

Benefit Summary 2020-2021

Helping you make informed choices
about your employee benefits.



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IMPORTANT:

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

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

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

Contact Information

Medical	SelectHealth	800.538.5038	www.selecthealth.org
Dental	EMI Health	800.662.5851	www.emihealth.com
Life and AD&D Insurance	Lincoln Financial Group	800.423.2765	www.lfg.com
Long-Term and Short-Term Disability	Lincoln Financial Group	800.423.2765	www.lfg.com
Flexible Spending Account	APA Benefits	801.561.4980	www.apachoicepoint.net
HSA	APA Benefits	801.561.4980	www.apachoicepoint.net
Vision	VSP	800.877.7195	www.vsp.com
Accident – Off the Job	Allstate	800.348.4489	www.allstatebenefits.com/mybenefits/
Accident – On and Off 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	Heather Sundquist	801.944.7022	hsundquist@ch.utah.gov
Broker – Arthur J. Gallagher & Co.	Kristine Petersen	801.559.2921	kristine_petersen@ajg.com

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. For more advanced claims issues, please contact your Benefits Coordinator or Kristine Petersen at Arthur J. Gallagher & Co..



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
- » 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

www.navigatemybenefits.com/cottonwoodheightscity



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 are a NEW HIRE or NOT YET REGISTERED:

Step 1. Go to www.navigatemybenefits.com/cottonwoodheightscity and click on 'New User Registration'

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

A screenshot of the login page for the 'Navigate My Benefits' system. The page is enclosed in a green border. It features a 'User Name' label above a text input field, a 'Password' label above another text input field, and a 'Login' button below the password field. Below the login section, there are two links: 'New User Registration' and 'Reset Password'. Blue arrows point from the 'Reset Password' link to a callout box on the right, and from the input fields to another callout box on the right.A blue-bordered box containing two input fields. The first is labeled 'Username:' followed by a horizontal line. The second is labeled 'Password:' followed by a horizontal line.

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, HSA, or be paid out. An employee must show proof of insurance coverage. For 2020-2021, the amount of contribution is equal to the amount the City pays for single coverage on the \$1,350 deductible plan.



Benefit Summary 2020-2021

	High Deductible HSA — Select Med+	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	
Annual Deductible	\$1,400/\$2,800	\$1,650/\$3,300
Annual Out-of-Pocket Maximum (includes deductible)	\$2,500/\$5,000	\$4,000/\$8,000
Coinsurance	20% after deductible	40% after deductible
Office Visits		
Primary Care Provider	\$15 after deductible	40% after deductible
Secondary Care Provider (SCP)	\$25 after deductible	40% after deductible
Telehealth	Covered 100% after deductible	40% after deductible
Chiropractic (15 visits per year) Not applied to Medical out-of-pocket maximum.	Not Covered	Not covered
Preventive Care		
Primary Care Provider (PCP) Secondary Care Provider (SCP) Adult and Pediatric Immunizations Elective Immunizations Diagnostic Tests: Minor	100% Covered	Not covered
Emergency Room		
Inpatient Medical, Surgical and Hospice Maternity and Adoption Rehab Therapy: (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: (Physical, Speech, Occupational- Up to 20 visits per calendar year for each type)	20% after deductible	40% after deductible
Urgent Care		
Kids Care	\$35 after deductible	40% after deductible
Mental Health and Chemical Dependency		
Office visit Inpatient Outpatient Injectable Drugs & Specialty Meds	\$15 after deductible 20% after deductible 20% after deductible 20% after deductible	40% after deductible
Prescription Drugs — Up to 30 day supply of covered medications		
Tier 1	\$7 after deductible	
Tier 2	\$21 after deductible	
Tier 3	\$42 after deductible	
Tier 4	\$100 after deductible	
Maintenance Drug Benefit — 90 day supply (Medco by Mail or Retail90) — Selected drugs		
Tier 1	\$7 after deductible	
Tier 2	\$42 after deductible	
Tier 3	\$126 after deductible	

Employee Contributions Per Pay Period	High Deductible HSA
Single	\$40.32
Two-Party	\$83.45
Family	\$112.89

Health Savings Account (HSA)

Administered by APA Benefits

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*		2020 IRS Allowed Maximum Annual Funding	
Single	\$600	Single	\$3,550
Two-Party	\$1,200	Two Party / Family	\$7,100
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 2020 the maximum amount the IRS allows you to contribute to your HSA is \$3,550 for a single and \$7,100 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.

