Benefit Summary 2024-2025

Helping you make informed choices
about your employee benefits.

Cottonwood Heights

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Eligible for Medicare?

Prescription Drug Coverage: If you and/or your dependents have Medicare or will become eligible in the next 12 months, federal law gives you more choices about your prescription drug coverage. (pg 41)

Medicare and your HSA: As you approach Medicare eligibility at age 65, please be aware of some important rules regarding Medicare and your health savings account (HSA)/ turning 65 often means automatic eligibility and sometimes automatic enrollment in Medicare. There is a difference between Medicare eligibility and Medicare enrollment. Medicare enrollment may disrupt your eligibility to contribute to HSA. For more information,visit Health Equity.

https://www.healthequity.com/doclib/bcbsma/hsa/medicare-and-your-hsa.pdf

Welcome to the City of Cottonwood Heights!

As a vital part of our employees' futures, it is important to us that you maintain your health, energy, peace of mind, and can be your best each day. We are pleased to offer employees a comprehensive health and wellness benefits package. We encourage you to learn all about your benefits, from medical and health benefits to the Rec. Center gym perks!

Contact Information

Medical	SelectHealth	800.538.5038	www.selecthealth.org
Dental	EMI Health	800.662.5851	www.emihealth.com
Life and AD&D Insurance	The Standard	888.937.4783	www.standard.com
Long-Term and Short-Term Disability	The Standard	888.937.4783	www.standard.com
Flexible Spending Account	APA Benefits	801.561.4980	www.apachoicepoint.net
HSA	Health Equity	866.346.5800	www.healthequity.com
Vision	VSP	800.877.7195	www.vsp.com
Accident – Off the Job	Allstate	800.348.4489	www.allstatebenefits.com/mybenefits/
Accident – On the Job	Unum	800.635.5597 (press 1)	www.unum.com/employees
Employee Assistance Program	Intermountain Healthcare	800.832.7733	www.intermountainhealthcare.org/eap
Benefits Coordinator	Maria Devereux	801.944.7022	mdevereux@ch.uh.gov

If you have general insurance questions, or questions on how the plan works, please refer to this benefit guide, your Summary of Benefits and Coverage (medical only) or contact your Benefits Coordinator. If you are having claims issues, need help finding a provider, or need preauthorization, contact the applicable insurance carrier as they are able to resolve most questions and issues within a single phone call.

Benefits Overview

Cottonwood Heights City is proud to offer a comprehensive benefits package to eligible, full-time employees who work 40 hours per week and part-time employees are offered all but medical. The complete benefit package is briefly summarized in this booklet.

You share the costs of some benefits (medical and dental), and Cottonwood Heights City provides other benefits at no cost to you (life, accidental death & dismemberment, EAP and disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through Cottonwood Heights City payroll deductions.

Benefits Offered

» Medical

» Dental

» Vision

» Life Insurance

» Accidental Death & Dismemberment (AD&D) Insurance

» Voluntary Life and AD&D

» Short-Term Disability

» Long-Term Disability

» Flexible Spending Account (FSA)

» EAP (Employee Assistance Program)

» Accident

Eligibility

You and your dependents are eligible for Cottonwood Heights City benefits on the first of the month following date of employment.

Eligible dependents are your spouse, domestic partner, 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 contact your Benefits Coordinator within 30 days.

Qualifying Events

» Marriage, divorce or legal separation.

» Addition of a dependent child through birth, adoption or a change in legal custody.

» Death of a spouse or dependent.

» Loss of other coverage.

Termination of Benefits

Benefits will be terminated on the last day of the month your employment with Cottonwood Heights City ends. The employee's portion of the benefits will be withheld on the final paycheck.

Navigate My Benefits

https://www.employeenavigator.com/benefits/Account/Login

Navigate 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 need assistance with Employee Navigator, please contact Maria Devereux, HR Manager at 801.944.7022.

If you are a NEW HIRE or NOT YET REGISTERED:

Step 1. Go to https://www.employeenavigator.com/benefits/Account/Login and click on 'Register as a new user'

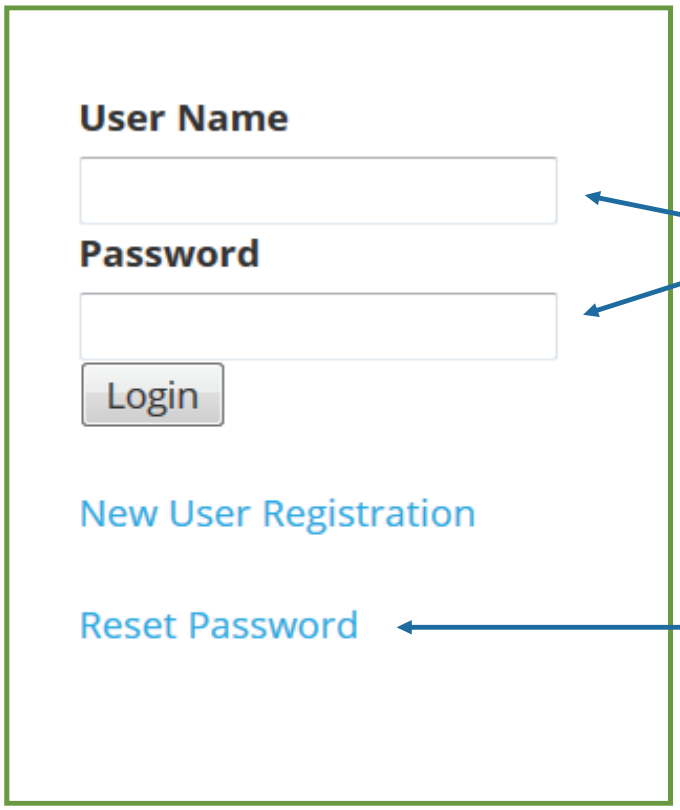
Step 2. Fill in the required fields. The company identifier is **Cottonwood Heights**. Then click 'Next'

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. Once logged in, the system will direct you through your required tasks and enrollments

Username: _____

Password: _____



If you are a current user and need to make a change to your benefits at open enrollment or because you experienced a life event you can login by entering your Username and Password.

If you are a current user and have forgotten your password please click 'Reset password'

Medical Benefits

Administered by SelectHealth

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Cottonwood Heights City.

Cottonwood Heights City offers you a High Deductible Health Plan (HDHP).

With this plan, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

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 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 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.

Health Insurance Waiver

An employee that has available alternate, comparable health insurance coverage, through an employee's spouse or otherwise, has the option to decline and waive medical insurance and have the city use a portion of the premium saving resulting from that waiver for additional contributions to a retirement account, or be paid out. An employee must show proof of insurance coverage. For 2024-2025 the amount of contribution is equal to the amount the City pays for single coverage on the $1750 deductible plan.

	Value and Med Networks / HSA Qualified	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Annual Deductible [1, 2]	$1,750 / $3,500	$2,000 / $4,000
Annual Out-of-Pocket Maximum [1, 2]	$3,000 / $6,000	$4,500 / $9,000
Coinsurance	20%	40%
Office Visits		
Primary Care Provider [3]	20% after deductible	40% after deductible
Secondary Care Provider (SCP) [3]	20% after deductible	40% after deductible
Intermountain Connect Care	0% after deductible	Not Available
Chiropractic (20 visits per year) (up to 20 visits per plan year)	20% after deductible	Not covered
Preventive Care		
Primary Care Provider (PCP) [3] Secondary Care Provider (SCP) [3] Adult and Pediatric Immunizations Elective Immunizations Diagnostic Tests: Minor	0%	Not covered
Emergency Room	20% after deductible	20% after deductible
Inpatient Medical, Surgical and Hospice [4] Maternity and Adoption Rehab Therapy [4]: (Physical, Speech, Occupational – Up to 40 days per calendar year for all therapy types combined)	20% after deductible	40% after deductible
Outpatient Surgery, Ambulance, Home Health, Hospice, Private Nurse, Rehab Therapy	Surgery, Ambulance, Home Health, Hospice, Private Nurse, Rehab Therapy : 20% after deductible	Surgery, Home Health, Hospice, Private Nurse, Rehab Therapy: 40% after deductible; Ambulance: 20% after deductible
Urgent Care	20% after deductible	40% after deductible
Kids Care	20% after deductible	Not Available
Mental Health and Chemical Dependency [4]		
Office visit Inpatient Outpatient Injectable Drugs and Specialty Meds [4]	20% after deductible	40% after deductible
Prescription Drugs—Up to 30 day supply of covered medications [4]		
Tier 1 Tier 2 Tier 3 Tier 4	20% after in-network deductible	
Maintenance Drug Benefit—90 day supply (Mail-Order, Retail)—Selected drugs [4]		
Tier 1 Tier 2 Tier 3	20% after in-network deductible	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

Employee Contributions Per Pay Period	Value and Med Networks / HSA Qualified
Single	$48.48
Two-Party	$100.34
Family	$135.75

[1] All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

[2] Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

[3] Refer to www.selecthealth.org/findadoctor to identify whether a Provider is a primary or secondary care Provider.

[4] Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--"Healthcare Management", in your Certificate of Coverage, for details.

