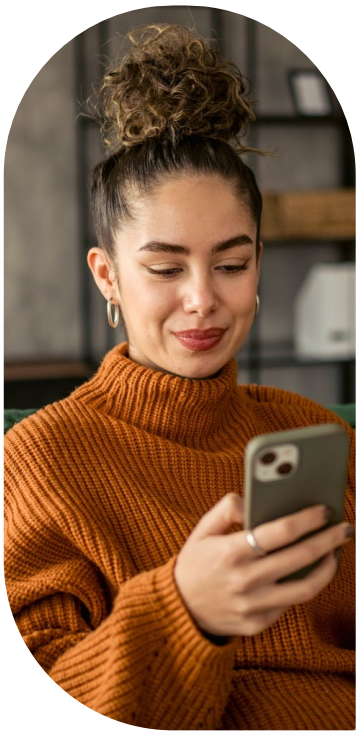
SALT LAKE COUNTY



2026

Employee Benefits

Invest in your wellbeing, one benefit at a time.

Benefits at Salt Lake County

2026 Contacts

Medical
Select Health
(801) 442-5038
www.selecthealth.org

PEHP
(801) 366-7555
www.pehp.org

Health Savings Account
Fidelity
(800) 544-3716
www.netbenefits.com

Dental
Cigna
(800) 244-6224
www.cigna.com

Vision
VSP
(800) 877-7195
www.vsp.com

Flexible Spending Account
ASI Flex
(800) 659-3035
www.asiflex.com

Life and AD&D Disability
The Standard
(800) 628-8600
www.standard.com

Pension, Hybrid & 401(k)
URS
(801) 366-7700
www.urs.org

Employee Assistance Program (EAP)
Vest
(385) 205-6789
www.vesteap.com

Onsite Clinic
HealthyMe Clinic
Government Center South
Building 2-500
(385) 468-0555

Employee Wellness
Healthy Lifestyles
(385) 468-4061
myhealthylifestyles@slco.org

Voluntary Benefits
vbcustomerservice@gbsbenefits.com *or call (801) 819-7744 with questions on Voluntary Benefits*

Accident, Critical Illness, Hospital Indemnity
Voya
(877) 236-7564
https://presents.voya.com/EBRC/SaltLakeCounty

Identity Theft Protection
Aura
(844) 931-2871
www.aura.com

Legal Insurance
LegalShield
(800) 654-7757
www.legalshield.com

Pet Insurance
MetLife Pet
(800) GET-MET8
www.metlife.com/getpetquote

Auto & Home
Farmers Insurance
(800) 438-6381, Code A20
www.myautohome.farmers.com

Human Resources – Benefits Team
(385) 468-0580
benefits@slco.org

Open Enrollment & Claims Support
GBS Benefits
Allison Miner, Account Manager
(801) 819-7793
allison.miner@gbsbenefits.com

Raquel Goodbeau, AM Support
(801) 819-7789
raquel.goodbeau@gbsbenefits.com

Mayors Finance – Payroll
Payroll Department
MF-Payroll@slco.org

COBRA Administration
GBS Benefits
Melissa Talbot
801-819-7772

The benefits in this guide are effective January 1, 2026 – December 31, 2026. This benefit guide serves as a summary of material modifications regarding certain plan provisions or costs for the 2026 plan year. This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

This guide is designed to highlight your benefit options so that you can make the best possible decisions for you and your family. The choices you make will remain in effect during the plan year, unless you have a qualifying life event.

We are committed to providing our employees with quality benefits programs that are comprehensive, flexible and affordable. Giving our employees the best in benefit plans is one way we can show you that as an employee, YOU are our most important asset.

This information, along with links to valuable resources, is available in our Edge course!

https://courses.gbsbenefits.com/SaltLakeCounty2026Benefits

Table of Contents

Benefits Overview

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget. The best thing you can do is "shop" for benefits carefully, using the same type of decision-making process you use for other major purchases.

1. **Take advantage of the tools available to you.** That includes this guide, access to plan information, provider directories, and enrollment materials.
2. **Be a smart shopper.** If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits because the wrong decision could be costly.
3. **Don't miss the deadline and keep record of your enrollment!** Pay attention to the enrollment deadline and be sure to enter your benefit elections in PeopleSoft in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify Benefits immediately if there are any discrepancies.

Who Is Eligible?

Elected, Appointed, Time-Limited and Merit employees are eligible for benefits. If you are hired to regularly work 20 or more hours per week, coverage will begin on the first day you begin working at Salt Lake County. You may also enroll your eligible dependents in the same plans you choose for yourself.

Eligible dependents include your legal spouse, your adult designee and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered. Disabled children over age 26 may be eligible for continued health coverage upon approval by the carrier.

How do I Designate an Adult Designee?

Salt Lake County offers coverage to a non-spouse or adult designee. An adult designee can be your significant other to whom you are not married or a family member with whom you share a relationship. To qualify, you and your designee must meet certain criteria which includes:

- Adult designee status for an eligible adult (a child must be over the age of 26 and not disabled) who is:
- Both unmarried and over age 18
- Proof of joint expenses

If you meet the criteria, you must complete an adult designee affidavit and supply the required financial documentation within 31 days. Affidavit found at: https://slco.org/contentassets/809e38a30e434b13b034500a057afb3a/affidavit-of-adult-designee.pdf

The IRS taxes an "imputed income" for this benefit, which will increase your taxable income for the year. The cost of including your adult designee will be added to your gross earnings and be subject to income tax.

When Do I Enroll?

You can enroll for coverage within 31 days of your date of hire, or during the annual open enrollment period. Outside of your open enrollment period, the only time you can change your coverage is within 31 days after you experience a qualifying event.

Benefits Overview

Making Changes During The Year

The IRS provides strict regulations about the changes to pre-tax elections during the plan year. Once you enroll in benefits, you will not be able to make any changes to your elections until the next annual open enrollment period, unless you experience a qualified life event.

Qualified life events include, but are not limited to:

- Change in your legal marital status
- Change in number of dependents
- A dependent no longer meets the eligibility requirements
- You and/or your dependent becomes eligible or loses eligibility for Medicare, Medicaid or the Children's Health Insurance Program (CHIP)
- Employee or dependents change in employment status resulting in loss or gain of eligibility for employer sponsored benefits
- A court or administrative order

It is your responsibility to notify the Benefits Department within 30 days after a qualified life event. Any benefit changes must be directly related to the qualified life event.

When Coverage Ends

For most benefits, coverage will end on the last day of the month in which:

- Your regular work schedule is reduced to fewer than 30 hours per week
- Your employment with Salt Lake County ends

Your dependent(s) coverage ends:

- When your coverage ends, or
- The last day of the month in which the dependent is no longer eligible

Health Care Reform and You

For the most up-to-date information regarding the ACA, please visit www.healthcare.gov.

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. We will automatically provide you a copy of the SBC and Uniform Glossary annually during open enrollment. Please contact Benefits should you need an additional copy.