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 you 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.



Group Supplemental Accident Insurance

Insured by Allstate and Unum

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

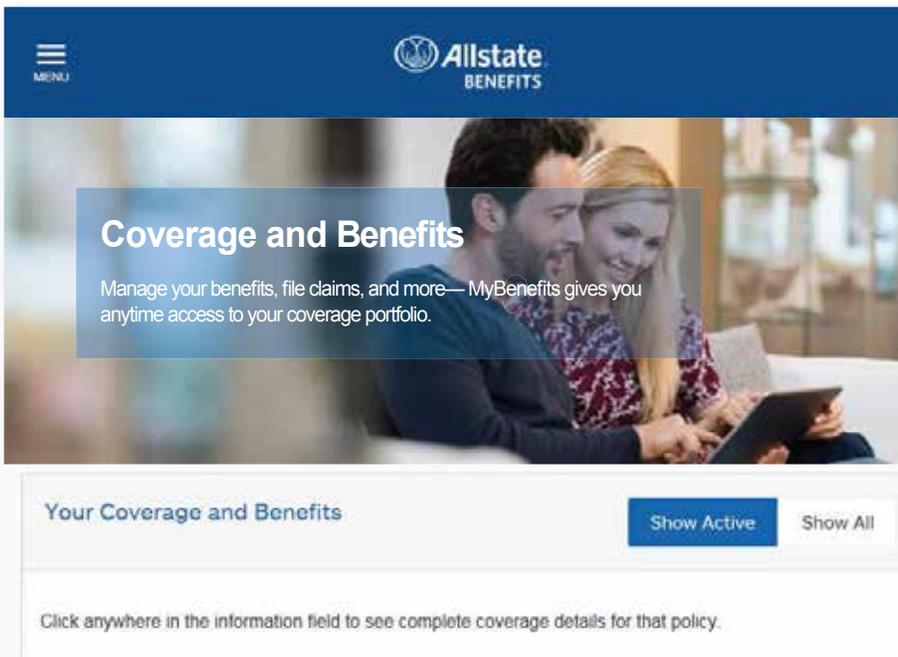
Benefit Enhancements (continued)	
Appliance	\$125
Medical Supplies	\$5
Medicine	\$5
Prosthesis	
One Device	\$500
Two or More	\$1,000
Physical Therapy	\$30
Rehabilitation Unit	\$100
Non-Local Transportation	\$400
Family Member Lodging	\$100
Post-Accident Transportation	\$200
Accident Follow-Up Treatment	\$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 Check
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 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 Check
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 not only determine your need for corrective eyewear but 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	\$10	Up to \$30
Bifocal	\$10	Up to \$50
Trifocal	\$10	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	\$55 copay	Not covered
Premium	\$95 - \$105	
Custom Progressive	\$150 - \$175	
Other lens enhancements	20% - 25% discounts	

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 Check
Employee	\$5.40
Employee + Child(ren)	\$8.63
Employee + Spouse	\$8.81
Family	\$14.21

Life and Accidental Death & Dismemberment Insurance

Insured by Lincoln Financial Group

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. The company provides basic life insurance at no cost to you.

Employee Amount — \$50,000

Spouse Amount — \$10,000

Each Child — \$10,000

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and 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 Lincoln Financial Group

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, not to exceed 5x's salary.