Health Savings Account (HSA)

Administered by Health Equity

Your Health Savings Account (HSA) is a personal savings account that works in conjunction with the High-Deductible Health Plan being offered by SelectHealth. You can use your HSA to pay for current and future qualified medical expenses—tax free.

Increase Your Healthcare Buying Power

Employees may make contributions to their own HSA. Because the money you contribute to your Health Savings Account is tax-deductible, using your HSA to pay for qualified medical expenses—from doctor's fees and dental work to prescription and over-the-counter medications—can help maximize your healthcare buying power! The company will contribute a base amount without any commitment from the employees to contribute their own dollars to their HSA.

Cottonwood Heights City Annual Contribution*		2024 IRS Allowed Maximum Annual Funding	
Single	$600	Single	$4,150
Two-Party	$1,200	Two Party / Family	$8,300
Family	$1,200	55+ Catch-Up	$1,000

*Contributions will be prorated for new hires, based on fiscal year. The city will be depositing HSA funds throughout the year: single=$50 a month, 2-party-family= $100 a month.

You can change HSA election as often as necessary and you don't have to contribute the funds in a lump sum. The funds you elect will be made through pretax payroll deductions. The more you contribute, the more you have available to pay for medical expenses on a tax-favored basis. The annual contribution limits run on a calendar year from January through December.

HSA Funding

In 2024 the maximum amount the IRS allows you to contribute to your HSA is $4,150 for a single and $8,300 for family coverage, but you don't have to contribute it as a lump sum. Employees age 55+ may contribute $1,000 catch-up contribution. You can contribute to pay for medical expenses on a tax-favored basis. The annual contribution limits run on a calendar year from January through December.

Convenient Payment Option

With a swipe of your HSA debit card, you can pay for prescriptions, doctor visits, dental expenses and more. Funds will automatically be deducted from your HSA.

HSA = Health Savings Account

HDHP = High Deductible Health Plan

Now, let's show what happens when you visit your provider.

As usual, you present your ID card to the provider, who submits a claim on your behalf to SelectHealth. Next, SelectHealth determines how much the plan will pay in network discounts and covered expenses. If you owe money, you may use your tax-advantaged HSA to pay for the expenses if funds are available. You and your provider will receive a health statement confirming how the expenses were paid.

If you decide to enroll in Medicare after delaying it, you should stop contributing to your HSA at least six months in advance. Otherwise, you may be hit with a tax penalty because Part A of Medicare provides six months of retroactive coverage upon enrollment. If you require HSA consultation, please consult a tax professional.

How Does an HSA Work?

Each time you visit your physician, pharmacy or hospital, give the provider your HDHP health insurance card. The charges for each of those visits will be submitted to your health insurance carrier and eligible charges will be applied to your annual deductible. Upon receipt of your Explanation of Benefits (EOB) from the health insurance carrier, which details the negotiated network discount on your medical visit, you pay the provider using the pretax money set aside in your HSA. When picking up a prescription from the pharmacy, present your HDHP health insurance card. The pharmacy will apply the SelectHealth discount and then you pay the pharmacy using your HSA debit card. The amount you pay will then be applied to your deductible.

Once your single or family deductible has been satisfied, your physician visits, hospital claims and pharmacy charges will be processed by your health insurance plan and your will pay coinsurance or pharmacy copay. You can pay these charges using your HSA debit card as long as you have a balance in your HSA.

Keep in mind, all the money left in your HSA at the end of the year each year rolls over. This allows you to accumulate—tax-free—a nest egg for future medical expenses.

HDHP Components

Annual Deductible—Amount that needs to be satisfied before health coverage begins. If you are enrolled on a plan with single coverage, you must satisfy single deductible. If you are enrolled on a plan with your spouse and/or child(ren) you must satisfy the family deductible.

Out-of-Pocket Maximum—The maximum amount your health insurance plan will require you to contribute out-of pocket towards the cost of your care per calendar year (excluding cost of premiums). This protects you and your family from very high costs by capping the total amount you will have to spend on healthcare annually.

Preventive Care—Your preventive care is free and not subject to deductible for participating providers.

Pharmacy—Your pharmacy benefit is subject to your single/family deductible.

Who is eligible for an HSA?

Anyone who satisfies all of the following:

» Covered by a Qualified High Deductible Health Plan (HDHP);

» Not covered under another medical plan that is not a HDHP;

» Not entitled to Medicare benefits; and

» Not eligible to be claimed on another person's tax return.

The annual contribution limits run on a calendar year from January through December.

Note

As of January 1, 2016, veterans who seek medical treatment at a VA hospital are now eligible to use their HSA funds for that treatment.

Accessing Your Health Equity HSA

Health Equity website: https://healthequity.com

Click **Login**

Click on **Health Equity** (not Wage Works)

Click "**Create username and Password**" at the bottom of the login box

You will be asked to complete a verification step

Then the system will walk you through setting up your account

Health Savings Account

An Health Savings Account (HSA) lets you put money away for future healthcare costs while saving on taxes. How? HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too.

- ☑ No 'use-it-or-lose-it,' keep your HSA forever
- ☑ Create a healthcare emergency safety net
- ☑ Invest[1] your HSA tax-free, like a 401(k)

Annual tax saving potential[2]

$1,660
Family plan

$830
Individual plan

2024 IRS Contribution Limits	
$8,300 Family plan	**$4,150** Individual plan
Members 55+ can contribute an extra $1,000	

See how much you can save

HealthEquity.com/Learn/HSA

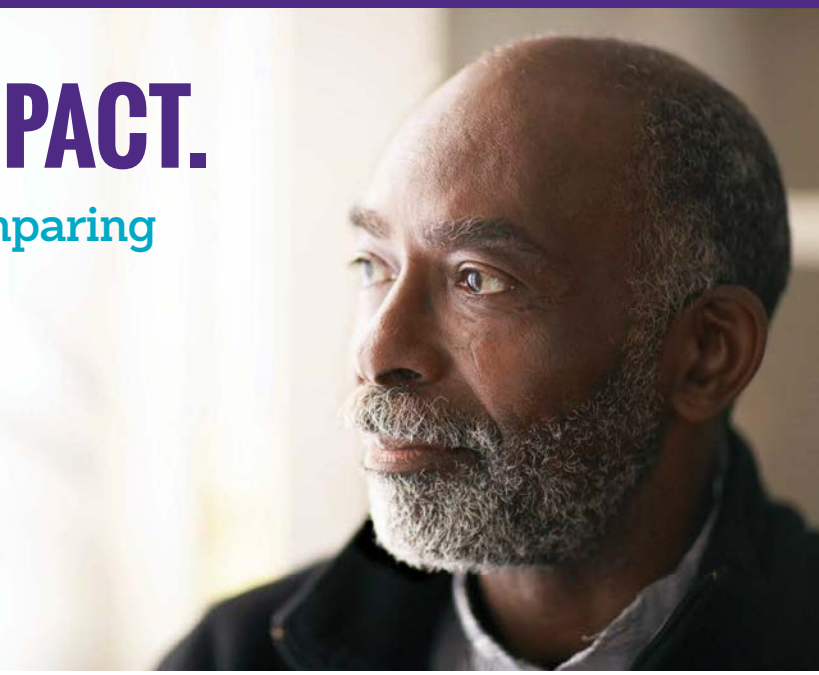
Common qualified medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies

[1]Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | [2]Estimated savings are based on an assumed combined federal and state income tax rate of 20%. Actual savings will depend on your taxable income and tax status. | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

LOW FEES. HIGH IMPACT.

Five questions to ask when comparing HSA investment offerings.



HSAs are the most tax-advantaged retirement savings vehicle, so it's no surprise more emphasis is being placed on HSA investing. Trusted third-party evaluations show that HealthEquity offers some of the lowest fees in the industry. But fees are only one part of the equation. Here are five questions to ask as you compare investment offerings among different HSA administrators.

01 ARE FEES AND PRICING TRANSPARENT?

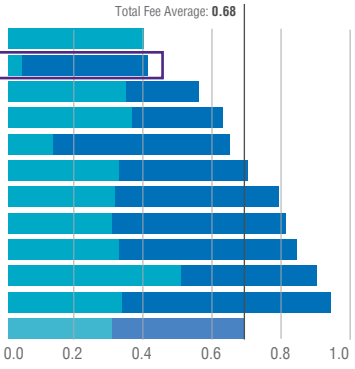
Financial services firms have a reputation for opaque pricing practices. That's why it's important to look beyond maintenance fees and consider underlying fund fees as well.

As the chart to the right illustrates, fund fees can significantly increase total fees even where advertised investment fees are zero.

In other words, "zero fees" does not always mean zero fees. So, be sure to look at the entire picture.