Medical

Select Health

Value and Med Networks Traditional Plan Calendar Year Benefits	**Tier 1 Value**	**Tier 2 Med**	**Out-of-Network**
Deductible	$1,000 / Single $2,000 / Family		$1,500 / Single $3,000 / Family
Out-of-Pocket Maximum	$4,000 / Single $8,000 / Family		$5,500 / Single $11,000 / Family
Preventive Care	100% Covered		Not Covered
Office Visits			
Primary Care	$25 AD	$25 AD	30% AD
Specialist	$35 AD	$35 AD	30% AD
Virtual Visits	100% Covered	100% Covered	Not Covered
Urgent Care	$45 AD	$45 AD	30% AD
Emergency Room		$150 AD	
Hospital Services			
Minor Lab Testing and X-Ray	100% Covered AD	100% Covered AD	30% AD
Major Diagnostic and Imaging Services	20% AD	20% AD	30% AD
OP Mental Health/Substance Abuse	20% AD	20% AD	30% AD
Inpatient Hospital	20% AD	20% AD	30% AD
Outpatient Surgery	20% AD	20% AD	30% AD
Pharmacy – Retail			
Tier 1	$10		
Tier 2	25% with a minimum of $25 and maximum of $75 AD		
Tier 3	50% with a minimum of $50 and maximum of $100 AD		
Mail Order	$20 / 25% AD / 50% AD		

AD = After Deductible

Download the SBC ↓ **Download the Plan Summary** ↓ **Provider Search**

Pharmacy Savings ↓ **Healthy Beginnings** ↓ **Choosing the Right Care** ↓

Medical

Select Health

Value and Med Networks/HSA Qualified Calendar Year Benefits	**Tier 1 Value**	**Tier 2 Med**	**Out-of-Network**
Deductible	$2,500 / Single $5,000 / Family		$2,500 / Single $5,000 / Family
Out-of-Pocket Maximum	$4,000 / Single $8,000 / Family		$8,500 / Single $17,000 / Family
Preventive Care	100% Covered		Not Covered
Office Visits			
Primary Care	$25 AD	$25 AD	30% AD
Specialist	$35 AD	$35 AD	30% AD
Virtual Visits	100% Covered AD	100% Covered AD	Not Covered
Urgent Care	$45 AD	$45 AD	30% AD
Emergency Room		$150 AD	
Hospital Services			
Minor Lab Testing and X-Ray	100% Covered AD	100% Covered AD	30% AD
Major Diagnostic and Imaging Services	10% AD	10% AD	30% AD
OP Mental Health/Substance Abuse	10% AD	10% AD	30% AD
Inpatient Hospital	10% AD	10% AD	30% AD
Outpatient Surgery	10% AD	10% AD	30% AD
Pharmacy – Retail			
Tier 1	$10 AD		
Tier 2	25% with a minimum of $25 and maximum of $75 AD		
Tier 3	50% with a minimum of $50 and maximum of $100 AD		
Mail Order	$20 AD/ 25% AD / 50% AD		

AD = After Deductible

Download the SBC | **Download the Plan Summary** | **Provider Search**

Pharmacy Savings | **Healthy Beginnings** | **Choosing the Right Care**

Medical

PEHP

Traditional – Summit Network Calendar Year Benefits	**In-Network**	**Out-of-Network**
Deductible	$1,000/ Single $2,000/ Family	$1,500 / Single $3,000 / Family
Out-of-Pocket Maximum	$4,000 / Single $8,000 / Family	$5,500 / Person $11,000 / Family
Preventive Care	100% Covered	Not Covered
Office Visits		
Primary Care	$25 AD	30% AD
Specialist	$35 AD	30% AD
Urgent Care	$45 AD	30% AD
Emergency Room	$150 AD	$150 AD
Hospital Services		
Minor Lab Testing and X-Ray	100% Covered AD	30% AD
Major Diagnostic and Imaging Services	100% Covered AD	30% AD
OP Mental Health/Substance Abuse	$35 AD	30% AD
Inpatient Hospital	20% AD	30% AD
Outpatient Surgery	20% AD	30% AD
Pharmacy – Retail		
Tier 1	$10	
Tier 2	25% AD, $25 minimum/$75 maximum	
Tier 3	50% AD, $50 minimum/$100 maximum	

AD = After Deductible

Download the SBC | Download the Plan Summary | Provider Search

Prescription Savings | PEHP Online Tools | Telemedicine Flyer

Medical

PEHP

HDHP – Summit Network Calendar Year Benefits	**In-Network**	**Out-of-Network**
Deductible	$2,500/ Single $5,000/ Family	$2,500 / Single $5,000 / Family
Out-of-Pocket Maximum	$4,000 / Single $8,000 / Family	$8,500 / Person $17,000 / Family
Preventive Care	100% Covered	Not Covered
Office Visits		
Primary Care	$25 AD	30% AD
Specialist	$35 AD	30% AD
Urgent Care	$45 AD	30% AD
Emergency Room	$150 AD	$150 AD
Hospital Services		
Minor Lab Testing and X-Ray	100% Covered AD	30% AD
Major Diagnostic and Imaging Services	100% Covered AD	30% AD
OP Mental Health/Substance Abuse	$35 AD	30% AD
Inpatient Hospital	10% AD	30% AD
Outpatient Surgery	10% AD	30% AD
Pharmacy – Retail		
Tier 1	$10 AD	
Tier 2	25% AD, $25 minimum/$75 maximum	
Tier 3	50% AD, $50 minimum/$100 maximum	

AD = After Deductible

Download the SBC | **Download the Plan Summary** | **Provider Search**

Prescription Savings | **PEHP Online Tools** | **Telemedicine Flyer**

Prescription Savings

Strategies to Save

The average American spends about $1,200 each year on prescription drugs. And with drug prices on the rise, 1 in 4 Americans are paying more today than they were a year ago. Consider the following ways to help lower your bills for pills:

- Go generic or ask your doctor or pharmacist if there's a similar drug with a generic version.
- Compare prices by using an app, like GoodRx, to find the least expensive option. Call stores and pharmacies as well.
- Order a 90-day supply and look into a mail-order program.
- Sign up for a drugstore or chain store reward program to receive coupons and accumulate points.
- Use a preferred pharmacy in your network.

If you have prescription drug questions, talk to your pharmacist for additional cost-cutting tips and guidance.

GoodRx

Stop paying too much for your prescriptions! With the GoodRx Comparison Tool, you can compare drug prices at over 70,000 pharmacies, and discover free coupons and savings tips.

Isn't health insurance all I need?

Your health insurance provides valuable prescription and other health benefits, but a smart consumer can save much more, especially for drugs that are not covered by health insurance (weight-loss medications, some antihistamines, etc.), drugs that have limited quantities, drugs that can be found for less than your copay, or drugs with a lower priced generic.

How can I find these savings?

The GoodRx Comparison Tool provides you with instant access to current prices on more than 6,000 drugs at virtually every pharmacy in America.

1. On the web: https://www.goodrx.com/ Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.
2. On your phone: Available in the App Store or Google Play. Or, simply visit m.goodrx.com from your phone.

Please Note:

- Prescription drug pricing displayed on the GoodRx Comparison Tool may be more or less than your insurance drug card.
- Please be sure to compare all discount pricing options before you purchase.
- Check your insurance carrier's pharmacy benefit before purchasing a 90-day supply.

Specialty Medication Assistance Program

GBS Rx Advantage

Salt Lake County Pharmacy Savings Opportunities for Specialty Medications

GBS Rx Advantage has partnered with your employer to address the increasing costs of specialty medications. The GBS Rx Advantage team works directly with you or your loved ones to find alternative funding options to reduce or eliminate your out-of-pocket costs.

If you are taking medications that qualify for the GBS Rx Advantage Patient Assistance Program (PAP) you will receive communication from a dedicated GBS team member that will help you navigate the entire process, doing much of the heavy lifting. It is important that you engage with the GBS Rx Advantage team and provide them with the information they request.

Notification

When your prescription is submitted to your pharmacy, the pharmacy will be notified to contact GBS Rx Advantage for a potential override. GBS will provide a two-month override once your information has been received.

Outreach

GBS Rx Advantage reach out to inform you of the program. After explaining, we will send an authorization form via Docusign. The authorization form must be completed in order for GBS Rx Advantage to act on your behalf for the sole purpose of prescription drug advocacy.

