2024

BENEFIT GUIDE

Bear River Mental Health

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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 24 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases.
If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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.employeenavigator.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
» 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
» Divorce
» Birth
» Adoption
» Loss of Coverage
» Death
» Spouse Open Enrollment

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				
(40) Hours – Grandfathered	Total Monthly Cost	$880.38	$1,822.40	$2,465.06
	BRMH Pays	$835.38	$1,682.40	$2,230.06
	Your Monthly Cost	**$45**	**$140**	**$235**
(30-39) Hours – 3/4 Time Benefit Eligible	Total Monthly Cost	$880.38	$1,822.40	$2,465.06
	BRMH Pays	$750.38	$1,447.40	$1,945.06
	Your Monthly Cost	**$130**	**$375**	**$520**
Dental				
(40) Hours – Grandfathered	Total Monthly Cost	$46.40	$83.76	$118.26
	BRMH Pays	$41.40	$73.76	$103.26
	Your Monthly Cost	**$5**	**$10**	**$15**
(30-39) Hours – 3/4 Time Benefit Eligible	Total Monthly Cost	$46.40	$83.76	$118.26
	BRMH Pays	$36.40	$63.76	$88.26
	Your Monthly Cost	**$10**	**$20**	**$30**
(20-29) Hours – 1 /2 Time Benefit Eligible	Total Monthly Cost	$46.40	$83.76	$118.26
	BRMH Pays	$26.40	$48.76	$68.26
	Your Monthly Cost	**$20**	**$35**	**$50**
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: 7/1/2024-6/30/2025	HDHP	
	In-Network	Out-of-Network
Annual Deductible (Single / Family)	$1,600 / $3,200	
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

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 Medical Networks

Find Participating Providers at www.pehp.org

PEHP Advantage — 37 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Intermountain Health (IH) 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
Holy Cross Hospital - Davis
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 Specialty Hospital (TOSH)
LDS Hospital

Salt Lake County (cont)
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
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
American Fork Hospital
Orem Community Hospital
Primary Children's Hospital – Lehi
Spanish Fork Hospital
Utah Valley Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George Regional Medical Center

Weber County
McKay-Dee Hospital

PEHP Summit — 40 PARTICIPATING HOSPITALS, 8,000+ PARTICIPATING PROVIDERS

Network consists of predominantly Holy Cross/Common Spirit, 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
Holy Cross Hospital - Davis
Lakeview 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
Holy Cross Hospital - Jordan Valley
Holy Cross Hospital - Jordan Valley West
Holy Cross Hospital - Salt Lake
Huntsman Cancer Hospital

Salt Lake County (cont)
Lone Peak Hospital
Primary Children's Medical Center
Riverton Children's Unit
St. Marks Hospital
University of Utah Hospital
University Orthopaedic 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
Park City Medical Center

Tooele County
Mountain West Medical Center

Uintah County
Ashley Valley Medical Center

Utah County
Holy Cross Hospital - Mountain Point
Mountain View Hospital
Primary Children's Hospital – Lehi
Timpanogos Regional Hospital

Wasatch County
Heber Valley Medical Center

Washington County
St. George 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

Administered by Health Equity

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: $4,150* for 2024
Family HSA: $8,300* for 2024

*For individuals age 55 or older, an additional $1,000 in “catch-up” contributions are allowed for 2024.

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	Family	Employee + One	Employee Only
100% Full-Time Employee	$390.00	$360.00	$200.00
75% to 99% Full-Time Employee	$310.00	$290.00	$160.00

HEALTH REIMBURSEMENT ARRANGEMENT

Bear River Mental Health has formally established an employer-sponsored Health Reimbursement 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.

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.

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.

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: $3,200

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 Delta Dental

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 Delta Dental. You can access services from any licensed dentist you wish. However, your costs will typically be lower if you choose a Delta Dental PPO dentist. You can find Delta Dental PPO providers online. Please see the information in "Contact Information" toward the back of this Guide.

	PPO & Premier Network	Non-Delta Dental
Dental Benefits		
Preventive (exams, x-rays, prophylaxis, fluoride, sealants)	100%	100%
Basic space maintainers, minor restorative, stainless steel crowns, endodontics, periodontics surgical, periodontics non-surgical, periodontal maintenance, denture repair/reline/rebase, extractions, surgical extractions, other oral surgery, palliative treatment, IV sedation & anesthesia, consultation)	80% after deductible	80% after deductible
Major (major restorative, prosthodontics removable, prosthodontics fixed, implants surgical, implants non-surgical)	50% after deductible (6 month waiting period)	50% after deductible (6 month waiting period)
Orthodontia (Dependent children)	50%	50%
Benefit Amount		
Lifetime Maximum (Per individual per calendar year)	$1,500	
Ortho Lifetime Maximum (Per individual per lifetime)	$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

Administered by USAble Life

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 USAble Life

Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance

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, not to exceed 50% off EE's amount

Children— Birth to Age 26: Increment of $2,000, up to $10,000

LONG-TERM DISABILITY INSURANCE

Administered by USAble Life

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

Administered by New Directions

When life's a little much,

reach out and get in touch.