Total Fee for Equal-Weighted 60/40 Portfolio, $14,000 Balance

	Total Fee %	Underlying Fund Fee %	Maintenance and Investment Fee %
Fidelity	**0.39**	0.39	—
HealthEquity	**0.40**	0.04	0.36
Bank of America	**0.55**	0.34	0.21
The HSA Authority	**0.62**	0.36	0.26
HealthSavings	**0.64**	0.13	0.51
Fifth Third	**0.69**	0.32	0.37
Bend	**0.78**	0.31	0.47
Lively	**0.80**	0.30	0.50
HSA Bank	**0.83**	0.32	0.51
Further	**0.88**	0.50	0.39
Optum	**0.93**	0.33	0.60
Average	**0.68**	**0.30**	**0.40**



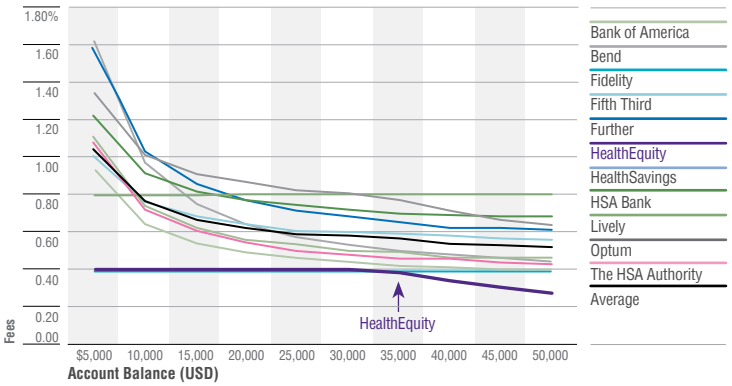
Source: Morningstar 2020 Health Savings Account Landscape: morningstar.com/lp/hsa-landscape. Due to Rounding, Underlying Fund Fee and Maintenance and Investment Fee may not sum to Total Fee.

02 ARE FEES CAPPED?

As you consider the total cost to invest, inquire whether fees are capped for high-balance HSA investors. Everyone wants members to use their HSA as a retirement savings tool. So, it doesn't make sense to penalize members who build health savings.

HealthEquity total fees are among the lowest in the industry (see chart right). We cap maintenance fees because we believe in rewarding members who show real progress on the journey to retirement readiness.

Total Fee for Equal-Weighted 60/40 Portfolio



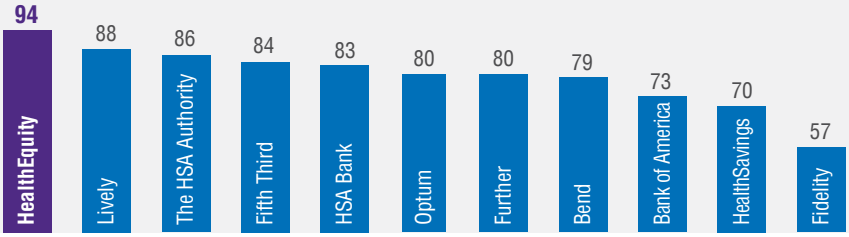
Source: Morningstar 2020 Health Savings Account Landscape: morningstar.com/lp/hsa-landscape

03

DO THEY CATER PRIMARILY TO WEALTHIER, SOPHISTICATED INVESTORS?

Some administrators are good at enabling day traders. But an HSA is not a brokerage account. Members either need money to spend in the near term or they need to save for healthcare expenses in retirement. Take time to validate that the investment offering is appropriate for your members and the realities of HSA investing.

Percent of Options Earning Gold and Silver Morningstar Medals



Source: Morningstar 2020 Health Savings Account Landscape: morningstar.com/lp/hsa-landscape

The chart left illustrates that HealthEquity offers a higher proportion of Gold and Silver medal Morningstar funds than anyone. Be confident that no matter their selection, your members will be investing in high-quality funds.

04

WILL THEY TRY TO CROSS-SELL MEMBERS OTHER PRODUCTS AND SERVICES?

There are a lot of companies in the consumer directed benefits space that don't focus on consumer directed benefits. The reality is that some vendors offer an HSA just to sell mutual funds and other financial products. As you review different administrators, consider:

- How often do they contact members and for what reasons?
- Is HSA their primary focus—or is it ancillary to their core business?
- How and to what extent do they use member data?

Make sure your team enjoys a remarkable experience. Choose a partner focused exclusively on the accounts your members use every day.

05

DO THEY HAVE AN ENGAGEMENT PROGRAM DESIGNED TO NURTURE NOVICE HSA MEMBERS?

Most members don't know the benefits of investing nor how to do it. Ask prospective administrators about their approach to education and engagement. How do they structure the experience for members who aren't already savvy investors?

- Find out if they have a systematic approach to drive and measure member engagement.
- Review samples of their member communications.
- Look for a track record of success, including documented results and outcomes.

Only targeted education delivered at the right moment will propel members on the journey to retirement readiness.

Find out more ways to power up your HSA.
866.855.8908 | HealthEquity.com

ONE PARTNER. TOTAL SOLUTION.

Only HealthEquity delivers the integrated solutions you need to simplify benefits and truly impact people's lives.

HSA | FSA | HRA | Commuter | COBRA | Wellbeing

Group Supplemental Accident Insurance

Insured by Allstate

An accidental injury can be costly, especially if you are financially unprepared. Your current medical coverage will help pay for expenses associated with an injury, but won't cover all of the out-of-pocket expenses you may face. Don't wait until you are rushed to the emergency room to realize you need more protection.

Cottonwood Heights offers you the choice of two Accident Insurance plans. One is administered by Allstate and is an Off-The-Job benefit. This plan has a much broader wellness and physician outpatient visit. The second is a 24-Hour Coverage (including On-The-Job) administered by Unum. This plan's wellness and physician outpatient visit is limited. You can elect both plans or choose between the two.

Allstate Off-The-Job Accident Benefits	
Accidental Death Employee Spouse Child	 $40,000 $20,000 $10,000
Common Carrier Accidental Death Employee Spouse Child	 $200,000 $100,000 $50,000
Dismemberment Employee Spouse Child	 up to $40,000 up to $20,000 up to $10,000
Dislocation or Fracture	up to $4,000
Hospital Confinement	$1,000
Daily Hospital Confinement	$200
Intensive Care	$400
Ambulance Regular Ambulance Air Ambulance	 $200 $600
Accident Physician Treatment	$100
X-ray*	$200
Emergency Room Services	$200
Benefit Enhancements	
Lacerations	$50
Burns <15% of body surface >15% or more	 $100 $500
Skin Graft (% of Burns Benefit)	50%
Brain Injury Diagnosis	$150
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI)	$50
Paralysis Paraplegia Quadriplegia	 $7,500 $15,000
Coma with Respiratory Assistance	$10,000
Open Abdominal or Thoracic Surgery	$1,000
Tendon, Ligament, Rotator Cuff of Knee Cartilage Surgery Surgery Exploratory	 $500 $150
Ruptured Disc Surgery	$500
Eye Surgery	$100
General Anesthesia	$100
Blood and Plasma	$300

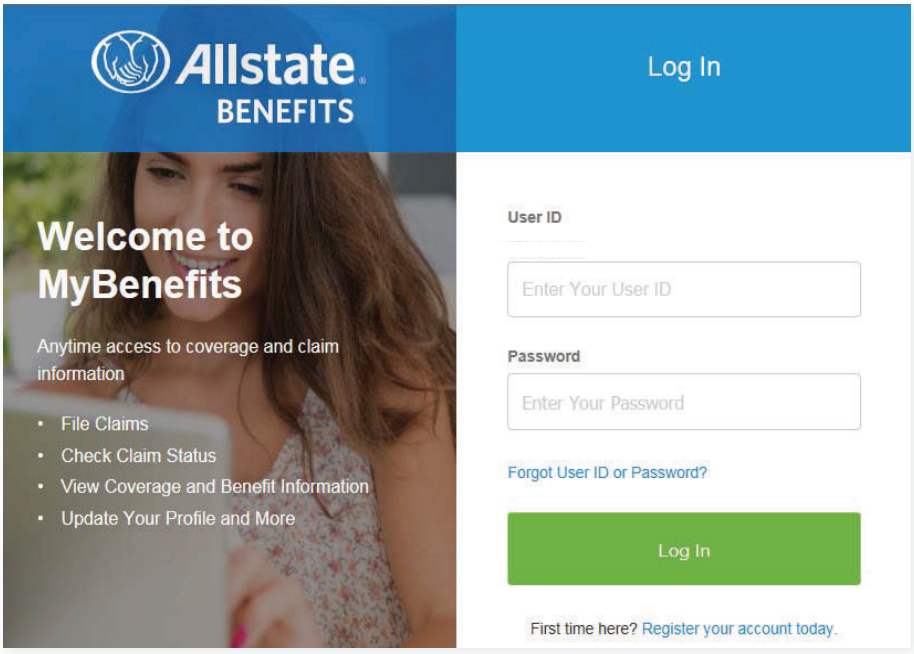
Benefit Enhancements (continued)	
Appliance	$125
Medical Supplies	$5
Medicine	$5
Prosthesis One Device Two or More	 $500 $1,000
Physical Therapy	$30
Rehabilitation Unit	$100
Non-Local Transportation	$400
Family Member Lodging	$100
Post-Accident Transportation	$200
Accident Follow-Up Treatment	$50
Additional Rider Benefit	
Outpatient Physician's Benefit	$100
Loss of Life or Limb	
Life, or both eyes, hands, arms, feet, or legs, or one hand or arm and one foot or leg	$40,000
One eye, hand, arm, foot, or leg	$20,000
One or more entire toes or fingers	$40,000
Complete Dislocation	
Hip Joint	$4,000
Knee or ankle joint, bone or bones of the foot	$1,600
Wrist joint	$1,400
Elbow joint	$1,200
Shoulder joint	$800
Bone or bones of the hand, collarbone	$600
Two or more fingers or toes	$280
One finger or toe	$120
Complete, Simple or Closed Fracture	
Hip, thigh (femur), pelvis	$4,000
Skull	$3,800
Arm, between shoulder and elbow (shaft), shoulder blade (scapula), leg (tibia or fibula)	$2,200
Ankle, knee cap (patella), forearm (radius or ulna), collarbone (clavicle)	$1,600
Foot, hand or wrists	$1,400
Lower jaw	$800
Two or more ribs, fingers or toes, bones of face or nose	$600
One rib, finger or toe, coccyx	$280