Intake

GBS Rx Advantage will conduct a pre-screening to determine if you will qualify for the PAP. If you do not qualify, you will be enrolled in our Canadian mail-order program.

Submission

If you qualify for the program, GBS Rx Advantage will proceed with submitting the application to the PAP. We may request additional information as requested by the PAP from you, or your health care provider. This may include financial information as most PAPs are income-based.

Follow-Up

The application is submitted to the PAP once all information and documents have been provided. Approval can take up to 4-8 weeks. GBS Rx Advantage will contact the PAP to check on approval status. For certain programs, you may need to call in to the program directly to inquire about approval status.

Outcome

If approved, you will need to stay in contact with the PAP to place orders for your medication. If denied, GBS Rx Advantage will look through the denial and submit an appeal if possible. If not, we will pursue other coverage options.

For more information regarding this program, please call GBS Rx Advantage at 801-819-7745 or email gbsRXadvantage@gbsbenefits.com

Volunteer Prescription Savings Program

GBS Rx Advantage

Salt Lake County Pharmacy Savings Opportunities for Brand-Only Medications

What is Volunteer Prescription Savings Network?

The Volunteer Savings Network allows the employer and members to save between 30% to 50% off brand-name medications through mail-order shipping from pharmacy partners through GBS Rx Advantage. While this program is not mandatory, every effort is being made to help reduce prescription costs.

Is there a copay for prescriptions filled through your company?

There are **no copays** charged to participants. The high program savings allows the employer to offer the program at no charge to members.

How do I enroll in the Volunteer Prescription Savings Program?

You will receive an email from HR introducing the program which will include information from GBS Rx Advantage. You may also receive an email from GBS Rx Advantage with an intake form to be completed.

What medications are included in the program?

Brand-name oral medications as well as a few select brand-injectables, brand-antidiabetic meds and brand-inhalers. Controlled substances are not eligible for this program. If you are on one of the High Deductible Health Plans (HDHP), restrictions may apply.

Common Medications

This is not an all-inclusive list. Please inquire about other brand-name medications with GBS Rx Advantage by calling 801-819-7745 or emailing gbsrxadvantage@gbsbenefits.com

- Anoro Ellipta
- Biktarvy
- Bydureon
- Eliquis
- Entresto
- Incruse Ellipta
- Januvia
- Jardiance 10mg
- Latuda
- Lialda
- Serevent Diskus
- Spiriva
- Tradjenta
- Trintellix
- Triumeq
- Trulicity
- Victoza
- Xarelto
- Xigduo
- Xiidra

Click **here** for additional information (refer to page 2).

Health Savings Account

Fidelity HSA

A Health Savings Account (HSA) paired with our qualified high deductible health plan helps you and your family plan, save and pay for qualified health care expenses. An HSA empowers you to build savings for health care expenses in a tax advantaged account.

Advantages of Health Savings Accounts

A Health Savings Account (HSA) is a tax advantaged savings account that you own and control. Here are some of the benefits:

- Funds roll over from year-to-year and never expire
- Portable when you move jobs or retire
- Triple tax advantage: you won't pay taxes on contributions, distributions, or earnings
- Able to invest your funds to grow your money tax-free
- Contribution elections can be changed mid-year without a life event

Who Is Eligible?

You must be enrolled in our qualified high deductible health plan and meet the following requirements:

- Have no other health insurance coverage except what's permitted by the IRS
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return

How Much Can I Contribute to an HSA?

Each year the IRS establishes the maximum contribution limit. The chart below represents the limits for 2026. These limits are for the total funds contributed, including company contributions, your contributions and any other contributions. Please keep in mind you can change your HSA allocation at any time during the plan year.

Resources Available for Download

AE Guidebook

Your Guide To Understanding A Health Savings Account

Tax Advantages Of HSAs Infographics

Facts, Plan Comparison Tool And More

HSA Microsite for Young Employees

HSA Workshop

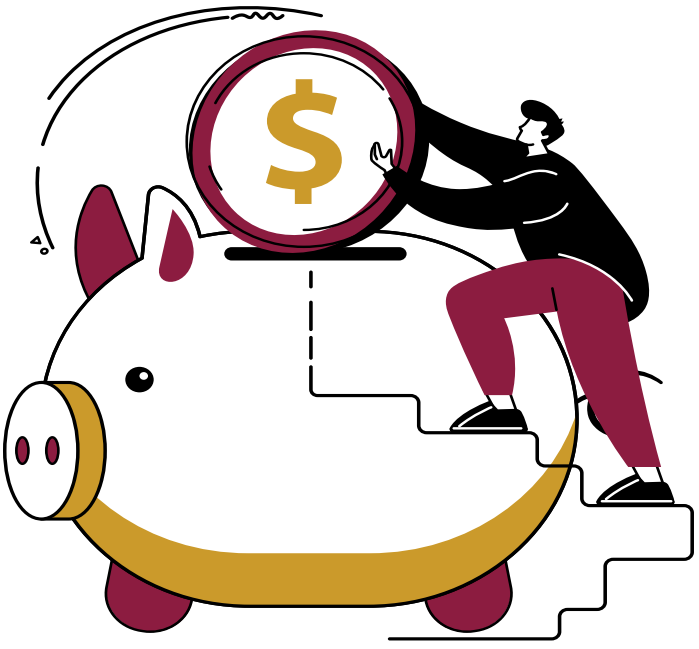
Is an HSA right for me?

Health Savings Account

Fidelity HSA

What Is A Qualified Health Care Expense?

You can use money in your HSA to pay for any qualified health care expenses for you, your spouse and your tax dependents, even if they are not covered on your plan. Examples of qualified health care expenses include: your insurance plan deductibles, copayments, and coinsurance; doctor's office visits; prescriptions; dental treatments and x-rays; and eyeglasses and vision exams You can use money in your HSA to pay for any qualified health care expenses you, your legal spouse and your tax dependents incur, even if they are not covered on your plan. Qualified health care expenses are designated by the IRS (Publication 502). They include medical, dental, vision and prescription expenses not covered by the insurance carrier.



Important

Any funds you withdraw for non-qualified expenses will be taxed at your income tax rate plus a 20% tax penalty if you're under age 65. After age 65, you pay taxes but no penalty.

Documentation is Key

An HSA can be used for a wide range of health care services within the limits established by law. Be sure you understand what expenses are HSA qualified, and be able to produce receipts for those items or services that you purchase with your HSA. You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified expenses had not been previously paid or reimbursed from another source, and
- The qualified expense had not been taken as an itemized deduction in any year. Do not send these records with your tax return. Keep them with your tax records.

IRS HSA Limits

	2026
Single	$4,400
Family	$8,750

At age 55, an additional $1,000 contribution is allowed annually

Employee Clinic

HealthyMe Clinic

Take advantage of convenient, quality healthcare – right at work!

The Salt Lake County HealthyMe Clinic is open to employees and dependents age 18 and older, Monday through Friday, 8 a.m. to 5 p.m. The clinic provides a wide range of medical and mental health services, including routine checkups, treatment for minor illnesses, wellness and preventive care, counseling, and chronic condition management.

Services are offered at low or no cost, depending on the care received and whether you're enrolled in a Traditional or High Deductible Health Plan (HDHP). It's an easy, affordable way to stay healthy and get the care you need close to home—or office!

The HealtyMe Clinic is operated by Intermountain Healthcare. The clinic and it's staff are fully compliant with HIPAA and other privacy laws. our personal health information is never shared with the County unless you provide authorization—for example, confirming a preventive care visit for Employee Wellness points.

