2027 Retiree Open Enrollment Booklet

State of Montana Benefit Plan

October 21 - November 7, 2026



Important: Use This Booklet to Learn About Your 2027 State Plan Benefits

Some information in this booklet has been updated since the 2027 State Plan Changes memo was mailed to you in September. Use this booklet for the most current information about your 2027 StatePlan benefits.

Complete Open Enrollment at doa.mt.gov/HCBD.

Open Enrollment is your annual opportunity to review benefit elections and change plans or covered dependents.

Action Required: Self-Report Nicotine Use to Avoid the $60 per Month Tobacco Surcharge

Scan the QR code for more Open Enrollment information, including benefit presentations, booklets, and to complete Open Enrollment.

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State Plan Overview

The State of Montana Benefit Plan (State Plan) is self-funded. This is different than traditional insurance.

Traditional Insurance

With traditional insurance, members pay an insurance company a monthly premium and if a member goes to a doctor or hospital the insurance company pays some of the cost. The insurance company decides what's covered and how much is paid out-of-pocket. They also accept financial risk if a member has a serious health condition like cancer or a heart attack.

Self-Funded State Plan

State Plan coverage is funded by the State of Montana via the employer contribution, by employees via their bi-weekly contribution, and by legislators and retirees via their monthly contributions. The State Plan:

- Provides coverage in accordance with state and federal law
- Sets the monthly rates and out-of-pocket costs
- Carries the liability for all 28,000 plan members

Third-Party Administrators (TPAs) and Vendors

With 28,000 plan members state-wide, the State Plan partners with outside companies to help it process claims and administer benefits, as well as relies on their expertise and cost-saving contracts.

Current TPAs:

- BlueCross BlueShield of Montana (BCBSMT) - Medical Benefits
- VSP Vision Care - Vision Benefits
- Delta Dental - Dental Benefits
- Navitus Health Solutions - Prescription Drug Benefits

Other Vendors:

- Premise Health operates the Montana Health Centers
- BCBSMT provides fully insured life insurance
- GuidanceResources administers the Employee Assistance Program (EAP)

Bottom Line

Since the State Plan is funded by both your contributions and taxpayer dollars, it's important that we all work together to make informed healthcare choices. You can do your part by reading this book to understand your benefits, reviewing updates from HCBD, participating in wellness programs, and visiting doa.mt.gov/HCBD.

For complete details about the State Plan, refer to the Wrap Plan Document (WPD) at doa.mt.gov/HCBD/Resources/Publications.

State Plan Enrollment

Benefit Overview

Retirees who enroll in the State Plan must enroll in Medical Benefits, which include:

- Medical coverage
- Prescription Drug coverage
- Basic Vision coverage
- Basic Life Insurance ($14,000 of term life coverage)

Optional Benefits

- Medical coverage for spouse or domestic partner or children
- Dental coverage
- Vision Hardware coverage

Mid-Year Benefit Change

Also known as a Special Enrollment Period. A period of time allowed by the State Plan, other than the Initial Enrollment Period or the annual Open Enrollment Period, during which an eligible employee, legislator, or retiree may request to add or terminate coverage under the State Plan as a result of certain events that create special enrollment rights.

If you qualify for and wish to make a change to your State Plan benefits due to a Special Enrollment Event (i.e. marriage, birth, divorce, gain/loss of coverage, etc.) you must do so within 60 days of the date of the event (91 days if the event is birth or adoption).

Details at doa.mt.gov/HCBD/Enrollment-Claims/Mid-Year-Changes.

Benefit Identification Cards

Due to the changes in the medical plan cost sharing requirements, all plan members will be receiving new medical benefit identification cards from BlueCross BlueShield of Montana after January 1, 2027.

If you enroll yourself and/or a dependent in a new benefit election (medical, prescription drug, dental, and/or vision) for 2027, you will receive identification cards after January 1, 2027.

If you elect to continue an existing benefit election, your current ID card(s) will remain valid in 2027 and you will not receive new ID cards for prescription drug, dental and/or vision. If you need a replacement ID card, contact the vendor directly.

Survivor Benefits

Surviving spouses or domestic partners and dependent children of retirees that pass away may remain covered by the State Plan if they elect to enroll in survivor coverage.

2027 Contributions and Benefit Changes

Beginning January 1, 2027, employees, legislators, retirees, and their families will see changes to monthly contributions and out-of-pocket costs. These changes are intended to respond to actual healthcare use and cost growth, support the State Plan's long-term financial stability, and help ensure retirees and their families can continue to rely on their health coverage.

Retiree Contribution Increase

Retiree rates will increase on January 1, 2027, by about 4%. See page 11 for additional details on monthly benefit costs.

Medical Plan Cost Sharing Changes

In-Network Plan Benefit Change	2026 Medical Plan Benefit	2027 Medical Plan Benefit
Deductible	$1,000 per individual	$2,000 per individual
Out-of-Pocket Maximum	$4,000 per individual $8,000 per family	$6,500 per individual $13,000 per family
Primary Care Provider Office Visit Copay	$25	$25 (no change)
Specialist Office Visit Copay	$35	$50
Urgent Care Copay	$35	$50

Changes will also occur to the out-of-network deductible and maximum out-of-pocket. The changes to the out-of-network deductible and maximum out-of-pocket can be found on page 14.

Pharmacy Plan Cost Sharing Changes

	2026 Copayment 1-34 days' supply	2027 Copayment 1-34 days' supply	2026 Copayment 35-90 days' supply	2027 Copayment 35-90 days' supply
$0 Preventive Products	$0	$0	$0	$0
Tier 1 Preferred generics and some lower cost brand products	$15	$25	$30	$50
Tier 2 Preferred brand products and some high-cost non-preferred generics	$50	$80	$100	$160
Tier 3 Non-preferred products	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
Tier 4 – Non-Medicare Retirees Specialty brand products	$200	$400	Coverage for specialty products is limited to a 30-day supply.	Coverage for specialty products is limited to a 30-day supply.
Tier 4 – Medicare Retirees Specialty brand products	$50	$100	Coverage for specialty products is limited to a 30-day supply.	Coverage for specialty products is limited to a 30-day supply.
Tier 4 Specialty generic products	$0	$0	Coverage for specialty products is limited to a 30-day supply.	Coverage for specialty products is limited to a 30-day supply.