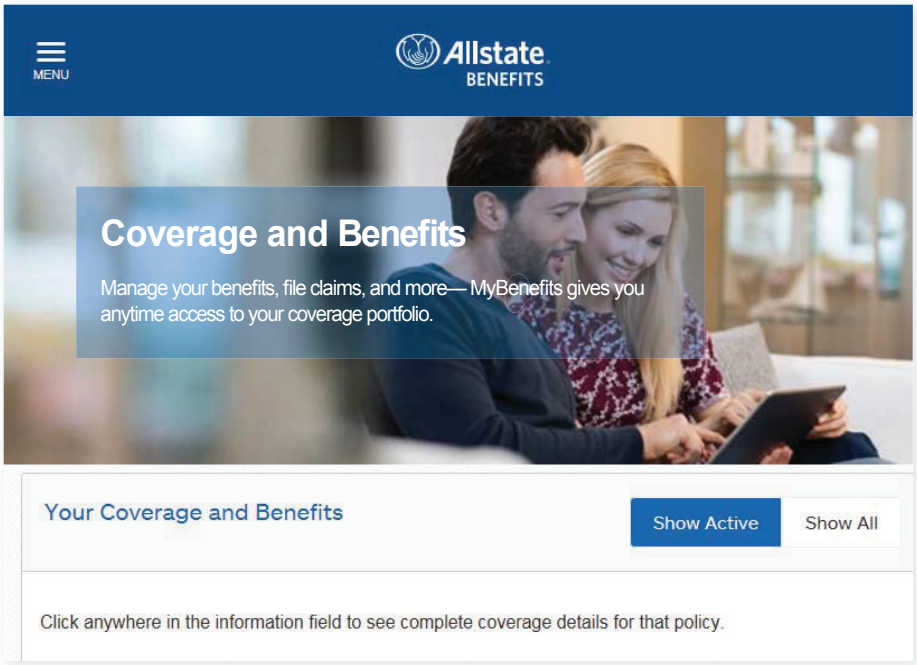
Allstate Rates

	Cost Per Pay Period
Employee	$6.44
Employee + Spouse	$9.77
Employee + Child(ren)	$15.08
Family	$18.88

MyBenefits

Innovative online capabilities at your fingertips





1. Online Access 24/7

Access your claim and benefit information anytime, day or night.

2. Fast File

Complete your claim submission online for quick processing. Use your mobile device to take a picture of your documents and submit using your smartphone, tablet or PC.

3. Express Claims Process

Have your Wellness or Outpatient Physician's Treatment benefit claim processed within 48 hours (supporting documentation required) by filing through our Express option. Elect to have your claim benefit payment directly deposited into your checking account.

4. Coverage Information

Print or view your coverage details or certificates on existing coverage.

5. Help Center

Gives you anytime access to our Forms Library, Upload Center, contact information and recent account activity.

6. Message Center

Alerts you of claim status updates and other important information.

7. Mobile Friendly

Use your mobile device to upload pictures of your claim forms and supporting documents.

For questions, please contact the Allstate Benefits Customer Care Center at

1-800-521-3535

Unum Accident Insurance 24-Hour Benefits (On the Job)	
Covered Injuries	**Benefit Amount**
Fractures	
Open	Up to $7,500
Closed	Up to $3,750
Chips	25% of closed amount
Dislocations	
Open	Up to $6,000
Closed	Up to $3,000
Burns	
2nd Degree	$0 - $1,000
3rd Degree	$2,500 - $10,000
Concussion	$150
Coma	$10,000
Ruptured Disc	$800
Torn tendons, ligaments, etc.	$150 - $1,200

Emergency and Hospitalization Benefits	Benefit Amount
Ambulance (ground, once per accident)[1]	$400
Emergency Room treatment	$150
Emergency Treatment in Physician Office/Urgent Care Facility	
Primary Care Physician, Specialist, Urgent Care	$50
Hospital Admission (admission or intensive care admission once per covered accident)	$1,000

Treatment and Other Services	Benefit Amount
Surgery benefit	$150 - $1,500
Physician follow-up visit (up to 2 visits per accident)	$50
Occupational, speech, physical therapy (up to 2 per accident each type)	$25
Prosthetic device or artificial limb	$100 - $1,500

Accidental Death and Other Covered Losses	Benefit Amount
Accidental Death*	
Employee	$50,000
Spouse	$20,000
Child	$10,000
*The accidental death benefit triples if the insured individual is injured as a fare-paying passenger on a common carrier: Employee– $150,000; Spouse– $60,000; Child– $30,00	
Initial Accident Dismemberment – one benefit per accident, not payable with initial accidental loss	
Loss of both hands or both feet	$15,000
Loss of one hand and one foot	$15,000
Loss of one hand or one foot	$7,500
Loss of two or more fingers, toes, or any combination	$1,500
Loss of one finger or toe	$750

THIS IS A LIMITED POLICY.

The 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 which may affect any benefits payable. For complete details of coverage and availability, please refer to policy form GA-1 or contact your Unum representative.

Unum Rates

	Cost Per Pay Period
Employee	$7.87
Employee + Spouse	$12.62
Employee + Child(ren)	$13.98
Family	$18.73

Dental Benefits

Administered by EMI Health

	In-Network Advantage Plus Network	In-Network Premier Network	Out-of-Network
Type 1—Preventive (Oral Exams, Cleanings, X-rays, Fluoride)	100%	100%	100%
Type 2—Basic (Fillings, Oral Surgery)	80%	80%	80%
Type 3—Major (Crowns, Bridges, Prosthodontics)	50%	50%	50%
Type 4—Orthodontics			
Dependent children up to age 19	50%	50%	50%
Adults	50%	50%	50%
Endodontics	Type 2—Basic	Type 2—Basic	Type 2—Basic
Periodontics	Type 2—Basic	Type 2—Basic	Type 2—Basic
Sealants	Type 2—Basic	Type 2—Basic	Type 2—Basic
Space Maintainers	Type 2—Basic	Type 2—Basic	Type 2—Basic
Specialists	Paid same as General Dentists		
Waiting Periods	None		
Deductible			
Per person	$0	$0	$50
Family Max	$0	$0	$150
Deductible Applies To	N/A	N/A	Type 2 and Type 3
Annual Maximum Per Person	$2,000 All maximums are combined up to limits above	$2,000 All maximums are combined up to limits above	
Orthodontics Lifetime Maximum	$1,500		
Network / Reimbursement Schedule	Advantage Plus	Premier	Premier

Provisions/Limitations/Exclusions	
Exams (including Periodontal), Cleanings and Fluoride	2 per year
Fluoride	Up to age 16
Sealants	Up to age 16
Space Maintainers	Up to age 16
Bitewing X-Rays	Up to 4, twice per year
Periapical X Rays	6 per year
Panoramic X-Ray	1 every 3 years
Impacted Teeth	Covered in Type 2—Basic
Provisions/Limitations/Exclusions	
Anesthesia—(Age 8 and over for the extraction of impacted teeth only)	Covered in Type 3—Major
Anaesthesia—(For children age 7 and under, once per year)	Covered in Type 3—Major
Implants	Covered in Type 3—Major
Crowns, Pontics, Abutments, Onlays, Dentures	1 every 5 years per toots
Fillings on the same surface	1 every 18 months

Benefits illustrated are in summary only. Refer to your Dental Handbook for a complete description of benefits, limitations and exclusions. All services are to object to EMI Health Table of Allowances. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Table of Allowances.

Employee Contributions Per Pay Period	Dental Plan
Single	$5.75
Two-Party	$12.15
Family	$20.39

Vision Benefits

Administered by VSP

Regular eye examinations can determine your need for corrective eye wear and also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a VSP doctor:

Service	In-Network	Out-of-Network
Exam Copay	$10	Up to $45
Lenses Single Bifocal Trifocal	 $10 $10 $10	 Up to $30 Up to $50 Up to $65
Frames	$130 Allowance, then 20% saving on the amount over the Allowance.	Up to $70
Contacts	$130 Allowance, Up to $60	Up to $105
Frequency (Lens, Frames)	Once in 12 months	Not covered
Laser Correction	15% off regular price, 5% off promotional price.	Not covered
Lens Options Progressive Premium Custom Progressive Other lens enhancements	 $55 copay $95 – $105 $150 – $175 20%-25% discounts	Not covered

No need for an ID card. To take advantage of your VSP vision benefit, simply contact a VSP provider and let them know you have VSP coverage—they handle the paperwork for you.

Rates

	Cost Per Pay Period
Employee	$5.40
Employee + Child(ren)	$8.63
Employee + Spouse	$8.81
Family	$14.21

Life and Accidental Death & Dismemberment Insurance

Insured by The Standard

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment if you die while employed by Cottonwood Heights City. Cottonwood Heights City provides basic life insurance at no cost to you.

