position and meets the requirements of "Seasonal < 6 Months", the Employee is moved into the "Seasonal < 6 Months" status.

2. "Seasonal < 6 Months" means an Employee hired in a position that is both filled for a particular season roughly the same time every year AND for a period of less than six (6) months. If the Employee is temporary, employment must be terminated at the end of the six (6) months. If the Employee is permanent, the Employee should be put on a leave of absence without pay at the end of the six (6) month period.

3. "Seasonal" means an Employee who performs duties interrupted by seasons and who may be recalled. Seasonal status is used when the Employee is expected to work six (6) months or more in a "Regular" position that is re-hired roughly the same time every year.

4. "Short-Term Worker" means an Employee who is hired to work ninety (90) days or less in a twelve (12) month period and is in a position that does not recur each year.

5. "Short-Term Recurring" means an Employee who is hired to work ninety (90) days or less in a twelve (12) month period and the position is filled on a recurring basis, roughly the same time of year and within six (6) months.

6. "Regular" means an Employee who is permanent or eligible to become permanent.

SCHEDULE DEFINITIONS

1. "Variable" means an Employee is expected to work an average of less than twenty (20) hours per week, or the number of hours vary, or the days worked are intermittent or unknown. Employee is not offered benefits until the Employee completes a Measurement Period of twelve (12) consecutive months, during which the Variable Employee averages twenty (20) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not for twelve (12) consecutive months.

2. "Full-Time" means an Employee is expected to work forty (40) hours per week. Employee is offered benefits when employment begins.

3. "Part-time" means an Employee is expected to work an average of twenty (20) hours or more, but less than forty (40) hours per week. Employee is offered benefits when employment begins.

AFFORDABLE CARE ACT (ACA) COVERAGE DETERMINATION DEFINITIONS

1. "Standard Measurement Period" or "SMP" means the 12-month period adopted by the Plan for during which Employees' work hours and applicable leave are measured to determine whether such Employees are eligible for coverage. The SMP begins each year on October 3rd.

2. "Initial Measurement Period" or "IMP" means the initial 12-month period during which a newly hired Employee's work hours and applicable leave is measured to determine whether such Employee is eligible for coverage.

3. "Initial Stability Period" or "ISP" means the 12-month period a Variable Employee may be eligible for coverage under the Plan after completion of an IMP. The Variable Employee remains eligible for benefits during the entire ISP, regardless of the number of hours worked and applicable leave, as long as the Variable Employee remains in active employee status with the Employer. A Variable Employee's ISP begins the first of the month following a 30-day administrative period.

4. "Standard Stability Period" or "SSP" means the 12-month period of time the Employees may be eligible for coverage under the Plan after completion of a SMP. An Employee remains eligible for benefits during the entire SSP, regardless of the number of hours worked and applicable leave, as long as the Employee remains in active employee status with the Employer. The SSP begins each January 1st, which is the 1st of the month following a 90-day administrative period.

ATTACHMENT 2: Dependent Health Benefits Eligibility

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien or is otherwise legally present in the United States or in any other jurisdiction that the related Participant or Retiree has been assigned by the Employer, who submits the Dependent Verification described in the next section, and who is either:

1. The Participant's or Retiree's legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established

An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant or a Retiree and has a court order or decree stating such from a court of competent jurisdiction, and regardless of a court order requirement to carry or pay for a legally separated or divorced spouse's coverage.

2. The Participant's or Retiree's domestic partner provided all of the following "Required Eligibility Conditions" are met:

   A. The Participant or Retiree and domestic partner are both eighteen (18) years of age or older;

   B. The Participant or Retiree and domestic partner share a common residence, as evidenced by the Shared Residence Affidavit;

   C. Neither the Participant or Retiree nor the domestic partner is married to any other person;

   D. The Participant or Retiree and domestic partner are not legally related to each other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild; and

   E. The Participant or Retiree and domestic partner have a financially-interdependent relationship as evidenced by at least one (1) of the following:

      1) Mutually granted powers of attorney or mutually granted health care powers of attorney; or

      2) Designation of each other as primary beneficiary in wills, life insurance policies, or retirement plans.