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

Children—\$10,000

Calculate Your Voluntary Supplemental Life Premium Per Pay Period

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

Voluntary Supplement Life Premiums Per Pay Period

Age	Employee Premiums Per Pay Period					Spouse Premiums Per Pay Period*				
	\$20,000	\$40,000	\$60,000	\$80,000	\$100,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Under 30	\$0.55	\$1.10	\$1.65	\$2.20	\$2.75	\$0.28	\$0.55	\$0.83	\$1.10	\$1.38
30–34	\$0.59	\$1.18	\$1.77	\$2.36	\$2.95	\$0.30	\$0.59	\$0.89	\$1.18	\$1.48
35–39	\$0.84	\$1.68	\$2.52	\$3.36	\$4.20	\$0.42	\$0.84	\$1.26	\$1.68	\$2.10
40–44	\$1.01	\$2.02	\$3.03	\$4.04	\$5.05	\$0.51	\$1.01	\$1.52	\$2.02	\$2.53
45–49	\$1.93	\$3.86	\$5.79	\$7.72	\$9.65	\$0.97	\$1.93	\$2.90	\$3.86	\$4.83
50–54	\$2.31	\$4.62	\$6.93	\$9.24	\$11.55	\$1.16	\$2.31	\$3.47	\$4.62	\$5.78
55–59	\$3.69	\$7.38	\$11.07	\$14.76	\$18.45	\$1.85	\$3.69	\$5.54	\$7.38	\$9.23
60 and over	\$6.26	\$12.52	\$18.78	\$25.04	\$31.30	\$3.13	\$6.26	\$9.39	\$12.52	\$15.65

Rates

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

Age Band	Per Pay Period Rate Per \$1,000
Under 25	0.0275
25–29	0.0275
30–34	0.0295
35–39	0.042
40–44	0.0505
45–49	0.0965
50–54	0.1155
55–59	0.1845
60–64	0.313
65 and over*	
*Coverage amount reduces at age 70	

Voluntary AD&D

Insured by Lincoln Financial Group

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.

Voluntary AD&D— 100% Employee Paid

	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Employee Only	\$0.92	\$1.84	\$2.76	\$3.68	\$4.60
Employee + Family	\$1.24	\$2.48	\$3.72	\$4.96	\$6.20

Calculate your Voluntary Accident Death and Dismemberment Premium per pay period

	AD&D Coverage Amount	Number of 25,000's	Premium Per Pay Period
Employee Only	\ 25,000 =	x 0.46 =	
Employee + Family	\ 25,000 =	x .62 =	

Short-Term Disability Insurance (STD)

Administered by Lincoln Financial Group

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.

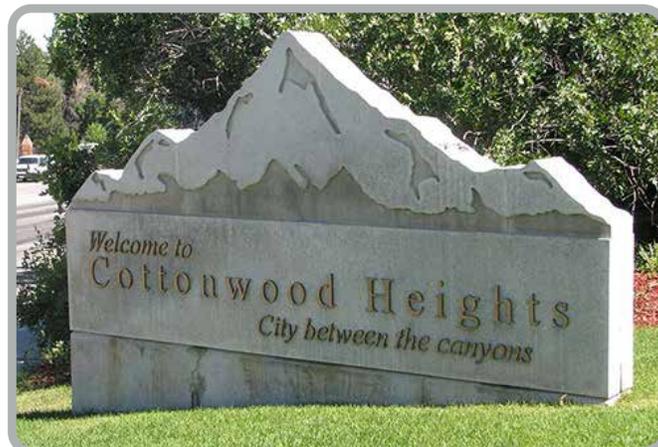
Long-Term Disability Insurance (LTD)

Insured by Lincoln Financial Group

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 (IpFSA). 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 (IpFSA)	\$2,750
Dependent Care Spending Limit	\$5,000

Here's How an FSA Works

1. You decide the annual amount (up to \$2,750 for IpFSA 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 IpFSA 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 Co-pay 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 System

Who is eligible?

All appointed and regular employees. Part-time employees working over 20 hours a week, excluding some officials, are eligible for the Utah Retirement System (URS). Appointed and elected employees who began working before July 1, 2011 may be eligible to opt out of the URS. Those employees who choose to opt out of the URS will receive their retirement into a 401(k) account. Seasonal and part-time (less than 20 hours per week) employees are not eligible for the 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.

