Plan Year

2021

Navigating your Benefits

Remember Open Enrollment is your chance to:

- Change, elect, or drop medical, dental, vision, Flexible Spending, and life insurance coverage.
- Update beneficiary information.
- Update personal contact information for self and dependents including address, dates of birth, social security numbers, etc.
- Contribute to Medical Flexible Spending and/or Dependent Care Flexible Spending.
- Contribute to Health Savings Account
- 2020 Flexible Spending elections do not carry over to 2021, so you must re-enroll.

Open Enrollment

This years open enrollment is passive, which means if you do not make changes during this session, your current benefit elections will carryover for 2021. Open Enrollment will begin October 19th, 2020 and end November 15th, 2020.

Eligibility

If you are a full-time employee working 36+ hours per week or a part-time employee working 20 to 35 hours per week you are eligible to enroll in the benefits described in this guide.

How to complete open enrollment

Log into Paycom Self Service or use the Paycom mobile app. Click the Benefits icon and then the 2021 Open Enrollment icon. Please note: you must go through each page and finalize your elections at the end in order to complete open enrollment.

Making changes throughout the year

Choose your benefits carefully. Medical, dental, vision, flexible spending and health savings account contributions are made on a pre-tax basis and IRS regulations state that you cannot change your pre-tax benefit options during the year unless you have a qualified life event. Qualified life events include:

- Marriage or divorce;
- Death of your spouse or dependent;
- Birth or adoption of a child;
- Your spouse terminating or obtaining new employment (that affects eligibility for coverage);
- You or your spouse switch from one qualifying status to a different one (full-time to part-time, part-time to PRN, PRN to full-time, etc.);
- Your dependent no longer qualifies as an eligible dependent.

You must notify Human Resources and provide documentation within 30 days of the qualifying event.

Our Commitment To You

Mountain View Hospital is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage as well as financial security to our employees and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

What's New for 2021

- Health Savings Account – a health savings account (HSA) is a tax-free savings account specifically for health related expenses. If you enroll in the Health Savings Account you must enroll in the HD Health Plan and will not be able to enroll in Flexible Spending.
- HD-Health Plan – This is a separate health plan designed specifically for participants who elect a Health Savings Account. If you elect a Health Savings account you must also elect the HD Health Plan.
- Guaranteed issue life insurance- all full-time and part-time employees who have never been denied coverage in the past can now enroll themselves, spouses, or dependent children up to the guaranteed amount with no medical questions or health exams.
- Guaranteed short term disability- all part-time employees who have never been denied coverage in the past can now enroll themselves with no medical questions or health exams.

When can I enroll

As a benefits-eligible employee, you have the opportunity to enroll in or make changes to your benefit plans during our annual benefits enrollment period. Open Enrollment is October 19th, 2020 to November 15th, 2020 with your benefit choices being effective January 1, 2021. Our benefits plan year is January to December.

Dependent eligibility

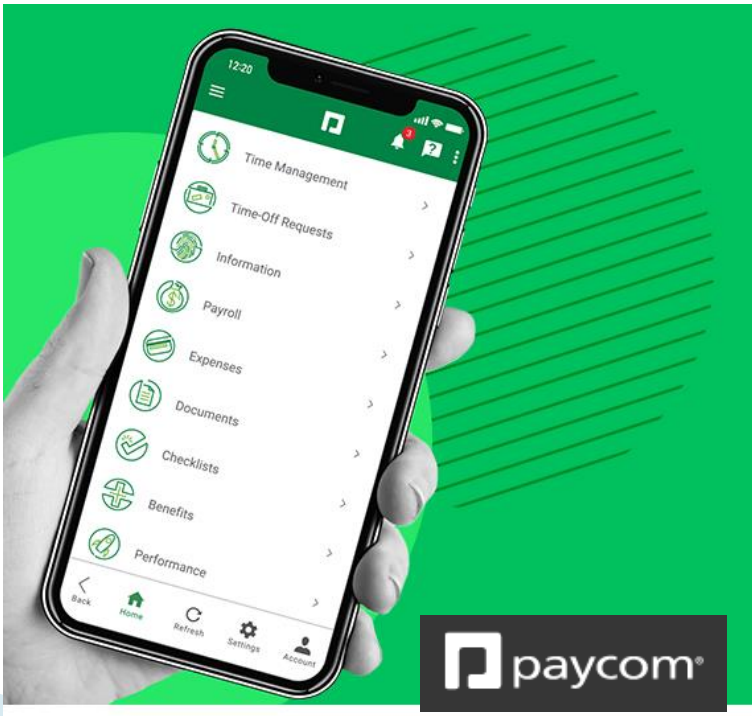
You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse and eligible children who reside in your household and depend primarily on you for support. This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage.

Paycom show me how to complete open enrollment

- Step 1- Login to Paycom at www.paycom.com or through the Paycom app. From the Notification Center or from the Benefits section click the current years Benefits Enrollment.
- Step 2- Review initial instructions and click “Start Enrollment”. Review, enter or make changes to your dependents and beneficiaries. Please note: If you have a previous dependent or beneficiary showing they are tied to a previous benefit and you will be unable to remove them. Please make sure they are listed as inactive or change them to inactive.
- Step 3- After reviewing each benefit plan, choose your coverage, then elect either to enroll or decline.
- Step 4- To complete enrollment click “Finalize” then “Sign and Submit”.

Helpful Tips

- Have your dependent/beneficiary information ready, such as Social Security numbers, before beginning the enrollment process.
- As you go through the enrollment process your selections will display and add up on the benefits summary tracker to the right.
- As you go through the open enrollment process your changes will be saved until you finalize, sign and submit your elections.



New for 2021

Health Savings Account

Beginning in your New Plan year, Mountain View Hospital will now offer two options for your Medical Coverage- A Traditional PPO Plan and a New High Deductible Health Plan – with an HSA Option. Both options are very beneficial but the options are different so we have listed the Plans and how they will work.

Some Highlights:

- If you sign up for the High Deductible Health Plan with the HSA Option you can elect to open an HSA Account to have money withheld pretax from your paycheck and go directly to your HSA Account. If you elect the HSA medical plan, you **cannot** elect to sign up for the Medical FSA Plan. You can still elect the Dependent Care FSA with the HSA Plan

- If you have funds remaining in your Medical FSA from the ending plan year, you will want to make sure you use them all before the end of the current plan year on December 31st, 2020. Also, if you are currently enrolled in the FSA plan and have a current MasterCard and choose to enroll in the HSA plan for 2021, do not dispose of your MasterCard, it will have access to your HSA funds in the new year.

- If you are unsure which pretax plan will work best for you, we have put together a comparison chart for you to review. If you still have questions, please call
- EBenefits Administration at 208-391-2567 or email info@ebenefitsadministration.com

Flexible Spending versus HSA comparison

FSA versus HSA Comparison Chart		
	Flexible Spending Account (FSA)	**Health Savings Account (HSA)**
Stands for	FSA=Flexible Spending Account	HSA=Health Savings Account
Who is eligible?	Any Full Time Benefits Eligible Employee	Employees enrolled in a high deductible health plan (HDHP) who do not have any other non-HDHP health plan, including coverage under Medicare, a spouses health plan or flexible spending account (FSA).
Contribution Limits	The IRS sets the limits yearly. The employer can offer up to the annual limit. For 2021-$2,750 (may change if the govt increases the amount for 2021)	The IRS sets the limits yearly. For 2021: Single coverage $3,600, families $7,200. These limits are $1,000 higher for individuals age 55 or older at any time during the year.
Who owns the account	Employer owns the FSA account	AN HSA account is owned by the employee.
Contributions subject to income tax?	No	No
Does interest accrue?	No	Yes
Disbursement of Funds	Funds are available for use up to the annual election amount as of the first day of the plan year.	Only funds paid in by the employee to date are available for use.
Catch-up contribution for older workers	No	Yes, members aged 55 to 65 may contribute up to $1,000 more to their account per year. This contribution is an “above the line” income tax deduction.