Meet the Providers:

Brenda Sheehan, DO is an osteopathic physician who approaches healthcare with a whole-person perspective. She takes the time to understand you and your health needs, providing thoughtful, ongoing support—especially for managing chronic conditions such as diabetes or high blood pressure.

Deanna Weeks, CMHC provides mental health counseling at the clinic. She has extensive experience working with individuals and families dealing with anxiety, depression, PTSD, trauma, relationship challenges, substance abuse, and disordered eating.

Download the Clinic Flyer ↓

	High Deductible Health Plan (HDHP)	Traditional PPO Plan
Services	Service Fee	
Preventive Care	$0	$0
Office Visit	$30	$10

Location and Hours
385-468-0555

Salt Lake Government Center
2001 S. State Street, SLC, UT | South Building – 2nd Floor- S2-500
Open 8:00 am to 5:00 pm Monday - Friday

Dental

Cigna - DPPO

Plan Features	In-Network Advantage Provider	In-Network Any Cigna Provider	Out-of-Network
Calendar Year Deductible (waived for Preventive Services and Orthodontics)	$0	$50 Single/ $150 Family	$50 Single/ $150 Family
Annual Maximum	$2,000	$1,200	$1,200
Preventive Services (e.g. x-rays, cleanings, exams) No Waiting Period	100%	80%	80%
Basic Services (e.g. fillings, extractions,root canals) No Waiting Period	90%	60% AD	60% AD
Major Services (e.g. dentures, crowns, bridges) No Waiting Period	50%	40% AD	40% AD
Orthodontics (for adults and children) No Waiting Period	50%	40%	40%
Orthodontic Lifetime Maximum		$1,750 per person	

Download the Full Plan Summary

Provider Search

Vision

VSP – VSP Advantage Network

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Salt Lake County's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

	In-network You Pay	**Out-of-network** Plan Reimburses You
Exam (once every calendar year)	$10	Up to $47
Frames (once every calendar year)	$0 copay; $180 featured frame allowance; $160 frame allowance; 20% off balance	Up to $80
Lenses (once every calendar year)		
Single Vision	Included in Prescription Glasses	Up to $30
Bifocal	Included in Prescription Glasses	Up to $50
Trifocal	Included in Prescription Glasses	Up to $62
Standard Progressive	$0	Up to $50
Contact Lenses in Lieu of Eyeglasses (once every calendar year)		
Elective	$0 copay; $160 allowance	Up to $145

Download the Full Plan Summary

Maximize your Benefits Flyer

VSP Member Extras Flyer

Provider Search

VSP Light Care Flyer

VSP Essential Eye Care Flyer

Flexible Spending Account

ASI Flex

A Flexible Spending Account (FSA) provides you the opportunity to pay for health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

How It Works

Each plan year you designate an annual election to be deposited into your health care and/or dependent care accounts. Your annual election will be divided by the number of pay periods in the plan year and deducted equally from each paycheck on a pre-tax basis. For health care expenses, you have immediate access to the total amount you elected to contribute for the plan year. With the dependent care, you have access to the amount of the current contributions in your account at the time you request reimbursement.

Things To Consider

- Be conservative when estimating your annual election amount. The IRS has a strict "use it or lose it" rule. You will forfeit any funds left in your account after the end of the plan year above the rollover amount ($680 for 2026).
- Your 2026 contributions must be used for expenses you incur January 1, 2026-December 31, 2026.
- The health care and dependent care FSAs are two separate accounts and funds cannot be transferred between accounts.
- You cannot stop or change your FSA contribution amount during the year unless you have a qualified change in family status.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.

FSA Reimbursement Options

To receive reimbursement from your FSA, you can submit a claim online, complete a paper claim form or use your FSA debit card. It is important to save your receipts. ASI Flex may ask you to provide a copy to substantiate a claim.

	Health Care FSA	Limited Health FSA	Dependent Care FSA
Maximum Plan Year Contribution Amount	Up to $3,400	Up to $3,400	Up to $7,500 ($3,750 if married and filing separate income tax returns)
Examples of Eligible Expenses	Medical, Rx, Dental, & Vision Deductible, Coinsurance, and Copays	Dental, Vision Expenses Only	Cost of childcare for children under age 13 so you and your spouse can go to work or look for work.

Basic Life and AD&D

The Standard

Life Insurance and Accidental Death & Dismemberment (AD&D) benefits provide you and your loved ones financial protection in the event of an illness, accident, or death.

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

Salt Lake County provides all eligible employees with a basic group life insurance and accidental death and dismemberment coverage at no cost to you. Public safety officers who die or are dismembered in an accident while acting in the line of duty may receive an additional AD&D benefit. You may continue the basic life or AD&D benefits if you leave the County by exercising the plan's portability or conversion options.

Plan Features:

- Life Benefit Amount: *$50,000*
- AD&D Benefit Amount: *$50,000*
- Maximum Benefit: *$50,000*
- Guarantee Issue: *Up to $50,000*
- Age Reductions: *Reduces to 50% at age 70; 25% at age 75*

Additional Plan Services

You also receive the following benefits at no additional cost:

Life Services Toolkit

The Life Services Toolkit helps you or your beneficiaries cope with grief and loss, get answers to legal questions, plan a memorial or a funeral, and address financial concerns. It also gives you access to online will preparation and other estate planning documents.

AD&D Occupational Assistance

The AD&D Occupational Assistance service provides access to a Workplace Possibilities (SM) Consultant who helps you return to productive work and life following a specified accidental dismemberment.

Travel Assistance

Travel Assistance provides you with assistance for pre-trip planning, medical assistance services, emergency transportation services, travel and technical assistance services and legal referral.

Basic Life Plan Summary ↓

Tool Kit Flyer ↓

Travel Assistance Flyer ↓

Optional Life and AD&D

The Standard

Optional Life Insurance and AD&D

You also have the option to purchase additional life insurance coverage for yourself, your spouse and your dependent children to age 26. However, you may only elect coverage for your dependents if you elected additional coverage for yourself. You pay for the cost of additional coverage through payroll deductions on a post-tax basis.

Coverage	Election Increments	Maximum Benefit	Guaranteed Issue
Employee Life Benefit	$25,000	$500,000	$300,000
Spouse Life Benefit	$25,000	Lesser of $500,000 or total employee benefit	$50,000
Child Life Benefit	$5,000	$15,000	$15,000

Coverage	Election Increments	Minimum Benefit	Maximum Benefit
Employee AD&D	$25,000	$25,000	$250,000
Employee + Family AD&D	$25,000	$25,000	$250,000

Employee or Spouse Age	Rate Per $1,000	Child Per $5,000
<25	$0.050	
25 – 29	$0.060	
30-34	$0.080	
35-39	$0.090	$0.48
40-44	$0.100	
45-49	$0.150	
50 – 54	$0.230	
55-59	$0.430	
60-64	$0.660	
65-69	$1.270	
70+	$2.060	

Note: The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have

Optional Life Plan Summary ↓

Optional AD&D Plan Summary ↓

Short Term Disability

The Standard

Disability insurance benefits replace a portion of your income if you are unable to work for a period of time, due to a qualified off-the-job injury or illness.