NONCONTRIBUTORY 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.

ICMA-RC offers the following plan:

1. 457 Deferred Compensation Plan
2. Roth deferral provision to 457 Plan
3. Roth IRA
4. Traditional IRA

URS (Utah State Retirement) offers the following plans:

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

Paydays

Paydays		
July 3 July 17 July 31* August 14 August 28 September 11 September 25 October 9 October 23	November 6 November 20 December 4 December 18 January 1 January 15 January 29* February 12 February 26	March 12 March 26 April 9 April 23 May 7 May 21 June 4 June 18
*Denotes pay check without benefits withheld		

Paid Holidays

Who is eligible?

Regular full-time employees working 40 hours per week and regular part-time employees at 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 3
Pioneer Day	July 24
Labor Day	September 7
Veterans Day	November 11
Thanksgiving Day	November 26
Day After Thanksgiving	November 27
Christmas Eve	December 24
Christmas Day	December 25
New Years Day	January 1
Martin Luther King Day	January 18
President's Day	February 15
Memorial Day	May 31
Floating Holiday*	(1) as scheduled

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) 40 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) 8 hours added April 1 to be used by June 30

Paid Time Off (PTO)

Who is eligible?

Regular 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 5	6.16	480	50%
6 to 10	7.39	480	65%
11 to 15	8.62	480	80%
16 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 one hour increments, except in the situation where employees may fall less than an hour short of reaching their regularly scheduled hours. In that case PTO can then be used to make up the time in ¼ 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

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 on the books, 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?

Regular 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

Vacation leave accrual is capped at 320 hours. Vacation leave in excess of 320 hours, as of the last payroll in the fiscal year, 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 regular 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.

Administrative Leave Without Pay

Who is eligible?

All employees.

An employee may petition the City Manager to take a leave without pay. Any approval will be handled on a case by case basis.

Family and Medical Care Leave (FMLA)

Who is eligible?

Employees who have worked for the City for at least 12 months and who have worked at least 1,250 hours during the 12-month period 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?

Regular 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 \$2,000 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.

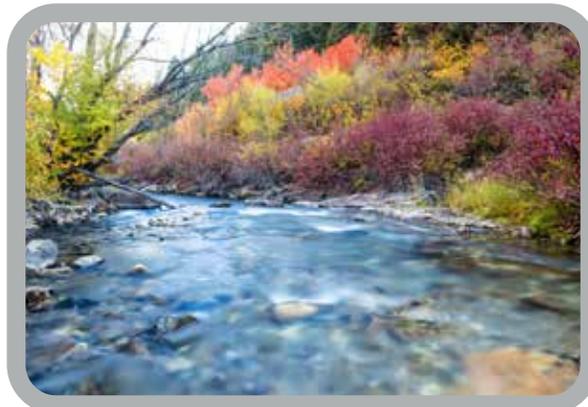
	Basic	Premium	Ultimate
Family Pass	\$112.50	\$157.50	\$212.50
Couple Pass	\$95.00	\$145.00	\$190.00

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 Contributions for Benefits

Benefit Plan	Per Paycheck Cost
HSA Plan	
Single	\$40.32
Two-Party	\$83.45
Family	\$112.89
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	
Employee	\$7.87
Employee+Spouse	\$12.62
Employee + Child	\$13.98
Employee + Children	\$13.98
Family	\$18.73
Accident — Allstate	
Employee	\$6.44
Employee+Spouse	\$9.77
Employee + Child(ren)	\$15.08
Family	\$18.88