Flexible Spending versus HSA comparison (continued)

FSA versus HSA Comparison Chart		
	Flexible Spending Account (FSA)	**Health Savings Account (HSA)**
Portability and forfeiture	No, this plan is not portable for the employee. FSA monies must be used while the member is still employed. Unused monies are forfeited if the member terminates employment, (other than retirement).	Yes, this plan is portable for the employee. HSA balance is not forfeited when the member changes employer or health plans.
Eligible Medical Expenses	All Qualified medical expenses defined under IRC 213(d)	Qualified medical expenses defined under IRC 213(d), except for amounts distributed to pay health insurance premiums. HSAs can be used to pay premiums for Temporary Continuation of Coverage, Long Term Care, and health insurance for retirees.
Non-medical expenses	No's funds can only be used for IRS approved 213(d) expenses to include medical, dental, vision and prescription expenses.	HSA funds can be used for non-health care distributions but are included gross income and subject to a 20% penalty if under the age of 65.
Proof of expenses required?	Yes; the member should be prepared to substantiate to the administrator the expense has been incurred, the amount of the expense and the eligibility.	If you elect to have any monies go pretax into an HSA Plan you **cannot** elect to have the Medical FSA plan as well; but you can elect the Dependent Care FSA Plan with the HSA account.

Medical and Prescription Drug Benefits

Each person's health care needs are different. That's why our medical plan offers two options so that you can choose the coverage best-suited to your personal situation. The below chart is a brief summary . Please see the full plan document for a complete list.

	PPO Plan		HSA Plan	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual/Calendar Year Deductible (Individual/Family)	$2,500 person/$5,000 family		$4,000 person/$8,000 family	
Out-of-Pocket Maximum (Individual/Family)	$4,250 person/$10,250 family	$6,500 person/$17,000 family	$5,500 person/ $11,000 family	
Co-insurance	$20 copay/ visit	40% co-insurance	80% after deductible	60% after deductible
Physician Services				
Doctors Office Visit	$20 copay/visit		80% after deductible	60% after deductible
Specialist Office Visit	$60 copay/visit		80% after deductible	60% after deductible
Preventative Care	Plan pays 100% of Maximum Allowance	Plan pays 60% of Maximum Allowance	Plan pays 100% of Maximum Allowance	Plan pays 60% of Maximum Allowance
Hospital Services				
Inpatient	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% Maximum Allowance after Deductible	20% Cost Sharing after deductible	40% Cost Sharing after deductible
Outpatient	Requires $300 Copayment Plan pays 80% of Maximum Allowance after Deductible	Requires $300 Copayment Plan pays 60% of Maximum Allowance after Deductible.	$300 copay/visit, 20% cost sharing after deductible	$300 copay/visit, 40% cost sharing after deductible

Prescription Drugs

Prescription Drugs				
Retail (30-day supply	PPO Plan		HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Generic	Retail: $20	Not Covered	20% after deductible	Not Covered
Preferred Brand	Retail: 35% co-insurance	Not Covered	20% after deductible	Not Covered
Non-preferred brand	50% co-insurance	Not Covered	20% after deductiible	Not Covered
Mail Order 90-day supply				
Generic	Retail: $30	Not Covered	20% after deductible	Not Covered
Preferred Brand	Retail: 25% co-insurance	Not Covered	20% after deductible	Not Covered
Non-preferred Brand	50% co-insurance	Not Covered	20% after deductible	Not Covered

PPO Health Plan and HSA Premiums 2021

Full-Time 36+ hours per week

	PPO Plan		HSA Plan	
	Per Pay Period	Monthly	Per Pay Period	Monthly
Employee Only	$27.00	$54.00	$22.00	$44.00
Employee+Spouse	$135.00	$270.00	$108.00	$216.00
Employee+Child(ren)	$113.00	$226.00	$90.00	$180.00
Employee+Family	$220.00	$440.00	$175.00	$350.00

Part-Time 20+ hours per week

Part Time	PPO Plan		HSA Plan	
	Per Pay Period	Monthly	Per Pay Period	Monthly
Employee Only	$72.00	$144.00	$57.00	$114.00
Employee+Spouse	$245.00	$490.00	$195.00	$390.00
Employee+Child(ren)	$205.00	$410.00	$163.00	$326.00
Employee+Family	$355.00	$710.00	$282.00	$564.00

Blue Cross of Idaho Rx

IngenioRx

MAIL ORDER PHARMACY

BLUE CROSS OF IDAHO RX MAIL ORDER PHARMACY

Getting your ongoing prescription medication is even easier with Mail Order Pharmacy provided by our pharmacy partner, IngenioRx. Have your regular medications delivered directly to you, with no extra cost.

Advantages

- Get regular supplies shipped automatically to your home by our mail order pharmacy partner, IngenioRx
- Talk to a an IngenioRx pharmacist anytime
- Order your prescriptions online or by phone any time
- Medications are shipped in tamper-proof packaging that are temperature-controlled when needed
- If you're traveling, you can have your medication shipped to a temporary address.

Costs

- Mail order service is included with no extra cost. Just pay your usual copayment or coinsurance.
- With mail order service, you can get a 90-day supply of your medication for what could be significantly less than from a retail pharmacy.
- A generic version of your drug could save you even more – an average of 30-80% less. IngenioRx may automatically send you a generic drug unless otherwise requested by your healthcare provider.

Questions?

Call Blue Cross of Idaho Rx at the number listed on the back of your member ID card or log in to your online member account at *members.bcidaho.com*.

Getting Started

1. If you need your prescription filled right away, ask your doctor to write two prescriptions:
   - The first for a short-term supply (30 days) to fill right away at an in-network retail pharmacy.
   - The second for the maximum supply allowed (up to a 90-day supply) with as many as three refills (if appropriate) to be sent to IngenioRx.
2. Sign up for mail order service by logging in to your member account at *members.bcidaho.com*.
   - Select ***Pharmacy***
   - Then select ***Manage My Drugs***
   - OR, call the Blue Cross of Idaho Rx Customer Service number on the back of your member ID card for help.
3. Find out how much your prescription will cost by logging in to *members.bcidaho.com* and selecting ***Pharmacy*** and then ***Manage My Drugs***, or by calling Blue Cross of Idaho Rx.
4. You can pay by:
   - Electronic check
   - Credit card
5. Please allow 10 days for delivery by standard delivery.

IngenioRx is an independent company that administers pharmacy benefits on behalf of Blue Cross of Idaho.

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Dental Benefits

Benefit	Delta Dental	Willamette
Annual/Calendar year maximum	$1,250 (PPO)	No Limit
Annual/Calendar year deductible (Individual/Family)	$50 (single person) $150 (family)	
Preventative Services	100% covered	You pay $15 copay
Basic Services	80% covered	You pay $15 copay
Major Services	50%	You pay $250 copay, plus $15 office visit copay
Orthodontia Lifetime Maximum	$1000 (Eligible under age 19)	You pay $2,500 copay, plus $15 office visit copay each time you visit there office.
Monthly Paycheck Deductions	*Monthly Rates are the same for both Dental Plans	
	Full Time	Part Time
Employee Only	$24.00	$44.00
Employee+Spouse	$52.00	$82.00
Employee+Child(ren)	$52.00	$82.00
Family	$100.00	$146.00

DELTA DENTAL

Delta Dental of Idaho

Willamette Dental Group

Benefit Summary

GENERAL BENEFIT PLAN SUMMARY

Mountain View Hospital

Group Number: 3280

Contract Effective Date: 01/01/2021

Benefit Overview	PPO	Premier	Non-Participating
Per Person Deductible Excluding Diagnostic, Preventive, Orthodontic services per benefit year	$50	$50	$50
Family Deductible Excluding Diagnostic, Preventive, Orthodontic services per benefit year	$150	$150	$150
Maximum Benefit Per eligible person per benefit year	$1,250	$1,000	$1,000
Services	You pay the % below		
Preventive & Diagnostic Services Examinations, X-rays, teeth cleaning	0%	20%	20%
Basic Services Fillings, root canals, extractions, oral surgery	20%	30%	30%
Major Services Crowns, implants, onlays, bridges, dentures	50%	60%	60%
Orthodontic Services Child Only Eligible under age 19; Maximum orthodontic lifetime benefit is $1000; Replacement of orthodontic appliance is not covered.	50%	50%	50%

PARTICIPATING AND NON-PARTICIPATING DENTISTS

If the dentist is a PPO or Premier participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee. Delta Dental will send payment to the participating dentist and the subscriber will be responsible for any co-payment and/or any non-covered services.