Employee Amount — $50,000

Spouse Amount — $10,000

Each Child — $10,000

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 die in an accident. Cottonwood Heights City provides AD&D coverage of $100,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above.

Voluntary Life

Insured by The Standard

You may purchase life insurance in addition to the company-provided coverage. You are guaranteed coverage of $100,000 ($40,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee — Increments of $10,000; $400,000 maximum amount

Spouse — Increments of $5,000; $250,000 maximum amount

Children — $10,000

Employees will need to complete an Evidence of Insurability (EOI) form when increasing life insurance of any amount.

Calculate Your Voluntary Supplemental Life Premium							
Supplemental Life Coverage Amount			Number of 1,000's	Rate from below			Premium Monthly or Per Pay Period
Employee		/ 1,000 =		x		=	
Spouse		/ 1,000 =		x		=	
Child(ren)		/ 1,000 =		x		=	

Voluntary Supplemental Life Monthly Premiums

Age Band	Employee and Spouse Monthly Premiums Per $1,000
Under 30	0.055
30-34	0.059
35-39	0.084
40-44	0.091
45-49	0.133
50-54	0.201
55-59	0.369
60-64	0.626
65-69	0.626
70-74	0.626
75+	0.626

Employee Navigator will calculate these rates for you. If you are having troubles , please contact HR.

Guaranteed Issue (GI)	
Employee	$100,000
Spouse	$40,000 (not to exceed 100% of the Employee's Election)
Children	$10,000

*Coverage amount reduces at age 70.

Voluntary AD&D

Insured by The Standard

You may also purchase Voluntary Accidental Death and Dismemberment in addition to the company provided coverage. This coverage is separate from Voluntary Life insurance and it is not required to have Voluntary Life in order to enroll in Voluntary AD&D. See the election amounts available below.

Employee:

Employee — Increments of $25,000; $500,000 maximum amount

Employee + Family:

Spouse Only: 60% of employee's amount

Child Only: 25% of employee's amount; not to exceed $50,000

Spouse and Child(ren): 50% of employee's amount for spouse and 20% of employee's amount for each child

	Monthly Rates Per $1,000
Employee Only	$0.020
Employee + Family	$0.020

Short-Term Disability Insurance (STD)

Administered by The Standard

Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness. Benefits begin on the 15th day of any injury, hospitalization or illness and can continue for up to 11 weeks. FMLA leave is run concurrent with short-term disability.

Benefit Amounts — 60% of weekly covered earnings.
Benefit Maximum — $1,000 per week.
Please see your Benefits Coordinator for more details.

Long-Term Disability Insurance (LTD)

Insured by The Standard

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. Cottonwood Heights City provides Long-Term Disability insurance (LTD) coverage for you at no cost.

Benefit Amounts — 60% of your monthly covered earnings

Benefit Maximum — Up to $6,000 per month

Flexible Spending Accounts (FSAs)

Administered by APA Benefits

You can save money on your dental and vision and/or dependent day care expenses with Limited Purpose FSA (lpFSA). You set aside funds each pay period on a pre-tax basis and use them tax-free for qualified dental and vision expenses only. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

Limited Purpose FSA (lpFSA) $3,200

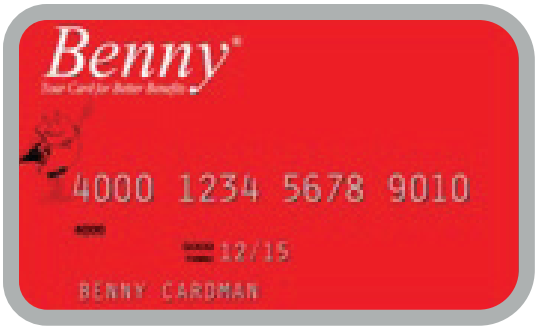
Dependent Care Spending Limit $5,000

Here's How an FSA Works

1. You decide the annual amount (up to $3,200 for lpFSA and $5,000 for Dependent Care) you want to contribute to either or both FSAs based on your expected dental and vision and/or dependent childcare/elder care expenses.
2. Your contributions are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA.
3. You can pay with the lpFSA debit card for eligible dental and vision expenses. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars

Note

For all Medical Expenses, your Health Savings Account (HSA) should be used.



Intermountain Healthcare
Employee Assistance Program (EAP)–100% Company Paid

What is an Employee Assistance Program? (EAP)

An Employee Assistance Program provides short-term, confidential counseling for you, your spouse or significant other and dependent children regardless if they are covered under your health insurance plan at no out-of-pocket expense to you.

Is it Confidential?

Yes, all discussions between you and the EAP counselor are confidential. Personal information is never shared with anyone (including Cottonwood Heights) at any time without your direct knowledge and approval. Exceptions are made only in cases governed by law to protect individuals threatened by violence.

Employee Assistance Program counselors are experienced, caring professionals who hold a Master's degree in counseling or a related field. They are certified or licensed by the appropriate state agency.

Counselors use a solution-focused therapy model and teach you how to resolve your unique problem while providing caring support along the way.

The entire cost of EAP services is covered in a monthly fee paid by Cottonwood Heights. All EAP services are free to you with no copay or deductible required.

Each household member is entitled to unlimited face-to-face visits per incident. Should you elect to receive mental health services through your medical benefit, Intermountain will not absorb the cost.

Setting up an appointment is as simple as calling the office. You will be offered an appointment time, generally within a couple working days of your initial call. Crisis cases are seen the same day, generally within two hours. No paperwork or approval is needed and there is no charge. Counselors are available around the clock for emergency and crisis situations.

Seeking help early minimizes the chances of problems escalating and requiring more extensive services. Often, a few visits with a counselor are all you need to gain perspective and regain a sense of control over your life.

Call **800.832.7733**
Or visit **www.eap@intermountainmail.org**

To reach an EAP Representative Call **800.832.7733**.

All services are free and accessible 24 hours a day, 365 days a year.

The EAP is your resource for everything–from the everyday to the unexpected.

At times, we can all use help with a personal problem or issue that is interfering with our life or work. Most people experience personal or family challenges in the course of their lives. Our professional counselors are available to discuss the issues you face in your life, including:

Life Changing Birth/Adoption	Legal Advice Finances
Child Care Parenting	Elder Care Relationships
Family Conflicts Stress	Grief Aging
Depression Job Pressures	Drugs/Alcohol Eating Disorders

Workers Compensation

Who is eligible?

All employees are eligible for Workers Compensation.

When am I eligible?

Eligibility begins the first day of employment.

1. All employees are covered by workers compensation, which provides medical reimbursement and disability benefits for job-related illness or injury. For exact coverage, check the workers compensation contract on file with Human Resources. Worker's compensation claims may not be filed with the insurer of the City's regular health insurance plan.
2. Employees may use PTO or other compensatory time to pay for mandatory employee benefits. Please refer to Workers Compensation Policy for more details. FMLA leave runs concurrent with workers compensation.
3. Medical Attention. An employee who sustains a bona fide, on-the-job injury should seek medical attention from WORK MED, located at 201 East 5900 South, or the nearest emergency room if necessary. The employee MUST inform the medical provider HOW, WHEN and WHERE the injury occurred.
4. Initial Reporting of Illness or Injury. Reporting the accident or illness is critical to qualification for payment under workers compensation. If an employee is injured while on the job, no matter how minor, the circumstances should be reported to the supervisor immediately. Human Resources will provide paperwork to all Department heads that must be completed and sent back to HR within 24 hours of the injury.
5. Reporting While Off the Job. While on leave because of a bona fide, on-the-job injury or illness, the employee must contact his supervisor or the City Manager on a weekly basis to report on his condition. Failure to provide the required medical status reports may result in revocation of the leave and/or immediate termination of employment.
6. Return to Service after a Workers Compensation Claim. A statement from the attending physician stating that the employee is able to resume normal duties will be required before the City will allow the employee to return to work. An injured employee must return to work promptly after such physician approval is received. Failure to return to work when directed may result in disciplinary action, up to and including termination. An employee who is able to return to work on light duty status may be required to work in a different department and perform duties not contained within his current job classification.
7. If no vacancy exists at the time of final release or settlement of a workers compensation claim, and if the City is unable (despite reasonable efforts) to place the employee in another position, the employee may be terminated and paid any accrued benefits then due.

COBRA

The consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost of the plan. Cottonwood Heights offers Medical, Dental, Vision and sometimes FSA as COBRA benefits. When you enroll in any of these group health benefits, you will receive an "initial cobra notice" in the mail and when you term any of these benefits, you will receive a "cobra election notice" in the mail.

If you have any additional questions, please see your Benefits Coordinator.

Utah State Retirement Systems

URS.org

Who is eligible?

All appointed and full-time employees. Part-time employees working over 20 hours a week, excluding some officials, are eligible for the Utah Retirement System (URS). Eligibility for elected officials is determined by certification date, minimum earnings and employment status. Seasonal and part-time (less than 20 hours per week) employees are not eligible for URS. In the Utah Retirement System, separate divisions exist for Police Officers, Firefighters and Public employees. Police employees must be employed for 40 or more hours a week to be eligible for the program. All other eligible employees must work an average minimum of 20 hours per week.