Voluntary Life— 100% Employee Paid

Employee Premiums per Pay Period					
Age	\$20,000	\$40,000	\$60,000	\$80,000	\$100,000
Under 30	\$0.55	\$1.10	\$1.65	\$2.20	\$2.75
30–34	\$0.59	\$1.18	\$1.77	\$2.36	\$2.95
35–39	\$0.84	\$1.68	\$2.52	\$3.36	\$4.20
40–44	\$1.01	\$2.02	\$3.03	\$4.04	\$5.05
45–49	\$1.93	\$3.86	\$5.79	\$7.72	\$9.65
50–54	\$2.31	\$4.62	\$6.93	\$9.24	\$11.55
55–59	\$3.69	\$7.38	\$11.07	\$14.76	\$18.45
60 and over	\$6.26	\$12.52	\$18.78	\$25.04	\$31.30

Spouse Premiums per Pay Period					
Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Under 30	\$0.28	\$0.55	\$0.83	\$1.10	\$1.38
30–34	\$0.30	\$0.59	\$0.89	\$1.18	\$1.48
35–39	\$0.42	\$0.84	\$1.26	\$1.68	\$2.10
40–44	\$0.51	\$1.01	\$1.52	\$2.02	\$2.53
45–49	\$0.97	\$1.93	\$2.90	\$3.86	\$4.83
50–54	\$1.16	\$2.31	\$3.47	\$4.62	\$5.78
55–59	\$1.85	\$3.69	\$5.54	\$7.38	\$9.23
60 and over	\$3.13	\$6.26	\$9.39	\$12.52	\$15.65



Families First Coronavirus Response Act

Emergency Paid Sick Leave

For many employers and their employees, the most significant provision is the introduction of Emergency Paid Sick Leave. This Act requires employers with fewer than 500 employees and government employers to provide employees who are unable to work or telework with two weeks of paid sick leave, calculated using the employee's regular rate of pay, due to one of the following reasons:

- (1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.
- (2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
- (3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- (4) The employee is caring for an individual who is subject to a quarantine or isolation order as described in (1), above, or has been advised as described in (2), above.
- (5) The employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 precautions.
- (6) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Under the Act, an employer's obligations are limited to paid leave of \$511 per day (\$5,110 in the aggregate) where leave is taken for reasons (1), (2), and (3) above (i.e., an employee's own illness or quarantine) calculated using 100% of an employee's regular rate of pay, and \$200 per day (\$2,000 in the aggregate) where leave is taken for reasons (4), (5), or (6) (i.e., care for others or school closures) calculated using two-thirds and the employee's regular rate of pay.

Full-time employees are entitled to two weeks (80 hours) of leave and part-time employees are entitled to the typical number of hours that they work in a typical two-week period. The Act allows employers to exclude employees who are health care providers or emergency responders from this coverage.

Under the Act, Emergency Paid Sick Leave expires on December 31, 2020 and any unused paid leave granted by the Act does not carry over into 2021.

Emergency Family and Medical Leave Expansion Act

The Act also temporarily amends the Family and Medical Leave Act (FMLA) to provide employees of employers with fewer than 500 employees and government employers who have been on the job for at least 30 days with the right take up to 12 weeks of job-protected leave for Public Health Emergency Leave.

To qualify for Public Health Emergency Leave, an employee must be unable to work or telework due to a need to care for the son or daughter under 18 years of age because the child's school or place of care has been closed, or the child care provider of such son or daughter is unavailable, due to a public health emergency. A "public health emergency" is defined to mean "an emergency with respect to COVID-19 declared by a Federal, State, or local authority." Note that an employee must provide advance notice as soon as practicable of a need for leave under this temporary provision when the need for leave is foreseeable.

The first ten days of leave may be in the form of Emergency Paid Sick Leave (described above) or an employee may choose to substitute accrued vacation leave, personal leave, or other medical leave during this period, but an employer may not require an employee to do so. An employee may also take unpaid leave for the first ten days. After ten days of leave, employers must continue paid Public Health Emergency Leave at a rate of no less than two-thirds of the employee's usual rate of pay. The Act limits the amount of required paid leave to no more than \$200 per day and \$10,000 in total.

As with Emergency Paid Sick Leave, the Act provides that an employer may exclude employees who are health care providers or emergency responders from Public Health Emergency Leave coverage.

As with traditional FMLA leave, this leave is job-protected, which means that an employer must return the employee to the same or equivalent position upon his or her return to work. However, there is an exception to the job protection provisions for employers with fewer than 25 employees if the employee's position does not exist after FMLA leave due to an economic downturn or other operating conditions that affect employment caused by the COVID-19 pandemic. The FFCRA's paid leave provisions are effective on April 1, 2020, and apply to leave taken between April 1, 2020, and December 31, 2020.

The Secretary of the Department of Labor has the authority to issue regulations to: (a) exclude certain health care providers and emergency responders from the list of those employees eligible for leave; and (b) exempt small businesses with fewer than 50 employees where the imposition of these requirements would jeopardize the viability of the business as a going concern. However, how and when businesses with fewer than 50 employees will be exempt is currently unclear. Additional regulations on this issue are expected.

IMPORTANT NOTICES AND DISCLOSURES 2020:

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- » All stages of reconstruction of the breast on which the mastectomy has been performed,
- » Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- » Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and co-insurance amounts.

Newborn's Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

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 Protection Disclosure Notice

The 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical carrier listed under "Contacts" in Guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the medical carrier or from any other person (including a primary care provider) in order to

obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact the medical carrier listed under “Contacts” in this Guide.

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 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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, 2020. Contact your state for more information on eligibility.

ALABAMA – Medicaid http://myalhipp.com 855.692.5447	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
ALASKA – Medicaid The AK Health Insurance Premium Payment Program http://myakhipp.com/ 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ 877.438.4479 All other Medicaid http://www.indianamedicaid.com 800.403.0864
ARKANSAS – Medicaid http://myarhipp.com 855.MyARHIPP (855.692.7447)	IOWA – Medicaid and CHIP (Hawki) Medicaid: https://dhs.iowa.gov/ime/members 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki 800.257.8563
CALIFORNIA – Medicaid https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx 800.541.5555	KANSAS – Medicaid http://www.kdheks.gov/hcf/default.htm 800.792.4884
COLORADO – Medicaid and CHIP Health First Colorado (Colorado’s Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 State Relay 711	KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx 877.524.4718 Medicaid: https://chfs.ky.gov
FLORIDA – Medicaid http://flmedicaidprecovery.com/hipp 877.357.3268	LOUISIANA – Medicaid www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
GEORGIA – Medicaid	MAINE – Medicaid http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 TTY: Maine relay 711
	MASSACHUSETTS – Medicaid and CHIP

http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp (Under ELIGIBILITY tab, see “what if I have other health insurance?”) 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcnp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 Toll-Free: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid

http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/hipp/ Medicaid: 800.432.5924 CHIP: 855.242.8282
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywwhipp.com/ 855.MyWHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com/ 307.777.7531

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

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

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

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

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 12/31/2019)

Certificate of Creditable Prescription Drug 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 SelectHealth 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 through 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 company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company 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 the company 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.

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).

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 the company 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 800.MEDICARE (800.633.4227). TTY users should call 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 800.772.1213 (TTY 800.325.0778).

Date: 7/1/2020
Name of Entity/Sender: Cottonwood Heights City
Contact--Position/Office: Heather Sundquist
Address: 2277 Bengal Blvd, Cottonwood Heights, UT 84121
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

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

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 Privacy Notice

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

The Health Insurance and Portability and Accountability Act of 1996

(HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations. The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as

"protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

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

How the Plans May Use and Disclose Health Information about You

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

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

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

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative

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

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

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

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

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

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

Special Use and Disclosure Situations

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

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

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

Workers Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers compensation laws and other similar programs.

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

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

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

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

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

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

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

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

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

Your Rights Regarding Health Information About You

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

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

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

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

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

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

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce

evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

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

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

Change to this Notice

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

Notice of Breach of PHI

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

Complaints

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

Other Uses and Disclosures of Health Information

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

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

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

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

Updated and effective March 26, 2013

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.

This benefit summary prepared by



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