If the dentist is a non-participating dentist, Delta Dental will base payment on the lesser of the Submitted Amount or Delta Dental's non-participating dentist Fee. It is the subscriber's responsibility to make full payment to the non-participating Dentist. For dental services rendered by an out-of-state dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Contract Fee in that area, if the out-of-state dentist is a participating dentist with a Delta Dental plan in the state in which the service is rendered.

Delta Dental of Idaho
555 E Parkcenter Blvd
Boise, ID 83706

Customer Service
(208) 489-3580
(800) 356-7586

Benefits and Limitations

Class I Preventive and Diagnostic Services
Examinations twice per year.
Cleanings twice per year (restricts against periodontal maintenance within the same time period).
Fluoride two times in any 12 consecutive month period for dependent children under age 19.
Full mouth series or panoramic X-rays once every 5 years.
Bitewing X-rays once every 12 months.
Class II Basic Services
Periodontal maintenance is allowed 4 times in 12 months if patient has had previously treated periodontal disease.
Scaling and root planing covered once per quadrant every 24 months. Periodontal surgery is payable once per quadrant in any 3 year period.
Fillings restricted to same tooth/surface once every 24 months.
Class III Major Restorative Services
Crowns, build-ups, stainless steel crowns, onlays, or bridges on same tooth once every 7 years.
Porcelain, porcelain substrate, and cast restorations are not payable for children less than 12 years.
Partials, or dentures 1 time per arch every 7 years, eligible for partials at age 16.
Implants
Implants are a covered benefit per tooth with a maximum lifetime benefit of $1,200 or the plan's annual maximum, whichever is less (Ages 19 and over).
Dependents
Eligible children must be under age 26.

GENERAL PLAN INFORMATION

1. Optional treatment: If the subscriber or eligible dependent selects a more expensive service than is customarily provided. For example, if teeth can be restored satisfactorily with amalgam or composite material, the cost of inlays, onlays and crowns are not covered and the cost difference between the covered and the non-covered procedure is to be borne by the patient.
2. Payment provisions: The following guidelines will be used to determine the date on which a service shall be paid:
   a. Full dentures or partial dentures: On the date the final impression is taken.
   b. Fixed bridges, crowns, and onlays: On the date the tooth or teeth are prepared.
   c. Root canal therapy: On the date the root canal is initiated.
3. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits (EOB).

4. Predeterminations: If your dental treatment involves services of $300 or greater, it is advisable to ask your dentist to submit a predetermination of benefits. A statement will be sent to you and your dentist estimating the amount of Delta Dental payment obligation and the amount that you will owe. These estimates will be subject to your continuing eligibility in the plan and the group contract remaining in effect. If claims for other completed dental services are received and processed prior to the completion date of the proposed treatment, this may reduce Delta Dental's estimated payment for the proposed treatment and increase your obligation to the dentist. Predeterminations are valid for ninety (90) days from the date issued by Delta Dental.

Orthodontic Services

Orthodontic services are for treatment to correct malposed teeth. To determine if the orthodontic coverage begins immediately or has a waiting period, please refer to the Benefit Summary.

Prior to beginning orthodontic services, please have your dentist submit a pretreatment plan based on your financial plan with your orthodontist. Once the pretreatment plan has been approved, Delta Dental will pay the appropriate amount listed on the Benefit Summary of the initial billed amount, providing it is no greater than one third of the total treatment plan, and the same percentage of the monthly billed amount.

If the patient is in treatment at the time eligibility begins, a pro-rated payment will be paid. The pro-rated allowance reduces the orthodontic payment based on length of treatment and the financial agreement. The subscriber must present the original signed Financial Agreement to Delta Dental for calculating the pro-rated amount due. Orthodontic benefits are limited by a lifetime maximum for an eligible person. Child orthodontic treatment is limited to eligible dependent children, and to payment of monthly or other periodic charges through completion of treatment or to age 19 or to the date eligibility terminates, whichever occurs first. If your plan includes adult orthodontic coverage, there is no age limit imposed.

WHAT SERVICES ARE NOT COVERED?

No payment will be made by Delta Dental and all charges for the following services will be the responsibility of the subscriber:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws . Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act , i.e., Medicaid.
2. Services for cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before an individual became eligible under the contract.
4. Prescription drugs, pre-medications and/or relative analgesia. General anesthesia and/or intravenous sedation other than for covered oral surgery. Charges for hospitalization, laboratory tests, and examinations and any additional fees charged by the dentist for hospital treatment.
5. Preventive control programs, including home care items.
6. Charges for failure to keep a scheduled visit with the dentist.
7. Repair, relines, or adjustments of occlusal guards.
8. Charges for completion of forms. A participating dentist may not make these charges to a subscriber or eligible dependent .
9. Prosthodontic services (Class III benefits), unless specified as a covered service in the Benefit Summary.
10. Orthodontic services (Class IV benefits), unless specified as a covered service in the Benefit Summary.
11. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances.
12. Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
13. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion. If orthodontic benefits have been selected under this contract, this exclusion will not apply to the orthodontic services.
14. Treatment by other than a dentist, except for services performed by a licensed dental hygienist or denturist within the scope of his or her license.
15. Processing Policies may limit benefits. Processing Policies applied to a claim are noted on the Explanation of Benefits

(EOB).

16. Services or supplies for which no charge is made, or for which the patient is not legally obligated to pay. This includes services or supplies furnished by a dentist who is related to the patient by blood or who is related to the patient by blood or marriage and who ordinarily dwells in the patient's household, the dentist providing service to him/her self, or services which would not have a charge in the absence of Delta Dental coverage.
17. Services or supplies received as a result of defect, or injury due to an act of war, declared or undeclared.
18. Services that are covered under a hospital, surgical/medical, or prescription drug program.
19. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
20. Myofunctional therapy.
21. Delta Dental is not obligated to pay claims received more than 12 months after the date of service.
22. Nutritional counseling, tobacco counseling and oral hygiene instruction are not covered benefits except for participants in Delta Dental's Health through Oral Wellness® (HOW®) program.

DELTA DENTAL®

HOW HEALTH *through* ORAL WELLNESS®

Here's [HOW] you can maximize your oral health at no additional cost.

A healthy mouth is a vital part of your overall health, and Delta Dental of Idaho cares about yours. That's why we're introducing Health *through* Oral Wellness® (or, HOW® for short). HOW is a unique, patient-centered program that adds additional benefits to your dental plan, based on your individual oral health needs. By having your dentist perform a simple risk assessment, you may have access to additional preventive and health-sustaining benefits.

HOW TO GET STARTED:

First, check with your employer to make sure your company is participating in the HOW program.

Second, simply request a free Health *through* Oral Wellness (HOW) risk assessment at the beginning of your dental visit.

Third, if you qualify based on your results, Delta Dental of Idaho will release, or 'unlock' specific additional benefits without an increase in premium.

BELOW ARE JUST SOME OF THE BENEFITS THAT MAY BE COVERED BASED ON RISK SCORES

- ☑ Additional cleanings
- ☑ Fluoride *(child and adult)*
- ☑ Oral hygiene instruction, nutritional counseling, or tobacco cessation counseling
- ☑ Additional sealants *(child and adult)*
- ☑ Periodontal maintenance *(gum disease treatment)*
- ☑ Drugs or medicaments dispensed in the office for home use

If you have questions or would like to contact us for more information about the Health *through* Oral Wellness program, please contact us by phone at (208) 489-3580 or toll-free at (800) 356-7586 or by email at customerservice@deltadentalid.com.

All enhanced benefits are subject to the patient meeting their plan's annual maximum and other limitations. A risk assessment must be performed at every routine re-care visit to occur at least once in the plan year. Enhanced benefits and standard policy requirements, including coinsurance percentages, copayments and plan maximums, may be subject to changes.

DELTA DENTAL®

HOW HEALTH *through* ORAL WELLNESS®

Instructions for your dentist:

At Delta Dental of Idaho, we understand that some patients need more dental care than others. That's why we offer our Health *through* Oral Wellness® (HOW®) program. Many Delta Dental of Idaho patients who are at risk for certain conditions may be eligible for additional preventive benefits at no additional cost to them.* To assess their risk level, they need your help! They need you to complete an oral health risk assessment using a clinical risk evaluation tool powered by PreViser®. This tool is provided to you by Delta Dental of Idaho at no charge. The risk assessment is quick and easy and may provide your patients with additional preventive benefits such as extra cleanings, extra periodontal maintenance, fluoride, sealants and more. You can perform this risk assessment on your patients immediately.

HOW TO GET STARTED:

First, simply create your PreViser account at go.deltadentalid.com/PreViser and follow the registration steps.

Second, begin your PreViser oral health risk assessment for your patient. If your patient is high-risk for a certain condition, Delta Dental of Idaho will "unlock" additional preventive benefits immediately.

BELOW ARE JUST SOME OF THE BENEFITS THAT MAY BE COVERED BASED ON RISK SCORES

- ☑ Additional cleanings
- ☑ Fluoride *(child and adult)*
- ☑ Oral hygiene instruction, nutritional counseling, or tobacco cessation counseling
- ☑ Additional sealants *(child and adult)*
- ☑ Periodontal maintenance *(gum disease treatment)*
- ☑ Drugs or medicaments dispensed in the office for home use

If you have questions or would like to contact us for more information about the new Health *through* Oral Wellness program, please contact us by phone at (208) 489-3580 or toll-free at (800) 356-7586 or by email at customerservice@deltadentalid.com.

*Additional preventive benefits are subject to the provisions of your patient's Delta Dental of Idaho policy. All enhanced benefits are subject to the patient meeting their plan's annual maximum and other limitations. A risk assessment must be performed at every routine re-care visit to occur at least once in the plan year. Enhanced benefits and standard policy requirements, including coinsurance percentages, copayments and plan maximums, may be subject to changes.

Willamette Dental Group

WILLAMETTE DENTAL GROUP BENEFITS OVERVIEW

REMINDER ABOUT YOUR WILLAMETTE DENTAL GROUP BENEFIT PLAN

- You pay $15 at the office for your cleanings, x-rays, exam and fillings
- Crowns cost a one-time $250 copay, plus a $15 office visit copay each time you visit our office
- Braces cost a one-time $2,500 copay, plus your $15 office visit copay each time you visit our office
- We have offices in Boise, Meridian, Idaho Falls, Twin Falls, and many others. Find office address online at *locations.willamettedental.com* or on Google
- Call **855.433.6825** to make your appointment. Please call ahead to cancel if you are unable to make your scheduled appointment time
- At your first appointment, you will pay $15 for your visit

FOR QUESTIONS CALL

Willamette Dental Group Member Services Team at **855.433.6825 Option 2**

CONVENIENT PLAN FEATURES

- No annual maximums*, deductibles, or waiting periods with predictable out of pocket costs
- Benefits and/or services are provided at Willamette Dental Group offices
- Extended hours: Monday - Friday 7am - 6pm and rotating Saturdays regionally
- Easy appointment scheduling – just call 1.855.433.6825
- Emergency services available in-person in 48 hours or less and on-call 24/7
- All dental specialty services available, including orthodontics for all ages

ABOUT WILLAMETTE DENTAL GROUP

For 50 years, it has been Willamette Dental Group's mission to deliver our proactive preventive dental care philosophy to our patients by focusing on promoting long term oral health.

We commit to service excellence through a dedicated team that exemplifies the following four core values: Health, Compassion, Innovation, Integrity.

APPOINTMENTS OR EMERGENCIES

Toll Free: 1.855.433.6825

Appointment Center Hours
Monday - Friday: 7am - 6pm PT
Saturday: 7am - 4pm PT

For Dental Emergencies
Call 24 hours / 7 days-a-week

QUESTIONS?

We have a full staff of member service representatives who will answer any question that you may have about your dental plan or service.

Toll Free: 1.855.433.6825

Member Services Hours
Monday - Friday: 8am - 5pm PT
E-mail: memberservices@willamettedental.com

willamettedental.com

Willamette Dental Group

Willamette Dental Group

ORTHODONTIC TREATMENT FOR THE ENTIRE FAMILY

As part of your Willamette Dental Group plan option, orthodontic treatment benefits are available for adults and children. With no waiting periods & a predictable, low copay, you and your family have access to affordable orthodontic care.

Willamette Dental Group, P.C., is committed to providing the quality care necessary for orthodontic treatment. Our licensed Orthodontists meet and maintain high credentialing standards and practice a proactive approach to dentistry, which means you will receive the most appropriate care based on your individual needs. In order to receive these benefits, all treatment must be provided by Willamette Dental Group providers.

In addition to standard braces, Willamette Dental Group offers Invisalign® treatment as an option for our patients at an additional cost. The suitability of Invisalign treatment for each patient is determined by his/her Willamette Dental Group orthodontist based on several factors including alignment goals, patient cooperation and current oral health.

QUESTIONS: **855.433.6825**

WITH A ONE-TIME $2500 COPAYMENT PLUS YOUR OFFICE VISIT COPAY AT EACH VISIT, AFFORDABLE ORTHODONTIC CARE IS WITHIN REACH!

IDAHO OFFICE LOCATIONS WITH ORTHODONTIC SERVICES

- Coeur d'Alene
- Idaho Falls
- Meridian
- Twin Falls

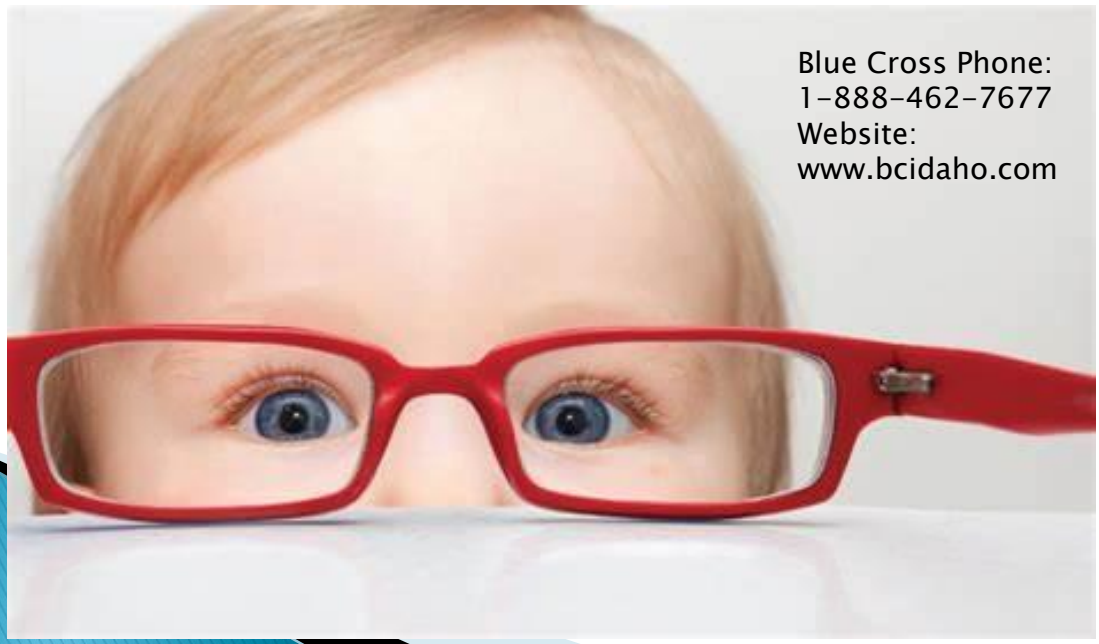
Vision

Blue Cross has partnered with VSP Vision Care. If you enroll in this benefit you will use your Blue Cross insurance card while accessing a VSP provider. Visit SeeMuchMore.com for more information on VSP.

Plan Features Include:

Routine Eye Exam (once every 12 months)	$10 Copay
Prescription Glasses	$25 Copay with $130 allowance
Frames (once every 12 months)	Frame allowance of $130 and featured frame allowance of $150
Lenses, Single Bifocal, Trifocal, Progressive (once every 12 months)	Fees up to $125
Elective Contact Lenses (once every 12 months)	$105 per pair. If medically necessary, up to $210

Coverage Level	Per Pay Period		Monthly Rate	
	Full Time	Part Time	Full Time	Part Time
Employee	$6.00	$12.00	$12.00	$24.00
Employee + Spouse	$13.00	$20.00	$26.00	$40.00
Employee + Child(ren)	$13.00	$20.00	$26.0	$40.00
Employee + Family	$17.00	$25.00	$34.00	$50.00



Blue Cross Phone:
1-888-462-7677
Website:
www.bcidaho.com

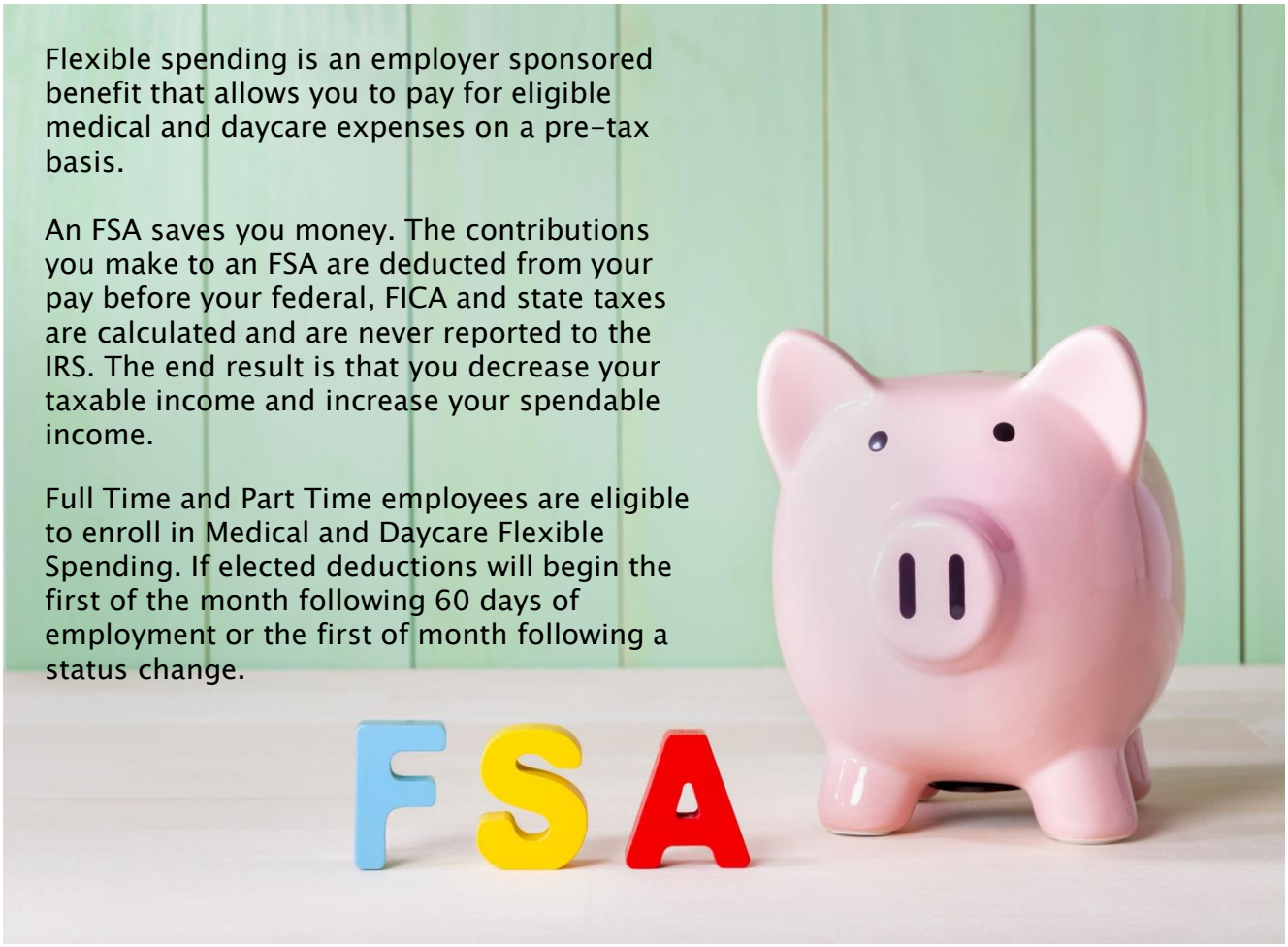
Vision (continued)

VISION CARE BENEFITS (VSP)	
For Covered Providers and Services Copayment	Participant pays $10 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses
Service Frequency Limitations	Participant may receive one (1) eye exam every Benefit Period Participant may receive one (1) pair of spectacle lenses or contact lenses every Benefit Period Participant may receive one (1) frame every other Benefit Period *If contact lenses are chosen you will be eligible for a frame the following Benefit Period.
Payment for Services Rendered:	
Participating VSP Doctor	**Exam**—Plan pays 100% after Copayment **Prescription Glasses**[1]—Basic Lenses and Medically Necessary Contact Lenses are covered in full. Frame allowance of $130 and featured frame allowance of $150 subject to VSP's promotional offer, and 20% off any Out-of-Pocket expenses. **Elective Contacts**[1]—includes an allowance of $60 for contact lens exam and $130 allowance for materials in place of benefits for Prescribed Lenses and Frames.
***Nonparticipating VSP Doctor** Professional Fees Eye Exam **Materials—Lenses per pair** Single Vision Bifocals, up to Trifocals, up to Lenticular, up to Progressive, up to Frame, up to **Contact Lenses—per pair** **Medically Necessary, up to Maximum Allowance**	 $50 $50 $75 $100 $125 $75 $70 $105 $210

[1] If a Participant chooses lenses and/or frames or contacts valued at more than the allowance, a 20% discount for materials and a 15% discount on the contact lens exam will be applied to the Participant's Out-of-Pocket costs from a Participating Provider.

*The Participating VSP Doctor is responsible for verifying benefits with VSP prior to rendering services. A Participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under this Plan.

Flexible Spending



Flexible spending is an employer sponsored benefit that allows you to pay for eligible medical and daycare expenses on a pre-tax basis.

An FSA saves you money. The contributions you make to an FSA are deducted from your pay before your federal, FICA and state taxes are calculated and are never reported to the IRS. The end result is that you decrease your taxable income and increase your spendable income.

Full Time and Part Time employees are eligible to enroll in Medical and Daycare Flexible Spending. If elected deductions will begin the first of the month following 60 days of employment or the first of month following a status change.

Annual Medical FSA Contribution
Minimum Contribution $100
Maximum Contribution $2,750

Annual Daycare FSA Contribution
Minimum Contribution $100
Maximum Contribution $5,000 (if married filing separately $2,500)

E Benefits Administration

1-888-503-0609
www.ebenefitsadministration.com

Flexible Spending (continued)

E Benefits Administration

Mountain View Hospital

What is a Healthcare FSA?

A flexible spending account is an employer sponsored benefit that allows you to pay for eligible medical expenses on a pre-tax basis. If you expect to incur medical expenses that won't be reimbursed by another plan, FSAs are a great way to save money while covering those costs.

How Does It Benefit Me?

An FSA saves you money. The contributions you make to an FSA are deducted from your pay before your federal, FICA and state taxes are calculated and are never reported to the IRS.

The end result is that you decrease your taxable income and increase your spendable income.

Federal Tax Rate	Annual FSA Contribution	Annual Tax Savings
25%	$2750	$675
29%	$2750	$783
31%	$2750	$873
33%	$2750	$891

* For illustrative purposes only. Based on a 7.65% FICA. Your tax situation may be different. Consult a tax advisor.

How a Healthcare FSA Works

Flexible spending accounts reduce your taxable income by setting aside pre-tax dollars to pay for eligible healthcare expenses.
Under the Mountain View Hospital Plan You can contribute up to $2,750 annually to your flexible spending account. This annual election amount will be deducted evenly out of each biweekly (26) pay check on a pre-tax basis and put into your FSA.

Changes to the annual election amount are only permitted due to a change of status such as marriage or birth of a child.

A big perk to an FSA is that it is pre-funded, meaning that you will have access to your full annual election amount at the very beginning of the plan year, regardless of the amount contributed to date. That is like having a tax-free, interest-free loan to help you pay for healthcare expenses. You will receive an FSA Debit MasterCard upon your enrollment in the plan that has full access to your annual election for your convenience.

Your plan includes a grace period extension. For 75 days following the end of your plan year (March 15th). This feature creates a grace period that immediately follows the end of the plan year. During this time frame, you may incur expenses and use the funds remaining in your account toward eligible FSA expenses. You have a 15 day run off period after the end of the Grace Period (until March 31st) to submit claims for the ending plan year. You have 30 days to submit claims if you terminate from the plan during the plan year.

Who's Covered

An FSA covers eligible expenses for you and all of your dependents, even if they are not covered under your primary health plan. You can join the Mountain View Hospital FSA plan 60 days after your hire date.

What's Covered

For a complete list of eligible expenses see IRS Publication 502: Medical and Dental Expenses.
Examples of eligible expenses:

Acne Treatments**	Allergy Medicine**
Antacids**	Bandages
Chiropractic Care	Cold Medicine**
Condoms	Contact Lenses & Cleaners
Copays, Co-Insurance & Deductibles	Dental Care
Diabetic Supplies	Eyeglasses
Hearing aids	Laser Eye Surgery
Orthodontia	Pain Relievers**
Pregnancy Tests	Prescription Drugs
Smoking Cessation Programs**	Sunscreen

** Over-the-counter (OTC) drugs and medicines (except insulin) are only eligible for reimbursement when prescribed by a physician.

Why should I enroll in a dependent care FSA?

Flexible Spending (continued)

Child and dependent care is a large expense for many American families. Millions of people rely on child care to be able to work, while others are responsible for older parents or disabled family members. If you pay for care of dependents in order to work, you'll want to take advantage of the savings this plan offers. Money contributed to a DCA is free from federal income, Social Security, and Medicare taxes and remains tax-free when it is spent.

Tax Status	DCA Contribution	Annual Savings
Married (Separately)	$2500	$691
Single	$5000	$1382
Married (Jointly)	$5000	$1382

Imagine the savings accrued in just their preschool years.

How a dependent care FSA Works

Participating in a dependent care FSA is like receiving a 30% discount from your care provider.

A dependent care FSA (DCA) is a flexible spending account that allows you to set aside pre-tax dollars for dependent care expenses. Since DCA contributions are deducted from your paycheck pre-tax, your taxable income is reduced. Participants enjoy a 30% average tax savings on their annual DCA contribution. As the contributions are deducted from your biweekly (26) pay check the amount contributed to date is available for use.

Qualifying Dependents

Your qualifying child under the age of 13, who shares the same residence with you, or Your spouse or qualifying child or relative who is physically or mentally unable to care for him/herself who shares the same residence with you and has income less than the federal exemption amount.

Annual Contribution Limits

The IRS limits annual contributions to $5,000 on income tax returns for single or married filing jointly, and $2,500 for married filing separately.

Eligible Expenses

Dependent care FSA funds cover care costs for your eligible dependents while you are at work:

- Before school or after school care (other than tuition)
- Custodial care for dependent adults
- Licensed day care centers
- Nursery schools or pre-schools
- Placement fees for a provider, such as an au pair
- Day camp, nursery school, or a private sitter
- Late pick-up fees
- Summer or holiday day camps

Ineligible Expenses

These items are never eligible for tax-free purchase with dependent care FSA funds:

- Expenses for children 13 and older
- Care provided by a relative that lives in your household or your dependent under age 19
- Educational expenses including kindergarten or private school tuition fees
- Amounts paid for food, clothing, sports lessons, field trips, and entertainment
- Care for dependent while sick employee stays home
- Overnight camp expenses
- Registration fees
- Transportation expenses
- Late payment fees
- Advanced payments

Please contact E Benefits Administration with any questions at 888-503-0609 or email info@ebenefitsadministration.com

Employee Assistance

LIVE HEALTHY WITH THE EAP

Free. Fast. Confidential.

The EAP (Employee Assistance Program) helps you **privately solve** problems that may interfere with your work, family, and life in general. EAP services are **FREE** to you, your dependents, and all household members. EAP services are always **confidential** and **provided by experts.**

CONFIDENTIAL COUNSELING

24-hour Crisis Help – toll-free access for you or a family member experiencing a crisis. 866-750-1327

In-person Counseling – up to 8 face-to-face counseling sessions are available for each new issue. Simply call for access to qualified, local counselors who can help you with a variety of problems such as family, parenting, relationship, stress, anxiety, and other challenges. 866-750-1327

Online Consultations – convenient access to online consultations with licensed counselors through RBH *e*Access at MyRBH.com. Online consultations are a great way to get support for brief issues, even when time is limited. www.MyRBH.com

WORKSITE SERVICES

All supervisors have fast access to phone consultations, trainings about the EAP and management topics, critical incident response, and online supervisor resources for using the EAP and making employee referrals during workplace challenges.

MYRBH.COM

Access current health news, tools for parenting, health topic movies, wellness resources, financial calculators, legal forms, and over 50 online trainings.

MyRBH Access Code: MtnViewHospital

MyRBH.com | 866.750.1327

LIFE-BALANCE RESOURCES

Legal Services – access a free, half-hour consultation, by phone or in person, for any non-work related issue, followed with a 25% discount in legal fees.

Financial Services – access free phone support for up to 30 days for each new financial issue, such as debt counseling, budgeting, and college or retirement planning.

Mediation Services – request free consultations for personal, family, and non-work related issues such as divorce, neighbor disputes, or real estate.

Will Kit – receive a free will template to complete in your own time.

Home Ownership Program – get free support and information about making smarter choices when shopping for a new home; making financing decisions; relocating; or selling a home.

Identity Theft Services – access support in planning the recovery process for restoring your identity and credit after an incident.

To find out more about your EAP call or visit us online.

RBH
Reliant Behavioral Health

Unum Basic Life and AD&D

Mountain View Hospital provides employer paid Basic Life and AD&D coverage to full time employees. This benefit is automatically added to your benefits. The only action required by you is to enter in your immediate dependents into paycom. Refer to your UNUM plan documents for complete benefit information.

Life Insurance	
Employee	$50,000
Spouse	$10,000
Children (unmarried up to age 26)	$10,000

*This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the even of your death.

Accidental Death & Dismemberment	
Employee	$50,000
N/A	N/A
N/A	N/A

*This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss.

For questions on Basic Unum policies please refer to the Basic Life and AD&D booklet located on the Mountain View Hospital intranet page under benefits.

Unum Voluntary Life and AD&D

NEW for the 2021 plan year Unum is offering ***guaranteed issue life insurance*** to all full time and part time employees who have never been denied coverage in the past. This means if you have missed enrolling during your new hire enrollment period you can get the coverage up to the guaranteed issue amount with no medical questions or health exams! They are also offering **guaranteed short term disability** to part time employees who have never been denied this benefit in the past!

Full time employees are automatically enrolled by Mountain View Hospital for $50,000 Life Insurance, $50,000 AD&D coverage, and $10,000 Dependent Life Insurance, Long Term Disability and Short Term Disability. The premiums for this coverage is covered by Mountain View Hospital. For those who would like to purchase additional coverage on themselves, spouse's or dependents now's the time.

Part time employees are eligible to enroll in all of the below Unum benefits. If you have never applied for Short Term Disability before this coverage is guaranteed for the 2021 plan year. If you have previously been denied Short Term Disability you may re-apply through Paycom but will need to complete health questions and coverage could be denied.

How guaranteed issue works for Life Insurance

*If you have applied and been denied in the past guaranteed issue is excluded. You may still apply but must complete health questions.

During your open enrollment	Future enrollments
If you enroll: • You can select any coverage amount in increments of $10,000, with no medical questions or health exams, up to the guaranteed issue amount of $200,000 • Your spouse can select any coverage amount in increments of $10,000, with no medical questions or health exams, up to the guaranteed issue amount of $50,000 • You can select any coverage amount for your child(ren) in increments of $5,000 up to the guaranteed issue amount of $10,000.	If you enroll during this open enrollment: • You can increase your coverage up to $200,000 with no health questions or physical exams. • You can increase your spouse's coverage up to $50,000 with no health questions or physical exams.

The maximum coverage available is $600,000 for employee and $300,000 for spouses.

If you do not enroll:
If coverage is offered again, you can apply for it. However you will need to answer health questions even for the minimum amount. You could be declined coverage.

Unum Voluntary Life and AD&D (continued)

Term Benefit Amount	
Employee	In increments of $10,000; not to exceed $600,000.
Spouse	Up to 100% of employee amount in increments of $5,000; not to exceed $300,000
Child(ren)–unmarried up to age 26	Up to 100% of employee coverage amount in increments of $2,000; not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $1,000.

Age Band	Employee Rate	Spouse Rate
<25	$0.530	$0.330
25–29	$0.640	$0.395
30–34	$0.850	$0.530
35–39	$0.960	$0.595
40–44	$1.070	$0.660
45–49	$1.600	$0.990
50–54	$2.450	$1.520
55–59	$4.000	$2.845
60–64	$6.700	$4.365
65–69	$13.530	$8.400
70–74	$21.940	$13.625
75+	$21.970	$13.635
Child life monthly rate is $0.400 per $2,000. One life premium covers all children.		

Unum Voluntary Life and AD&D (continued)

	AD&D Cost	Monthly Cost
Employee	Per $10,000	$0.100
Spouse	Per $5,000	$0.050
Child(ren)- unmarried up to age 26	Per $2,000	$0.076

*Accidental Death and Dismemberment coverage is guaranteed and does not need evidence of insurability. Premiums are taken bi-weekly through payroll deduction.

Short Term Disability

Mountain View Hospital offers an employer paid Short Term Disability benefit through Unum. This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. You are eligible for Short Term Disability (STD) coverage if you are an active Full Time employee. Coverage will take affect the first of the month following 30 days of employment or the first of the month following a status change. This is an employer paid benefit.

Short Term Disability coverage is available to part time employees. You may calculate your premium through your benefits in paycom by selecting the Voluntary STD plan. Premiums are collected bi-weekly through payroll deduction.

Refer to your Unum plan document for complete benefit information.

Coverage	Full Time	Part Time
Weekly Benefit Amount	Employer is providing a benefit of 60% of your weekly earnings	Employee may select Voluntary STD.
Maximum Benefit Amount	$1,500 per week	
Elimination Period	You can begin to receive STD benefits if, the disability is in result of a covered injury or sickness. Could begin to receive benefits after a minimum of 14 days.	You can begin to receive STD benefits if, the disability is in result of a covered injury or sickness. Could begin to receive benefits after 30 days.

How guaranteed issue works for Short Term Disability – (Employees working 35 hours or less per week) *If you have applied and been denied in the past guaranteed issue is excluded. You may still apply but must complete health questions.

During your open enrollment	Future enrollments
If you enroll: • Your coverage is automatically approved with no health questions or physical exams.	If you enroll during a future open enrollment • You will be required to answer health questions and your coverage could be denied.

Long Term Disability

Mountain View Hospital offers an employer paid Long Term Disability benefit through Unum. This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. You are eligible for Long Term Disability (LTD) coverage if you are an active full time employee. Coverage will take affect the first of the month following 30 days of employment or the first of the month following a status change. This is an employer paid benefit. Refer to your Unum plan document for complete benefit information.

Coverage	Full Time Only
Monthly Benefit Amount	Employer is providing a benefit of 60% of our monthly earnings
Maximum Benefit Amount	$1,500 per month
Elimination Period	You can begin to receive LTD benefits if, after 90 days of disability, you are still disabled.

Ancillary Benefits

Mountain View Hospital gives you the opportunity to purchase valuable insurance to protect your finances from a variety of common situations–and can give you the assurance that you've made a smart decision for yourself and your family. The following benefits are considered Unum Ancillary Benefits and if enrolled in will be deducted bi-weekly through payroll deduction. Enrollment is not automatic and requires approval from Unum.

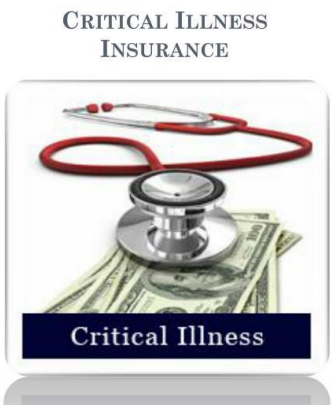
Enrollment in these polices requires you to email benefits@mvhospital.net to schedule an appointment with Alpine Castle Lake Insurance.

Group Accident Insurance

Group Hospital Insurance

Group Whole Life Insurance

Group Critical Illness Insurance



Better benefits at work.

If you have an accident, will it hurt your bank account too?

Unum's accident insurance gives you something to fall back on.

Life can take a tumble.

With a full-time job and three active kids, Marsha's a busy woman. And as a single mom, she's also thrifty. So if her kids break something other than a window, she doesn't want an injury to break her bank account as well.

Benefits that pay for covered accidents while you are on the road to recovery

Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- broken bones
- burns
- torn ligaments
- concussion
- eye injuries
- ruptured discs
- cuts repaired by stitches

Some covered expenses include:

- emergency room treatment
- doctor office visit
- hospitalization
- physical therapy

See the schedule of benefits for full list of covered injuries and expenses.

How to apply To learn more, watch for information from your employer.

Who's at risk?

- Every 10 minutes almost 500 people will suffer disabling injuries in the United States.[1]
- About two-thirds of disabling injuries suffered by American workers are not work-related, and therefore not covered by workers' compensation.[2]

An illustrative example of how accident coverage can help you with your expenses*

40-year-old claimant

Accident: Fall at home
Injury: Broken toe and ACL tear (knee ligament injury)

Out-of-pocket expenses incurred:

$100 emergency room copay
$250 deductible
$750 copay for surgery ($3,750 x 20%)
$150 copay for 10 physical therapy visits

Total out-of-pocket expenses: $1,250

Benefits paid:

$150 emergency room visit
$100 appliance (knee brace)
$100 fractured toe
$400 surgical ligament tear repair
$ 50 follow-up appointment
$150 for six physical therapy sessions

Total benefit paid under policy: $950

*Costs of treatment and benefit amounts may vary.

Get the coverage you need.

Choose the coverage that's right for you. Your accident insurance plan can provide benefits for covered accidents that occur on and off the job. Accident insurance is offered to all eligible employees ages 17 to 80 who are actively at work.[3] You decide if it's right for you and your family.

Five reasons to buy this coverage at work

1. No health questions to answer. If you apply, you automatically receive this base plan.
2. You own the policy so you can keep it even if you leave the company or retire. Unum will bill you directly for the same premium amount.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.
4. Your base coverage is guaranteed renewable for life.
5. Premiums are conveniently deducted from your paycheck.