Short-term Disability

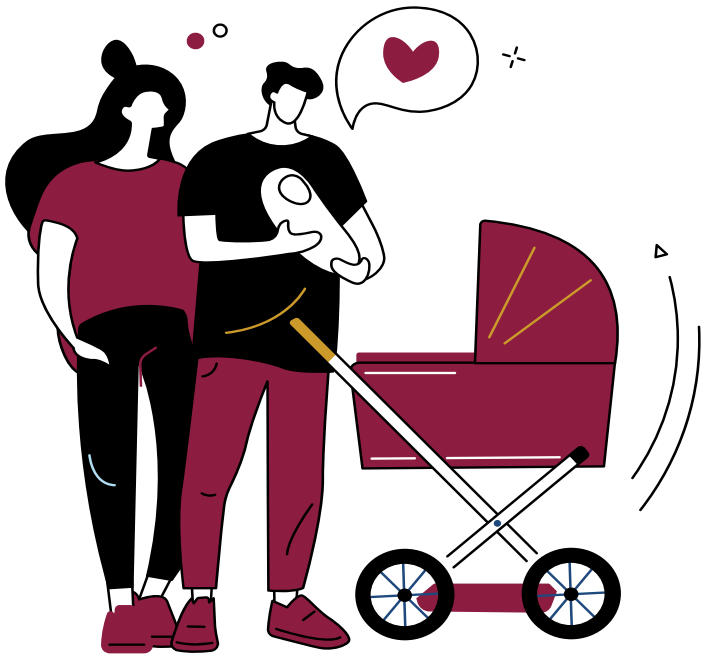
Short-term disability provides a source of income should your qualified disability keep you from working for more than a week.

Definition of Disability

The definition of disability is used to determine an employee's eligibility for benefits. An individual's physical or mental inability to perform the major duties of his/her occupation because of illness or injury.

Plan Features	Short-term Disability
Benefit Amount	66.67% of weekly salary
Maximum Benefit	$3,000 weekly
Benefit Waiting Period	14 days
Maximum Benefit Duration	11 weeks

Download the Full Plan Summary **Watch the STD Video**



Long Term Disability

The Standard

Disability insurance benefits replace a portion of your income if you are unable to work for a period of time, due to a qualified off-the-job injury or illness.

Employer Paid Long-term Disability

Long-term disability provides an ongoing source of income if your disability is prolonged. Salt Lake County pays 100% of the program's premiums for its eligible employees.

Definition of Disability

The definition of disability is used to determine an employee's eligibility for benefits. An individual's physical or mental inability to perform the major duties of his/her occupation because of illness or injury.

Plan Features	Long-term Disability
Benefit Amount	60% of weekly salary
Maximum Benefit	$15,000 monthly
Benefit Waiting Period	90 days
Maximum Benefit Duration	2-years own occupation or Social Security Normal Retirement Age

Download the Full Plan Summary **Watch the LTD Video**

Employee Assistance Program

VEST

VEST's services are designed to care for your mental health and wellbeing and that of your family. VEST provides services in two ways – through in-the-moment support and traditional counseling.

In-the-Moment Situational Support

VEST provides 24/7/365 support through their Care Center. The center is an anonymous and unlimited resource to provide in-the-moment support with whatever is happening in your life. Whether you need referrals for services or just someone to talk to, a Care Connector will be there offering a listening ear and tools to help you cope.

EAP Support

The second service provided by VEST is EAP Support. Whether you need short-term counseling or a financial or legal consultation, the EAP will connect you with a local provider – using your responses about preferences or needs to find the best possible fit. As with the Care Center conversations, all EAP services are confidential and free.

Additional Services

In addition to coaching and counseling, VEST provides access to a wide variety of expert courses on demand through their website, monthly webinars and other activities. Members can also sign up to receive weekly tips and wellness advice sent out by Hope, while Norm shares weekly helps for supervisors and managers.

Get Connected!

Get started by downloading the free VEST app from the Apple or Android store or by using the QR code.

- Use the code SLCounty to register
- Select "Text" or "Talk" to reach a Care Connector

You can also reach VEST by calling: 385-364-6444

Registration Code: **SLCounty**

Email: go@vesteap.com

Website: https://www.vesteap.com

Pension, Hybrid & 401(k)

URS

Your Retirement Benefits
As a benefits eligible employee, Salt Lake County is investing in your future retirement through the Utah Retirement Systems (URS). Depending on when you first entered URS, you will participate in either the Tier 1 or Tier 2 retirement plan.

Tier 2 Retirement Plan
If you are a Tier 2 participant (hired after June 30, 2011), you have a choice between two plans:
- 401(k) Plan
- Pension ("Hybrid") Plan

The County contributes the same percentage to both options.

Making Your Election
You have **12 months from your initial hire date** to choose between the 401(k) and Hybrid plans.

During your first year, contributions automatically go into the **Hybrid Plan**.
If you choose the **401(k) Plan** by the end of that 12-month period, your funds will be **transferred** accordingly.

Once you make your election, your choice is **permanent** for the duration of your URS-eligible employment.

Contribution Details
If the State determines that Hybrid Plan funding needs exceed the legislated 10% employer contribution, the County will continue contributing 10%, and the difference (currently less than 1%) will be deducted from your paycheck as a post-tax contribution.
If you select the 401(k) Plan after your first year, any prior Hybrid contributions will be refunded or shifted to a Roth 401(k) account.

Preparing to Retire

URS

If you are thinking about retiring or have any questions, please see below for guidance on the process.

Step 1:

Contact URS

URS is available to discuss your options at 801-366-7700. Contact URS 1-3 months before retirement date and request a packet.

Step 2:

Choose Your Retirement Date

Work with your Division and the HR Benefits Team regarding your retirement date and review HR policy 4-900: Retirement. Contact HR Benefits at 385-468-0580 to schedule a retirement meeting to discuss your benefits and next steps in the process

Resources to help with your retirement decisions

- Review URS Guide "Preparing to Retire" : www.urs.org/content/members/publications
- Review your retirement Options at: www.urs.org/content/members/publications
- Attend a free URS Seminar Visit: www.urs.org/us/seminars
- If you wish to buy out years of service: Contact URS at 801-366-7770 for a cost calculation
- Insurance coverage is offered: To those currently enrolled and hired before December 31, 2012, per HR Policy 4-300.

Healthy Lifestyles

SLCo Wellness Team

Take charge of your well-being with the **SLCo Employee Wellness program!** As part of the Salt Lake County Health Department, we're here to celebrate and reward the healthy choices you make every day. Our mission is to empower Salt Lake County employees to adopt sustainable health and wellness behaviors to improve quality of life and support a thriving workforce. The SLCo Employee Wellness Program helps you maintain your health and balance with resources for all employees and their spouses/adult designees, such as workshops, group walks, nutrition classes, mindfulness activities, fitness challenges, health coaching, a wellness app, and tobacco cessation support. To enroll, simply email **employeewellness@saltlakecounty.gov** —and start earning points and incentives on your wellness journey today!

Points & Incentives

All Salt Lake County employees—and their spouses or adult designees—are invited to take part in the SLCo Employee Wellness Program and enjoy the benefits of a healthier lifestyle. Eligible employees and their spouses/adult designees who qualify for benefits can earn up to $250 in cash rewards and an additional $275 HSA incentive by engaging in a variety of wellness activities throughout the year. Wellness pays—join today and start earning cash and HSA incentives! Participants can begin earning points on **January 1st** and continue through **October 31st** each year. The total incentive amount is based on the number of points earned during this period. **Cash rewards are distributed in December**, and **HSA incentives are issued the following January**—rewarding you for making wellness a priority all year long.

POINTS	CASH REWARD	HSA REWARD
150-499	$50	$50
450-699	$175	$175
700-899	$200	$200
900+	$250	$275

IMPORTANT: To qualify for incentives, participants must provide documentation of an annual physical exam completed by a licensed medical provider.

Accident

Voya

Accident insurance can help provide you with a cushion to help cover expenses and living costs when you get hurt. While you can count on health insurance to cover medical expenses, it doesn't usually cover indirect costs that can arise with a serious or even not-so-serious injury. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up.