The amount of benefit paid is determined by your hire date, age, years of service credit, final average salary, and a benefit formula designed by the Utah Retirement System. The URS has designated two categories of employees according to enrollment date. Once you are enrolled in the URS as either a Tier 1 or a Tier 2 employee, you will keep that designation, even if you stop working for a participating employer for a period of time and then return at a later date.

URS ACCOUNT ACCESS: To access your Utah Retirement System account, go to **www.urs.org**. You can login to my URS which will display your years of service and account information. You can also view account statements, update your address and beneficiaries and print forms.

TIER 1 EMPLOYEES: Employees initially enrolled in the Utah Retirement System before July 1, 2011 are classified as Tier 1 employees. The City will pay the full URS Tier 1 rate for eligible employees. All City employees are enrolled in the Noncontributory System.

NON CONTRIBUTORY SYSTEM: If you leave employment covered by the Utah Retirement System, you are not eligible for a refund, but your retirement funds will remain in your account and you will receive a benefit when you retire. Benefits are vested after four years of service.

TIER 2 EMPLOYEES: Employees initially enrolled in the Utah Retirement System on or after July 1, 2011 are classified as Tier 2 employees. The City will pay the required URS Tier 2 rate for eligible employees. Tier 2 employees may choose between a defined contribution or a hybrid plan which are described below. Employees have one year after employment begins to make this irrevocable choice of plans.

DEFINED CONTRIBUTION PLAN: The full City contribution will be put into a 401(k) account administered by the URS. Employees may elect to make voluntary contributions as well. Employees in this plan become vested after four years of service.

HYBRID PLAN: This plan is a combination defined benefit (pension) and defined contribution. As long as the defined benefit rate remains below 10 percent for public employees, employees will receive the difference between the 10 percent of the required contribution rate into a 401(k) account administered by the URS. If the defined benefit rate reaches or exceeds 10 percent, employees will no longer receive any of this amount into a 401(k) account.

In addition, if the defined benefit rate exceeds 10 percent, employees will be required to pay the portion of the contribution amount above these rates. Employees on this plan may elect to make voluntary 401(k) contributions as well. Employees in this plan become vested after four years of service.

For additional information regarding your Utah Retirement System accounts, contact the URS or your Benefits Coordinator.

Social Security Exempt

Cottonwood Heights City is exempt from participation in the federal Social Security program; consequently, City employees do not participate in, and do not accrue benefits under, the federal Social Security program. In lieu of the Social Security contribution the City has elected to contribute to a retirement savings account for individual employees.

Employee Savings Plans

Employees have the option to participate in a variety of retirement savings plans. These plans are available through the Utah State Retirement System and ICMA-RC. Contributions to your savings plan can be made through payroll deductions with pre-tax or post-tax dollars. There are several different options, and different funds which you can invest in. Please see Benefits Coordinator for additional information.

URS (Utah State Retirement) systems offers the following plans:

1. URS 401(k) Defined Contribution Plan
2. URS 457 Deferred Compensation Plan
3. Roth IRA
4. Traditional IRA

Paydays

Friday Pay Date		
7/12/2024 7/26/2024 8/9/2024 8/23/2024 9/6/2024 9/20/2024 10/4/2024 10/18/2024 11/1/2024	11/15/2024 *11/29/2024 12/13/2024 12/27/2024 1/10/2025 1/24/2025 2/7/2025 2/21/2025 3/7/2025	3/21/2025 4/4/2025 4/18/2025 5/2/2025 5/16/2025 *5/30/2025 6/13/2025 6/27/2025
*Denotes pay check without benefits withheld		

Paid Holidays

Who is eligible?

All full-time employees working 40 hours per week and eligible part-time employees on a pro-rated basis.

When am I eligible?

On date of hire.

BENEFIT: The City is closed in recognition of the listed scheduled holidays and provides time off with pay to its employees. A personal floating holiday is also available to the employees during each budget year. The floating holiday is not accumulated or vested past the end of the budget year or paid out upon termination.

Independence Day	July 4
Pioneer Day	July 24
Labor Day	September 2
Veterans Day	November 11
Thanksgiving Day	November 28
Day After Thanksgiving	November 29
Christmas Day	December 25
New Years Day	January 1
Martin Luther King Day	January 20
President's Day	February 17
Memorial Day	May 26
Juneteenth	Observed June 16
Floating Holiday*	(1) as scheduled

Holidays on Saturday or Sunday

When a holiday falls on a Saturday, the preceding Friday shall be the observed holiday. When a holiday falls on a Sunday, the following Monday shall be the observed holiday.

Employees on duty for emergency services on designated holidays shall be compensated in accordance with the policy set forth in Section 13 of the Personnel Policies and Procedures manual dealing with overtime.

Police Department Employees:

Due to the nature of scheduling in the Police Department, sworn employees will accrue holiday hours on a quarterly basis. Hours for the quarter will be added on the first day of the quarter and must be used by the end of the quarter in which accrued. Any holiday hours left on the books after the end of the quarter will be removed.

Hours will be accrued as follows:

First Quarter: (July through September) 24 hours added July 1 to be used by September 30

Second Quarter (October through December) 32 hours added October 1 to be used by December 31

Third Quarter (January through March) 24 hours added January 1 to be used by March 31

Fourth Quarter: (April through June) 16 hours added April 1 to be used by June 30

Paid Time Off (PTO)

Who is eligible?

All full-time employees working 40 hours per week and regular part-time employees working a minimum of 20 hours per week accrue PTO on a pro-rated basis.

When am I eligible?

PTO accrual begins on the first paycheck.

It is the policy of Cottonwood Heights to provide Paid Time Off (PTO) for regular full-time and part-time, regular employees. PTO gives you the flexibility to take time off from work for the reasons you choose. PTO leave can be utilized for planned leaves from work (including vacations) and unforeseen absences from work (including illness, emergencies and bereavement).

Vacations shall be scheduled well in advance so as to meet the operating requirements of the City and, insofar as possible, the preference of the employee. If you are in a situation where you are at risk of losing your PTO, you may use PTO prior to using accrued comp time. The management of your PTO hours is very important. If you utilize all your time for vacations and have not kept a reserve for unforeseen events, you may find yourself in a leave without pay situation which is subject to discipline, up to and including termination.

BENEFIT: For regular full time employees (benefit prorated for part-time employees based on their actual hours worked per week.)

Year of Service	Per Pay Period Accrual Rate	Maximum Accrual of Hours	Hours Vested at Separation
Less than 1	6.16	N/A	0
1 to 4	6.16	480	50%
5 to 9	7.39	480	65%
10 to 14	8.62	480	80%
15 and Over	9.85	480	80%

Computation

Note: Vesting does not begin until the completion of your first year and is based on an employee's anniversary date.

1. **PTO Usage Guidelines for Non Exempt Employees**
   - » All time off will be authorized by the employee's immediate supervisor, preferably at least one week prior to the event, if possible.
   - » PTO must be utilized in a minimum of quarter-hour increments.
   - » PTO must be accrued, meaning it has appeared on the previous paycheck prior to use. During an employee's first year the city may grant use of unaccrued PTO time that would be accrued during the first year of employment. This exception must be approved by the employee's supervisor and the City Manager.
   - » Employees are allowed to go into arrears with PTO the first 12 months of employment as long as by the end of the 12-month period they are in the positive. If an employee has holiday leave or comp time on the books, that must be used prior to going in arrears.
   - » Any deficit balance due to excess utilization of PTO at the end of the first year will be deducted from the final payroll if an employee is terminated or quits employment with the city.
   - » Immediate supervisors may deny requests for leave based on scheduling needs of the department. Preference for requested leave may be given to employees who have a large amount of accrued PTO.
   - » Excessive PTO usage that is not pre-authorized may require substantiation by the employee in the form of a doctor's signed excuse for illness or some other type of evidence, at the discretion of the City Manager.
2. **PTO Usage Guidelines for Exempt Employees**
   - » All time off will be authorized by the employee's immediate supervisor, preferably at least one week prior to the event, if possible.
   - » PTO may not be utilized in less than eight hour increments.
   - » PTO must be accrued, meaning it has appeared on the previous paycheck prior to use. During an employee's first year the city may grant use of unaccrued PTO time that would be accrued during the first year of employment. This exception must be approved by the employee's supervisor and the City Manager.
   - » Employees are allowed to go into arrears with PTO the first 12 months of employment as long as by the end of the 12-month period they are in the positive. If an employee has holiday leave or comp time on the books, that must be used prior to going in arrears.
   - » Any deficit balance due to excess utilization of PTO at the end of the first year will be deducted from the final payroll if an employee is terminated or quits employment with the city prior to earning the required PTO to cover the deficit.
   - » Immediate supervisors may deny requests for leave based on scheduling needs of the department. Preference for requested leave may be given to employees who have a large amount of accrued PTO.
   - » Excessive PTO usage that is not pre-authorized may require substantiation by the employee in the form of a doctor's signed excuse for illness or some other type of evidence, at the discretion of the City Manager.