3. The Participant's or Retiree's Dependent child who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child who has been Placed For Adoption (must provide pre-adoption placement agreement) with the Participant or Retiree or spouse/domestic partner and for whom as part of such placement the Participant or Retiree or spouse/domestic partner has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant or Retiree or spouse/domestic partner has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining eighteen (18) years of age; and

   B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's or Retiree's child meets the criteria of an incapacitated child.

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

If both spouses are employed by the Employer, and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under the State of Montana Benefit Plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Wrap Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify Medicaid or for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the State of Montana, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: State of Montana Benefit Plan, Health Care & Benefits Division, (406) 444-7462, (800) 287-8266, or TTY (406) 444-1421, PO Box 200130, Helena, MT 59620-0130, benefitsquestions@mt.gov. Failure to notify the Plan Administrator within 60 days after the qualifying event will result in loss of COBRA continuation coverage rights.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered

employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.
You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection

and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator contact information

State of Montana Benefit Plan
(State Plan) Health Care &
Benefits Division
125 N Roberts St.
PO Box 200130
Helena, MT 59620-0130
Ph: (406) 444-7462, (800) 287-8266, TTY (406) 444-1421
Fax: (406) 444-0080
Email:
BenefitsQuestions@mt.gov
Website: benefits.mt.gov

STATE OF MONTANA BENEFIT PLAN

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy of your personal health information that is maintained by the State of Montana Benefit Plan (the "Plan"), sponsored by the State of Montana for State employees, retirees, and dependents. We are required to provide you with this notice to explain how we may use your personal health information and when we can disclose that information to others.

This notice describes the privacy practices of the Plan, including group medical benefits, prescription drug benefits, dental and vision benefits, health flexible spending accounts, Montana Health Centers, wellness plan, and employee assistance programs. This notice does NOT apply to other State of Montana benefits like life insurance, disability, or retirement programs.

We will follow the terms of this notice. We have the right to change our privacy practices and the terms of this notice, and changes will apply to all information we already have about you and any new information we may receive in the future. We will post the revised notice on the Health Care & Benefits Division website and provide you with a copy of the revised notice, or information about the changes and how to obtain a revised notice.

When it comes to your health information, you have certain rights. This section explains those rights and some of our responsibilities to help you.

Get a copy of your health information	• You can ask to see or obtain an electronic or paper copy of your claims information and other health information we have about you. You may also take photos of your information or send a copy to a third-party provider or upload to a mobile health app. **See page 5 for information on how to do this**. • We will provide a copy or a summary of your health and claims records, usually within 15 days of your request. We may charge a reasonable, cost-based fee. • **Note:** If you store or access your health information on your personal cell phone or tablet, the protections for the privacy of your information explained in this notice may not apply.
Ask us to amend your health information	• You can ask us to correct your health information if you think that information is incorrect or incomplete. **See page 5 for information on how to do this**. • If we deny your request, we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, mobile, home, or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. You may also ask us not to disclose your information to family members or others involved in your care or payment of that care. In certain circumstances, your dependents may request restrictions on your ability to see their information. **See page 5 for information on how to do this**. • We will permit any requests allowed by law or our policies, but we are not required to agree to any request.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information during the six years prior to the date you ask, who we shared it with, and why. **See page 5 for information on how to do this.** • We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one free accounting per year but may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will also post a copy of this notice on our website.
Choose someone to act for you	• If you have given someone medical power of attorney, or you have a legal guardian, that person can exercise your rights and make choices about your health information. • We will verify that person has this authority and can act for you before we take any action.
File a complaint	• If you believe your privacy rights have been violated, you may file a written complaint with us. **See page 5 for information on how to do this.** • You may also file a complaint with the regional Office for Civil Rights of the United States Department of Health and Human Services. **See page 5 for information on how to do this.** • We will not retaliate against you for filing a complaint.