Available family coverage

Who can have it?	
Spouse coverage	Ages 17 to 80, if actively at work or not disabled[4]
Child coverage	Available to eligible children, stepchildren, and legally adopted children, ages 14 days until their 25th birthday, who are not disabled and/or married.[5]

My accident coverage

Coverage plan chosen: _____

Cost per pay period: $ _____

Date deductions begin: ___/___/____

(For your records — complete during your enrollment)

Mountain View Hospital LLC

Hospital Indemnity Insurance

can pay benefits that help you with the costs of a covered hospital visit.

How does it work?

You can receive benefits when you're admitted to the hospital for a covered accident or illness. The money is paid directly to you – not to a hospital or care provider.

It can complement your health insurance to help you pay for the costs of a hospital stay. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.

What's included?

- $1,500 for each covered hospital admission - once per year
- $100 for each day of your covered hospital stay, up to 15 days - once per year
- $200 for each day you spend in intensive care, up to 15 days - once per year
- $150 for emergency room treatment for a covered accident once per year
- $100 for ambulance or $500 for air ambulance transportation for a covered accident once per year

Why is this coverage so valuable?

- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Who can get coverage?

You	If you're actively at work
Your spouse	Ages 17-64
Your children	Dependent children until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

This plan has a pre-existing condition limitation. See the disclosures for more information.

Hospital Indemnity Insurance

Exclusions and Limitations

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- Participating in war or act of war, whether declared or undeclared;
- Treatment for alcoholism or drug addiction unless the insured individual is addicted to a narcotic taken on the advice of a physician;
- Treatment for dental care or dental procedures, unless treatment is the result of a covered accident;
- Elective procedures and/or cosmetic surgery or reconstructive surgery, unless it is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part or because of congenital disease or anomaly of a covered dependent child;
- An elective abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
- Participating or attempting to participate in a felony or being engaged in an illegal occupation;
- Committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- Hospital confinement caused by, contributed to by, or resulting from mental illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer's disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this policy;
- Any hospital confinement of a newborn following the birth unless the newborn is sick or injured.

The definition of hospital does not include certain facilities. See your contract for details.

Pre-existing conditions

Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of a sickness or injury, whether diagnosed or not, for which you received medical treatment, medical advice, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed drugs or medicine to be taken during the months prior to your effective date) will not be paid if the date of the covered loss occurs during the first months after your effective date.

Termination of employee coverage

If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer.

Otherwise, your coverage under the policy ends on the earliest of the:

- Date this policy is cancelled;
- Date you are no longer in an eligible group;
- Date your eligible group is no longer covered;
- Date of your death;
- Last day of the period for which you made any required contributions; or
- Last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

THIS INSURANCE PROVIDES LIMITED BENEFITS.

This coverage is a supplement to health insurance. It is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GHI-1 or contact your Unum representative.

Unum complies with all state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Get lifetime coverage and useful cash benefits, too.

Whole Life Insurance provides much more than a death benefit — it also offers valuable "living benefits" that you can use during times of need. And you can keep your Whole Life coverage after you retire, making it an essential complement to Term Life.

Whole Life provides a lifetime of coverage.

Whole Life: Benefits for a lifetime

What is Whole Life?

- Whole Life offers "living benefits" you can use when you need them, as well as a death benefit.

What features are available?

- **Cash value.** This policy accumulates cash value.* You can borrow funds from this value as needed.
- **Living benefit option rider.** If you are diagnosed with a terminal illness, you can request up to 100% of your policy's benefit amount and use it for any purpose.**
- **Long term care benefits.**† Your policy may include a long term care rider — see your plan administrator.

How does it work?

- **Your premiums are level for life.** Premiums will be conveniently deducted from your paycheck.
- **Your death benefit is level, too.** The benefit does not decrease with age.
- **You own the policy.**†† You can keep the policy if you leave or retire. You'll pay the same premium.

Three reasons to buy Whole Life at work — now!

1. **Whole Life rates.** The rates available through your employer are typically more affordable than those available elsewhere.
2. **Age-based premiums.** Premiums are based on your age when you purchase, and don't increase as you get older. So the earlier you buy, the lower your premium will be for the life of your policy.
3. **Guaranteed issue.** Generally available during the initial enrollment at your workplace. When it's offered to you, you can purchase coverage up to a set amount, without medical exams or health questions. If you don't purchase the maximum amount, you have the option to increase it up to that level during future enrollments — no questions asked!#

Premium payment options

You may have two options for paying premiums:

- "Lifetime premium." Coverage continues as long as you pay your premiums.
- "Paid-up at 70." Available when purchased between the ages 15 and 50. Adjusts the premium so that the policy is fully paid up when you turn 70.

Sample rates based on $25,000 benefit amount

	Lifetime premium		Paid-up at 70	
Issue age	Weekly premium	Guaranteed cash value at 65	Weekly premium	Guaranteed cash value at 65
25	$ 4.19	$9,840	$ 4.92	$10,996
35	$ 6.44	$8,850	$ 7.76	$10,567
45	$10.80	$7,140	$13.93	$ 9,716

Sample non-tobacco user rates. Premium rates vary by age, coverage amount and tobacco use. For illustration purposes only.

How to apply To learn more, watch for information from your employer.

Group critical illness insurance with wellness benefit

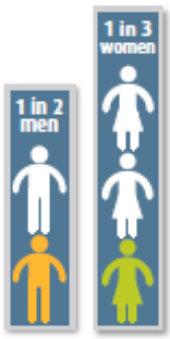
Better benefits at work.

Could your bank account survive a serious illness?

Be prepared with group critical illness insurance from Unum.

Who's at risk?

- The odds of developing cancer during a lifetime are one in two for men and one in three for women.[1]
- Every 40 seconds someone in America will have a stroke.[2]



Key advantage

You can use this coverage more than once. If you receive a full benefit payout for a covered illness, your coverage can be continued for the remaining covered conditions. The diagnosis of a new covered illness must occur at least 90 days after the most recent diagnosis. Each condition is payable once per lifetime.

Three reasons to buy this coverage at work

1. You get affordable rates when you buy this coverage through your employer, and the premiums are conveniently deducted from your paycheck.
2. Coverage is portable. You may take the coverage with you if you leave the company or retire without having to answer new health questions. Unum will bill you directly.
3. Coverage becomes effective on the first day of the month in which payroll deductions begin.

How can critical illness insurance help?

Critical illness insurance can pay a lump sum benefit at the diagnosis of a covered illness. You choose the level of coverage — $5,000 or $10,000 — and you can use the money any way you see fit.

Covered conditions	
Heart attack	Blindness
Major organ failure	End-stage renal (kidney) failure
Occupational HIV	Coronary artery bypass surgery; pays 25% of lump sum benefit
Benign brain tumor	

Covered conditions with time limitations	
Stroke	Evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event
Coma	Coma resulting from severe traumatic brain injury lasting for a period of 14 or more consecutive days
Permanent paralysis	Complete and permanent loss of the use of two or more limbs for continuous 90 days as a result of a covered accident

Cancer conditions	
Cancer	Carcinoma in situ;[3] pays 25% of lump sum benefit

Please refer to the policy for complete details about these covered conditions.

How to apply To learn more, watch for information from your employer.

If you have questions regarding Mountain View Hospital's benefits please email: benefits@mvhospital.net

Coverage	Partner	Phone	Website
Medical Plans PPO and HSA	Blue Cross of Idaho	1-888-462-7677	www.bcidaho.com
Delta Dental	Delta Dental	208-489-3580	www.deltadentalid.com
Willamette Dental	Willamette Dental	1-855-433-6825	www.locations.willamettedetnal.com
Vision	Blue Cross of Idaho (VSP)	1-888-462-7677	www.bcidaho.com
Flexible Spending and Health Savings Account	E-Benefits	1-888-503-0609	www.ebenefitsadministration.com
Unum-Life/Disability/Ancillary	Unum	1-866-679-3054	
Mountain View Hospital Benefit Specialist	Angela Cook Mon-Thur 8AM-3:30PM	208-542-7284	benefits@mvhospital.net
Idaho Falls Community Hospital Benefit Specialist	Emily Austin	208-557-2630	benefits@mvhospital.net