PTO / Vacation Buy Out

All full-Time employees will be eligible to have PTO/vacation bought out by the City as per the following guidelines:

» Leave year runs July 1 to June 30.
» Employees must have more than 120 hours of PTO/vacation on the books as of June 1 to participate. The city will only purchase time accrued above the 120 hours.
» The city will purchase up to 100 hours of PTO/vacation from the employee. This will be paid out according to the vesting schedule.

Part-time employees can participate in this program as well but the part-time employees cannot go below 60 hours and the city will only purchase up to 40 hours. All other program guidelines stated above must be followed.

Note: Vacation will be paid out at the PTO vesting rate.

Sworn Police Officer Vacation and Sick Pay

Vacation

Who is Eligible?

All full-time and part-time sworn employees accrue and are eligible to use accrued vacation leave.

Probationary sworn employees accrue vacation but are prohibited from using leave prior to completing one month of employment with Cottonwood Heights, **unless authorized by the Chief of Police**.

If a sworn officer has had his or her service date adjusted in accordance with current policy, the adjusted service date will be used for the purpose of determining the rate of vacation accrual.

Vacation Accrual

Full-time sworn employees shall accrue vacation according to the following schedule:

Years of Service	Per Month	Maximum Accrual of Hours
Less than 1	8	320
1 through 8	8	320
9 through 16	12	320
17 and over	16	320
Police Appointed Staff	16	320

Vacation leave accrual is capped at 320 hours. Vacation leave in excess of 320 hours, by June 30, shall be forfeited.

An employee who is terminated or resigns voluntarily shall be compensated for 25% of their accumulated sick leave at their current rate of pay.

Sick Leave

Who is Eligible?

All full-time and part-time sworn employees accrue and are eligible to use accrued sick leave.

Accumulation of Sick Leave

» Eligible sworn employees shall accumulate sick leave hours at the rate of eight (8) hours per month.
» There is no limitation to the amount of sick leave that may be accrued and carried forward to succeeding years.
» Sick leave shall not be accrued during a period in which the member has been granted leave without pay.

Use of Sick Leave

Sick leave may be used to cover a sworn employee's absence from work due to their own illness, medical condition, or injury. Sick leave may also be used to cover a member's absence from work to care for an ill or injured member of the member's immediate family based on FMLA eligibility.

Employees who want to convert sick leave to vacation leave may do so by submitting a written request to the Finance Department by June 15 of each year.

Additional information can be found in the Personnel Manual.

Jury / Witness Duty

Who is eligible?

All employees.

Employees will be granted leave for jury or witness duty. If the jury or witness service is completed during regular work hours, an employee is expected to return to work upon completion of the service. The employee shall receive their regular pay when performing jury and witness duty and their PTO is not charged. Any income earned and received from jury or witness duty during an employee's scheduled working hours shall be turned over to the Finance Department for reimbursement to the City and the employee shall be paid at his/her current rate for the same period of time.

Military Leave

Who is eligible?

All employees.

A regular employee shall be granted a leave of absence for active service in any branch of the armed forces of the state of Utah or the United States as provided in Utah Code Ann. §39-3-1, et seq. An employee who is entitled to a leave of absence under this provision shall on receipt of his orders promptly provide a copy of the relevant non-restricted portion of such orders to his supervisor and Human Resources. The City acknowledges that USERRA APPLIES TO ALL PUBLIC AND PRIVATE EMPLOYERS IN THE UNITED STATES, REGARDLESS OF SIZE. THE DEFINITION OF "SERVICE IN THE UNIFORMED SERVICES" UNDER USERRA COVERS ALL CATEGORIES OF MILITARY TRAINING AND SERVICE, INCLUDING DUTY PERFORMED ON A VOLUNTARY OR INVOLUNTARY BASIS, IN TIME OF PEACE AND WAR.

A. A regular employee shall be granted leave with compensation for workdays lost while on active duty in the National Guard or in the armed forces reserves for the purpose of annual encampment, field competitions or other required duties in connection with reserve training and instruction. Paid military leave shall not exceed 120 hours (15 - 8-hour days) in any one calendar year. (See Utah Code Ann. §39-3-1, et seq.). Employees on military assignment will only accrue PTO and/or vacation and sick time off while on the 120 hours paid leave or while using their PTO and/or vacation and sick time off. The accrual will only occur if utilizing full weekly compensation (40 hours a week). PTO and/or vacation time off maximum hours caps will apply to those on military assignments, as with any other employee.

Bereavement Leave

Who is eligible?

All full-time employees.

The city desires to support employees during their times of grief and bereavement. An employee may receive three (8 hour) days of paid bereavement leave (per occurrence) following (a) the death of a member of the employee's immediate family, or (b) the end of a pregnancy through miscarriage or stillbirth as provided in Utah Code Ann. 10-3-1103(4), as amended.

The term "immediate family" means relatives of the employee or the employee's spouse (or domestic partner) including in-laws, step relatives, or equivalent relationship as follows:

- spouse
- parents
- siblings
- children
- all levels of grandparents
- all levels of grandchildren

Individual employee circumstances may be discussed with the employee's supervisor and Human Resources to determine whether additional considerations are needed.

Family and Medical Care Leave (FMLA)

Who is eligble?

Employees who have worked for the city for at least 12 months and who have worked prior to requesting a leave.

Benefit: Employees may request family leave for any of the following reasons:

» To care for a child after birth or after an adoption or foster care placement (In this case, the leave must take place within 12 months of the birth, adoption, or placement for foster care)

» To care for the employee's spouse, child, or parent with a serious health condition.

» To meet the needs of a personal serious health condition.

» Qualifying exigencies when employees spouse, child or parent is called to active duty.

» Up to 26 weeks caregiver leave to spouse, child, parent or next of kin serving as the caregiver of an active-duty military member who suffered an injury or became ill in the line of duty.

How do I apply for Family Leave?

An employee with a foreseeable family leave (for example, the birth of a child) must provide the City with 30 days advance notice. In other situations, the employee should notify the City as soon as practical, usually within one or two business days. Family leave applications and other materials are available from the Human Resource Office.

How is Family Leave taken?

When taking Family and Medical Leave, the City will require you to use contemporaneously any accrued paid leave (PTO and compensatory time, holiday, etc.) Each employee is entitled to up to 12 weeks of unpaid leave during any 12-month period, minus any leave taken in the prior 12 months. The employee may take family medical leave all at once or may be eligible to take it in blocks. If the employee and spouse both work for the City, they may request a combined total of up to 12 weeks of unpaid leave each year, if the leave is required to:

» Care for a child following birth, adoption, or foster care placement; or Care for the employee's seriously ill parent. (The leave is not applicable to care for a spouse's parent.)

Otherwise, each employee is eligible for up to the full 12 or 26 weeks each year for an eligible FMLA reason.

How does Family Medical Leave affect my benefits?

For an employee on family leave, medical, dental, and life insurance benefits will continue. If an employee goes on unpaid leave during FMLA they are responsible to repay their portion of the health insurance premiums. Payment plans can be arranged with the Finance Department.

The employee's participation in these plans ends if the employee:

1. Notifies the City that he/she does not intend to return to work.
2. Fails to return from leave
3. Comes to the end of the leave period; or
4. Fails to pay the required premiums

In some cases, the employee can continue coverage under the provisions of COBRA.

What happens when I return to work?

The purpose of a family or medical leave is to ensure that the employee can take care of pressing personal situations. Therefore, the FMLA also includes provisions that protect the employee's job. In brief, he cannot be discriminated against for requesting an FMLA leave. When he returns to work, under most circumstances he must be restored to his original job or, if that is not possible, to an equivalent job with equal pay, benefits and other terms and conditions of employment.

What if I do not return to work?

If you do not return to City service after the expiration of Family and Medical Leave, you will be required to repay the City for any City-paid benefit contributions made for you during the qualified unpaid leave period unless the reason you do not return to work is (1) the continuation, reoccurrence, or onset of a serious health condition that entitles you to leave to care for a child, parent or spouse with a serious health condition, or if you are unable to perform the functions of your position due to your own serious health condition or (2) other conditions beyond your control that prevent you from returning. If you choose not to return to work, and do not meet the conditions listed above, the City will commence legal proceedings to obtain reimbursement for City-paid benefit contributions.

Please check the employee manual for detailed information

Tuition Reimbursement

Who is eligible?

All full-time employees.

When am I eligible?

After an employee has passed initial probationary period of employment and has received a satisfactory or higher rating on their most recent performance review, with no unresolved disciplinary actions.

This program is to provide employees equitable financial assistance for courses of study which are directly related to the employees' current position or are beneficial to the City. The City Manager has sole discretion to determine coursework eligible for this program. Tuition reimbursement is subject to budgetary constraints and course eligibility. Employee work commitments must be addressed. The completion of coursework does not guarantee that the employee will advance or receive a pay increase.

Employees must be taking classes that meet one of the three defined eligibility requirements in order to qualify for Tuition Reimbursements:

» Employee is enrolled in a program leading to a degree in a field relevant to their current position within the City.

» The course of study or certification is required of the employee by the City.

» Employee is not enrolled in a degree program but is taking on individual course work that is related to the employee's current job with the City.

School Eligibility

Undergraduate and graduate level courses must be taken for academic credit through colleges and universities accredited by the Northwest Association of Schools and Colleges, or an equivalent association to be eligible for reimbursement. The City recognizes the value of online learning to help balance education and work/life demands and will reimburse for these types of courses.

