Coverage Period: 01/01/2026 – 12/31/2026 Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 https://www.bcbsmt.com/member/2026-policy-documents or by calling 1-888-901-4989. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay.
Are there services covered before you meet your deductible?	health are covered before you meet your	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?		Even though you pay these expenses, they don't count toward the out-of-pocket
Will you pay less if you use a network provider?	1-888-901-4989 for a list of participating providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge and what your plan pays (balance billing)</u> . Be aware, your <u>network provider might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</u>
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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.

		What You	ı Will Pay	Limitations Everytions 9 Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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.
If you visit a health care provider's office or clinic	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.
or chine	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% coinsurance	35% coinsurance	Recommended Clinical Review; see your <u>plan</u> document* for details.
If you have a test	Imaging (CT/PET scans, MRIs)	25% coinsurance	35% coinsurance	Recommended Clinical Review; see your <u>plan</u> document* for details.

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{benefits.mt.gov}}$

		What You Will Pay		Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	\$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 you need drugs to	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.	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.
treat your illness or condition More information about prescription drug coverage is available at	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.	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.
benefits.mt.gov or call 1-866-333-2757 for Commercial members or 1-866-270-3877 for	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 3 Non-Preferred brand prescriptions do not accrue towards the pharmacy out-of-pocket maximum.
Medicare RX members.	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 $\underline{\text{plan}}$ or policy document at $\underline{\text{benefits.mt.gov}}$

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

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document at $\underline{\text{benefits.mt.gov}}$

		What You Will Pay		Limitationa Evacationa & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	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. <u>Deductible</u>
If you need help	Habilitation services	\$25/visit; deductible does not apply	35% coinsurance	and <u>coinsurance</u> apply to other therapy services.
recovering or have other special health needs	Skilled nursing care	25% coinsurance	35% coinsurance	Recommended Clinical Review. 70 days maximum per benefit period.
	<u>Durable medical equipment</u>	25% coinsurance	35% coinsurance	Recommended Clinical Review for items \$2,500 and over.
	Hospice services	Hospice services 25% coinsurance 35% coinsurance	35% coinsurance	Recommended Clinical Review. Includes bereavement counseling.
16 1 11 1	Children's eye exam	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
uental of eye care	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 comorbidities, 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 <u>medically necessary</u> 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 <u>plan</u> or policy document at <u>benefits.mt.gov</u>

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 <u>plan</u> 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$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	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$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 <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
<u>Deductibles</u>	\$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 <u>plan's</u> overall <u>deductible</u>	\$1,000
■ Specialist copayment	\$35
■ Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

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



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 بمكن الوصول النها مجاثاً. اتصل على الرقم 2897-107-285 (2717) أو تحدث إلى مقدم الخدمة.

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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.
اردو Urdu	توجه 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۔6984-710-855 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں.
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.
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 (ТТҮ: 711) или обратитесь к своему поставщику услуг.
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.
فارسي 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 6984-710-855 (تلهتایپ: 711) تماس بگیرید یا با ارائهدهنده خود صحبت کنید.
Diné Navajo	SHOOH: Diné bee yániłti'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.
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.
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.
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।
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહ્યયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. ચોગ્ય ઑક્ઝિલરી સહ્યય અને ઍક્સેસિબલ ફ્રૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
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.
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.
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