With Voya Group Accident Insurance you can have peace of mind knowing:

- Coverage is guaranteed issue – no evidence of insurability required at initial enrollment.
- Benefits are paid directly to you unless assigned to someone else.
- Benefits are paid in addition to any other coverage.

Plan Features	Low Plan	High Plan
Accident Physician / Urgent Care	$100 / $225	$150 / $300
Emergency Room	$300	$350
X-ray	$125	$200
Ambulance	$500 ground / $2,000 air	$600 ground/ $2,500 air
Dislocation/Fracture Benefit	Up to $7,700/Up to $6,720	Up to $10,000/Up to $12,000
Hospital Confinement/Daily Benefit	$1,500 admission / $300 day	$2,000 admission / $350 day
Accident Follow-Up Visits	$100	$150
Lacerations	Up to $480	Up to $960
Organized Sport	25% increase to benefits, up to $1,000 max	
Wellness Benefit	$50 per person per year	

Accident Plan Bi-Weekly Premiums

	Low Plan	High Plan
Employee Only	$3.66	$6.92
Employee & Spouse	$5.49	$10.38
Employee & Child(ren)	$7.00	$13.20
Family	$8.84	$16.66

Download the Full Plan Summary

Critical Illness

Voya

Critical Illness insurance provides a lump sum benefit to help you cover the out-of-pocket expenses associated with a critical illness diagnosis.

With Voya Group Critical Illness Insurance you can have peace of mind knowing you're covered in the event of:

100% Coverage:
- Heart Attack
- Cancer
- Stroke
- Sudden Cardiac Arrest
- Major Organ Transplant
- Coronary Artery Bypass
- Type 1 Diabetes
- Severe Burn
- Benign Brain Tumor
- Bone Marrow Transplant
- Stem Cell Transplant
- Permanent Paralysis
- Loss of Sight, Hearing or Speech
- Coma
- MS
- ALS
- Parkinson's Disease
- Advanced Dementia including Alzheimer's Disease
- Huntington's Disease
- Muscular Dystrophy
- SLE

50% Coverage:

Myasthenia Gravis

25% Coverage:
- Carcinoma in Situ
- Open Heart Surgery for Valve Replacement or Repair
- ICD Placement
- Infectious Disease
- Addison's Disease
- Systemic Sclerosis

10% Coverage:
- Transient Ischemic Attacks
- Ruptured or Dissecting Aneurysm
- Abdominal Aortic Aneurysm
- Thoracic Aortic Aneurysm
- Transcatheter Heart Valve Replacement or Repair
- Coronary Angioplasty
- Pacemaker Placement
- Skin Cancer

12 Childhood Conditions

Plan Features	Employee	Spouse	Dependent
Coverage	$15,000 or $30,000	100% of Employee's amount	100% of Employee's amount
Guarantee Issue	$30,000	$30,000	All child amounts are GI
Pre-Existing	None	None	None
Wellness Benefit	$100 per person per year		

Download the Full Plan Summary

Hospital Indemnity

Voya

An inpatient stay in the hospital is expensive, and there may be additional costs unrelated to your stay such as having a baby or missing work. Hospital Indemnity coverage pays a cash benefit when you are admitted for an inpatient stay for a minimum of **20** confinement hours. You can use the monies to pay for medical bills not covered by insurance, or in any way you see fit.

With Voya's Group Hospital Indemnity Insurance:

- Benefits from a Hospital Indemnity plan can be used to assist you in paying deductibles, coinsurance, out-of-network costs, daily living expenses, etc.
- Benefits are paid regardless of other coverage and this plan is compatible with Health Savings Accounts.

Benefits Include:	Low Plan	High Plan
Guarantee Issue	Yes	
Pre-Existing	No Pre-Ex	
Maternity Waiting Period	No waiting period	
First Day Hospital Confinement	$500 / ICU $1,000	$1,000 / ICU $2,000
Daily Hospital Benefit *Up to 31 days*	$100 per day	$200 per day
Intensive Care *Up to 31 days*	$200 per day	$400 per day
Wellness Benefit	$50 per person per year	$100 per person per year

Hospital Indemnity Bi-Weekly Premiums

	Low Plan	High Plan
Employee Only	$3.49	$6.89
Employee & Spouse	$5.29	$10.62
Employee & Child(ren)	$6.92	$13.92
Family	$8.72	$17.64

Download the Full Plan Summary

Legal Services

LegalShield

Help Protect Yourself and Your Family with LegalShield

The legal plan, administered by LegalShield, provides you and your family with direct access to an experienced provider law firm on a wide range of personal legal matters including, but not limited to:

Advice and consultation

Collection letters, legal research, and the ability to meet with your provider lawyer in-office or by phone.

Family law

Adoption and paternity, guardianship, name change, juvenile matters, pre-nuptial agreements, elder law matters, gender rights, immigration assistance, pet protection, reproductive matters, and more.

Home

Deeds, home sales or purchases, neighbor disputes/easements, eviction and tenant issues (tenant only), foreclosures, 2nd home rental, and more.

Finance

Bankruptcy, collection letters, contracts/financial disputes, IRS audit services, personal property disputes, consumer protection, and more.

Wills and Estate Planning

Codicils, Living Wills/Wills, Living Trusts/Special Needs Trusts, Physician's Directive, Power of Attorney, Probate, and more.

Motor Vehicle

Driver's license restoration, motor vehicle property damage, moving traffic violations/traffic tickets, property damage claims, and more.

Additional benefits include letters and phone calls made on your behalf, contract and document review, 24/7 emergency access for covered legal emergencies, free legal forms and resources, and a mobile app.

To learn more, go to www.shieldbenefits.com/saltlakecounty.

Legal Services Bi-Weekly Premiums

Legal Protection	$8.75

Download the Full Plan Summary ↓

ID Theft Protection

MetLife ID Theft powered by Aura

Financial Fraud Protection

Monitors credit, asset titles, and financial accounts for suspicious activity, one-tap credit lock, and financial tools to help keep money and assets safe.

Identity Theft Protection

Get alerted to threats to personal information, online accounts, social media and more. Plus, we automatically request removal of personal info from data broker sites to protect it from thieves and spammers.

Privacy & Device Protection

Tools to manage passwords, protect devices from malware and viruses, secure public Wi-Fi connections, keep browsing activity private, and more.

Family Safety (With Family Plans)

Fully integrated family safety tools help parents and caregivers keep a pulse on loved ones' online safety. Inclusive family plans cover unlimited dependent minors and up to 10 additional adult loved ones with no restrictions.

Services & Support

24/7 US-based customer support, white-glove fraud resolution services, access on-the-go via the all-in-one Aura app, and more.

ID Theft Insurance Policy

Each adult is backed by their own separate $5M ID theft insurance policy* to reimburse for eligible losses and expenses resulting from ID theft.

ID Theft Protection Bi-Weekly Premiums

Employee Only	$3.90
Family	$6.44

Download the Full Plan Summary

Pet Insurance

MetLife

More than ever, pets play such a huge role in our lives. We want to do everything to keep them safe and healthy. Help make sure your furry family members are protected against unplanned vet expenses for covered accidents or illnesses with MetLife Pet Insurance.

Product Overview	Pet Insurance can help reimburse you for covered vet visits, accidents, illness and more. Plus, it can help keep your pet safe and healthy with preventive care like X rays and ultrasounds.
Why Needed	› The average annual cost for a routine vet visit is $212 for a dog and $160 for a cat. › The average annual cost for a surgical vet visit is $426 for a dog and $214 for a cat › A small monthly payment can help plan for these expenses. › Pet insurance may not cover preexisting conditions, so enroll your pet when they're healthy.
Flexible Coverage	Choose the plan that works for you and your pet. Flexible Options include: › Annual limit- $500 to Unlimited › $0 ––$2,500 deductible options › Reimbursement percentages from 50% to 90%
What Is Covered	› Illnesses › Exam fees › Surgeries › Medications › Hospital stays › Ultrasounds › X-rays and diagnostic tests
Additional Value	Take your pet to any licensed veterinarian, specialist or emergency clinic in the U.S. › Group discount available. › Multi-Policy Discount › Telehealth Concierge Service › And more!

