Your Benefit Summary

Effective July 1, 2020 - June 30, 2021

BEAR·RIVER
MENTAL HEALTH
SERVICES, INC.

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IMPORTANT:
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

WELCOME TO YOUR BENEFITS!

Bear River Mental Health is proud to offer a robust benefits package to our employees and their families! Our benefits package is designed around choice, flexibility and value.

To learn about the available plans and choose which ones are right for your lifestyle and budget, take a look at this Benefits Guide. Highlights of all the plans and some additional decision-making tools are available online too. If you have general questions on your benefits or how to enroll, reach out to Human Resources or a Gallagher Benefit Advocate—their contact info is toward the back of this Guide under "Contact Information."

In addition, a Summary of Benefits and Coverage (SBC) is available at www.navigatemybenefits.com to help you make your healthcare coverage choices. The SBC summarizes information about your medical plan options and is in a standard format required by the Affordable Care Act. A paper copy is also available, free of charge. Please contact Human Resources to request a copy.

BENEFITS OVERVIEW

Bear River Mental Health is proud to offer a comprehensive benefits package to eligible employees. The complete benefit package is briefly summarized in this booklet. You can request plan booklets, which give you more detailed information about each of these programs.

You share the cost of some benefits (Medical and Dental) and Bear River Mental Health provides other benefits at no cost to you (Life, Accidental Death and Dismemberment, and Long Term Disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through Bear River Mental Health payroll deductions.

Benefit Plans Offered

» Medical

» Dental

» Vision

» Health Savings Account

» Health Reimbursement Account

» Flexible Spending Account

» Life and Accidental Death & Dismemberment

» Voluntary Life and Accidental Death & Dismemberment

» Long-Term Disability

» Accident, Critical Illness, and Hospital Insurance

ELIGIBILITY

You are eligible to enroll for benefits if you are a regular employee in an eligible position working 20+ hours per week.
In order to enroll in medical benefits you must work 30+ hours per week. Benefits commence on the first day of the next calendar month following your date of hire unless your hire date is the 1st working day of the month then coverage begins that month.

Eligible dependents are your spouse, children under age 26, or disabled dependents of any age. Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. **If you experience a qualifying event, you must make any changes in Navigate My Benefits or contact HR within 30 days.**

A qualifying event occurs if you experience a:

» Marriage
» Birth
» Loss of Coverage
» Spouse Open Enrollment
» Divorce
» Adoption
» Death

This booklet gives you an overview of the main features of your benefit plans. The plans are administered according to legal plan documents and insurance contracts. Although we've tried to summarize the provisions of these legal documents clearly and accurately, if any information presented here conflicts with the legal documents, the legal documents will govern.
For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents. All benefit plans are subject to change from time to time and Bear River Mental Health reserves the right to amend or cancel any benefits described in this booklet, with or without notice. This document does not guarantee any benefits.

ONLINE ENROLLMENT SYSTEM

Employee Navigator

www.employeenavigator.com

Employee Navigator will be used for all employees to make benefit elections offered at Open Enrollment and for newly hired employees. It will also be used to make changes due to qualifying events and to change personal information such as address and name changes due to marriage or divorce.

If you are a **NEW HIRE**:

Step 1. Go to www.employeenavigator.com and click on 'Register as a new user'

Step 2. Fill in the required fields. The company identifier is **BearRiverMentalHealth**. Then click 'Next'

Step 3. Create a User Name and Password. Then check the 'I Agree with the Employee Navigator terms of use' before you 'Finish'

Step 4. You may now login to the site. Click the 'Start' button to begin benefit elections

If you are **IN OPEN ENROLLMENT**:

Step 1. Login to Employee Navigator at www.employeenavigator.com and Click on 'Start Benefits'

Step 2. Confirm all Personal Information is correct and click 'Save' to begin benefits elections

Step 3. Select all dependents you want to cover on each benefit and choose the plan you want to enroll in. Complete Step 4 for all benefits offered to you by your employer.

Step 4. Complete your Open Enrollment by reviewing all benefits (enrolled or declined) and click 'Agree' to finish.

If you are MAKING A CHANGE DUE TO A QUALIFYING EVENT:

Step 1. Login to Employee Navigator at www.employeenavigator.com

Step 2. Click on 'Benefits' then 'Add or Adjust Coverage' or 'Drop Coverage'

Step 3. Select reason for coverage change (i.e. Employee Loss of Coverage, Marriage, Newborn, etc.)

Step 4. Enter the date of change and any other required information to make the change

Step 5. Complete enrollment and 'Agree'

If you are UPDATING PERSONAL INFORMATION:

Step 1. Login to Employee Navigator at www.employeenavigator.com

Step 2. Click on 'Profile' then 'Profile Updates'

Step 3. Select 'Personal Information' or other file you wish to update (i.e. Address, Phone Number, etc.)

Step 4. Select 'Edit' and make necessary change and 'Save'

RATE AND CONTRIBUTIONS

Bear River Mental Health is covering most of your benefit costs. Your basic life insurance coverage, long term disability benefits, and Employee Assistance Plan (EAP) are fully paid by Bear River Mental Health. In addition, Bear River Mental Health covers the greater portion of your and your dependent's medical and dental premiums. This table shows how much of the premiums are paid by Bear River Mental Health and what part is your responsibility. In addition, there are voluntary benefits with reasonable group rates that you can purchase through Bear River Mental Health payroll deductions.

		Employee Only	Employee + One	Family
Medical				
Full-Time Employees	Total Monthly Cost	$912.10	$1,888.02	$2,553.86
	BRMH Pays	$867.10	$1,748.02	$2,318.86
	Your Monthly Cost	**$45**	**$140**	**$235**
Part-Time Employees (75% - 99% FTE)	Total Monthly Cost	$912.10	$1,888.02	$2,553.86
	BRMH Pays	$782.10	$1,513.02	$2,033.86
	Your Monthly Cost	**$130**	**$375**	**$520**
Part-Time Employees (50% - 74%)	Total Monthly Cost	Benefited part-time employees must work 75% or more to qualify for medical insurance.		
	BRMH Pays			
	Your Monthly Cost			
Dental				
Full-Time Employees	Total Monthly Cost	$38.12	$68.82	$97.16
	BRMH Pays	$33.12	$58.82	$82.16
	Your Monthly Cost	**$5**	**$10**	**$15**
Part-Time Employees (75% - 99% FTE)	Total Monthly Cost	$38.12	$68.82	$97.16
	BRMH Pays	$28.12	$48.82	$67.16
	Your Monthly Cost	**$10**	**$20**	**$30**
Part-Time Employees (50% - 74%)	Total Monthly Cost	$38.12	$68.82	$97.16
	BRMH Pays	$18.12	$33.82	$47.16
	Your Monthly Cost	**$20**	**$35**	**$50**
Vision				
All Employees – 10-120B Plan	Total Monthly Cost	$7.79	$15.23	$24.79
	BRMH Pays	$0	$0	$0
	Your Monthly Cost	**$7.79**	**$15.23**	**$24.79**
All Employees – 120B Plan	Total Monthly Cost	$5.77	$11.28	$16.85
	BRMH Pays	$0	$0	$0
	Your Monthly Cost	**$5.77**	**$11.28**	**$16.85**
Health Savings Account				
Employer Monthly Contributions	100% FTE	$200	$360	$390
	75% - 99% FTE	$160	$290	$310

MEDICAL BENEFITS

Administered by PEHP

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Bear River Mental Health offers you a High Deductible Health Plan through PEHP. This plan is supported by two very large networks of medical care providers: Advantage Network (Intermountain Healthcare) and Summit Network (non-Intermountain Healthcare). The plan provides excellent coverage of preventive services, such as routine physical exams and immunizations, that are very important to you and your family's health.

Coverage Period: 7/1/2020-6/30/2021	HDHP	
	In-Network	Out-of-Network
Annual Deductible (Single/Family)	$1,500/$3,000	
Annual Out-of-Pocket Maximum (Single/Family)	$3,000/$6,000	
Coinsurance	20%	40%
Preventive Care	No charge	40% after deductible
Outpatient Services		
Office Visit	20% after deductible	40% after deductible
Specialist Visit	20% after deductible	40% after deductible
PEHP ConnectCare	$49 before deductible	NA
PEHP Value Clinics	20% after deductible	NA
Mental Health	20% after deductible	Not covered
Substance Abuse	20% after deductible	Not covered
Diagnostic Lab & X-Ray	20% after deductible	40% after deductible
Surgery	20% after deductible	40% after deductible
Rehabilitation	20% after deductible	40% after deductible
Other Services		
Urgent Care	20% after deductible	40% after deductible
Emergency Room	20% after deductible	
Inpatient Hospitalization	20% after deductible	40% after deductible
Prescription Drugs		
Generic – Tier 1	$15 copay after deductible	$15 copay after deductible
Preferred Brand – Tier 2	$30 copay after deductible	$30 copay after deductible
Non-Preferred Brand – Tier 3	$65 copay after deductible	$65 copay after deductible

PEHP Health & Benefits

COPAY AND COINSURANCE

A copay is a flat dollar amount you pay for a medical service. Coinsurance is when you pay a percentage of the cost.

PLAN YEAR DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses not subject to a copay. The family deductible applies if you have family members enrolled in your plan along with you. However, once the total family deductible is met, no one else in the family has to pay the balance of their deductible.

OUT-OF-POCKET (OOP) MAXIMUM

The OOP maximum is the most you pay in a plan year for in-network covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the plan year for in-network covered services. On a family plan, each person has their own OOP maximum. However, once the total family OOP is met, no one else in the family has to pay the balance of their OOP maximum.

OUT-OF-NETWORK

When you use out-of-network providers, your plan will pay for services based upon their allowed amount. You will be responsible for the remaining costs. When you use out-of-network services, your plan will only pay a percentage of the allowable amount. You may be responsible for the balance.

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

PEHP NETWORK CHOICE

PEHP Advantage 34 PARTICIPATING HOSPITALS, 7,500+ PARTICIPATING PROVIDERS

Network consists of predominantly Intermountain Healthcare (IHC) providers and facilities.

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital

Cache County
Logan Regional Hospital

Carbon County
Castleview Hospital

Davis County
Davis Hospital
Intermountain Layton Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Alta View Hospital
Intermountain Medical Center
The Orthopedic Speciality Hospital (TOSH)
LOS Hospital
Primary Children's Medical Center
Riverton Hospital

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Palk City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
American Fork Hospital
Orem Community Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
Dixie Regional Medical Center

Weber County
McKay-Dee Hospital

PEHP Summit 40 PARTICIPATING HOSPITALS, 7,500+ PARTICIPATING PROVIDERS

Network consists of predominantly Steward, MountainStar, and University of Utah hospitals & clinics providers and facilities.

Beaver County
Beaver Valley Hospital
Milford Valley Memorial Hospital

Box Elder County
Bear River Valley Hospital
Brigham City Community Hospital

Cache County
Cache Valley Hospital

Carbon County
Castleview Hospital

Davis County
Lakeview Hospital
Davis Hospital

Duchesne County
Uintah Basin Medical Center

Garfield County
Garfield Memorial Hospital

Grand County
Moab Regional Hospital

Iron County
Cedar City Hospital

Juab County
Central Valley Medical Center

Kane County
Kane County Hospital

Millard County
Delta Community Hospital
Fillmore Community Hospital

Salt Lake County
Huntsman Cancer Hospital
Jordan Valley Hospital
Jordan Valley Hospital-West
Lone Peak Hospital
Primary Children's Medical Center
Riverton Children's Unit
St. Marks Hospital
Salt Lake Regional Medical Center
University of Utah Hospital
University of Orthopedic Center

San Juan County
Blue Mountain Hospital
San Juan Hospital

Sanpete County
Gunnison Valley Hospital
Sanpete Valley Hospital

Sevier County
Sevier Valley Hospital

Summit County
Palk City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
Mountain View Hospital
Timpanogos Regional Hospital
Mountain Point Medical Center

Wasatch County
Heber Valley Medical Center

Washington County
Dixie Regional Medical Center

Weber County
Ogden Regional Medical Center

PEHP.ORG

You're on the go—and so is your health plan. Log in at www.pehp.org to:

» Track your care and your spending, including your deductible

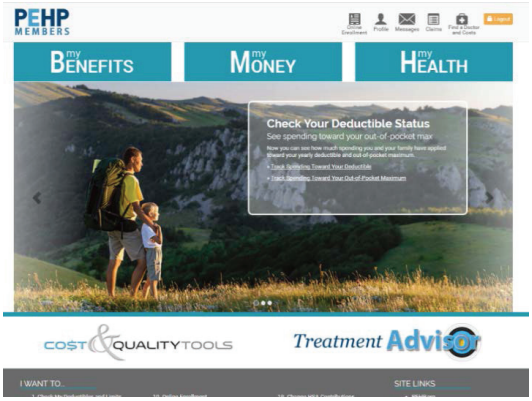
» Find in-network doctors, hospitals, and pharmacies

» Refill prescriptions and get dose reminders

» Find the forms you need

» Learn more about your benefits

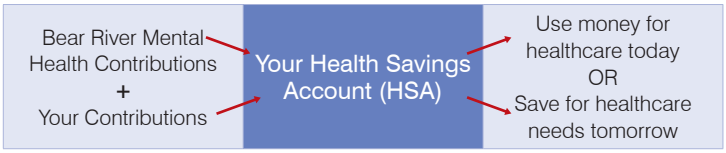
Getting started is easy. Go to pehp.org, click Log In and then select Member. Follow the prompts to create your account. You'll need your member ID number, which is on your PEHP ID card.



HEALTH SAVINGS ACCOUNT

What is an HSA?

If you enroll in Bear River Mental Health High Deductible Health Plan (HDHP), then you may be eligible to open an HSA. An HSA is a bank account where you can set aside money to pay for expenses that your health plan does not cover. The money in your HSA is not considered income, so it is not subject to taxes.



IRS CONTRIBUTION LIMITS

Yearly HSA Contribution Limits:
Individual HSA: $3,550* for 2020
Family HSA: $7,100* for 2020

*For individuals age 55 or older, an additional $1,000 in "catch-up" contributions are allowed for 2020.

Your money rolls over every year. There is no "use it or lose it" rule.

For qualified expensed please refer to IRS Publication 502.

How does an HSA work?

You can use the money in your HSA at any time to pay for eligible medical expenses. When you visit a provider, no copay is required at the time of service. The provider will submit a claim to your health plan for the services you received.

Your health plan will then send you an Explanation of Benefits (EOB) outlining the negotiated/allowed charges. The provider will then send you an invoice reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan.

You can then pay the invoice with money from your HSA (either your HSA debit card or as a reimbursement to you). Remember to keep your receipts, in case the IRS requests them.

Who can open an HSA?

You are eligible to open and contribute to an HSA if you meet the following requirements:

» You must be covered by a qualified high-deductible health plan.

» You must **not** be enrolled in or covered by Medicare or Tricare.

» You must **not** be covered by your own or a spouse's general Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or any other non HSA-qualified health plan.

» You must **not** be claimed as a tax dependent on another person's taxes.

» You have **not** received any Veteran's Administration health benefits for a non-service connected disability in the last three months.

Employer Contributions

Employer Contributions Per Month	Employee + 3 or more	Employee + 2	Employee + 1	Employee Only
100% Full-Time Employee	$390.00	$390.00	$360.00	$200.00
75% to 99% Full-Time Employee	$310.00	$310.00	$290.00	$160.00

HEALTH REIMBURSEMENT ARRANGEMENT

Bear River Mental Health has formally established an employer-sponsored Flexible Spending Account. This benefit will be available to all employees who meet the following criteria:

» Have attained the age of 65 or will be 65 during the plan year.

» Are currently enrolled on the High-Deductible Health Plan.

» Are not eligible per IRS standards for a Health Savings Account.

Funds from the employer-sponsored FSA must be used for qualified medical expenses and will roll over from plan year to plan year. Funds must be used within 12 calendar months upon termination of employment. Unused funds at the end of the 12-month grace period will be paid out to the participant and will be subject to any applicable State and Federal tax.

Employees who are 65 or older and have Medicare Part A coverage only, BRMH will contribute 75% of the HSA amount to an HRA. If employee dependent has greater than Part A coverage 75% of the employee only amount will be contributed.

What is an HRA?

A health reimbursement arrangement (HRA) is an account funded only by Bear River Mental Health to help pay for qualified healthcare expenses. The money in your HRA is not considered income, so it is not subject to taxes.

FLEXIBLE SPENDING ACCOUNTS

Looking for a way to save money on healthcare and/or dependent day care? Flexible Spending Accounts (FSAs) save you money by reducing the taxes you pay. Your FSA contributions are deducted from each paycheck before federal, FICA and, in most cases, state taxes are calculated. So in effect, you do not pay taxes on your eligible FSA expenses.

How does an FSA work?

FSA contributions are taken from your paycheck on a pre-tax basis according to your annual elections. Once you have elected your annual deductions, you cannot change your elections under most circumstances.

When you have an eligible healthcare or dependent day care expense, you can pay for it with tax-free money. The accounts are not connected: you pay for healthcare expenses and dependent day care expenses with separate accounts.

MAXIMUM IRS CONTRIBUTIONS

Healthcare FSA: $2,750

Dependent Care FSA: $5,000 for single employees or married employee filing jointly. $2,500 for married employees filing separately

For qualified expensed please refer to IRS Publication 502.

You may use money in your FSA to pay for eligible expenses incurred by you, your spouse and your dependents. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

If you have an HSA, your healthcare FSA can only be used for eligible dental and vision expenses. Once you've met your deductible, you can use your healthcare FSA for eligible medical expenses.

GRACE PERIOD

You have up to 45 days after the end of your plan year to use any remaining money in your healthcare or Dependent Care FSA plans. This means you can receive services and be reimbursed from the prior year's FSA accounts.

DENTAL BENEFITS

Administered by Dental Select

Going to the dentist is not on anyone's list of favorite things to do, but Bear River Mental Health's dental benefits make it as painless as possible with comprehensive coverage through Dental Select. You can access services from any licensed dentist you wish. However, your costs will typically be lower if you choose a Dental Select PPO dentist. You can find Delta Dental PPO providers online. Please see the information in "Contact Information" toward the back of this Guide.

	PPO Indemnity Platinum Network	
	In-Network	Out-of-Network
Dental Benefits		
Preventive Routine exams, cleanings, and x-rays – (2 per year)	100% after deductible	100% after deductible of UCR
Basic Fillings, extractions, oral surgery, endodontics, periodontics	80% after deductible	80% after deductible of UCR
Major Implants, Crowns, bridges, inlays, and onlays	50% after deductible	50% after deductible of UCR
Orthodontia Children and Adults	50% after deductible	50% after deductible
Benefit Amount		
Lifetime Maximum	$1,500	
Ortho Lifetime Maximum	$1,500 6 month waiting period	
Deductible (Plan Year)		
Individual	$25	$25
Family	$75	$75
Applies To	Basic and Major	

Usual, Customary, and Reasonable

Benefits are paid at the negotiated fee level for in-network providers. Benefits for services from out-of-network providers will be paid at the 90th percentile of the amount charged by the majority of dentists in the area.

VOLUNTARY VISION BENEFITS

Administered by Opticare of Utah

To help you take care of your eyesight, Bear River provides vision care coverage through Vision Service Plan (VSP). You can access vision care services from any provider you wish. However, your costs will typically be lower if you choose a VSP network provider. You will not receive a VSP identification card – simply let your provider know you are a VSP member when you make your appointment. You can find VSP providers online. Please see the information in "Contact Information" toward the back of this Guide.

	Plan: 120B		Plan: 10-120B	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exam				
Eyeglass Exam	No Benefit	No Benefit	$10 copay	$40 allowance
Contact Exam	N/A	N/A	$10 copay	$40 allowance
Dilation	N/A	N/A	Retail	Included above
Contact Filling	N/A	N/A	Retail	Included above
Standard Plastic Lenses				
Single Vision	$10 copay	$85 allowance for lenses, options, and coatings	$10 copay	$85 allowance for lenses, options, and coatings
Bifocal (FT 28)	$10 copay		$10 copay	
Trifocal (FT 7x28)	$10 copay		$10 copay	
Lens Options				
Progressive	$50 copay		$50 copay	
Premium Progressive Options	No discount		No discount	
Glass Lenses	15% discount		15% discount	
Polycarbonate	25% discount		25% discount	
High Index	25% discount		25% discount	
Coatings				
Scratch Resistant Coating	$10 copay		$10 copay	
Ultra Violet Protection	$10 copay		$10 copay	
Other Options	Up to 25% discount		Up to 25% discount	
Frames				
Allowance Based on Retail Pricing	$120 allowance	$80 allowance	$120 allowance	$80 allowance
Additional pairs of glasses throughout the year	Up to 50% off retail		Up to 50% off retail	
Contacts				
Contact benefit is in lieu of lens and frame benefit	$120 allowance	$80 allowance	$120 allowance	$80 allowance
Conventional	Retail		Retail	
Disposables	Retail		Retail	
Frequency				
Exams, Lenses, Frames, Contacts	Every 12 months			
Refractive Surgery				
LASIK	$250 off per eye	Not covered	$250 off per eye	Not covered

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Administered by LifeMap | www.lifemap.com | 800.286.1129

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment if you pass away while employed by Bear River Mental Health The company provides basic life insurance of $50,000 to you, $2,000 to your spouse and $2,000 to your children at no cost to you.

Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or pass away in an accident. Bear River Mental Health provides AD&D coverage of $50,000 to you at no cost. This coverage is in addition to your company-paid life insurance described above.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Administered by LifeMap | www.lifemap.com | 800.286.1129

You may purchase Life and Accidental Death and Dismemberment (AD&D) insurance in addition to the company-provided coverage. You may also purchase Life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $300,000 for you and up to $50,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee— Up to five times your salary in increments of $5,000, maximum of $500,000

Spouse— Increments of $5,000, up to $250,000

Children— Increment of $2,000, up to $10,000

Step-Up Guarantee for Voluntary Life:

If you as the employee purchase an amount of $10,000 or greater during your initial open enrollment period, you can always increase coverage up to the guarantee issue amount during future annual enrollments without answering medical questions.

LONG-TERM DISABILITY INSURANCE

Administered by LifeMap | www.lifemap.com | 800.286.1129

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset—your ability to earn an income. LTD coverage provides income when you have been disabled for 90 days or more.

Benefit Amounts— 60% of base monthly earnings

Benefit Maximum— $10,000 per month

Pre-existing—Disabilities that occur during the first 12 months of coverage due to pre-existing condition during the 3 months prior to coverage are excluded.

EMPLOYEE ASSISTANCE PROGRAM (BASIC PLAN)

Sometimes life hits a rough patch. Just when you think things are fine, the kids hit their teens or someone needs counseling. Now you have somewhere to turn. The EAP (Employee Assistance Program), run by Reliant Behavioral Health, gives you private, expert support to get you through tough times. It covers all financial dependents, living at home or away, plus other household members, whether they're related or not.

HOW IT WORKS

Call the EAP for a wide range of work/life balance services to help you through a variety of life's challenges.

1. **"Why me?"**
   Maybe you need legal direction or are struggling with parenting issues. Or you just want to talk to someone. Whatever's bugging you, it doesn't have to spiral out of control. The EAP can help.

2. **A friendly ear.**
   Call the EAP, let them know you have LifeMap Assurance Company coverage, and then explain what's happened. Or, you can go online to explore your benefits. Either way, a caring person will connect you with experts in your area who can help.

3. **Make an appointment.**
   Once you have a professional's name and number, give them a call. Explain that you're using your employer's EAP benefit through Reliant Behavioral Health.

Need help? Call 1 (866) 750-1327.
Or, go to ibhsolutions.com:

- Select **Members** in the top right corner
- Click on the RBH logo
- Enter your Access Code: LifeMap
- Click **My Benefits**

Also, get help on the go with our app, RBH Mobile, for iPhone and Android.

It gives you on-the-go access to contact info, events and other resources.

SERVICES PROVIDED

Counseling: Up to 4* visits for grief, anxiety, stress, parenting, etc. Or, get instant support anywhere with the AI mental health chatbot

24/7 crisis help: Toll-free access for you or a family member experiencing a crisis

Adult/eldercare: Support in finding quality information and services including transportation, meals, exercise activities, prescription drug information, in-home care and housing

Legal support and mediation: A free, half-hour consult, plus a 25% discount on legal services and personal or family mediation (legal services not provided for employer-related issues)

Financial services: Telephonic consult and up to 30 days of support for resolution of financial issues with a financial professional, plus a 25% discount off normal fees if a CPA is retained

Online legal forms: Free state-specific wills, living trusts, contracts, leases and more

Identity theft: Help with planning the recovery process for restoring your identity and credit after an incident

Home ownership: Free support for buying, financing, moving or selling

Childcare services: Free help with school issues, teen challenges, adoption, college planning, day care, and more

Work/life balance: Online, interactive tools through ibhsolutions.com, such as self-directed courses, retirement-planning resources and more

Wellness: Go to ibhsolutions.com for health assessments, wellness content, webinars and more

Pet concierge: Info on choosing, traveling and caring for pets, plus referrals to vets, groomers, kennels, etc.

Lunch & learn webinars: Free monthly supervisor and employee webinars followed by a live Q + A

LifeMapCo.com

**For our members in California: California allows up to three counseling visits in a 6-month period.*

This document is intended to give a brief overview of the product and how it may be used. This in no way serves as a certification of coverage and should be used for educational purposes only.

LifeMap®
Insurance for every step of life.

VOLUNTARY BENEFITS

Our goal is to help working Americans have the financial protection they need.

Employees need a financial safety net to help keep bills paid during an illness or accident and to help manage the out-of-pocket costs not covered by health insurance. That's where our coverage comes into help pay those out-of-pocket expenses that major medical insurance can't cover.

The following benefits are available to you:

Accident Coverage

Accidents are unexpected. How you care for them shouldn't be. Accident insurance from Colonial can help prepare you for what happens after you or a covered family member has an accident by providing you benefits to help pay the unexpected costs that aren't covered under your health insurance.

» You are paid benefits to help you with the care and treatment of a covered accidental injury

» Your benefits are paid directly to you.

» Benefit amounts are paid based on the type of injury you have and how your doctor treats it.

» You are paid benefits regardless of any other insurance you may have with other insurance companies

» You can cover your spouse and dependent children. Benefits are not reduced for spouses and children.

» A Health Screening benefit is included in the plan.

Critical Illness Coverage

Critical illness Insurance plans complement major medical coverage by helping you pay the direct and indirect out-of-pocket costs if you, or a covered family member is diagnosed with a specified critical illness.

» A lump sum benefit is payable upon diagnosis of a covered critical illness. A survival period is not required.

» Benefits are paid directly to you, allowing you to determine how to best use your benefit.

» Benefits are paid based on the face amount you select regardless of any other coverage you may have with other insurance companies.

Hospital Confinement Coverage

How will you cover your deductible and/or coinsurance if you are admitted to the hospital? A benefit is paid directly to you if you (or a covered family member) are admitted to the hospital and stay 20+ hours.

» The benefit is paid directly to you, allowing you to determine how to best use your benefit.

» Your benefit is paid regardless of any other coverage you may have with other insurance companies.

» The hospital admission benefit is paid if you are admitted for accidents or illnesses.

» You can cover your spouse and dependent children. Benefits are not reduced for spouse and children.

OTHER BENEFITS

Retirement

Provider: Utah State Retirement System (URS)

Benefit: Bear River Mental Health funds the Tier 1 (employees in the system prior to July 1, 2011) and Tier 2 (employees hired on or after July 1, 2011) retirement plans in the Utah Retirement System. The Tier 2 plan has two retirement benefit options: (1) The Hybrid Retirement System combines a pension and 401(k) plan. (2) The Defined Contribution Plan is 401(k) only. The employee must make an election to participate in either option within 12 months of employment. Your final election is irrevocable and remains in place throughout your life.

Bear River Mental Health may contribute a percentage of your salary to a 401(k) plan. This is not a matching plan.

Death Benefit: If you are a non-retired member of URS and employed at time of death, your beneficiary will receive an insurance payment representing 75% of your highest salary.

Other: Employees may contribute to a 401(k), 457, Traditional IRA, and a Roth IRA.

Leaves

Personal Leave: Accumulates at 12 hours per month (This amount increases with longevity) for all employees with benefits. Accumulated personal leave is prorated for all benefitted employees working 50% or more.

Long-Term Sick Leave: Accumulates at 2 hours per month for all employees with benefits. Accumulated long term sick leave is prorated for all benefitted employees working 50% or more.

Holiday: Up to 12 days determined annually for all employees with benefits. Employees receive credit for hours normally worked on any given holiday.

COBRA Participants

COBRA participants pay 102% of the actual monthly premium.

Other

The Center may qualify as an approved site under the National Health Service Corps, which allows specific professional employees to apply for student loan repayment. Bear River Mental Health cannot guarantee approval of these applications, but encourages those who qualify to apply.

This document is not Center policy, but is intended to be a brief summary of Center benefits. For specific information, review Bear River Mental Health Services, Inc. Personnel Policies and Procedures Manual and each carrier's policy. These items are subject to change at any time.

CONTACT INFORMATION

Benefit	Administrator	Phone	Website
Medical	PEHP	801.366.7500	www.pehp.org
Health Savings Account	Health Equity	866.346.5800	www.healthequity.com
Dental	Dental Select	800.999.9789	www.dentalselect.com
Voluntary Vision	Opticare of Utah	800.EYE.CARE	www.opticareofutah.com
Flexible Spending Account	APA Benefits	801.561.4980	www.apachoicepoint.net
Life and AD&D Insurance	LifeMap	800.286.1129	www.lifemap.com
Long-Term Disability	LifeMap	877.254.0085	www.lifemap.com
Employee Assistance Program	LifeMap	866.750.1327	www.ibhsolutions.com
Voluntary Benefits - Colonial	Sheri Paskins Pam Anderson	801.509.0933 801.261.9097	spaskins@xmission.com pjandrsn@yahoo.com
Retirement	Utah Retirement Systems	801.366.7700	www.urs.org
Bear River Mental Health – HR	Morris Hansen Rob Johnson	435.752.0750	morrish@brmh.com robj@brmh.com
Gallagher - Broker	Jessica Eckert	801.559.2932	Jessica_eckert@ajg.com

KEY TERMS

BRAND NAME PRESCRIPTION DRUG

A prescription drug that is sold under a trademarked name. An equivalent generic drug may or may not be available at lower cost, depending on whether the patent on the brand name drug has expired.

COPAY

A flat dollar amount you pay for a medical service.

COINSURANCE

The percentage of the charges you are responsible for paying. For example, the plan pays 80% and you pay 20%.

DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses not subject to a copay.

EXPLANATION OF BENEFITS

The statement you receive from your insurance company detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

GENERIC PRESCRIPTION DRUG

A prescription drug made and distributed after the brand name drug patent has expired, and available at a lower cost than brand name prescriptions.

OUT-OF-POCKET (OOP) MAXIMUM

The most you pay in a calendar year for covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services.

IN-NETWORK

Services from a provider or facility that is contracted with the insurance company. In-network providers agree to accept set fees for covered medical services and not bill you for any amounts over those fees. In-network providers also agree to bill the insurance company directly, so you will not have to pay up front and submit your own claims to the insurance company.

OUT-OF-NETWORK

Services from a provider or facility that is not contracted with the insurance company. If you receive services out-of-network, then you will typically have a higher coinsurance and you will be responsible for the difference between the provider's billed charge and the allowable charge.

PREVENTIVE CARE

Measures taken to prevent diseases. This includes routine cancer screenings, exams and certain drugs and immunizations. Most preventive care is covered-in-full by the plan, with no cost to you.

IMPORTANT NOTICES AND DISCLOSURES

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

» All stages of reconstruction of the breast on which the mastectomy has been performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance;

» Prostheses; and

» Treatment of physical complications of all stages of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact your plan administrator.

Newborn's Act Disclosure

Group health plans and health insurance issuers 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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Qualified Medical Child Support Orders

Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions, and procedures as all other plan participants.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

You may be eligible for assistance paying your employer health plan premiums. The following is current as of January 31, 2020. Contact State of Utah for more information on eligibility.

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov
CHIP: http://health.utah.gov/chip
877.543.7669

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called
"fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of

Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take. For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims. or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations.

You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2013

Prescription Drug Coverage and Medicare Date of this Notice: July 2020

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bear River Mental Health and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Bear River Mental Health has determined that the prescription drug coverage offered by Bear River Mental Health is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Bear River Mental Health coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your Bear River Mental Health prescription drug coverage, be aware that you may not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Bear River Mental Health and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare and You handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

» Visit www.medicare.gov.

» Call your State Health Insurance Assistance Program (see inside back cover of your copy of the Medicare and You handbook for their telephone number) for personalized help.

» Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213.

Remember to keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Mental Health Parity Notice

The Mental Health Parity Act (MHPA) provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. In general, group health plans offering mental health benefits cannot set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. For more information about this notice or your current prescription drug coverage, please contact Human Resources.

A plan that does not impose an annual or lifetime dollar limit on medical/surgical benefits may not impose such a dollar limit on mental health benefits under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

For more information about mental health coverage under your plan, please refer to the plan's Summary Plan Description (SPD). You may obtain a copy of the SPD by contacting Human Resources.

Family & Medical Leave Act (FMLA)

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees.

There may be times when you need an extended leave of absence. The company has a Family and Medical Leave Policy that is in compliance with The Family and Medical Leave Act of 1993 (FMLA), as amended. FMLA provides an entitlement of up to 12 weeks, which protects employees' jobs and benefits in the event of a medical or family circumstance, which requires the employee to take time off from work without pay. In general, the employee must have worked for at least 12 months and at least, 1,250 hours within the last 12 months immediately prior to the first day of leave.

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)
- Adoption of a child by an employee (within 12 months after placement)
- Placement of a child with the employee for foster care (within 12 months after placement)
- Care of a child, spouse or parent having a serious health condition
- Incapacity of the employee due to a serious health condition.
- Military Leave

Additional leave laws may apply to you depending upon your specific state and if you or a dependent or a military member. Whenever possible leave must be requested in advance. If you have questions about FMLA or any leave requests, please contact Human Resources.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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.

[1] 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.

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 Bear River Mental Health			4. Employer Identification Number (EIN) 87/0401386
5. Employer address 90 E 200 N			6. Employer phone number 435-213-9908
7. City Logan	8. State UT	9. ZIP code 84321	
10. Who can we contact about employee health coverage at this job? Morris Hansen			
11. Phone number (if different from above) 435-213-9908	12. Email address morrish@brmh.com		

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:

full-time employees who work at least 30 hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

your spouse, children under age 26, and disabled dependents of any age.

☐ 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)

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This benefit summary prepared by

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