Let's be real: life can be tough. When your responsibilities start to feel overwhelming and showing up each day with a smile on your face seems difficult, it's important to reach out for help. You can lean on your free and confidential Employee Assistance Program (EAP) for support.

We've got your back.

A free benefit from your workplace, the EAP can help you or anyone in your household:

- Be more present and productive at work
- Receive support when you don't feel ilke yourself
- Get help with responsibilities that are distracting or stressful
- Grow personal and career skills
- Be a caring, loving friend or family member
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life

We're here for you, always.

Life happens, regardless of the day or time. That's why we make ourselves available 24/7, even on holidays. So whenever you need to reach out, we're here for you.

Support Line
Call anytime
800-624-5544

Mobile app
Search for New Directions EAP

SERVICES

- ☑ Counseling
- ☑ Consultation on
  - Finances
  - Legal needs
  - Managing employees
  - Life
- ☑ Crisis support
- ☑ Coaching
- ☑ Adult and child care resources
- ☑ Personal and professional training
- ☑ Digital behavioral health tools

ndbh.com
800-624-5544

Services are free and your employer will not know you reached out.
Flip this sheet over to see some common reasons people use EAP.

VOLUNTARY BENEFITS

Administered by Colonial Life

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 16 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.

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

Medical	PEHP	801.366.7500	www.pehp.org
Health Savings Account	Health Equity	866.346.5800	www.healthequity.com
Dental	Delta Dental	480.720.7054	www.deltadentalins.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	USAble	800.370.5856	www.USAbleLife.com
Long-Term Disability	USAble	800.370.5856	www.USAbleLife.com
Employee Assistance Program	New Directions	866.750.1327	www.ndbh.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	435.213.9908 435.752.0750	morrish@brmh.com robj@brmh.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

Patient Protections Disclosure

The Bear River Mental Health Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, PEHP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the PEHP at 801.366.7500 or www.pehp.org.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from PEHP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PEHP at 801.366.7500 or www.pehp.org.

Women's Health & 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 was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the 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. Therefore, the following deductibles and coinsurance apply:

HDHP (Individual: 20% coinsurance and $1,500 deductible; Family: 20% coinsurance and $3,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 435.213.9908 or morrish@brmh.com.

Newborns' And Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 **1-877-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.

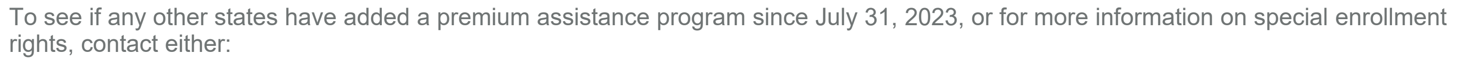
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage 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 **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269



To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Bear River Mental Health is committed to the privacy of your health information. The administrators of the Bear River Mental Health Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Morris Hansen – HR Manager at 435.213.9908 or morrish@brmh.com.

HIPAA Special Enrollment Rights

Bear River Mental Health Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Bear River Mental Health Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Morris Hansen – HR Manager at 435.213.9908 or morrish@brmh.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Bear River Mental Health

About Your Prescription Drug Coverage and Medicare

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 the medical plan 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 (a 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 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) 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 don't 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. You may have 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…

Contact the person listed below for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Bear River Mental Health changes. You also may request a copy of this notice at any time.

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 & You" handbook. You'll get 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 the inside back cover of your copy of the "Medicare & 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 (TTY 1-800-325-0778).

Remember: 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).

Date: **July 01, 2024**
Name of Entity/Sender: **Bear River Mental Health**
Contact—Position/Office: **Morris Hansen – HR Manager**
Office Address: **90 E 200 N**
Logan, Utah 84321-4034
United States
Phone Number: **435.213.9908**

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Morris Hansen.

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

PART B: Information About Health Coverage Offered by Your Employer

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

<table>
<tr><td colspan="2">3. Employer name
Bear River Mental Health</td><td colspan="2">4. Employer Identification Number (EIN)
87-0401386</td></tr>
<tr><td colspan="2">5. Employer address
90 E 200 N</td><td colspan="2">6. Employer phone number
435.213.9908</td></tr>
<tr><td colspan="2">7. City
Logan</td><td>8. State
Utah</td><td>9. ZIP code
84321-4034</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Morris Hansen</td></tr>
<tr><td>11. Phone number (if different from above)</td><td colspan="3">12. Email address
morrish@brmh.com</td></tr>
</table>

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:

X Some employees. Eligible employees are: full time employees who at least 30 hours per week.

- With respect to dependents:

X We do offer coverage. Eligible dependents are: your spouse, children under age 26 and disabled dependents of any age.

˜ We do not offer coverage.

X 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)

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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)

Notes:

Notes:

This benefit summary prepared by

Gallagher

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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