*Coinsurance does not apply to out-of-pocket maximum.

Pharmacy Out-of-Pocket Maximum	2026	2027
Per Individual	$1,800	$2,500
Per Family	$3,600	$5,000

How to Complete Open Enrollment

You will need to complete your Open Enrollment election to provide the State Plan with information about you and your covered spouse or domestic partner's nicotine use, go to page 27 for details. If you do not complete your Open Enrollment election, you will automatically be charged the Tobacco Surcharge of $60 per month.

In addition, the Vision Hardware Plan must be elected and/or re-elected each Plan Year. If you fail to elect the Vision Hardware Plan coverage will terminate effective January 1, 2027.

You will also be receiving a Retiree Open Enrollment Election Form in the mail as an alternative to completing your elections online. If completing the printed election form, it must be returned to HCBD by November 7, 2026. Only complete one Open Enrollment Election, either online, via a mobile device, or by returning the form.

1. Access & Login

1. To access the benefits enrollment system, go to doa.mt.gov/HCBD.
2. Navigate to the "Off State Network Benefit Enrollment System Access" button then login using the prompts provided.
    - First time users will need to register with a username and password then answer a few security questions. The case-sensitive company key is stateofmontana.

After you have created an account, you have the option to enroll using the MyChoice Mobile App on your smartphone or tablet. Download the app through the Google Play Store for Android or the Apple App Store for iOS. Once downloaded, login at doa.mt.gov/HCBD to receive your access code. The enrollment process is slightly different on the mobile app and may not perfectly align with the steps outline in the rest of this section.

2. Start Enrollment

To begin Open Enrollment, navigate to the "Start Here" button to review your personal information and add or edit any dependents you wish to enroll on State Plan coverage. You will need to provide each dependent's legal name, Social Security Number, and date of birth to add them to your coverage*.

*You will be required to provide documentation to prove your relationship to each dependent.

3. Completing Enrollment

Choose to re-enroll in your current plans or use the “Next” and “Back” buttons to review and elect options available to you.

You will be able to compare your current elections to prior year elections throughout the enrollment process.

Choose or decline coverage for each available option and select which family members you want to cover.

Note: You will make your vision election at the same time you make your medical election. If you elect Vision Hardware coverage, the cost will not be reflected in the total monthly contribution amount until you reach the Vision section in the enrollment system. Any dependents added to your medical coverage will also be added to your vision election.

4.Review & Finalize Elections

Make sure your personal information, elections, dependents, and beneficiaries (if applicable) are accurate, then approve your elections.

To finish, click “I Agree.” When your enrollment is complete, you will receive a confirmation number and can print your Benefit Summary for your records.

If you need to provide dependent verification documentation, you will receive instructions on how to upload the required documentation after you completed your enrollment by clicking “I agree.”

Visit doa.mt.gov/HCBD anytime you want to learn more about your benefits or to change your coverage due to a qualifying life event.

Medicare Eligibility and Enrollment

It is important that retirees, survivors, and their spouse or domestic partner and/or dependents covered by the State Plan enroll in Medicare Parts A and B when they become eligible.

When you become eligible for Medicare Parts A and B, the State Plan will coordinate your State Plan benefits with the benefits you are eligible for with Medicare. If you do not enroll in Medicare Parts A and B, the State Plan will pay claims as if you were enrolled, which will result in larger out-of-pocket costs for you.

Medicare Retiree Rate

Your monthly premium contribution amount (see rates on page 11) will automatically be reduced to the Medicare Retiree Rate the first of the month following the date you or your spouse or domestic partner become Medicare eligible.

Medicare Part D Coverage

As a State Plan retiree, you and your spouse or domestic partner and/or dependent's Medicare Part D prescription drug coverage is provided by the State Plan. When enrolled on State Plan coverage, you may **not** purchase Medicare Part D coverage with any other provider. If you enroll in other Medicare Part D coverage, all your State Plan coverage (medical, prescription drug, vision, dental, and basic life insurance) will be terminated. Contact Navitus MedicareRx for more information call (866) 270-3877, TTY 711, or visit MedicareRX.Navitus.com.

Not Yet Medicare Eligible But Unable to Work

Public Consulting Group (PCG) assists State Plan members with applying for Social Security Disability Insurance (SSDI) and early Medicare coverage. This service applies to retirees and survivors, and their spouses, and dependents, who are experiencing health conditions that would prevent them from working full-time. These services are paid for by the State, with no cost to you. If you, or your dependents, are interested in learning more about these services, call PCG at (800) 805-8329, TTY 711, or email disability@pcgus.com.

Dependent Eligibility Documentation

If you add a spouse or domestic partner and/or children to the State Plan, you will be required to provide the following:

Dependent Children

- A copy of the Dependent child's birth certificate, adoption order or pre-adoption papers, or
- A copy of a court-ordered parenting plan, custody agreement or guardianship order.

Domestic Partner

- Declaration of Domestic Partner Relationship and Affidavit of Shared Residence forms (available at doa.mt.gov/HCBD/Resources/Forms); and
- A copy of mutually granted powers of attorney or healthcare powers of attorney; or
- A copy of mutual designations of primary beneficiary in will, life insurance policies or retirement plans. Domestic partners are automatically defaulted to a non-qualified tax dependent status.

Grandchildren

- A copy of the grandchild's adoption order or pre-adoption papers; or
- A copy of a court-ordered custody agreement or legal guardianship.

Spouse

- A copy of the certified marriage certificate; or
- A copy of the front page of the most recent tax return showing the tax filing status as "married". Any financial information may be blacked out; or
- A copy of the recorded and notarized Affidavit of Common Law Marriage (available at doa.mt.gov/HCBD/Resources/Forms).

Stepchildren and Domestic Partner Children

- Required documentation listed above for spouse or domestic partner, if individual is not enrolled; and
- A copy of the stepchild's or domestic partner child's birth certificate, adoption order or pre-adoption papers; or
- A copy of a court-ordered parenting plan, custody agreement or guardianship order.

2027 Monthly Benefit Costs

Non-Medicare Retiree Monthly Contributions

Non-Medicare Retiree Plans	Medical*	Dental	Vision Hardware	Potential LLW Incentive
Non-Medicare Retiree Only	$1,590.00	$42.37	$7.64	Up to $60 off
Non-Medicare Retiree & Non-Medicare Spouse	$2,549.00	$63.77	$14.42	Up to $120 off
Non-Medicare Retiree & Medicare Spouse	$1,879.00	$63.77	$14.42	Up to $120 off
Non-Medicare Retiree & Children	$2,042.00	$62.27	$15.18	Up to $60 off
Non-Medicare Retiree, Non-Medicare Spouse, & Children	$2,826.00	$71.27	$22.26	Up to $120 off
Non-Medicare Retiree, Medicare Spouse, & Children	$2,372.00	$71.27	$22.26	Up to $120 off

*Medical includes medical, prescription drug, basic vision ($10 copay for an annual eye exam per member at an In-Network VSP Vision Care provider) and basic life insurance.

Basic Life Insurance

Non-Medicare retirees must also pay $0.63 per month for Basic Life Insurance coverage.

Medicare Retiree Monthly Contributions

Medicare Retiree Plans	Medical*	Dental	Vision Hardware	Potential LLW Incentive
Medicare Retiree Only	$598.00	$42.37	$7.64	Up to $60 off
Medicare Retiree & Non-Medicare Spouse	$1,594.00	$63.77	$14.42	Up to $120 off
Medicare Retiree & Medicare Spouse	$1,072.00	$63.77	$14.42	Up to $120 off
Medicare Retiree & Children	$978.00	$62.27	$15.18	Up to $60 off
Medicare Retiree, Non-Medicare Spouse, & Children	$1,830.00	$71.27	$22.26	Up to $120 off
Medicare Retiree, Medicare Spouse, & Children	$1,246.00	$71.27	$22.26	Up to $120 off

*Medical includes medical, prescription drug, and basic vision ($10 copay for an annual eye exam per member at an In-Network VSP Vision Care provider).

For complete details about the State Plan, refer to the Wrap Plan Document (WPD) at doa.mt.gov/HCBD/Resources/Publications.

Medical Plan

BlueCross BlueShield of Montana (BCBSMT) is the State Plan's Medical Plan third-party administrator. BCBSMT processes medical claims for the State Plan. The self-funded State Plan decides rates, out-of-pocket costs, and coverage.

The State Plan uses BCBSMT's large nationwide network of in-network providers. Using in-network providers is the best way to control how much you pay out-of-pocket for healthcare.

Medical Benefits

- Medical coverage from BCBSMT
- Prescription Drug coverage from Navitus Health Solutions
- Basic Vision coverage from VSP Vision Care (VSP)
- All plan members covered on the medical plan are entitled to one routine vision and eye health evaluation each Plan Year for a $10 copay at an In-Network VSP provider at no additional cost.
    - VSP, not BCBSMT, administers this benefit. Note that if the provider bills as a medical visit, the $10 copay does not apply and normal medical benefits take effect.
- Basic Life Insurance for non-Medicare retirees only from BCBSMT ($14,000 of term life coverage)
- Use of all Montana Health Centers and its 24/7 virtual telehealth services at no cost for plan members over 2 years old, operated by Premise Health. (Not available for Medicare retirees.)
- Use of select One Health Clinics for no-cost comprehensive primary care services
- No-cost annual health screening provided by Montana Health Centers
- No cost access to BCBSMT’s 24/7 Nurse Line by calling (877) 213-2565. Registered nurses are on call to answer your health questions and give general health tips 24 hours a day, seven days a week.

Who to Contact with Questions

Contact BCBSMT for questions about claims or billing, in-network providers, online account information, what’s covered, recommended clinical reviews, case management, and appeals. BlueCross BlueShield of Montana, (888) 901-4989, TTY 711, or bcbsmt.com.

Contact HCBD for questions about eligibility (who’s covered), mid-year changes, open enrollment, benefit contributions, and the Live Life Well Incentive. Health Care & Benefits Division, (800) 287-8266, TTY (406) 444-1421, BenefitsQuestions@mt.gov, or doa.mt.doa/HCBD.

Medical Plan Cost Sharing

Providers and medical facilities are either in-network or out-of-network with BlueCross BlueShield. Receiving services out-of-network results in a separate deductible and maximum out-of-pocket and you may be balanced billed.

In-Network Provider or Facility

In-network providers and facilities have contracted with BlueCross BlueShield of Montana (BCBSMT). All deductibles and maximums will be based upon a Plan Year, which is January 1 through December 31.

Cost Sharing for In-Network Provider or Facility

Benefit Type	Medical Plan Benefit
Montana Health Center	$0 Copay
Designated One Health Clinics	$0 Copay
Primary Care Office Visit*	$25 Copay
Specialist Office Visit*	$50 Copay
Urgent Care Office Visit*	$50 Copay
Deductible*	$2,000 per member per Plan Year
Coinsurance* (What the plan pays after you meet your deductible.)	75% after deductible met 100% after maximum out-of-pocket met
Maximum Out-of-Pocket	$6,500 per member, $13,000 per family

*Counts towards maximum out-of-pocket

Find In-Network Care

Using BCBSMT's Provider Finder allows you to check and compare costs before your appointment, find and compare doctors or facilities, understand benefits coverage, estimate cost, and learn more about providers.

Find an in-network provider, clinic, hospital, and/or facility by taking the following steps:

1. Go to bcbsmt.com
2. Click "Find Care" in the top bar and select "Find a Doctor or Hospital"
3. Click "Search as a Guest"
4. Enter the city or zip code for the location you would like to find your provider and/or facility
5. Choose "Blue Preferred PPO" as the plan/network type

For complete details about the State Plan, refer to the Wrap Plan Document (WPD) at doa.mt.gov/HCBD/Resources/Publications.

Out-of-Network Provider or Facility

If you use an out-of-network provider or facility, the cost sharing is shown below. It applies to all services unless stated otherwise in the Wrap Plan Document (WPD).

It is important to note that you may be balance billed by an out-of-network provider or facility. You are responsible for the balance bill and it does not count towards your deductible or maximum out-of-pocket.

Cost Sharing for Out-of-Network Provider or Facility

Benefit Type	Medical Plan Benefit
Deductible*	$3,000 per member per Plan Year (This is separate from the $2,000 deductible shown on page 13.)
Coinsurance* (What the plan pays after you meet your deductible. Balance billing does not count towards maximum out-of-pocket.)	65% plus balance billing
Maximum out-of-pocket	$7,450 per member plus balance billing $15,900 per family plus balance billing (These are separate from annual maximum out-of-pocket shown on page 13.)

*Counts towards maximum out-of-pocket

Out-of-Network Provider Benefit Exception

When a covered service is rendered by an out-of-network provider, charges will be paid as if the service was rendered by an in-network provider under any of the following circumstances:

- Charges for an emergency, as defined by the State Plan, limited to only emergency medical procedures necessary to treat and stabilize an eligible injury or illness and then only to the extent that the same are necessary for the plan member to be transported, at the earliest medically appropriate time to an in-network hospital, clinic, or other facility, or discharged.
- Charges incurred as a result of and related to confinement in or use of an in-network hospital, clinic, or other facility only for out-of-network provider services and providers whom or which the member does not have any choice in or ability to select.
- Charges for emergency use of an air ambulance.

Prescription Drug Plan

Navitus Health Solutions (Navitus) is the pharmacy benefit manager and processes pharmacy claims for the State Plan. Prescription Drug coverage is included in your medical benefits. Questions regarding the Prescription Drug Plan should be directed to Navitus. Non-Medicare Retirees contact Navitus at (866) 333-2757, TTY 711, or navitus.com. Medicare Retirees contact Navitus Medicare Rx at (866) 270-3877, TTY 711, or medicarerx.navitus.com.

Prescription Drug Plan Benefits

Benefit Structure	**Retail In-Network Pharmacy** (34-day supply)	**Retail Out-of-Network Pharmacy** (10-day supply)	**In-Network Retail or Mail Order Pharmacy** (90-day supply)	**Applies to Prescription Maximum Out-Of-Pocket**
$0 Preventive products*	$0 copay	$0 copay	$0 copay	Yes
Tier 1 - Preferred generics and some lower cost brand products	$25 copay	$25 copay	$50 copay	Yes
Tier 2 - Preferred brand products and some high-cost non-preferred generics	$80 copay	$80 copay	$160 copay	Yes
Tier 3 - Non-preferred products (may include some high-cost non-preferred generics)	50% coinsurance	50% coinsurance	50% coinsurance	No
Tier 4 - Specialty drugs filled at a Preferred Specialty Pharmacy	$400 Copay for Brand Specialty Medications $0 copay for generic specialty medications	N/A	Limited to a 30-day supply	Yes
Tier 4 - Specialty drugs filled at Preferred Specialty Pharmacy **(Medicare retirees only)**	$50 copay for brand specialty medications $0 copay for generic specialty medications	N/A	N/A	Yes
Tier 4 - Specialty drugs filled at non-preferred pharmacy	50% coinsurance	N/A	Limited to a 30-day supply	No

*$0 Preventive products apply to certain medications (as defined by the Affordable Care Act [ACA]) and other select medications. See the formulary for a list of $0 covered products.

For complete details about the State Plan, refer to the Wrap Plan Document (WPD) at doa.mt.gov/HCBD/Resources/Publications.

Prescription Maximum Out-of-Pocket

Prescription maximum out of pocket is $2,500 per individual and $5,000 per family. This is separate from medical maximum out-of-pocket (see medical plan cost sharing on pages 13 and 14). Maximum out-of-pocket are be based upon a Plan Year, which is January 1 through December 31.

Find In-Network Pharmacies and Prescription Drug Formulary

For a full list of in-network pharmacies, formulary list (which prescriptions are covered and which tier a covered prescription falls under), and a cost comparison tool, go the applicable Navitus website.

Save with a 90-Day Supply of Your Medication

You can get a three-month (90-day) supply of some maintenance medication for a two-month copay. The State Plan pays less for many medications when a 90-day supply is filled at an in-network retailer or preferred mail order pharmacy. We pass those savings on to you by reducing your copay.90-day supply options include most in-network retail pharmacies (refer to Navitus network directory), Ridgeway Pharmacy (call (800) 630-3214 or visit ridgewayrx.com) or Costco Pharmacy (call (800) 607-6861 or visit pharmacy.costco.com (membership not required)).

Specialty Pharmacy

Lumicera Health Services is the State Plan's preferred pharmacy to handle specialty medications (drugs that require special administration). Using a pharmacy other than Lumicera for specialty medications could cost significantly more and does not accumulate toward your prescription annual maximum out-of-pocket. Contact Lumicera Health Services at (855) 847-3553, TTY 711, or lumicera.com.

My Health Navigator

My Health Navigator is a State Plan sponsored program available to plan members at no additional cost (Medicare retirees are not eligible). My Health Navigator helps plan members identify the safest, most effective and least costly medications, control health issues, and navigate a complicated healthcare system.

My Health Navigator Can Help You:

- Minimize Prescription Costs and Simplify Medication Management
- Get Answers About Your Health and Control Healthcare Expenses
- Manage Long-Term and Chronic Conditions
- $0 copay diabetic test strips and savings on some Continuous Glucose Monitoring (CGM) sensors as part of the My Health Navigator Diabetes Program.
- Reduced copay on some asthma medications and $0 copay peak flow meter and holding chamber as part of the My Health Navigator Asthma Program.

More information at MyHealthNavigator.net, or by phone at (406) 780-8018, or TTY 711.

Dental Plan

Delta Dental is the State Plan's third-party administrator for dental benefits and processes dental claims for the State Plan. Dental coverage is an optional benefit. Questions regarding the Dental Plan should be directed to Delta Dental, (866) 496-2370, TTY 711, or DeltaDentalins.com/StateofMontana.

Dental Networks

To find an in-network dentist, go to DeltaDentalins.com/StateofMontana and create an account.

You can visit any licensed dentist and receive coverage under the State Plan, but you will usually get the most value from your State Plan benefit when you choose a PPO or Premier Dentist. PPO and Premier Dentists agree to accept the Delta Dental Allowance. You will only be responsible for your deductible and coinsurance amounts up to the maximum payable amount when using a PPO or Premier Dentist. A non-network dentist can bill you your deductible and coinsurance amounts, plus any amount over the Delta Dental allowance.

You are responsible for any amount over the $1,800 maximum payable amount regardless of provider network status.

Preferred Provider (PPO Dentist)

Have agreed to the lowest contracted fees. Your annual maximum dollars go further and you won't be balanced billed.

Premier Dentist

Have agreed to reduced contracted fees (not as low as PPO). Still provides dental insurance benefit, although you may end up paying more out-of-pocket. You won't be balance billed.

Non-Network Dentist

There's no contracted fee agreement, so your dentist can charge any amount. You still receive State Plan benefits, but using a non-network dentist can result in you reaching your annual maximum sooner and potentially being balanced billed, as well as having to pay up front for services.

Waiting Periods

There are no waiting periods for basic, major, or prosthodontics services. For details including what is covered under Basic and Major Benefits see the dental section of the Wrap Plan Document (WPD) or call Delta Dental.

Dental Plan Cost Sharing

Dental Plan Benefits

Services	Benefit Coverage
Diagnostic & Preventive Benefits Exams, Cleanings, X-Rays, Sealants	100%
Basic Benefits Fillings, Posterior Composites	80%
Endodontics (Root Canals) Covered Under Basic Services	80%
Periodontics (Gum Treatment) Covered Under Basic Services	80%
Oral Surgery Covered Under Basic Services	80%
Major Benefits Crowns, Inlays, Onlays, Cast Restorations	50%
Prosthodontics Bridges, Dentures, Implants	50%
Pregnancy*	100%

*One additional oral exam and one additional routine cleaning during pregnancy. Written confirmation of the pregnancy must be provided by the enrollee or their dentist when the claim is submitted.

Deductible

Deductibles are based upon a Plan Year, which is January 1 through December 31. Diagnostic & Preventive Benefits are not subject to the deductible.

- $50 per member
- $150 per family

Maximum Amount Plan Pays

- $1,800 per Plan Year, which is January 1 through December 31
- $1,500 lifetime for implant benefits

Vision Plans

VSP Vision Care is the State Plan's Vision Plan third-party administrator. The State Plan has two vision plans, a Basic Vision Plan and a Vision Hardware Plan. Questions regarding the Vision Plans should be directed to VSP Vision Care at (800) 877-7195, TTY (800) 428-4833, or Montana.VSPforMe.com.

Find an In-Network Provider

To find an in-network doctor near you, go to vsp.com and select “Find a Doctor”. You may search by location, office name, or provider name.

If an in-network provider is not available in your geographic area, or you are not able to schedule an appointment with an in-network provider within 30 days of calling, contact VSP Vision Care for assistance with accessing in-network benefits. Approval must be received from VSP Vision Care to access an out-of-network provider at in-network benefits before receiving services.

Make sure both your eye doctor and the store where you purchase your hardware are in-network.

Eligibility

Basic Vision Plan: Included with State Plan medical benefits at no additional cost for employees, legislators, retirees, COBRA participants, and eligible dependents (spouse, domestic partner, and/or children) enrolled in State Plan medical coverage.

Vision Hardware Plan: Employees, legislators, retirees, COBRA participants, and eligible dependents (spouse, domestic partner, and/or children) enrolled in medical benefits are eligible to elect the optional Vision Hardware Plan. If you elect Vision Hardware coverage, it will apply to everyone covered under your medical plan. You must enroll each Plan Year during the annual Open Enrollment Period to continue coverage.

For detailed information on who’s eligible for the State Plan, refer to the Wrap Plan Document (WPD).

Basic Vision Plan

All plan members covered on the medical plan are entitled to one routine vision and eye health evaluation each Plan Year for a $10 copay at an In-Network VSP Vision Care provider at no additional cost. If you use a VSP provider, discounts are available for certain services and hardware. Details at doa.mt.gov/HCBD/vision.

Basic Vision Plan Benefits

Coverage	In-Network	Out-Of-Network
Exam Copay	$10	$10
Exam Allowance (once per Frequency Period*)	100% after Copay	Up to $45
Discounts	Yes	No

*Frequency Period based on the Plan Year, which is January 1 through December 31.

For complete details about the State Plan, refer to the Wrap Plan Document (WPD) at doa.mt.gov/HCBD/Resources/Publications.

Vision Hardware Plan

Vision hardware coverage is available for an additional cost and must be elected each Plan Year during Open Enrollment. Coverage includes one routine vision and eye health evaluation and vision hardware benefits. If elected, Vision Hardware coverage applies to all individuals covered under your medical plan.

Vision Hardware Plan Benefits

Coverage	In-Network	Out-Of-Network
Exam Copay	$10	$10
Exam Allowance (once per Frequency Period)	100% after copay	Up to $45
Materials Copay*	$20	$20
Basic Prescription Lenses Allowance Single Vision (one pair per Frequency Period)	100% after copay	Up to $45
Basic Prescription Lenses Allowance Lined Bifocal (one pair per Frequency Period)	100% after copay	Up to $55
Basic Prescription Lenses Allowance Lined Trifocal (one pair per Frequency Period)	100% after copay	Up to $65
Basic Prescription Lenses Allowance Lined Lenticular (one pair per Frequency Period)	100% after copay	Up to $80
Contact Lenses Allowance (prescription contact lenses in lieu of glasses)	$150 allowance, then 20% off balance	Up to $95
Frame Retail Allowance at VSP Vision Care Doctor (every other calendar year)	$150 allowance, then 20% off balance	Up to $52
Frame Retail Allowance at Costco, Walmart, or Sam's Club Optical (every other calendar year)	$80 allowance	Up to $52

*Materials are eyeglass lenses, frames, and/or contact lenses

Frequency period and maximums based on the Plan Year, which is January 1 through December 31.

Montana Health Centers

Premise Health operates the Montana Health Centers. The Montana Health Centers offer the same kinds of services you would find at your regular doctor's office and more, all at no-cost to you and a much lower cost to the self-funded State Plan. The Montana Health Centers are located in Anaconda, Billings, Butte, Helena, and Missoula. For more information on the Montana Health Centers, contact Premise Health at (855) 200-6822, TTY 711, doa.mt.gov/HCBD/Health-Center. Appointments can be made at MyPremiseHealth.com or via phone at (855) 200-6822.

Who Can Use the Montana Health Centers

Employees, legislators, COBRA participants, and their covered spouse or domestic partner and/or dependent children age two or older, as well as non-Medicare eligible retirees and their covered non-Medicare eligible spouse or domestic partners and their non-Medicare eligible dependent children age two and older. Medicare eligible retirees and their Medicare eligible dependents may only use the Montana Health Centers for flu shots and State-Sponsored Health Screenings.

Services

The Montana Health Centers offer acute care, chronic disease management, and wellness, as part of a robust integrated primary and behavioral healthcare offering.

Primary care services include treatment for colds, flus, COVID-19, infections, minor stitches, strains, sprains, wound care, asthma, cardiovascular disease, chronic kidney disease, chronic stress, pre-diabetes, diabetes, gastroesophageal reflux disease, high blood pressure, specialized diets, tobacco cessation and much more.

Primary Care & Wellness Coaching

The Montana Health Center provides integrated primary, behavioral health, preventive care, and wellness coaching, including:

- Same day service for acute conditions
- Virtual behavioral health
- Comprehensive wellness physicals and health screenings
- Behavioral care such as stress management and tobacco cessation
- Sports physicals, personal training, weight management
- Personalized coaching, individual goal setting
- Nutrition guidance, diabetes, blood pressure, or cholesterol management
- And more

A team of healthcare professionals including physicians, physician assistants, nurse practitioners, nurses, dietitians, and fitness experts are here to help.

24/7 Virtual Telehealth

The State Plan provides a no-cost telehealth benefit to all eligible plan members called Virtual Primary Care. This service is provided through the State Plan's contract with Premise Health.

Common conditions that can be treated during the VPC appointment include cough, fever, sore throat, stomachache, headache, earache, cold, flu, COVID, allergies, nausea, vomiting, diarrhea, or general skin concerns.

Get access from anywhere in the U.S. to board certified physicians 24 hours a day, 7 days a week, and 365 days per year.

More information at doa.mt.gov/HCBD/Health-Center. Appointments can be made at MyPremiseHealth.com or via phone at (833) 930-4530.

One Health Clinics

Plan members have access to comprehensive primary care at eligible One Health Clinic locations in Montana.

- Services at eligible One Health Clinics have no additional out-of-pocket costs.
- Access to many of the services available at One Health Clinics hinges on you having a primary care relationship with a One Health provider. Establish care with a One Health provider to be eligible for no co-pay and no out-of-pocket on prescriptions and labs.
- Only services provided at the One Health Clinics have no out-of-pocket cost. Services provided by another facility or provider will apply to regular State Plan benefits, even if a One Health Clinic provider refers you.

Plan members have access to comprehensive healthcare at One Health clinics in Ashland, Chinook, Glendive, Hardin, Harlem, Lewistown, & Miles City.

More information at doa.mt.gov/HCBD/Medical/One-Health.

Live Life Well Programs

The Live Life Well Program's mission is to promote healthy lifestyle choices and improve the health, well-being and quality of life for State Plan employees, legislators, COBRA participants, retirees and their dependents.

Wellness Program Benefits

Plan members may choose to participate in as many wellness programs as they like. Most programs have no additional out-of-pocket cost. Examples of program offerings:

- Weight Management
- Disease Prevention Programs
- Prenatal and Maternity Benefits and Programs
- Wellness Coaching
- Preventive Benefits (health screenings, health risk assessment, vaccinations, etc.)
- Nicotine Cessation Programs
- Chronic Disease Support (arthritis, diabetes, asthma, etc.)
- Care Management Programs
- Monthly Wellness Classes and Workshops

More information at doa.mt.gov/HCBD/Live-Life-Well.

Healthy Weight Incentive

Earn a $200 incentive by successfully completing and reporting program requirements.
Incentive Requirements:

1. Participation in one eligible program for a duration of four months or more. Eligible programs include:
    a. Weight Watchers
    b. Healthy For Life Self-Study Program
    c. Diabetes Prevention Program
2. Losing 10% of starting weight or achieving a normal body max index (BMI).
3. Participating in regular physical activity (flexible based on personal needs).

The Healthy Weight Incentive is available to retirees of the State Plan and their covered spouse or domestic partner. One incentive can be earned per retiree and/or spouse or domestic partner per Plan Year.

More information at doa.mt.gov/HCBD/Live-Life-Well.

Live Life Well Incentive

One of the Live Life Well Program's offerings is an opportunity to earn $60 off the monthly benefit contribution by completing four activities which show a retiree is engaged with maintaining a healthy lifestyle. The Incentive is available to covered retirees and their enrolled spouse or domestic partner.

Live Life Well Incentive

To earn $60 per month off your 2026 monthly benefit contribution, you must complete the following activities by October 31, 2026.

1. Complete a Health Assessment via the MediKeeper Wellness Platform.
2. Complete a State-sponsored Health Screening through a Montana Health Center or Montana Health Center off-site event.
3. Self-report Nicotine Free status or completion of an eligible alternative.
4. Complete and self-report an Eligible Provider Visit, which is an annual checkup with a medical provider. Any kind of medical provider is acceptable, from a nurse practitioner to a specialist, depending on who is most appropriate for your health needs.

More information and instructions for how to self-report incentive activities are available at doa.mt.gov/HCBD/Live-Life-Well.

Employee Assistance Program

The Employee Assistance Program (EAP) helps you privately solve problems that may interfere with your work, family, and life in general. EAP services are free to you and your dependents. EAP services are confidential and provided by experts. **GuidanceResources provides EAP services 24/7 to all employees, retirees, their dependents, and household members.** GuidanceResources can be reached at (844) 506-5374, TTY 711, or GuidanceResources.com, Web ID: MontanaEAP.

Confidential Emotional Support

Highly trained clinicians will listen to your concerns and help you or your family members with any issues, including anxiety, depression, stress, grief, loss and life adjustments, as well as relationship or marital conflicts.

Work-Life Solutions

Specialists provide qualified referrals and resources for just about anything on your to-do list, such as finding child or elder care, hiring movers or home repair contractors, or planning events, locating pet care, and more.

Financial Resources

Financial experts can assist with a wide range of issues, such as retirement planning, taxes, relocation, mortgages, insurance, budgeting, debt, bankruptcy and more.

Legal Guidance

Talk to attorneys for practical assistance with your most pressing legal issues, including divorce, adoption, family law, wills, trusts and more. Get a free 30-minute consultation and a 25% reduction in fees.

Online Support

GuidanceResources online is your 24/7 link to vital information, tools and support. Create an account at GuidanceResources.com for articles, podcasts, videos, slideshows, on-demand trainings, and Ask the Expert for personal responses to your questions.

Basic Life Insurance

State Plan Life Insurance Plans are fully insured and administered by BlueCross BlueShield of Montana (BCBSMT). Questions regarding life insurance should be directed to BlueCross BlueShield of Montana at (866) 739-4090, TTY 711, or service.ancillary.bcbs.com.

Plans are term life, provide inexpensive protection, do not earn cash value, and premiums are paid after tax. Employees and legislators are eligible until separation from service. At separation, contact BCBSMT for portability or conversion options.

At retirement, Basic Life Insurance may be continued without portability or conversion until Medicare eligible if enrolling in the State Plan as a retiree. Basic Life Insurance may be converted once a retiree becomes Medicare eligible.

Basic Life Insurance

Basic Life Insurance is part of the medical benefit for all active employees, legislators, and non-Medicare retirees. It provides $14,000 of term life coverage.

Beneficiary Designation

Non-Medicare retiree enrollment in Basic Life Insurance coverage requires you to designate a beneficiary. It is important you have designated beneficiaries in the event of your death. You can add, delete, or change your beneficiary information at any time. Details at doa.mt.gov/HCBD/Life-Accident.

Tobacco Surcharge

The State Plan charges a Tobacco Surcharge for retirees who use nicotine. The surcharge adds $60 per month to the contribution amount for retirees who use nicotine and/or $60 per month if the retiree's covered spouse or domestic partner uses nicotine.

Note: The Tobacco Surcharge is separate from the Live Life Well (LLW) Incentive nicotine attestation. Indicating you are not a nicotine user to earn the LLW Incentive does not remove the Tobacco Surcharge, you must complete Open Enrollment to attest your nicotine use for the Tobacco Surcharge.

Definitions

Nicotine

- Nicotine is an addictive stimulant proven to have negative health effects. Nicotine is found in a variety of products such as cigarettes, cigars, chewing tobacco, vaping or electronic products, oral products and more.

Nicotine Free

- You may self-report you are Nicotine Free if you have never used nicotine, have quit using nicotine, use only FDA-approved Nicotine Replacement Therapy (NRT), or infrequently use nicotine (less than 4x per month).
- You may self-report you are Nicotine Free if you are currently using nicotine but HAVE completed an eligible alternative (nicotine cessation program or a nicotine counseling session with a medical provider) during the past 12 months.

Nicotine User

- You are a nicotine user and may not self-report you are Nicotine Free if you are currently using nicotine and have not completed an eligible alternative (nicotine cessation program or a nicotine counseling session with a medical provider) during the past 12 months.

To avoid the $60 per month Tobacco Surcharge you need to annually self-attest your, and if applicable, your covered spouse or domestic partner's, nicotine use. More information at doa.mt.gov/HCBD.

Notice of Privacy Practices

The State of Montana Notice of Privacy Practices is available at doa.mt.gov/HCBD. If you have any questions about your privacy rights, please contact the State Plan at the following address:

- Contact Office or Person: Privacy Official
- Plan Name: State of Montana Benefit Plan
- Telephone:(800) 287-8266 or TTY (406) 444-1421
- Email: BenefitsQuestions@mt.gov
- Address: Health Care & Benefits Division, PO Box 200130, Helena, MT 59620-0130

A copy of the Notice of Privacy Practices is available at 125 N. Roberts St., Helena, MT 59601. You may request a copy by calling HCBD or sending a request by email to the above address.

Disclaimer

The Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010. The United States Departments of Health and Human Services, Labor, and Treasury have issued regulations to help entities comply with PPACA. However, additional clarifications to address issues that may arise under these regulations could also be published by the Departments on an on-going manner through administrative guidance possibly in another form than a regulation. Where the statutes or regulations were not clear regarding benefits, the State of Montana made a reasonable interpretation of the act and made a good faith effort to comply with the statutes and regulations. The State of Montana reserves the right to alter provisions of this document and its plan to comply with applicable law.

State of Montana Non-Discrimination Statement

State of Montana complies with applicable federal and state non-discrimination laws and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or related medical conditions, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, national origin, ancestry, age, disability, military service, veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively, including qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English, including qualified interpreters and information written in other languages. If you need these services, contact HCBD at (800) 287-8266. If you believe that State of Montana has failed to provide these services or has discriminated against you in another way, you can file a grievance. If you need help filing a grievance, the State Diversity Coordinator is available to help you. You can file a grievance in person or by mail, fax, or email to: State Diversity Program Coordinator, Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3871 Email: SABHRSHR@mt.gov.

Benefit Term Decoder

The following explanations are to help you understand the terms in this book and do not replace the definitions found in the Wrap Plan Document (WPD). The definitions in the WPD govern the rights and obligations of the State Plan and plan members.

- **Balance Billing** - The amount over the State Plan's allowable charge that may be billed to the plan member by an out-of-network provider.

- **Benefit Payment/Contribution** - What you pay each month for your State Plan coverage.

- **Coinsurance** - The percent the State Plan pays after you meet your deductible.

- **Copay** - A copay is a fixed dollar amount you pay for a covered service.

- **Deductible** - A deductible is how much you must pay each Plan Year before the State Plan starts to pay.

- **Grandfathered Month** - If you were hired before August 1, 1998, and have had no lapse in State Plan coverage, you are entitled to one extra month of employer contribution and benefits coverage upon retiring or leaving State employment.

- **Initial Enrollment Period** - A period of time when an employee, legislator, or retiree initially becomes eligible to enroll in State Plan benefits.

- **In-Network Provider and/or Facility** - In-network providers and/or facilities have contracted with our third-party administrators.

- **Maximum Out-of-Pocket** - The maximum out-of-pocket is the most you will have to pay for covered services in a Plan Year.

- **Mid-Year Benefit Change** - Also known as a Special Enrollment Period. A period of time allowed by the State Plan, other than the eligible employee, legislator, or retiree's initial enrollment period or the annual Open Enrollment Period, during which an eligible employee, legislator, or retiree may request or terminate coverage under the State Plan as a result of certain events that create special enrollment rights. To change your State Plan benefits due to a Special Enrollment Event (i.e. marriage, birth, divorce, gain or loss of coverage, etc.) you must do so within 60 days of the date of the event (91 days if the event is birth or adoption).

For complete details about the State Plan, refer to the Wrap Plan Document (WPD) at doa.mt.gov/HCBD/Resources/Publications.

- **Out-of-Network Providers and/or Facilities** - Out-of-network providers and facilities have chosen not to sign a contract with our third-party administrators. If you use an out-of-network facility or provider, the State Plan will pay a fair rate for your care, but the out-of-network provider or facility may balance bill you for more. You are responsible for any balance bills you receive.

- **Open Enrollment Period** - A period each fall in which you can make changes to your State Plan benefits for the following Plan Year. These changes take effect January 1 of the following year.

- **Plan Member** - Anyone covered on the State Plan including employees, legislators, retirees, COBRA participants, spouses or domestic partners, and children.

- **Plan Year** - The Plan Year starts January 1 and ends December 31 each year.

- **Recommended Clinical Review** - Establishes in advance the medical necessity or experimental or investigational nature of certain care and services covered under the State Plan.

- **Specialty Drugs** - Specialty drugs usually require special handling, administration, unique inventory management, a high level of patient monitoring and more intense support than conventional therapies. They could include all routes of administration (self-injectable, oral, or infused). They are typically very expensive.

- **State Plan** - The self-funded State of Montana Benefit Plan.

- **Tobacco Surcharge** - $60 per month charge for being a Nicotine User.

Language Assistance

State of Montana is required by federal law to provide the following information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-866-270-3877 (TTY:711)。

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS : 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-270-3877 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-866-270-3877 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-270-3877 (TTY: 711).

Vendor Contact Information

Vendor / Service	Contact Information
BlueCross BlueShield of Montana Medical Claims, Benefits, In-Network Providers	Phone: (888) 901-4989 or TTY 711 Website: bcbsmt.com
BlueCross BlueShield of Montana Basic Life Insurance, Portability and Conversion	Phone: (866) 739-4090 or TTY 711 General Inquiries: service.ancillary.bcbs.com For claims related questions, contact HCBD.
Delta Dental Dental Benefits, Claims, In-Network Providers	Phone: (866) 496-2370 or TTY 711 Website: DeltaDentalins.com/StateOfMontana
GuidanceResources Employee Assistance Program (EAP), Available to legislators, their dependents, and household members.	Phone: (844) 506-5374 or TTY 711 Website: GuidanceResources.com Web ID: MontanaEAP
Lumicera Health Services Specialty Prescription Drugs	Phone: (855) 847-3553 or TTY 711 Website: Lumicera.com
Montana Health Centers	Phone**:** (855) 200-6822 or TTY 711 General Information: doa.mt.gov/HCBD/Health-Center Appointments: MyPremiseHealth.com or (855) 200-6822
My Health Navigator	Phone: (406) 780-8018 or TTY 711 Website: MyHealthNavigator.net
Navitus Prescriptions, In-Network Pharmacies, Formulary	**Non-Medicare Prescriptions and Customer Service** Phone: (866) 333-2757 or TTY 711 Website:Navitus.com **Medicare Prescriptions and Customer Service** Phone: (866) 270-3877 or TTY 711 Website: MedicareRX.Navitus.com
One Health Clinics	Website: doa.mt.gov/HCBD/One-Health
Public Consulting Group (PCG) Assistance with SSDI & Early Medicare Coverage	Phone: (800) 805-8329 or TTY 711 Email: disability@pcgus.com
VSP Vision Care Vision Service Providers & Hardware Coverage	Phone: (800) 877-7195 or TTY (800) 428-4833 Website: Montana.VSPforMe.com