We typically use or share your health information in the following ways without your authorization:

Treatment	• Providing, coordinating, or managing health care by a health care provider or doctor. Treatment can include coordination or management of care between a provider and a third party, consultation with, or referrals between providers. • For example, the Plan may share information about you with your treating providers.
Payment	• Activities by the Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. • For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits between the two plans.
Health care operations	• Activities by the Plan such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and communications, and claims and appeals. Health care operations can include vendor evaluations, credentialing, training, underwriting, premium rating, arranging for medical review and audit activities, and business planning. • Activities for individual-level care coordination and case management. We may also contact you or your physician to provide information about treatment alternatives or other health-related benefits that could improve your health. • We will not use your genetic information for underwriting purposes. We may use some health information in risk rating and pricing, such as age and gender, as permitted under state and federal law. • Except for activities related to individual-level care coordination and case management, we will only disclose the minimum necessary information that relates to the task being performed.

We may also disclose limited health information on your status as a Plan member or if you have enrolled or disenrolled in a health benefit option offered through the Plan. We may disclose summary health information to your employer to obtain premium information for coverage under the Plan, or to modify, amend or terminate the Plan. Summary information summarizes health and claims information but has names and other identifying information removed.

You should know that your employer will not use health information obtained from the Plan for any employment-related actions. However, your employer may collect health information from other sources, such as the Family Medical Leave Act and workers compensation coverage that is not protected under HIPAA.

We may collect, use, or share your health information in the following ways, as permitted by law. We will verify that a use or disclosure is not prohibited by law before disclosing your information.

Types of disclosures:

Required by Law	• Disclosures made to federal, state or local agencies as required by law.
Persons Involved in Your Care	• Disclosures to persons involved in your care or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgement to decide if the disclosure is in your best interest. Special rules apply if we disclose health information about a deceased individual to family members and others. We may disclose information to any persons involved, prior to death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
Public Health	• Disclosures for public health reasons, such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
Abuse, Neglect, or Domestic Violence	• Disclosures to report a suspected case of abuse, neglect, or domestic violence to government authorities authorized by law to receive such information.
Health Oversight Activities	• Disclosures to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
Judicial and Administrative Proceedings	• Disclosures for judicial or administrative proceedings, including responding to court orders, discovery requests, subpoenas or other lawful process once HIPAA's administrative requirements are met.
Law Enforcement Purposes	• Disclosures for law enforcement purposes such as providing limited information to locate a missing person or report a crime.
Preventing Serious Threats to Health and Safety	• Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety. This includes disclosures to law enforcement officials to identify or apprehend an individual in certain circumstances.
Specialized Government Functions	• Disclosures for specialized government functions related to the military and veterans, national security and intelligence, or to correctional institutions about an inmate(s).
Workers Compensation	• Disclosures to workers compensation programs as necessary to comply with federal or state workers compensation laws.

Research	• Disclosures for research purposes, if the research study meets federal privacy requirements, or for certain activities related to preparing a research study.
Death	• Disclosures to a coroner or medical examiner to identify a deceased person, determine cause of death, and to funeral directors to carry out their duties.
Organ, Eye or Tissue Donation	• Disclosures to entities that handle organ procurement, banking, or transplantation of organs, eyes or tissue to facilitate donation or transplantation.

We will disclose your health information to our business associates.

Business associates are vendors that we contract with to perform functions on behalf of the Plan, including claims administration for medical, prescription drugs, dental and vision benefits, enrollment activities, benefits consulting, employee assistance and wellness programming and our Montana Health Centers. Our business associates are required by law and by contract to protect the privacy of your health information.

Additional Restrictions on Use and Disclosure of Your Health Information

Federal and state privacy laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. We will follow the more stringent and protective law, where it applies to us. Such laws may protect the following categories of information:

- Alcohol and substance use disorder, including counseling notes
- Biometric information
- Sexually transmitted diseases
- Mental health, including psychotherapy notes
- Communicable diseases
- Genetic information
- Prescriptions
- HIV/AIDS
- Minors' information
- Child or adult abuse or neglect, including sexual assault

Uses and disclosures of your alcohol/substance use disorder notes and mental health/psychotherapy notes are generally prohibited without your written consent or a court order. However, these notes may be disclosed for treatment purposes without the need for your consent to mental health care providers or the State's employee assistance program.

Disclosures Requiring Your Written Authorization

Except for situations described in this notice and as federal privacy law permits, we will use and disclose your health information only with a written authorization from you. This includes using or disclosing alcohol/substance use disorder or psychotherapy counseling notes, using or disclosing your information for certain marketing communications, or sharing with individuals not directly involved in your care such as your attorney. Marketing communications do not include appointment or drug refill reminders, a description of your benefits, or communications about treatment alternatives, We will not sell your health information, and we do not allow our business associates to sell your health information.

Once you give us authorization to use or disclose your health information, you may take back or revoke that authorization at any time in writing. However, if we have already acted based on your written authorization, your revocation will not apply to those uses or disclosures. **See page 5 for information on how to exercise your rights.**

How We Keep Your Information Safe

The security of your health information is very important to us. The information we get from you, or others on your behalf is protected by strict security safeguards. We annually validate the controls our business associates maintain by a thorough review of third-party audits such as the SOC II Type II audit. Our security program is based upon industry best practices and complies with the security standards set forth in NIST special publication 800-53. These standards include security policies and procedures, employee training, facility controls to limit physical access to systems that store data, limiting access to those who "need to know", encrypting data both at rest and in motion in a manner consistent with applicable NIST standards, authenticating users who access the data systems, and regularly testing security systems and processes.

Exercising Your Rights

- Contact Your Health Plan. If you have any questions about this notice or need information on how to exercise your rights, contact the Health Care & Benefits Division:

  Attn: Privacy Officer
  State of Montana Benefit Plan
  % Health Care & Benefits Division
  PO Box 200130
  Helena, MT 59620-0130
  (406) 444-7462; (800) 287-8266; TTY (406) 444-1421
  benefits.mt.gov; benefitsquestions@mt.gov

- Submit a written request. To exercise your rights described in this notice, you may submit your written requests to us at the address above.

- File a complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the address above.

- Notify the Secretary of the U.S. Department of Health and Human Services of your complaint. Information on how to file a complaint is available on the Department's website at: www.hhs.gov/ocr/privacy/hipaa/complaints. We will not take any action against you for filing a complaint.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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Effective date: October 1, 2025

NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT: Group health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

Call BlueCross BlueShield of Montana at (888) 901-4989 for more information.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit benefits.mt.gov/Resources/Publications or by calling 1-888-901-4989. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,000 Individual Out-of-Network: $1,500 Individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Services with a copayment and preventive health are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical In-Network: $4,000 Individual / $8,000 Family Medical Out-of-Network: $4,950 Individual / $10,900 Family Pharmacy: $1,800 Individual / $3,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover. Non-Preferred (Tier 3) brand and Non-Preferred specialty (Tier 4) products do not accrue towards the pharmacy out-of-pocket maximum.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsmt.com or call 1-888-901-4989 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit; deductible does not apply	35% coinsurance	Copayment applies only for evaluation and management. Additional charges are subject to deductible and coinsurance.
	Specialist visit	$35/visit; deductible does not apply	35% coinsurance	Copayment applies only for evaluation and management. Additional charges are subject to deductible and coinsurance.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	35% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	35% coinsurance	Recommended Clinical Review; see your plan document* for details.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	35% coinsurance	Recommended Clinical Review; see your plan document* for details.

* For more information about limitations and exceptions, see the plan or policy document at benefits.mt.gov

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at benefits.mt.gov or call 1-866-333-2757 for Commercial members or 1-866-270-3877 for Medicare RX members.	$0 Preventive products	No Charge (certain preventive care and select medications).	No Charge (certain preventive care and select medications), limited to a 10 day supply.	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program, Navitus. If generic is available and chosen over brand, regardless of how prescription is written, member is responsible for the difference in cost plus applicable brand copayment. Fills provided by a non-preferred pharmacy are limited to 10 day supply. Certain prescriptions require prior approval before the drug can be authorized for coverage. Tier 3 Non-Preferred brand prescriptions do not accrue towards the pharmacy out-of-pocket maximum.
	Tier 1 Preferred generics and some lower cost brand products	$15 copayment retail 1-34 day supply, $30 copayment retail 35-90 day supply, $30 copayment mail order up to 90 day supply.	$15 copayment retail, limited to a 10 day supply.	
	Tier 2 Preferred brand products and some high cost non-preferred generics	$50 copayment retail 1-34 day supply, $100 copayment retail 35-90 day supply, $100 copayment mail order up to 90 day supply.	$50 copayment retail, limited to a 10 day supply.	
	Tier 3 Non-preferred products (may include some high cost non-preferred generics)	50% coinsurance retail or mail order up to 90 day supply.	50% coinsurance retail, limited to a 10 day supply.	
	Tier 4 Specialty products	$200 copayment Preferred Specialty Pharmacy.	50% coinsurance Non-Preferred Specialty Pharmacy or retail.	Specialty prescriptions should be obtained from a specialty pharmacy. Specialty prescriptions are limited to a 34 day supply. Non-Preferred Specialty prescriptions do not accure toward the pharmacy out-of-pocket maximum. A $50 copayment will apply to Preferred Specialty Pharmacy products for Medicare retirees only.

* For more information about limitations and exceptions, see the plan or policy document at benefits.mt.gov

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	35% coinsurance	Recommended Clinical Review; see your plan document* for details.
	Physician/surgeon fees	25% coinsurance	35% coinsurance	
If you need immediate medical attention	Emergency room care	Facility Charges: 25% coinsurance ER Physician Charges: 25% coinsurance	Facility Charges: 25% coinsurance ER Physician Charges: 25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	Recommended Clinical Review; see your plan document* for details.
	Urgent care	$35/visit; deductible does not apply	35% coinsurance	Ancillary charges are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	35% coinsurance	Recommended Clinical Review.
	Physician/surgeon fees	25% coinsurance	35% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/office visit; deductible does not apply 25% coinsurance for other outpatient services	35% coinsurance	Recommended Clinical Review; see your plan document* for details.
	Inpatient services	25% coinsurance	35% coinsurance	Recommended Clinical Review. Residential treatment facilities will be covered if medical necessity criteria are met.
If you are pregnant	Office visits	$25 Primary Care/ $35 Specialist; deductible does not apply	35% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Recommended Clinical Review.
	Childbirth/delivery professional services	25% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	35% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at benefits.mt.gov

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	35% coinsurance	Recommended Clinical Review. 70 visit maximum per benefit period.
	Rehabilitation services	$25/visit; deductible does not apply	35% coinsurance	Recommended Clinical Review. Deductible and coinsurance apply to other therapy services.
	Habilitation services	$25/visit; deductible does not apply	35% coinsurance	
	Skilled nursing care	25% coinsurance	35% coinsurance	Recommended Clinical Review. 70 days maximum per benefit period.
	Durable medical equipment	25% coinsurance	35% coinsurance	Recommended Clinical Review for items $2,500 and over.
	Hospice services	25% coinsurance	35% coinsurance	Recommended Clinical Review. Includes bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery (except for correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long term care
- Routine eye care (Adult)
- Routine foot care (except for individuals with co-morbidities, such as diabetes)
- Weight loss programs (except preventive services)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visit maximum combined with Chiropractic per benefit period)
- Chiropractic care (20 visit maximum combined with Acupuncture per benefit period)
- Hearing aids (for dependent children under age 19, and medically necessary cochlear implants, per medical policy)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

* For more information about limitations and exceptions, see the plan or policy document at benefits.mt.gov

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-888-901-4989, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Montana at 1-888-901-4898, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform, or the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or 1-800-332-6148. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Consumer Assistance Program at 1-800-332-6148 or visit www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4989.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-901-4989.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-901-4989.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-901-4989.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$2,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,000**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,000**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**25%**
Other coinsurance	**25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The plan would be responsible for the other costs of these EXAMPLE covered services

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsmt.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسی Farsi	توجه: اگر فارسی صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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State Diversity Program Coordinator
Department of Administration
State Human Resources Division
125 N Roberts St.
P.O. Box 200127
Helena, MT 59620
Phone: (406) 444-3871
Email:
SABHRSHR@mt.gov

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)