Get a Quote Today

Obtain quotes 24/7 online by visiting: http://www.metlife.com/getpetquote or call 1.800.GETMET8. Be sure to let the representative know you are an employee of Salt Lake County. Pet insurance is a direct bill product and not offered via a payroll deduction.

Download the Full Plan Summary

Auto & Home

Farmers

Protect what matters most with special group rates on **auto and home insurance** available to Salt Lake County employees.

Through Farmers, you can access competitive pricing, flexible coverage options, and convenient payroll deduction for easy premium payments. Whether you have a home, drive a car, or both, this program can help you safeguard your property and finances. You can get a free, no-obligation quote anytime and make changes or cancel your policy directly with the vendor.

For a no-obligation quote call 1-888-761-1972 today.

Download the Flyer

Salt Lake County

Employee Perks

Onsite Childcare

As a County employee, you have access to onsite childcare provided by La Petite Academy. The academy is located at the County's new campus in Midvale, where employees will enjoy preferred enrollment, but County employee discounts are available at all La Petite Academy locations throughout the valley*. Click here to download the flyer.

- Serving infants through Pre-K with a child-centered inquiry-based curriculum
- Healthy, balanced meals prepared on site.
- Focus on outdoor education and gross motor playtime
- Flexible enrollment options
- 10% tuition discount for County employees
- Live streaming video, real-time updates and direct messaging through the exclusive SproutAbout app.

*All enrollments based on center availability

Fitness Center/Recreation Center Pass

As a valued team member of Salt Lake County, you can take advantage of our All-County recreation pass for employees!

With this pass, you can access the fitness center at the Government Center, and **all** of the Salt Lake County Recreation Centers. Passes are only $15 per month, and you can add family members for an additional fee. (Note: The discount is available to benefits eligible employees.)

Call (385) 468-1789 or visit the Recreation Center's web page for more information.

Service Awards

County employees are eligible for Service Awards based on years of county service. Employees are first recognized upon reaching their 5th anniversary. Every five years thereafter employees will be recognized and thanked for their commitment to the County with a service award. Starting with the 10th anniversary, the award includes a reward. Several selections, including cash, are available for this gift. When you reach your anniversary, a packet will mailed containing instructions for choosing and collecting your reward.

Trip Reduction

Salt Lake County offers its employees a variety of trip-reduction processes on a subsidized basis. The County does this to reduce the number of drive-alone commuters to help reduce congestion and improve air quality in Salt Lake County and its neighboring counties.

Trip Reduction benefits are available to all current Salt Lake County employees (merit, full or part-time, and temporary employees with EINs).

To schedule an appointment, ask questions, or to send completed forms, email TRP@saltlakecounty.gov or call (385) 468-7070.

Tuition Reimbursement

Salt Lake County financially supports the educational pursuits of its employees through the Tuition Reimbursement Program.

For current program details and information about eligibility, please contact Cynthia Carrington at (385) 468-0576.

Full Time Employees Cost of Coverage

January 1, 2026 – December 31, 2026

Employee Cost Per Pay Period

Medical – High Deductible Health Plans

Status	PEHP & Select Health HSA Plans
Employee Only	$0
Family	$0

Medical – Traditional Plans

Status	PEHP & Select Health Traditional Plans
Employee Only	$74.27
Employee +1	$163.13
Family	$219.77

Dental

Status	Cigna
Employee Only	$5.26
Employee + 1	$6.74
Family	$10.15

Vision

Status	VSP
Employee Only	$3.30
Employee + 1	$6.60
Family	$10.62

Part Time Employees Cost of Coverage

January 1, 2026 – December 31, 2026

Employee Cost Per Pay Period

Medical – High Deductible Health Plans

Status	PEHP & Select Health HSA Plans
Employee Only	$96.53
Family	$277.26

Medical – Traditional Plans

Status	PEHP & Select Health Traditional Plans
Employee Only	$148.53
Employee +1	$326.27
Family	$439.55

Dental

Status	Cigna
Employee Only	$10.52
Employee + 1	$13.48
Family	$20.31

Vision

Status	VSP
Employee Only	$3.30
Employee + 1	$6.60
Family	$10.62

Salt Lake County

Group Health Plan Notices

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator at eschurter-Sullivan@saltlakecounty.gov or (385) 468-0580

Medicare Part D Notice

Important Notice About Your Creditable Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

PLEASE CONTACT HUMAN RESOURCES FOR MORE INFORMATION ABOUT WHAT HAPPENS TO YOUR COVERAGE IF YOU ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN.

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. Your medical benefits brochure contains a description of your current

prescription drug benefits. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact Human Resources for further information.

NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE PRESCRIPTION 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).

Women's Health and Cancer Rights Act Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the plan administrator.

Newborns' and Mothers' Health Protection Act Notice

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

HIPAA Non-Discrimination Requirements

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating with regard to eligibility, premiums, or contributions on the basis of specified health status-related factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

Notice of HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

Special Enrollment Provisions

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

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

Other mid-year election changes may be permitted under your plan (refer to "Permitted Midyear Election Changes" section below).

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

Permitted Midyear Election Changes

Under Internal Revenue Service (IRS) regulations, in order to be eligible to take premium contributions using pre-tax dollars, elections generally must be irrevocable for the entire plan year (with the exception of HSA benefit elections, for which prospective election changes must be allowed at least monthly and upon loss of HSA eligibility). As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will generally remain in place until the next open enrollment period, unless you have an approved election change event and certain other conditions are met as outlined in IRS Code Section 125. See your Section 125 premium conversion plan summary plan description (SPD) for further details and a complete listing of permitted change in election events.

Examples of permitted change in election events include:

- Change in legal marital status (e.g., marriage, divorce, annulment, or legal separation)
- Change in number of dependents (e.g., birth, adoption, or death)
- Change in your employment status or your spouse's or covered child's change in employment (e.g., reduction in hours affecting eligibility or change in employment)
- Your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage
- You and/or your spouse or covered child has a change of residence
- Your spouse or covered child makes an election change during an open enrollment period under his or her employer's cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse's or covered child's change.
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment

These are just some examples of permitted mid-year change in election events. Consult with Human Resources for other circumstances that may be permissible mid-year change in election events.

You must notify Human Resources within 30 days of the above change in status, with the exception of the loss of eligibility or enrollment in Medicaid or state health insurance programs - which requires notice within 60 days.

HIPAA Notice of Privacy Practices

Notice of Health Information Privacy Practices

This Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice describes the legal obligations of your group health plan and your legal rights regarding certain health information, called protected health information (PHI), held by the group health plan under the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the corresponding regulations (collectively referred to as "HIPAA"). The group health plan is sponsored by your employer. If you have any questions about this notice or about the group health plan's privacy practices, or wish to exercise any of your privacy rights, please contact human resources.

How the Health Plan Uses and Discloses Protected Health Information

Under HIPAA, the plan may use or disclose protected health information (PHI) under certain circumstances without your permission, provided that the legal requirements applicable to the use or disclosure are followed. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all the ways permitted to use and disclose information will fall within one of the categories. Most of the time the plan will use, disclose, and request only the minimum information necessary for these purposes.

FOR TREATMENT. The plan may use or disclose PHI to facilitate medical treatment or services by health providers. The plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.

FOR PAYMENT. The plan may use or disclose PHI to make payments to health care providers who are taking care of you. The plan may also use and disclose PHI to determine your eligibility for plan benefits, to evaluate the plan's benefit responsibility, and to coordinate plan coverage with other coverage you may have. For example, the plan may share information with health care providers to determine whether the plan will cover a particular treatment. The plan may also share your PHI with another organization to assist with financial recoveries from responsible third parties

FOR HEALTH CARE OPERATIONS. The plan may use and disclose PHI to run the plan. For example, the plan may use PHI in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. However, the plan will not use genetic information for underwriting purposes.

TO BUSINESS ASSOCIATES. The plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain, transmit, use, and disclose protected health information, but only after they agree in writing to safeguard PHI and respect your HIPAA rights. For example, the plan may disclose PHI to a third-party administrator to process claims for plan benefits.

AS REQUIRED BY LAW. The plan will disclose PHI when required to do so by federal, state, or local law.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY. The plan may use and disclose PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

TO THE EMPLOYER. The plan may disclose PHI to certain employees of the employer who are involved with plan administration. These employees are permitted to use or disclose PHI only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. PHI cannot be used for employment purposes without your specific authorization.

WORKERS' COMPENSATION. The plan may disclose PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

PUBLIC HEALTH. The plan may disclose PHI for public health activities, including, for example, to prevent or control disease, injury, or disability; or to report child abuse or neglect.

HEALTH OVERSIGHT. The plan may disclose PHI to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES. The plan may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

LAW ENFORCEMENT. The plan may disclose PHI if asked to do so by a law-enforcement official in certain limited circumstances.

FAMILY MEMBERS. The plan may disclose PHI to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures. With only limited exceptions, all mail regarding the plan will be sent to the employee unless we have agreed otherwise. This includes mail relating to participation of the employee's spouse and other family members in the plan, such as availability of plan benefits and information on the processing of any plan benefits (including explanations of benefits (EOBs)).

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS. The plan may disclose PHI to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES. The plan may disclose PHI to authorized federal officials for national security activities authorized by law.

MILITARY. The plan may disclose PHI as required by military and veterans authorities if you are or were a member of the uniformed services.

RESEARCH. In very limited situations, the plan may disclose protected health information to researchers; however, usually we will need to get your authorization.

COMPLIANCE WITH HIPAA. The plan is required to disclose PHI to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

AUTHORIZATIONS. Other uses or disclosures of PHI not described above will be made only with your written authorization. For example, the plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose PHI for marketing; or to sell PHI. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

Your Rights

You have the rights described below with respect to PHI about you, subject to certain conditions and exceptions.

GET A COPY OF HEALTH AND CLAIMS RECORDS. You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT HEALTH AND CLAIMS RECORDS. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

REQUEST CONFIDENTIAL COMMUNICATIONS. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

ASK US TO LIMIT WHAT WE USE OR SHARE. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED. You can complain if you feel we have violated your rights by contacting Human Resources. You can file a complaint with the U.S. Department of Health and Human

Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO: (1) Share information with your family, close friends, or others involved in payment for your care. (2) Share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

IN THESE CASES, WE NEVER SHARE YOUR INFORMATION UNLESS YOU GIVE US WRITTEN PERMISSION: (1) Marketing purposes. (2) Sale of your information.

The Plan's Responsibilities

- The plan is required to:
- Maintain the privacy and security of your PHI.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

More Information

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact Human Resources and the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.
- The plan reserves the right to change the terms of this notice and to make new provisions effective for all PHI that the plan maintains, including PHI created or received prior to any revision. If significant changes are made, the plan will furnish you with a revised copy.

Important Information on How Health Care Reform Impacts Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your plan generally requires 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 your Human Resources office.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider. For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:
- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered, then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources.

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Prohibition on Preexisting Condition Exclusions

Effective for Plan Years on or after January 1, 2014, group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A preexisting condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your

annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1 2]

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

When Can I Enroll in Health Insurance Coverage through the Marketplace? You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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

[*NOTE: The following two paragraphs are part of the current model Exchange Notice provided by the DOL and therefore is included. However, because the COVID public health emergency has ended, and because we are past these temporary COVID-specific special enrollment periods, these two paragraphs are no longer relevant.*]

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

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

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

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

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact the plan administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

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

1. Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Your Employee Rights Under the Family and Medical Leave Act (FMLA)

The FMLA only applies to employers that meet certain criteria. A covered employer is a:

- Private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year (including a joint employer or successor in interest).
- Public agency (including a local, state, or Federal government agency) regardless of number of employees.
- Public or private elementary or secondary school, regardless of number of employees.

What is FMLA Leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with job-protected leave for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take up to 12 workweeks of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,

- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness may take up to 26 workweeks of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in one block of time. When it is medically necessary or otherwise permitted, you may take FMLA leave intermittently in separate blocks of time, or on a reduced schedule by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is not paid leave, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I Eligible to Take FMLA Leave?

You are an eligible employee if all of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a covered employer if one of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management

How Do I Request FMLA Leave?

Generally, to request FMLA leave you must:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You do not have to share a medical diagnosis but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You must also inform your employer if FMLA leave was previously taken or approved for the same reason when requesting additional leave.

Your employer may request certification from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What Does My Employer Need to Do?

If you are eligible for FMLA leave, your employer must:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your employer cannot interfere with your FMLA rights or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your employer must confirm whether you are eligible or not eligible for FMLA leave. If your employer determines that you are eligible, your employer must notify you in writing:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where Can I Find More Information?

Call 1-866-487-9243 or visit dol.gov/fmla to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. Visit www.dol.gov/agencies/whd/contact/complaints to learn about the WHD complaint process.

Your Rights under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service;

then an employer may not deny you

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment.

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets*. An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

Medicare and Health Savings Accounts (HSAs)

If you are approaching Medicare eligibility and you currently contribute to a Health Savings Account (HSA) that is integrated with a High Deduction Health Plan (HDHP), it is important to understand how HSA eligibility rules and Medicare enrollment interact.

An individual is not eligible to make HSA contributions (nor eligible to have employer contributions made to their HSA) if the individual has other coverage including being enrolled in Medicare. An individual who is enrolled in Medicare is not eligible for continued HSA contributions, however, funds that existed in the HSA prior to Medicare enrollment may continue to be used for ongoing medical expenses.

It is important to be aware that Medicare enrollment based on age or disability cannot be waived by individuals who are receiving Social Security benefits. However, Medicare enrollment may be delayed by delaying the receipt of Social Security benefits. For those that delay applying for Medicare, enrollment is generally retroactive for up to six months (that is, Medicare coverage will begin up to six months prior to the month in which they applied). Because the first month of Medicare enrollment will be retroactive for individuals who delay applying for Medicare, those individuals should use extra care when determining the amount of their HSA contributions to avoid excess contributions and possible adverse tax consequences.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing.

What is "balance billing" (or sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

EMERGENCY SERVICES. If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER. When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

IF YOU THINK YOU'VE BEEN WRONGLY BILLED, the federal phone number for information and complaints is: 1-800-985-3059. Also visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Continuation Coverage Rights Under COBRA

Your employer's group health plan may not be subject to COBRA (and this notice will not apply) if your employer had fewer than 20 employees on a typical business day during the preceding calendar year. If your plan is not subject to COBRA, it may be subject to state continuation rights which are similar to COBRA continuation rights.

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

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

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

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

How is COBRA Continuation Provided?

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

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

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A

or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

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

SALT LAKE COUNTY

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This Employee Benefits Guide was created for the employees of Salt Lake County by GBS Benefits.