Application

To participate in this program an employee must complete the appropriate paperwork and submit it to their department head or designee 15 days prior to the beginning of class. Department heads or designee will review the request to ensure the employee scheduling is covered and that the class relates directly the employee's current job, or a degree program relevant to their current position. Department heads or designee will then send the paperwork to Administrative Services no less than 10 days prior to the beginning of class. Human Resource will review to ensure the funding is available, and forward to the City Manager for final approval. Once the tuition reimbursement application has been approved, the employee will be notified.

1. Unless specific approval from the City Manager is obtained in advance, an employee may not take a course during scheduled working hours. When the educational program requires class work during normal work hours, the employee and his/her supervisor must agree on such a schedule in advance and make necessary arrangements to assure that expectations for ongoing work assignments are met.
2. An eligible employee may receive reimbursement for tuition only. This policy does not cover costs for books, exams, travel, parking or other related student fees.

Reimbursement

1. The maximum reimbursement for all courses of study, including certification, career development and job-related graduate study, will not exceed $2,500 per employee per fiscal year. Tuition costs will not be reimbursed for classes that have not been previously approved.
2. Reimbursement is based on satisfactory completion of the course. Satisfactory completion is defined as a final grade of "B-"or better. For classes graded by pass/fail criteria the employee must obtain a passing grade.
3. An employee eligible for reimbursement from another source (such as federal/state aid, scholarships, or grants) may seek assistance under the tuition reimbursement program, but reimbursement will only be approved for the difference between the amount received from the other funding source and the actual documented expense up to the City's allowed annual maximum.
4. Following successful completion of the course, employees wishing to be reimbursed must submit final grades and a copy of the receipt showing the class is paid. Employees need to attach to this form a copy of the final grade and expense receipts for tuition. Employees, who receive any financial support, as noted above, need to attach to their Reimbursement Request Form all documentation from the school of the amount received from each source of financial support, reflecting the time period the assistance applied to and what classes it applied to.

Expectation of the City

An employee who voluntarily terminates employment with the City within twelve (12) months of completing the course work for which they were reimbursed shall refund the entire amount of the reimbursement to the City. An employee who voluntarily terminates employment with the City from months 12 to 24 of completing the course work for which they were reimbursed shall refund 50% of the amount of the reimbursement to the City. Employees must sign the Deduction Authorization form prior to reimbursement granting the right to withhold any such amounts from final compensation due them.

Tax Implications

It is the understanding of the City that tuition reimbursement is excluded from gross income for income tax purposes. However, employees should refer to their own tax advisors to understand how the tax code affects them individually.

Cottonwood Height's Recreation Membership

Who is eligible?

All Full-Time Employees.

When am I eligible?

At date of hire.

Benefit: The employee is eligible to join the Cottonwood Heights Recreation Center at a discounted price equal to one-half of the regular resident cost for an annual pass (subject to change). The prices listed below are for an annual membership. Three-month memberships are also available. Please call **801.943.3190** for those rates.

	Basic	Premium	Ultimate
Family Pass	$140	$170	$230
Couple Pass	$115	$145	$205

Employees may receive a free day pass on a daily basis rather than pay for a single annual membership. Contact the Recreation Center for more information.

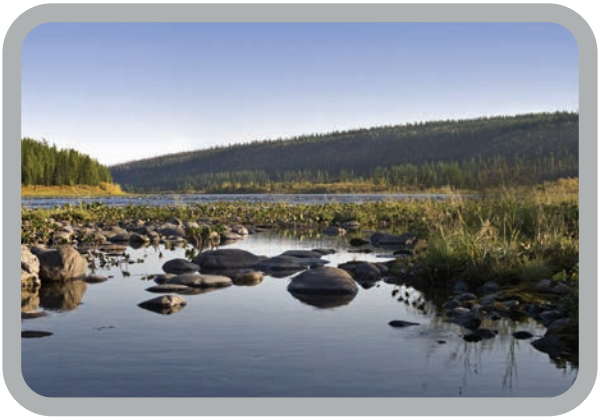
Death Benefits

Benefit: When an employee dies, the listed beneficiaries will be eligible for the following benefits from the City:

» All applicable URS benefits including the employee's pension and retirement funds

» The employee's life insurance.

» Payment for PTO and compensatory time accrued will be paid to the designated life insurance beneficiaries.



Employee and Employee Contributions for Benefits

Health Insurance Costs; What to expect

Benefit Plan	Per Pay Period Cost
***Medical: Value and Med Networks / HSA Qualified**	
Single	$48.48
Two-Party	$100.34
Family	$135.75
Dental	
Single	$5.75
Two-Party	$12.15
Family	$20.39
Vision	
Single	$5.40
Two-Party	$8.63
Employee + Children	$8.81
Family	$14.21
Accident—Unum – 100% Employee Paid	
Employee	$7.87
Employee+Spouse	$12.62
Employee + Child	$13.98
Employee + Children	$13.98
Family	$18.73
Accident—Allstate – 100% Employee Paid	
Employee	$6.44
Employee+Spouse	$9.77
Employee + Child(ren)	$15.08
Family	$18.88

*City pays 85% of Medical Insurance - Employee pays 15%

Voluntary Life—100% Employee Paid

Age Band	Employee and Spouse Monthly Premiums Per $1,000
Under 30	0.055
30-34	0.059
35-39	0.084
40-44	0.091
45-49	0.133
50-54	0.201
55-59	0.369
60-64	0.626
65-69	0.626
70-74	0.626
75+	0.626

Notices and Disclosures

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:

Value and Med Networks / HSA Qualified (Individual: 20% coinsurance and $1,750 deductible; Family: 20% coinsurance and $3,500 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 801.944.7022 or mdevereux@ch.uh.gov.

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).

HIPAA Special Enrollment Rights

Cottonwood Heights City Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Cottonwood Heights City 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 Maria Devereux - Human Resources Manager at 801.944.7022 or mdevereux@ch.uh.gov.

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.

Qualified Medical Child Support Orders

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

Patient Protections Disclosure

The Cottonwood Heights City 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, SelectHealth 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 SelectHealth at 800.538.5038 or www.selecthealth.org.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from SelectHealth 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 SelectHealth at 800.538.5038 or www.selecthealth.org.

Preventive Care

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Contacts" in this Guide.

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 January 31, 2024. 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://kynect.ky.gov 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 and CHIP**
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 January 31, 2024, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Notice Of Creditable Coverage

Important Notice from Cottonwood Heights City

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 Cottonwood Heights City 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. **Cottonwood Heights City 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 coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current Cottonwood Heights City coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into Cottonwood Heights City benefit plan during the Open Enrollment period under Cottonwood Heights City benefit 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 Cottonwood Heights City 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 Cottonwood Heights City 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:	**Cottonwood Heights City**
Contact—Position/Office:	**Maria Devereux - Human Resources Manager**
Office Address:	**2277 E Bengal Blvd.** **Cottonwood Heights, Utah 84121** **United States**
Phone Number:	**801.944.7022**

Statement of ERISA Rights

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

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

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

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

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

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

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

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

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

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

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Maria Devereux.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Cottonwood Heights City
Maria Devereux - Human Resources Manager
1265 E Fort Union Blvd Ste 250
Cottonwood Heights, Utah 84047-1838
United States
801.944.7022

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Michelle's Law Notice

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

» The date that is one year following the date the medically necessary leave of absence began; or
» The date coverage would otherwise terminate under the plan
For the protections of Michelle's Law to apply, the child must:

» Be a dependent child, under the terms of the plan, of a participant or beneficiary; and

» Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lost student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Human Resources.

HIPAA Notice Of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Cottonwood Heights City is committed to the privacy of your health information. The administrators of the Cottonwood Heights City 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 Maria Devereux - Human Resources Manager at 801.944.7022 or mdevereux@ch.uh.gov.

Family Medical Leave Act

Family & Medical Leave Act (FMLA)
FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women. FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees. There may be times when you need an extended leave of absence. The company has a Family and Medical Leave Policy that is in compliance with The Family and Medical Leave Act of 1993 (FMLA), as amended. FMLA provides an entitlement of up to 12 weeks, which protects employees' jobs and benefits in the event of a medical or family circumstance, which requires the employee to take time off from work without pay. In general, the employee must have worked for at least 12 months and at least, 1,250 hours within the last 12 months immediately prior to the first day of leave.

Circumstances Permitting Family and Medical Leave
» Birth of an employee's child (within 12 months after birth)

» Adoption of a child by an employee (within 12 months after placement)

» Placement of a child with the employee for foster care (within 12 months after placement)

» Care of a child, spouse or parent having a serious health condition

» Incapacity of the employee due to a serious health condition

» Military Leave

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

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.

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.

[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.

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 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 Maria Devereux.

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.

3. Employer name Cottonwood Heights City		4. Employer Identification Number (EIN) 20-2154375
5. Employer address 2277 E Bengal Blvd		6. Employer phone number 801.944.7022
7. City Cottonwood Heights	8. State Utah	9. ZIP code 84121
10. Who can we contact about employee health coverage at this job? Maria Devereux		
11. Phone number (if different from above)	12. Email address mdevereux@ch.uh.gov	

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:

- With respect to dependents:

x We do offer coverage. Eligible dependents are

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.

* 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)

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting