Get Connected

Working Together to Build Health & Financial Wellness

Stronger. Smarter. Better.

City of Greensboro

2024 BENEFITS

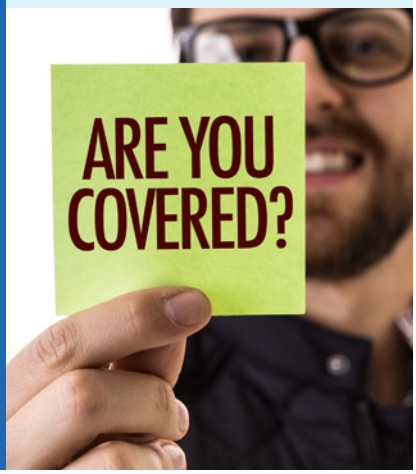
GREENSBORO
NORTH CAROLINA

Using this Guide

The Employee Benefits Guide provides a comprehensive overview of benefit options and more, including eligibility, election periods, and costs. In addition, it offers descriptions and detailed explanations of each plan that is a component of the Total Compensation Benefits package.

We hope that this guide will be a valuable tool for all employees and we want you to know that the City of Greensboro is here for you with more resources than ever to help guide you on this important journey

Sincerely,
The People & Culture Department



GREENSBORO
PEOPLE & CULTURE

WHAT'S INSIDE...

From the City Manager

As we near the end of another year, I want to thank each and every one of you for your hard work. Your dedication and service help to make Greensboro the most desirable mid-sized city in America. As you strive to meet and exceed the needs of our community, the City of Greensboro continues to support its employees with one of the most attractive and comprehensive benefits packages for an organization of our size. I hope you will take full advantage to engage and learn about the opportunities you have to provide coverage for you and your family.

I truly appreciate how the Benefits Division of the People & Culture Department continues to overcome the challenges in healthcare delivery and the availability of affordable coverage options for our employees. At a time when healthcare costs continue to rise at rates of 10 percent or more and plan designs are paying less, we remain committed to maintaining our exceptional healthcare plan designs and strengthening our plan funding. This year, there will be a 5 percent rate increase in the medical plans for City contributions, active employees and retirees to cover the additional cost projections for 2024. I am thankful for the P&C team's continued efforts to develop innovative plans that care for employees, retirees and their families. It is worth noting these plans are well-designed for individual choice and provide access to the best service providers in our area.

The City will continue to offer the Choice Plan and the Choice Plus Plans through United Healthcare, while offering a new High Deductible Health Plan (HDHP) in 2024. The HDHP is designed to offer lower monthly premiums with a higher deductible than the Choice and Choice Plus plans. All three plans will continue to provide the same great access to a wealth of local network providers, hospitals and pharmacies. Those who enroll in the High Deductible Health Plan are eligible to sign up for a Health Savings Account (HSA) through Fidelity Bank. With this account, you can set aside money on a pre-tax basis to pay for qualified medical expenses while The City contributes a set amount to the HSA.

We are also introducing the new Short Term Disability plan administered by the Standard Insurance Company effective on January 1, 2024. This plan is designed to ensure that all employees have access to income in the event of a short term illness that may prevent them from working. This new plan replaces the Donated Leave and City Manager Leave Plans. Employees who are on Donated Leave or City Managers Leave on January 1 may remain on those plans until their prior approved leave is exhausted.

One of the best ways to keep medical costs low is through awareness and prevention. Please take advantage of the many incentives offered in our Get Connected Wellness program. Employees may earn up to $160 in gift cards plus eight hours of paid time off through the Rally Rewards program.

I hope you will carefully review the information provided by the Benefits Team and make your selections through INFOR Cloud Suite from November 1-17. Remember, all employees must either make their selections or decline coverage during this time. If you have questions or concerns, you can contact the People & Culture liaison in your department or a member of our P&C Benefits team. Stay connected throughout the year by accessing your myuhc.com account, checking CityNet for announcements about health and financial wellness programs, reading the G-Team and G-Force newsletters, and downloading the iEngage Benefits app.

Thank you all for everything you do for our city and its residents. Your contributions are vital to making the City of Greensboro an employer of choice.

Taiwo Jaiyeoba
City Manager

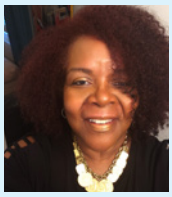
2024 OPEN ENROLLMENT

During Open Enrollment, you are encouraged to evaluate your benefits and make changes for the upcoming year that are best for you and your family. This guide provides detailed information about the 2024 benefit options, so please read it thoroughly. It is important for you to remember that Open Enrollment is the ONLY time to make benefit changes unless you have a qualifying event during the course of the year.

MANDATORY Open Enrollment begins November 1, 2023 and ends November 17, 2023.

- To elect benefits for Medical, Dental, Vision, Life and Disability insurance, City Flex Flexible Spending Accounts and Unum Supplemental Plans you must use the Online Benefits Enrollment Portal.
- Flexible Spending Accounts (FSA) do not automatically roll over to the next year. You must make an election online in order to have coverage in 2024. **Please check your first paycheck in January to confirm that your FSA elections and payroll deductions are correct.**
- All costs for coverage will be annualized and divided into twenty six (26) equal payments.
- Annual Leave and Sick Leave Accruals will be updated twice a month. There are no changes to the Annual Leave accrual amounts based on years of service.
- **PLEASE PRINT YOUR CONFIRMATION STATEMENTS AND SAVE FOR YOUR RECORDS**

BENEFITS DIVISION



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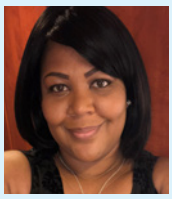

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Engineering & Inspections		
P&C Representative	Tanya Beatty	336-373-2952
Administration, Maintenance	Christine Patterson	336-373-2334
Development Services	Kim Foster	336-412-6313
Executive		
CMO, Economic Development, Internal Audit, MWBE	Haley Wilson	336-433-7366
Field Operations		
P&C Representative	Laina Djibril	336-412-3926
Right of Way, Storm Water	Dovie D. McBrayer	336-373-2793
Finance		
Admin Services, Administration	Delma Wilson	336-373-2077
Equipment Services	Pamela Hopkins	336-373-2807
Fire		
P&C Representative	Tracy Hinshaw	336-412-5718
Business Partner	Kimberly Gross	336-412-3929
GM 911		
P&C Representative	Jeneen Reitano	336-373-2147
Benefits Assistant	Brianna Lowe	336-373-7637
Housing & Neighborhood Development	Regina Womble-Miller	336-373-2754
Human Rights	*Vacant*	336-373-2502
Information Technology - P&C Representative	Kiran Purswani	336-373-2490
Law	Jennifer Smith-Sutphin	336-373-2694
Legislative	Angela Lord	336-373-2301
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P&C Representative	Robin Toler	336-373-2475
Benefits Assistant	Amanda Bashor	336-373-2698
Office of Workforce Development	Syretha A. Brown	336-373-3025
Parks & Recreation		
Business Partner	Mike Goodman	336-373-3258
P&C Representative	Deanne Williams-Blake	336-373-2963
P&C Backup	Mitzi Dew	336-373-4683
People & Culture	Deanna Berlin	336-373-2614
Planning	Olivia Byrd	336-373-2986
Police		
P&C Representative	Delisha Council	336-373-2535
P&C Representative	Leslie Wilson	336-373-2175
Transit - P&C Representative	Heather Rooney	336-373-4529
Transportation - P&C Representative	Kelly Ingram	336-373-4511
Water Resources - P&C Representative	Jennifer McDowell	336-373-2899
Business Partner	Bria Fennell	336-373-3662
Mitchell, Townsend, Lake Brandt	Misty Nelson	336-373-7890
N. Buffalo, Osborne	Lavonne Knight	336-433-7221
Operations	Veronica Covert	336-373-3673

ELIGIBILITY

You are eligible to enroll in the City's Healthcare plans if you are a Benefit Eligible employee who is scheduled to work at least 20 hours per week. **Your coverage starts the first of the month following 30 days of employment.** Your eligible dependents may also participate in the plan.

ELIGIBLE DEPENDENTS

An eligible dependent is considered to be:

- Your legal spouse
- A dependent child up to age 26 regardless of the following:
  - Your or your spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian;
  - Regardless of their marital status, student or employment status
  - Whether they are your tax dependent
- A child age 26 or over who is or becomes disabled and dependent upon you
- A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order

To be eligible for coverage under the plans, a dependent must reside within the United States.

QUALIFYING EVENTS

The choices you make as a benefits eligible employee will remain in place from your effective date (the first of the month following 30 days of employment) in 2024 through December 31, 2024. You cannot add or drop coverage until our next Open Enrollment period (for the plan year beginning January 1, 2025) unless you experience a "qualifying event."

Some of the following qualifying events will allow you to make changes to your current benefits. Notification is your responsibility. You must notify your departmental P&C Representative or Benefits Assistant within 31 days of the "qualifying event" date for changes to be accepted. Otherwise, you will have to wait until the next Open Enrollment period.

A qualifying event is considered to be:

- Marriage or Divorce
- Birth or adoption of an eligible child
- Change on a dependents eligibility status
- Receiving a Qualified Medical Child Support Order (QMSCO)
- Becoming eligible for Medicare or Medicaid
- Change in your or your spouse's employment status (gain or loss of other coverage)
- Dependent no longer meets eligibility criteria

Get Connected

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VIRTUAL DOCTOR VISITS

When you don't feel well or when someone you love is sick, the last thing you want to do is sit in the doctor's waiting room. With Virtual Visits you can see and speak to a doctor online anytime from your mobile device or computer.

- up to $49, depending on plan choice
- using Dr On Demand, Amwell or Walmart Doctor

FREE CARE MANAGEMENT SERVICES

- Asthma Disease Management Program
- Coronary Artery Disease Management
- Chronic Obstructive Pulmonary Disease Management
- Diabetes Healthcare Management
- Heart Failure Management

INGAGED MOBILE APP

Download the iNGAGED app to:

- view benefits, City resources and documents - 24/7
- access carrier policy information and group numbers
- quickly contact a benefit carrier using the "tap to call" feature
- keep up to date with important benefits announcements

$50 UNUM PLAN WELLNESS BENEFIT

Your Unum plan also pays a Wellness Benefit for one wellness test each year. With Unum's Wellness Benefit, you and other covered family members can receive a valuable incentive for important tests and screenings. Many of these tests are routinely performed, so it's easy to take advantage of this benefit.

SELF-CARE FROM ABLETO

On-demand access to self-help for stress and emotional well-being.

Get access to self-care techniques, coping tools, meditations and more — anytime, anywhere. With Self Care, you'll get personalized content that's designed to help you boost your mood and shift your perspectives. Tap into tools created by clinicians that are suggested for you based on your responses to a short, optional assessment. Self Care is here to help you feel better —and it's available at no additional cost to you.

FREE EMPLOYEE FITNESS CENTERS

Being physically fit is not just about losing weight to look good. There is a high correlation between fitness and physiological health. Below are three facilities that you have free access to:

- MMOB - *300 W. Washington St.*
- MEDFORD SERVICE CENTER - *401-C Patton Ave.*
- GTA - *223 W. Meadowview Rd.*

REAL APPEAL WEIGHT LOSS SUPPORT

Real Appeal will help motivate you and improve your health with an evidence-based virtual weight loss program. Real Appeal teaches you how to eat healthier and be active, helping you achieve your weight loss goals.

RECHARGE ROOMS

Get away from the stresses of the job long enough so that the brain can reset, and when the batteries are fully recharged, you are ready to tackle even the toughest projects with renewed energy.

- MMOB
  300 W. Washington St.
- MEDFORD SERVICE CENTER
  401-C Patton Ave.
- GTA
  223 W. Meadowview Rd.

2024 HEALTH REWARDS WELLNESS PROGRAM

By enrolling in the Get Connected program, you can earn up to $160 in electronic gift cards and 8 hours of Paid Time Off (PTO). To get started and register for single sign on access visit www.myuhc.com. Once signed in, under quick links, select Rally Health and Wellness. You can also download the Rally App on your mobile device and register using the code, CITY07.

Earn $100 in Electronic Gift Cards

Choose any items to total $100. All rewards are automatically loaded to your Rally account.

Annual Biometric Screening	$50
Annual Physical or Prenatal Exam	$50
Annual Preventive Screening	$50
RALLY Annual Health Survey	$25
RALLY Missions, Challenges, Game Changers or Trophy Tourneys	$25
RALLY Take a quiz about your health	$25
Real Appeal UHC Real Appeal Program	$25

All activities must be completed from January 1, 2024 thru December 31, 2024. Gift cards are considered taxable income.

2024 Onsite Biometric Screening Events*

March 12	MMOB	9 am to 2 pm
May 21	Coliseum	9 am to 2 pm
August 15	Field Operations	2-6 pm
October 17	Coliseum	9 am to 2 pm
December 10	Water Resources	2-6 pm

Sign up at www.greensboro-nc.gov/BioFlyer

*Dates subject to change

2024 Fairs

May	Employee Health Fair
October	Open Enrollment Benefits Fair

All events are free. Please plan to attend in advance.

FREE Mental Wellness Resources

- Optum Live and Work Well Employee Support Program
- Telemental Health Services through Amwell or Doctor on Demand, *Co-pays may apply*
- SelfCare by AbleTo

Earn up to 8 Hours of PTO

Complete your annual physical and participate in **ANY FIVE** of the COG Wellness Activities to earn PTO. You DO NOT have to get one point in each area. However, we encourage participation in all areas.

Annual Physical	REQUIRED
Emotional Wellness	1 POINT
Mental Wellness	1 POINT
Physical Wellness	1 POINT
Intellectual Wellness	1 POINT
Financial Wellness	1 POINT
Occupational Wellness	1 POINT
Social Wellness	1 POINT

PTO will be awarded the first quarter of 2025. Unless otherwise posted, each activity is a 1 point value. You can also earn your own points! Submit your wellness points at https://form.jotform.com/230304969544157.

Earn a $60 Bonus in 2024!

You can earn an additional $5 per month by reaching your personalized step goal 12 days out of the month! ($60 value)

RALLY Rally Stride Program	$5 per month

UHC Rally Activities & Gift Card Support
1-844-334-4944
Monday thru Friday 9 am to 9 pm EST

Free Employee Fitness Centers!
Get access here: https://form.jotform.com/92274502418152

GREENSBORO PEOPLE & CULTURE

Download the iNGAGED Benefits App to access your benefits information and stay connected to Wellness! Access Code: GSO

Wellness Questions? Contact Whitney Montouth at 336-433-7217 or whitney.montouth@greensboro-nc.gov

UNITED HEALTHCARE MEDICAL PLAN COVERAGE

The City of Greensboro offers medical and prescription drug plan coverage administered through United Healthcare and OptumRx.

There are three Health Plan options:

- ***Choice Plan:*** offers in-network-only benefits for covered services.
- ***Choice Plus Plan:*** offers in-network and out-of-network benefits for covered services.
- ***High Deductible Health Plan (HDHP):*** offers in-network and out-of-network benefits for covered services.

These plans are preferred provider organizations (PPOs) and offer access to providers in United Healthcare's networks providing you with quality care and significant savings in comparison to receiving out-of-network services.

Choice Plan

Use our national network to help save money.

Save money by staying in our network.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network. If you don't use the network, you'll have to pay for all of the costs.

There's no need to select a primary care physician (PCP) or get referrals to see a specialist.

Consider choosing a PCP. Your PCP can be your partner in managing your care. They can help you avoid duplicating tests and services and connect you to a specialist.

Preventive care is covered 100 percent in our network.[1]

Look for care in our network first.

The doctors and facilities in our national network have agreed to provide you services at a discount. We have:

- **907,587** physicians and health care professionals.*
- **5,597** hospitals.*
- **67,000+** pharmacies.*

Search the network at **welcometouhc.com/cog**

*As of 6/30/2018

How paying for network care works.

Copayment[1]
You pay

+

Deductible[1]
You pay 100%

+

Coinsurance[1]
You pay a percentage of the cost

After reaching the out-of-pocket limit
Plan pays 100% of covered expenses for the plan year

The fixed amount you pay for certain covered health services (e.g., doctor visits, prescriptions).

The amount you pay before your insurance plan pays a portion.

The percentage you pay after you reach your deductible.

Out-of-pocket limit
The most you pay for health care in one plan year (includes all of your network payments).

For all of the **COVERAGE DETAILS,** see your official health plan documents.

UnitedHealthcare®

[1]Age appropriate preventive care services are covered 100 percent when received in the plan network. You may be required to receive approval for some services before they can be covered.

Choice Plus Plan

Get a plan with access to a national network and the choice of out-of-network coverage.

Save money by staying in our network.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network.

There's coverage if you need to go out of the network.

You can receive care and services from anyone in or out of our network. Out-of-network means that a provider does not have a contract with us. It's important to remember, seeing an out-of-network provider will cost you more.

There's no need to select a primary care physician (PCP) or get referrals to see a specialist.

Consider choosing a PCP. Your PCP can be your partner in managing your care. They can help you avoid duplicating tests and services and connect you to a specialist.

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*As of 6/30/18

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Plan pays 100% of covered expenses for the plan year

The fixed amount you pay for certain covered health services (e.g., doctor visits, prescriptions).

The amount you pay before your insurance plan pays a portion.

The percentage you pay after you reach your deductible.

Out-of-pocket limit
The most you pay for health care in one plan year (includes all of your network payments).

If you go out of the network, your costs may be higher. Out-of-network providers can even bill you for amounts higher than what your plan will cover. For all of the **COVERAGE DETAILS,** see your official health plan documents.

[1]Age appropriate preventive care services are covered 100 percent when received in the plan network. You may be required to receive approval for some services before they can be covered.

UnitedHealthcare®

High Deductible Health Plan

Your high deductible health plan (HDHP) is built to help you keep more money in your pocket while covering routine preventive care. Though you have a higher deductible to meet before your plan starts sharing costs with you, enrolling in a health savings account (HSA), if eligible, can help you save and pay for qualified medical expenses.

- Lower monthly premiums — keeping more money in your pocket, especially if you don't use health care often
- Preventive care is covered 100% by our plans in our network
- Discounted rates for services — offered by network providers

Look for care in our network first.

The doctors and facilities in our national network have agreed to provide you services at a discount. We have:

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- **67,000+** pharmacies.*

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UnitedHealthcare®

FIDELITY HEALTH SAVINGS ACCOUNT (HSA)

A tax-advantaged way to pay for Qualified Medical Expenses. A Health Savings Account (HSA) can be an easy and smart way to save money to pay for qualified medical expenses for you and your dependents. With its triple tax advantages, easy access to funds, and future growth potential, it's a unique savings vehicle that provides benefits today and in the future.

Maximize Tax Savings by Enrolling in a High Deductible Health Plan (HDHP) and the Fidelity Health Savings Account (HSA)

- You must first enroll in an HSA-eligible High Deductible Health Plan that satisfies certain IRS requirements with respect to deductibles and out-of-pocket expenses.
- You generally pay more up front for medical expenses before the plan begins to pay for covered services. In return, you will generally pay less in premiums than in other medical plans and general preventative care services are fully covered
- The HSA account allows you to enjoy tax-deductible contributions, tax free earnings and tax free distribution for qualified expenses
- You own the account and you keep your HSA dollars year after year- even if you change employers or health plans
- You generally pay more up front for medical expenses before the plan begins to pay for covered services. In return, you will generally pay less in premiums than in other medical plans and general preventative care services are fully covered. Enrollment in an HSA-eligible health plan is one of the requirements to be eligible to establish an HSA.

What is an HSA?

- An HSA is an individual account used in conjunction with an HSA-eligible health plan to cover out-of-pocket qualified medical expenses on a tax-advantaged basis.
- Your HSA belongs entirely to you and can be used to pay for both current and future qualified medical expenses for you and your eligible dependents.
- You can contribute to your account, withdraw contributions to pay for current qualified medical expenses, and potentially grow your account on a tax-free2 basis by investing your savings in a wide array of investment options.

How much you can contribute to an HSA in 2024:

Coverage Level	2024
Individual Coverage in an HSA-Eligible Health Plan	$4,150
Family Coverage in an HSA-Eligible Health Plan	$8,300
Additional Catch-Up Contribution (if age 55 or older)	$1,000

City Contributions:

Coverage Level	2024
Individual - Employee only	$500
Employee plus Dependents	$1,000

Both amounts are prorated annually depending on your date of hire.

Please note: You cannot enroll in the Flexible Medical Spending Account and the Health Savings account per IRS Publication 969.

Fidelity INVESTMENTS

Pharmacy Benefit

Your covered medications.

OptumRx® is your UnitedHealthcare® plan's pharmacy care services manager. OptumRx is committed to helping provide you with safer, easier and lower cost ways to get the medication you need.

The UnitedHealthcare Prescription Drug List (PDL) is the list of medications that are covered by the plan. The PDL is organized by cost levels, known as tiers. Choosing medications in the lower tiers may save you money.

Tier 1
Lower-cost Medications

Tier 2
Midrange-cost Medications

Tier 3
Higher-cost Medications

Find out if your medication is **covered** by visiting welcometouhc.com/cog.

Save on your medications.

- Use home delivery. Up to a three-month supply of your medications will ship free to your home, often at a lower cost than retail. You also get 24/7 phone support, medication refill reminders and more. And it saves you trips to the pharmacy.
- Use network pharmacies and you will generally pay less out-of-pocket. Our network includes thousands of pharmacies across the country.
- Use lower tier medications, such as generics. Ask your doctor or check your PDL for lower-cost options. If you have a medication that is placed in a higher tier (Tier 3, for example), check to see if a lower-tier option is available.

2024 Highlights

Your plan may require one or more of the following for your prescription to be covered:

Medical Necessity—evaluates the clinical appropriateness of a medication regarding condition and severity to be treated.

Notification—physician authorization required to promote better decisions.

Supply limits—only a certain amount of the medication is allowed for coverage.

Restricted Generics—only a physician may require a brand name product if a generic is available. There is no ancillary charge if the physician orders a brand. However, there is a charge if a member requests a brand prescription in this scenario.

Check your prescription drug list (PDL).

Your PDL lists covered medications. The list is broken into sections called tiers. Choosing medications in lower tiers may save you money. Check your PDL often.

Talk to your doctor.

When you talk with your doctor, use the **Health4Me** app to confirm coverage and costs. You can also talk about what you need to do to get your medication.

UnitedHealthcare®

Manage your pharmacy benefits on the go.

With **myuhc.com** and the Health4Me® app[1] you can:

- Enroll in home delivery.
- Find network pharmacies.
- Refill prescriptions and set up refill reminders.
- Estimate and compare medication costs.
- Search your plan's PDL.

[1]The Health4Me® app can also help determine how a medication is covered and whether or not there are other options to help save you money.

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $49 or less.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$49 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit — bringing a potential $2,000[4] cost down to $49.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on $131 difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $49; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

MEDICAL COVERAGE AT-A-GLANCE

		Medical Plans				
		Choice Plan*	Choice Plus Plan		HDHP	
		WHAT YOU PAY IN-NETWORK	WHAT YOU PAY IN-NETWORK	OUT OF NETWORK	WHAT YOU PAY IN-NETWORK	OUT OF NETWORK
Deductible						
	Employee	$500	$500	$750	$2,000	$4,000
	Family	$1,000	$1,000	$1,500	$4,000	$8,000
Covered Services						
Doctors and Specialists	Doctor Visit (Illness or Injury)	$25 Copay	$25 Copay	20%	20% After Deductible	30% After Deductible
		$15 Copay Tier 1 Premium Designated Provider	$15 Copay Tier 1 Premium Designated Provider	N/A	20% After Deductible	30% After Deductible
	Virtual Visit (online)	0%	0%	N/A	20% After Deductible	30% After Deductible
	Specialist Visit	$50 Copay	$50 Copay	20%	20% After Deductible	30% After Deductible
Preventive Care	Screenings & Counseling	0%	0%	0% max $300	0%	Not covered
	Immunizations	0%	0%	0% max $300	0%	Not covered
	Well-Child & Well-Woman Visits	0%	0%	0% max $300	0%	Not covered
	Labs & Imaging Tests	0%	0%	0% max $300	0%	Not covered
Emergency Care	Urgent Care Visit	$30 Copay	$30 Copay	20%	20% After Deductible	30% After Deductible
	Emergency Room	$200 Copay	$200 Copay	$200 Copay	20% After Deductible	20% After Deductible
	Emergency Transportation	20%	20%	20%	20% After Deductible	20% After Deductible
Other Care	Mental Health Visit (outpatient)	$25 Copay	$15 Copay	50%	20% After Deductible	30% After Deductible
	Mental Health Visit (inpatient)	20%	20%	50%	20% After Deductible	30% After Deductible
	Outpatient Surgery Facility Fee	20%	20%	20%	20% After Deductible	30% After Deductible
	Hospital Stay Facility Fee	20%	20%	20%	20% After Deductible	30% After Deductible
	Hospital Stay Provider Fee	0%	0%	20%	20% After Deductible	30% After Deductible
Out-of-Pocket Limit						
	Employee	$3,000	$2,500	$2,900	$4,000	$8,000
	Family	$6,000	$5,000	$6,500	$8,000	$16,000
Prescriptions						
Retail *(up to 31-day supply)*	Tier 1	$10	$10	20%	20% After Deductible	30% After Deductible
	Tier 2	$35	$35	20%	20% After Deductible	30% After Deductible
	Tier 3	$50	$50	20%	20% After Deductible	30% After Deductible
Home Delivery *(90-day supply)*	Tier 1	$20	$20	Not covered	20% After Deductible	30% After Deductible
	Tier 2	$70	$70	Not covered	20% After Deductible	30% After Deductible
	Tier 3	$100	$100	Not covered	20% After Deductible	30% After Deductible

**Out of Network not covered*

This information does not replace your official health plan documents. Please see your official health plan documents for all coverage details, which includes limitations and exclusions. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

EMPLOYEE MEDICAL CONTRIBUTIONS

		Medical Plan Rates		
		Choice Plan EMPLOYEE PAYS PER PAY PERIOD (26)	**Choice Plus Plan** EMPLOYEE PAYS PER PAY PERIOD (26)	**HDHP** EMPLOYEE PAYS PER PAY PERIOD (26)
Full-Time				
Coverage Level	Employee Only	$17.93	$31.64	$16.91
	Employee/ Spouse	$223.89	$252.59	$179.14
	Employee/ Children	$139.08	$184.38	$111.12
	Employee/ Family	$270.42	$297.08	$216.31
	Employee/Spouse/Family**	$162.35	$207.61	$142.76
Part-Time 20 *(20-Hour Work Schedule)*				
Coverage Level	Employee Only	$165.34	$176.16	$166.17
	Employee/ Spouse	$336.79	$368.79	$333.26
	Employee/ Children	$293.26	$323.24	$291.66
	Employee/ Family	$410.46	$448.75	$406.00
Part-Time 25 *(25-Hour Work Schedule)*				
Coverage Level	Employee Only	$132.20	$140.95	$132.93
	Employee/ Spouse	$269.43	$295.08	$266.61
	Employee/ Children	$234.61	$258.60	$233.33
	Employee/ Family	$328.37	$359.04	$324.80
Part-Time 30 *(30-Hour Work Schedule)*				
Coverage Level	Employee Only	$82.67	$88.09	$83.08
	Employee/ Spouse	$168.40	$184.43	$166.63
	Employee/ Children	$146.63	$161.62	$145.83
	Employee/ Family	$205.23	$224.40	$203.00

This option is closed to new enrollment

PRE-65 RETIREE MEDICAL CONTRIBUTIONS

		Pre-65 Retiree Medical Plan Rates	
		Choice Plan	Choice Plus Plan
30 Years of City Service		**Monthly**	**Monthly**
Coverage Level	Retiree Only	$152	$199
	Retiree/ Spouse	$706	$1,036
	Retiree/ Children	$654	$856
	Retiree/ Family	$1,097	$1,413
25 Years of City Service		**Monthly**	**Monthly**
Coverage Level	Retiree Only	$320	$367
	Retiree/ Spouse	$874	$1,204
	Retiree/ Children	$823	$1,024
	Retiree/ Family	$1,265	$1,571
20 Years of City Service		**Monthly**	**Monthly**
Coverage Level	Retiree Only	$487	$534
	Retiree/ Spouse	$1,041	$1,371
	Retiree/ Children	$990	$1,191
	Retiree/ Family	$1,432	$1,748
Less than 20 Years of City Service		**Monthly**	**Monthly**
Coverage Level	Retiree Only	$824	$871
	Retiree/ Spouse	$1,377	$1,707
	Retiree/ Children	$1,326	$1,527
	Retiree/ Family	$1,768	$2,084
Disability - Grandfathered Retirees		**Monthly**	**Monthly**
Coverage Level	Retiree Only	$148	$198
	Retiree/ Spouse	$628	$672
	Retiree/ Children	$379	$522
	Retiree/ Family	$705	$891
Disability - Totally Disabled Retirees		**Monthly**	**Monthly**
Coverage Level	Retiree Only	$39	$84
	Retiree/ Spouse	$783	$826
	Retiree/ Children	$552	$695
	Retiree/ Family	$1,202	$1,386
Dependent Only		**Monthly**	**Monthly**
Coverage Level	Spouse Only	$824	$871
	Child Only	$824	$871
	Spouse/ Children	$1,254	$1,527
	Children Only	$1,254	$1,527

CONTINUATION OF BENEFITS RECONCILIATION ACT (COBRA)

As a City employee, you and your covered dependents have the option to continue your health and/or dental coverage if your coverage would otherwise end because of certain qualifying events including:

Coverage for up to 18 months following:

- Termination of employment
- Work hours reduced
- Working status changes from benefit eligible to non-benefit eligible

Coverage up to 29 months:

- Retirement under Social Security Disability

Coverage up to 36 months:

- Employee's death
- Divorce or legal separation
- Medicare Coverage
- Ineligible dependent (aged out child)

Notification

- Notification must be made to the City within 60 days of the qualifying event.
- Within 14 days of notification of the qualifying event, the affected party will be notified by first class mail of their right to continue coverage.

Cost and Payments

- The cost of continuing health and/or dental coverage will be the full cost of the premium at group rates plus a 2% administrative fee.
- The City does not contribute to the cost of Cobra.
- Payments are due on the first day of each month.

Loss of Coverage

- COBRA insurance will be canceled for non-payment of premiums.
- Upon Medicare eligibility medical plan coverage will cease.
- COBRA insurance will cease at the end of the eligibility period.
- If the City ceases to provide the same benefits to its employees, COBRA participants' insurance will cease at the same time.

OUR LEGAL DUTY: HIPAA AND ACA

Health Insurance Portability and Accountability Act of 1996, (HIPAA) was enacted in 1996 to:

- Make sure your protected health information is kept private.
- Give you notice of our legal duties and privacy practices with respect to protected health information about you.
- Follow the terms of the notice that is currently in effect.

Privacy Regulations

- Privacy provisions of HIPAA restrict how Protected Health Information (PHI) of those covered under the medical and/or dental plan(s) may be used or disclosed by the City of Greensboro, UHC, Delta Dental, Superior Vision, and Flores & Associates (CityFlex administrator).
- PHI may be used when enrolling in the medical and/or dental plan(s), the medical spending account, or when assistance is requested for problem resolution.
- HIPAA does not apply to information used in pre-employment screenings, workers' compensation claims, medical surveillance required by law for accommodations under the Americans with Disabilities Act (ADA), assessments for "fitness for duty", or drug testing.
- HIPAA also does not apply to information voluntarily given by you to any unauthorized individual, such as a co-worker.

Affordable Care Act of 2010 includes changes to how employers report medical coverage and how individuals and their families file their taxes.

- Per ACA Guidelines all benefit eligible employees must ENROLL or WAIVE the medical plan.
- Form 1095-C will be issued with your annual W-2 Form.
- You must file form 1095-C with your income tax return.

Benefits

- Families are allowed to maintain uninterrupted medical and/or dental plan coverage.
- Reasons for which medical and/or dental plan coverage can be terminated are restricted.
- Employees and dependents in poor health are ensured the availability of health insurance.

DELTA DENTAL PLAN COVERAGE

The City of Greensboro offers a dental plan administered by Delta Dental. The plan gives you the flexibility to use both in-network and out of network providers. However, when you use out-of-network providers, you will be responsible for a $50 Annual deductible and for paying any expenses that exceed the plan's usual and customary charges.

DENTAL PLAN HIGHLIGHTS

You can choose dentists from two of the nation's largest dental networks—Delta Dental PPOSM and Delta Dental Premier®:

Delta Dental PPO Network:

- More than 95,000 Delta Dental PPO Providers nationally
- Over 1,679 participating providers in North Carolina
- Larger discounts

Delta Dental Premier Network:

- More than 148,000 Delta Dental Premier Providers nationally
- Over 2,730 participating providers in North Carolina
- Larger network

Preventive dental services by a Non-Network dentist will be paid at 90% of UCR after a $50 deductible.* SAVE MONEY by visiting a Delta Dental Provider.

DELTA DENTAL®

	Delta Dental Plans		
	Delta Dental PPO Dentist IN-NETWORK	**Delta Dental Premier Dentist** IN-NETWORK	**Non-Participating Dentist** OUT OF NETWORK
Diagnostic & Preventive			
Preventive Care - Exams and cleanings (twice a year) - Xrays and Sealants	100% No Deductible	100% No Deductible	100% after $50 Deductible**
Basic Services - Fillings and crown repair - Endodontics, periodontics and surgery	80% No Deductible	80% No Deductible	80% after $50 Deductible**
Major Services - Crowns, inlays, onlays, cast restorations and bridges - Implants and related services	50% No Deductible	50% No Deductible	50% after $50 Deductible**
Orthodontics - Children up to age 26	50% No Deductible	50% No Deductible	50% after $50 Deductible**
Orthodontics - Adults	50% No Deductible	50% No Deductible	Not Covered

Nonparticipating Dentist - $50 deductible per person total per benefit year limited to a maximum deductible of $100 per family per benefit year. The deductible applies to all services.

****When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This Nonparticipating Dentist Fee may be less than what your dentist charges, which means that you will be responsible for the difference.***

	Dental Plan Rates							
	Full-Time		Part-Time 20 *(20-Hour Work Schedule)*		Part-Time 25 *(25-Hour Work Schedule)*		Part-Time 30 *(30-Hour Work Schedule)*	
Coverage Level	PER PAY PERIOD (26)	ANNUAL	PER PAY PERIOD (26)	ANNUAL	PER PAY PERIOD (26)	ANNUAL	PER PAY PERIOD (26)	ANNUAL
Employee Only	$1.85	$48	$10.62	$276	$8.42	$219	$5.77	$150
Employee/ Spouse	$12.46	$324	$24.92	$648	$22.15	$576	$18.92	$492
Employee/ Children	$13.85	$360	$27.46	$714	$24.40	$635	$20.88	$543
Employee/ Family	$16.62	$432	$32.08	$834	$28.56	$743	$24.58	$639
Employee/Spouse/ Family***	$13.38	$348	N/A	N/A	N/A	N/A	N/A	N/A

Delta Dental Maximum Payments:

- Delta Dental PPO Dentist or Delta Dental Premier Dentist: $1,750 per person total per benefit year on all services except orthodontic services. $2,400 per person total per lifetime on orthodontic services. (Includes adult orthodontic services.)
- Non-participating Dentist: $1,250 per person total per benefit year on all services except orthodontic services. $2,400 per person total per lifetime on orthodontic services. (Adult orthodontic services are not covered.)
- These are not separate maximums by type of dentist. You must use a Delta Dental PPO or Delta Dental Premier Dentists in order to access the $1,750 Maximum Benefits payable.

	Retiree Dental Plan Rates
Coverage Level	**Monthly**
Retiree Only	$42
Retiree/ Spouse	$83
Retiree/ Children	$91
Retiree/ Family	$105

******This option is closed to new enrollment***

SUPERIOR VISION PLAN COVERAGE

The City offers two vision plans insured by Superior Vision. Participation in this program is voluntary, so the cost of this benefit will be paid 100% by the employee. If you choose not to enroll in the vision plan keep in mind that the United Healthcare Medical plans cover an annual eye exam with a $50 copay.

VISION PLAN HIGHLIGHTS

See the savings that the city offers through the Superior Vision plan.
There are two plan options:

- Basic and Enhanced
- Comprehensive eye exams are available every 12 months
- More than 100 national and local retail brands covered
- Contact lenses and glasses may be purchased from participating providers at greatly reduced prices.

Discounts on Non-Covered Exam and Materials

- Frames: 20% off amount over allowance
- Lens options: 20% off retail
- Progressives: 20% off amount over standard progressive retail
- Refractive Surgery: 15% - 50% discount

SuperiorVision™

	Superior Vision Plans	
	Basic	**Enhanced**
Comprehensive Eye Exam - Annual Exam	$15 co-payment	$10 co-payment
Eye Glass Lenses - Annually	$30 co-payment	$25 co-payment
Eye Glass Lenses Options	Standard single vision, bifocal or trifocal lenses, factory scratch coat	Standard single vision, bifocal, trifocal, standard progressives, polycarbonate, basic anti-reflective lenses, factory scratch coat
Frame Allowance	$130 every two years	$150 every year
Covered Contact Lenses* - Elective	100% after a $30 co-payment annually	100% after a $25 co-payment annually
Non-Covered Contact Lenses* - Elective	$100 allowance annually	$150 allowance annually

**Contact lenses are in lieu of eyeglass lenses and frames benefit.*

	Superior Vision Plan Rates			
	Basic Plan		**Enhanced Plan**	
Coverage Level	PER PAY PERIOD (26)	ANNUAL	PER PAY PERIOD (26)	ANNUAL
Employee Only	$1.98	$51	$3.29	$85
Employee/ Spouse	$3.85	$100	$6.38	$166
Employee/ Children	$4.04	$105	$7.61	$198
Employee/ Family	$5.86	$152	$9.69	$252

OPTUM LIVE & WORK WELL EMPLOYEE SUPPORT PROGRAM

This program offers confidential support for managing stress, anxiety and depression; parenting and family needs; workplace concerns; sleep issues; and substance abuse. Each employee and eligible household member receive 10 free visits, per episode, per calendar year. The plan is effective 01/01/2023 for all general and roster employees.

EMPLOYEE SUPPORT PROGRAM HIGHLIGHTS

Call to speak with a specialist who will listen to your needs and connect you to the appropriate resource, whether it's a clinician, counselor, mediator, lawyer or financial advisor. A clinician may be a psychologist, or master's level specialist trained in social work, professional counseling or family and marriage therapy.

Take advantage of short-term counseling or get a referral for more extended care.

Will try to accommodate any gender, language or cultural preferences.

Free Services

- As part of your benefits, your Live and Work Well Employee Support Program services are available at no extra cost to you.
- Each employee and eligible household member receive **10 free visits**, per episode, per calendar year.
- Includes referrals, seeing in-network clinicians, access to liveandworkwell.com and initial consultations with mediators or financial and legal experts.
- Want to retain a lawyer after your consultation? You'll get a 25 percent discount.

Other Available Resources

You and your family also have 24-hour private access to liveandworkwell.com. This interactive website offers tools and resources to help you enhance your work, health and life. Any member of your household can use liveandworkwell.com, even children living away from home.

On the site, you can:

- Check your benefit information
- Submit online service requests
- Search the online clinician directory
- Use our virtual help centers to find information and resources for hundreds of everyday work and life issues
- Access financial calculators, legal articles and other tools
- Search our databases for childcare, nursing homes and other local resources
- Participate in interactive, customizable self-improvement programs

OPTUM®

Helping people find real-life solutions.

Your Live and Work Well Employee Support Program

800-789-3145

Or log on to liveandworkwell.com

Access code: Greensboro

Mental Health Support

Unlimited solution-focused consultations

In-person or virtual counseling sessions* **10 FREE VISITS**

Legal assistance/mediation services

Financial assistance

Online support and self-help tools

**number of sessions yet to be confirmed*

Management Services

Unlimited consultations

Managing employee work performance

Formal referrals

Work Life Services

Child/Parenting

Adult/Eldercare

Convenience Services

Life Learning

Critical Incident Response

Onsite Crisis Intervention

Virtual Crisis Intervention

Debriefings

Training Services

Professional Development Workshops

Wellness Seminars

Bank of ten (10) hours; to be used as client sees fit across training and CIRS

FLORES FLEXIBLE SPENDING ACCOUNTS (FSAs)

CityFlex is an FSA, a voluntary tax savings program which can help you save your money while saving your health! ***There are two kinds of flexible spending accounts:***

- ***Medical Account:*** Allows the use of tax-free dollars for uninsured medical, dental, and vision expenses (such as co-pays and deductibles), as well as some over-the-counter medications.*
- ***Dependent Care Account:*** Allows the use of tax-free dollars for approved expenses related to childcare such as day care, after school programs, and adult day care.

FLEXIBLE SPENDING ACCOUNTS

CityFlex is available to all benefited employees, regardless of their full-time or part-time status.

How it Works

- Money is deposited into your flexible account on a biweekly basis after a deduction is taken each pay period in equal amounts.
- Estimate your yearly expenses wisely! You can only be reimbursed for your qualifying expenses.
- The Annual medical and dependent care elections are deducted from your pay check on a pre-tax basis biweekly and deposited into your Flexible Spending Accounts.
- All funds for the Medical FSA account are immediately available for use when you receive the Flores Benefits Card in the mail
- The Dependent Care FSA is pre-funded for one month so that you can file claims while payroll deductions are processing. All Dependent Care claims must be filed with Flores for reimbursement
- Flores may on occasion contact you to provide supporting documents for Medical Claims. Please respond as quickly as possible to avoid loosing the pre-tax status on your account.

Medical Spending Account

- Expenses can be for anyone in your taxable household.
- You must enroll/re-enroll each year during Open Enrollment.
- New hires may enroll within 30 days of employment for the remainder of the calendar year in which they were hired.
- Elections are for one year unless and can be changed based on the need.
- The FSA maximum limit is projected to increase from $3,050 to $3,200 in 2024 (subject to IRS guidelines).

Please note: You cannot enroll in the Flexible Medical Spending Account and the Health Savings account per IRS Publication 969.

Day Care/Dependent Care

- This account allows you to set aside up to $5,000 for day care expenses.
- Expenses are for your child(ren) to age 13 effective 01/01/2024, disabled spouse, or parent who lives with you.
- You must enroll/re-enroll each year during Open Enrollment.
- New hires may enroll within 30 days of employment.
- Elections are for one year.

Remember: if you don't use the funds, you lose them!

Flores

** Effective 4/1/2020 some over the counter medications are now available without a prescription. Please check the irs.gov website for a full list of covered items.*

What's covered under medical spending account?

MEDICAL
Acupuncture, Alcohol Treatment, Chemotherapy, Chiropractic Services, Co-payments, Coinsurance payments, Deductibles, Drug Abuse Treatment, Hearing Aids, Hospitalization, Medically Necessary Nursing, Oral Contraceptives, Over the Counter Drugs*, Physical Therapy, Physician Fees, Prescription Drugs, Psychiatric Fees, Psychologist Fees, Routine Physicals, Smoking Cessation Treatment, Therapy, Vaccinations, Well-Baby Care, X-rays

DENTAL
Braces, Crowns, Dental X-rays, Dentures/ Bridges, Examinations, Fillings, Root Canals, Routine Check-ups

HANDICAPPED ASSISTANCE
Artificial Limbs, Braces, Braille Books (over cost of regular books), Guide for Blind, Hearing Trained Dog, Note Taker Expenses, Orthopedic Shoes, Seeing Eye Dog, Telephone Equipment for Deaf, Wheelchairs

VISION
Contact Lenses & Solution, Eye Examinations, Glasses

EXAMPLES OF INELIGIBLE MEDICAL EXPENSES
Cosmetic Procedures (Based on the 1991 IRS rules), Diaper Service, Ear Piercing, Exercise Equipment, unless prescribed for a specific illness, Club Memberships, unless prescribed for a specific illness, Insurance Premiums (Effective 01/01/90), Marriage Counseling provided by a Clergyman, Prescription Drugs used for cosmetic reasons, Weight Loss Programs unless prescribed for a specific illness

FSA TAX SAVINGS EXAMPLE

	Flexible Spending	
	If You Participate	If You Don't
Annual Salary Before Taxes	$25,000	$25,000
Less: Medical Spending Account Deposit	($1,500)	$0
Taxable Income	$23,500	$25,000
Less: Income Taxes & Social Security	($5,170)	($5,500)
Take-Home Pay	$18,330	$19,500
Less: Medical Expenses	-$0	($1,500)
Net Pay You Can Spend	$18,330	$18,000
Tax Savings	$330	$0

What's covered under the day care/dependent care spending account?

COVERED EXPENSES
- Before and/or after-school and summer care for children from 1st grade to age 13
- Day care for pre-school children
- Day care for handicapped child of any age
- Day care for disabled spouse or parent(s) who live with you
- Payments to a housekeeper if services are partly for the care of a child or a disabled dependent
- Payments to day care providers outside the home for disabled dependents

NON-COVERED EXPENSES
- Expenses for education
- Expenses for food, clothing and entertainment
- Payments to a dependent to care for another dependent
- Payments to a housekeeper while you are home sick
- Payments for special activities such as Tumblebees
- Payments for overnight or special activity camps

LIMITATIONS
- Use of debit cards for day care payments are not allowed
- Both parents or single parent must work, be disabled or full-time student
- Cannot pay expenses to your spouse or other dependent
- Reimbursement is limited to $5,000
- Cannot pay expenses to your child under age 19, whether they are a dependent or not

THE STANDARD LIFE INSURANCE

The City offers two types of life insurance:

- Basic Term insurance that includes Accidental Death and Dismemberment and,
- Supplemental Term Life for employees and eligible dependents

BASIC TERM & SUPPLEMENTAL LIFE

Basic Term Insurance – the City pays for this coverage:

- Every benefit eligible employee will have coverage equal to two times his or her base annual salary. If death is a result of an accident, the life benefit will be doubled.
- Each dependent enrolled in the medical plan will automatically be enrolled in the Term Life insurance with $2,500 of coverage
- Any coverage of more than $50,000, when paid by an employer, is considered income by the IRS. This type of income is called imputed income and since it is paid by the City, this imputed income is taxed just like your regular pay.

Supplemental Term Life - you pay for this via payroll deductions:

- Employees may purchase Supplemental Life in increments of $10,00 up to $300,000.
- You may enroll your Spouse or Dependent child in the Supplement Life Insurance
- Spouses can be enrolled in $10,000 of Term Life Coverage
- Children can be enrolled $5,000 of Term Life Coverage
- The Cost of Supplemental Dependent life is $4.60 per month

	Supplemental Term Life
Age	**Rate Per $1000 of Benefit**
< 30	$0.074
30 – 34	$0.079
35 – 39	$0.103
40 – 44	$0.162
45 – 49	$0.276
50 – 54	$0.418
55 – 59	$0.699
60 – 64	$0.794
65 – 69	$1.472
70 – 74	$2.417
75 and over	$7.970

THE STANDARD SHORT TERM DISABILITY PLAN

The Short Term Disability Plan is paid by the City for all active full-time and part-time benefit-eligible employees.

SHORT TERM DISABILITY PLAN

Benefits:

- Covers 70% of your weekly base salary.
- Maximum benefit period is 166 days.
- Waiting period for benefits is 14 calendar days.
- No pre-existing exclusions. Effective 01/01/2024.

Claims

Claims should be reported to The Standard as soon as the employee believes they will be out of work for more than 14 calendar days.

Short Term Disability Claims can be filed online at STDforms@standard.com or you may contact The Standard Disability Benefits toll free at 1-800-368-1135.

THE STANDARD LONG TERM DISABILITY (LTD)

The Standard Insurance administers the Long Term Disability (LTD) program for City of Greensboro employees.

There is a Basic Plan that is paid by the City for all benefit-eligible employees. The Standard also offers a Buy-Up Plan that is paid by the employee. Coverage terminates when the employee separates from the City's employment.

BASIC LTD PLAN

Benefits

- Covers all active full-time and part-time benefit eligible employees.
- Paid for by the City of Greensboro.
- Covers 50% of income up to $5,000 per month.
- Benefit duration is two years.
- Waiting period for benefits is 180 days.
- Partial disability benefits are available.
- 3/12 Pre-existing conditions exclusion.
- $100 minimum benefit.

BUY-UP LTD PLAN

Benefits

- Covers active full-time and part-time benefit eligible employees who enroll in the Buy-Up plan.
- Paid for by the employee.
- Premiums are based on employee's salary; as salary increases, premiums increase.
- Covers 60% of income up to $6,000 per month.
- Benefit duration is up to the employee's Social Security Normal Retirement Age.
- Waiting period for benefits is 180 days.
- Partial disability benefits are available.
- 3/12 Pre-existing conditions exclusion.
- 30% minimum benefit.
- Buy-up premiums are deducted pre-tax.

Claims

Claims should be reported to The Standard as soon as the employee believes they will be absent from work beyond 180 calendar days.

Contact an P&C Benefits Consultant to file a claim. To check the status of a claim that has already been filed, please call The Standard's Disability Benefits toll-free number at 1-800-368-1135.

	Long Term Disability Buy-Up		
Annual Earnings	Per Pay Period Deduction	Annual Earnings	Per Pay Period Deduction
$12,000	$3.35	$66,000	$18.43
$15,000	$4.19	$69,000	$19.26
$18,000	$5.03	$72,000	$20.10
$21,000	$5.86	$75,000	$20.94
$24,000	$6.70	$78,000	$21.78
$27,000	$7.54	$81,000	$22.61
$30,000	$8.38	$84,000	$23.45
$33,000	$9.21	$87,000	$24.29
$36,000	$10.05	$90,000	$25.13
$39,000	$10.89	$93,000	$25.96
$42,000	$11.73	$96,000	$26.80
$45,000	$12.56	$99,000	$27.64
$48,000	$13.40	$102,000	$28.48
$51,000	$14.24	$108,000	$30.15
$54,000	$15.08	$111,000	$30.99
$57,000	$15.91	$117,000	$32.66
$60,000	$16.75	$120,000	$33.50
$63,000	$17.59		

Long Term CARE (LTC)

Long Term Care (LTC), offered by LifeSecure, gives individuals and couples financial protection for the future.

CLOSED to new enrollment effective 07/01/2018.

UNUM SUPPLEMENTAL BENEFITS : CRITICAL ILLNESS, ACCIDENT AND HOSPITALIZATION

Guaranteed Issue — coverages are guarantee issue — no health questions asked!! There are 3 Critical Illness options of coverage. Cancer coverage is included on the Critical Illness plan.

All plans include a wellness benefit for each covered person.

- $50/year per insured on the Critical Illness plan.
- $50/year per insured on the Accidental Injury plan.
- $50/year per insured on the Hospital Indemnity plan

GROUP CRITICAL ILLNESS

How It Can Protect

- Pays a lump sum benefit upon diagnosis of covered illness after the effective date of coverage.
- Benefit is paid directly to the employee and can be used however the employee chooses.

Advantages

- Multiple payouts automatically included. A benefit can be paid for each covered condition.
- Coverage can be taken with you when you leave the City.
- Dependent children under age 26 are automatically covered at 50% of employee's benefit amount.
- No benefit reduction.

Additional Diagnosis Benefit

- Additional benefits payable for diagnosis of another critical illness.
- Includes 100% Reoccurrence Benefit.

Plan Details

- Employee options $10,000, $20,000 or $30,000 benefit.
- Spouse coverage available at 100% of Employee Coverage Amount.
- Includes Cancer coverage and a $50 wellness benefit.
- Children automatically included with employee coverage at 50%.

	Unum Supplemental • Critical Illness		
Age	**$10,000**	**$20,000**	**$30,000**
<25	$3.07	$4.67	$6.27
25-29	$3.77	$6.07	$8.37
30-34	$4.97	$8.47	$11.97
35-39	$6.27	$11.07	$15.87
40-44	$8.77	$16.07	$23.37
45-49	$12.67	$23.87	$35.07
50-54	$18.77	$36.07	$53.37
55-59	$26.47	$51.47	$76.47
60-64	$38.27	$75.07	$111.87
65-69	$56.17	$110.87	$165.57
70-74	$84.07	$166.67	$249.27

What may be covered by critical illness insurance?

Cancer
Heart Attack
Stroke *(whose effects are confirmed at least 30 days after the event)*
Blindness
Major Organ Failure
Occupational HIV
End-stage Renal (Kidney) Failure
Permanent Paralysis
Several Other Medical Instances

GROUP ACCIDENTAL INJURY

How It Can Protect

- Pays a lump sum benefit based on type of injury sustained on or off your job and treatment needed.
- Benefits are paid directly to the employee.
- Benefit can be used however employee chooses.

Product Features

- On and off the job injury effective 01/01/2023.
- Includes a $50 wellness benefit per year for each insured person.
- $50 wellness benefit is easy to collect. You just call Unum and tell us you have had your exam. No paperwork required.

Who is Eligible

- Family coverage is available: employee, spouse and children.
- Children, stepchildren and legally adopted children from newborn to age 26, regardless of marital or student status.

	Unum Supplemental • Group Accident
Employee Only	$12.60
Employee/ Spouse	$21.00
Employee/ Children	$23.52
Employee/ Family	$31.92

The $50 wellness benefit is for each plan so the max benefit is $150 per insured person.

GROUP HOSPITAL INDEMNITY

How It Can Protect

- Pays a lump sum benefit when employee has a covered hospital admission.
- Benefits can be used however employees choose.

Advantages

- Coverage is portable.
- Coverage is Guarantee Issue regardless of health.

Who is Eligible

- Hospital Admission: $1,000 per calendar year.
- Hospital Confinement: $100 per day, up to 60 days per year.
- $50 wellness benefit per year for each insured person.
- Portability included.

	Unum Supplemental Hospital Indemnity
Employee Only	$14.80
Employee/ Spouse	$39.39
Employee/ Children	$20.70
Employee/ Family	$45.29

The average cost of a hospital stay is $9,700.

Low Cost Basic Financial Protection Products

Example of a 45-49 year old

Accident Plan	$12.60
$10,000 CI Plan	$12.67
Hospital Plan	$14.80
	$40.07 per month
	-$150.00 wellness
Cost per month	$27.57
Cost per week	$6.36

City of Greensboro is offering Total Pet Plan to employees.

Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy.

That's why we're offering **Total Pet Plan**, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

$11.75/month for one pet or
$18.50/month for a family plan
Available by payroll deduction.

For more details and how to enroll, visit petbenefits.com/land/cityofgreensboro.

TOTAL PET PLAN INCLUDES:

PETplus

DISCOUNTS ON PRODUCTS & RX

- Up to 50% off on products like prescriptions, preventatives, food, toys and more
- Shipping is always free and same-day pickup is available for most human-grade prescriptions

View available products and pricing at petplusbenefit.com.

Pet Assure

DISCOUNTS ON VETERINARY CARE

- Instant 25% savings on all of your pet's in-house medical services at participating vets
- No exclusions due to age, health, pre-existing conditions or type of pet

Visit petbenefits.com/search to locate a participating vet.

AskVet

24/7 PET TELEHEALTH

- Access real-time vet support, even when your vet's office is closed
- Unlimited support on your pet's health, wellness, behavior and more

PetTag

LOST PET RECOVERY SERVICE

- Durable tag can be scanned from any smart phone to access your contact information, helping lost pets return home quicker than a microchip
- Easily update your information online with no need to request a new tag

Pet Benefit Solutions | petbenefits.com | info@petbenefits.com | (800) 891-2565

City of Greensboro is offering Wishbone Pet Insurance to employees.

Nobody wants to imagine their pet getting sick or injured - but when it comes to your pet's health, it's best to expect the unexpected.

Enroll in pet health insurance from Wishbone and receive 90% reimbursement on your pet's veterinary care. With a low deductible of $250, protecting your pet's health and your finances has never been easier!

Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Once you file a claim, expect to be reimbursed via direct deposit or mailed check in 5 business days or less. It's that easy!

POLICYHOLDERS ENJOY:

- Optional Routine Care Plans
- Fast Claims Processing
- Easy-to-Use Member Account
- No Waiting Periods on Accidents or Illnesses
- Lost Pet Recovery Service from **ThePetTag**
- 24/7 Pet Telehealth from **AskVet**

Get a quote & enroll at www.wishboneinsurance.com/cityofgreensboro

This program is not payroll deducted. Employees pay their premiums directly to the Insurance Company.

Wishbone Pet Insurance is program managed by Odie Pet Insurance Marketing, Inc. and is underwritten by Clear Blue Insurance Group. Please visit www.getodie.com for more information.

Pet Benefit Solutions | petbenefits.com | info@petbenefits.com | (800) 891-2565

RETIREMENT

All benefit eligible general employees and public safety employees are members of the North Carolina Local Governmental Employees' Retirement System (NCLGERS)

- All employees contribute 6% of their salary on a pre-tax basis to the Retirement System.
- The City contributes to the retirement program as well.
- An employee becomes vested in the Retirement System after five (5) years of membership.
- Upon termination an employee may elect to receive their contributions and interest, if applicable, with completion of the necessary paperwork.
- All employees' contributions and interest will be paid upon retirement or death.
- To be eligible for the City's contributions an employee must retire from the Retirement System.

RETIREMENT

An employee may retire on SERVICE based on the following criteria:

	Unreduced Benefits	Reduced Benefits
General Employees		
	AGE 60 *with 25 years of service*	**AGE 50** *with 20 years of service*
	AGE 65 *with 5 years of service*	**AGE 60** *with 5 years of service*
	ANY AGE *with 30 years of service*	
Police Officers		
	AGE 55 *with 5 years of service as an officer*	**AGE 50** *with 15 years of service as an officer*
	ANY AGE *with 30 years of service*	
Firefighters		
	ANY AGE *with 30 years of service*	**AGE 55** *with 5 years of service*

North Carolina Local Governmental Employees' Retirement System (NCLGERS) ORBIT System

- ORBIT is a web-based tool that provides you with full access to your personal retirement account information. This system makes managing your retirement account easier than ever.
- ORBIT allows you to safely and securely access your personal account information 24 hours a day.
- As a member of NCLGERS, you are part of one of the strongest and best-managed public pension plans in the country. North Carolina's pension fund has historically been ranked as one of the top five in the nation.

An employee may retire on DISABILITY based on the following criteria:

- An employee must have five years of service.
- The employee must be totally and permanently disabled from his/her job.
- Police Officers and Firefighters no longer have a service requirement if they become totally and permanently disabled in the line of duty as of July 1, 2011.
- Disability determination is made by the Retirement System's Medical Review Board.
- Retirement designation may be changed within three years of retirement. (Ex. The retiree may submit paperwork requesting a service retirement to be changed to a disability retirement or a total disability retirement.)

BENEFITS AT RETIREMENT

North Carolina Total Retirement Plans

The formula for calculating monthly pension benefits is:

- 1.85% times the average final compensation (AFC) times the number of years of creditable service including sick leave. AFC is based on the highest consecutive 48 months of income.
- Retirees have an option to roll their deferred compensation plans to the NCLGERS for an additional monthly benefit for life.
- For retirement estimates go to: www.orbit.myretirement.com.

	Schedule of Benefit Options		
Payment Option	**Payment Name**	**Retiree Benefit**	**Beneficiary Benefit**
1	Maximum	Monthly benefit for life	Lump sum return of employee's contributions that have not been paid out
2	100% Survivorship	Monthly benefit for life	After the retiree dies, the same monthly benefit for life
3	50% Survivorship	Monthly benefit for life	After the retiree dies, a monthly benefit equal to one-half of the retiree's benefit for life
4	Social Security Leveling	• Monthly benefit for life • Increased to age 62 • Reduces at age 62 by estimated Social Security for age 62 (determined at retirement)	Lump sum return of employee's contributions that have not been paid out
6-2	100% Survivorship with Pop-Up	• Monthly benefit for life • Reduced from Option #2 • Increasing to Maximum at beneficiary's death	After the retiree dies, the same monthly benefit for life
6-3	50% Survivorship with Pop-Up	• Monthly benefit for life • Reduced from Option #3 • Increasing to Maximum at beneficiary's death	After the retiree dies, a monthly benefit equal to one-half of the retiree's benefit for life

DEATH BENEFITS

- If death occurs to an active employee, the following Benefits at Death may be available. See table below.
- A death benefit (life insurance) will be payable to a named beneficiary(ies) after one year of service in the amount of $25,000 up to a maximum of $50,000.
- This benefit is payable up to 180 days after the last day paid.

	Benefits at Death		
For Whom	**Benefit**	**Criteria**	**Payable To**
General Employees Firefighters Police Officers	Employees' contributions and interest if any	Employee must have made a contribution to the Retirement System.	Named beneficiary(ies)
General Employees Firefighters	Monthly pension benefit for life	Employee must complete 20 years of service, or be age 60 with at least five years of service.	One named beneficiary other than the estate.
Police Officers	Monthly pension benefit for life	Officer must have completed 20 years of service; be age 50 with 15 years of service; or be age 55 with five years of service, or completed 15 years as an officer (regardless of age) if killed in the line of duty.	One named beneficiary other than the estate.

	401 (a)	457/ ROTH 457	401 (k) / ROTH 401 (k)
General Employees	• The City contributes 3.25% of base salary to the plan, before Social Security is deducted. • Eligibility begins the first payroll following 30 days of employment.	• Employees may contribute immediately after employment. • Employee contributions can be in dollar amounts or salary percentages up to the maximum IRS limits, which change each year.	• Employees may contribute immediately after employment. • Employee contributions can be in dollar amounts or salary percentages up to the maximum IRS limits, which change each year.
Firefighters	• The City contributes 3.25% of base salary.	• Firefighter eligibility begins the second payroll following 30 days of employment. • Employee contributions must be in percentages up to the maximum IRS limits, which change each year. • If the firefighters' contribution is 2.00% into the 457 account, then the City will match up to a total of 5% *(5% is inclusive of the 3.25% City contribution).*	• Employees may contribute immediately after employment. • Employee contributions can be in dollar amounts or salary percentages up to the maximum IRS limits, which change each year.
Police Officers		• Police Officers may participate in the 457 program with their own money with no City contribution. • Employee contributions can be in dollars or percentages up to the maximum IRS limits, which change each year.	• The City contributes 5% of pensionable earnings to the State 401(k) plan. • Officers are eligible the first pay period after being sworn. • Employee contributions can be in dollars or percentages up to the maximum IRS limits, which change each year.

DEFERRED COMPENSATION

The programs below offer additional retirement savings opportunities for employees to contribute their own money on a pre-tax basis. The City contributes to the 401(a) and 401(k) plans.

- 401 (a)
- 457
- 401(k)

401 (a)

City Contributions *Administered by MissionSquare Retirement*

Limitations

- Yearly maximum contributions set by the IRS are allowed in addition to contributions to the 457 plan.
- Withdrawals are only allowed after separation of employment.
- Investment changes can be made any time.

Withdrawals

- Withdrawals are only permitted at termination, retirement, or death.
- There is an early withdrawal penalty prior to age 59 ½ unless the employee retires at age 50 or on disability.
- Minimum distribution to the participant must begin at age 70 ½.

457 PRE-TAX AND 457 ROTH POST-TAX

Employee Contributions *Administered by MissionSquare Retirement*

Limitations

- Yearly maximum contributions set by the IRS are allowed in addition to contributions to the 401(k) plan.
- Investment and contribution changes can be made any time.
- Suspension of contributions can be done at any time by contacting MissionSquare Retirement or the City Payroll division.

Withdrawals

- Participant loans are allowed, but have adverse impacts on your account.
- Withdrawals are only permitted at termination, retirement, death or in the event of a hardship.
- There are no early withdrawal penalties prior to age 59 ½.
- Minimum distribution to the participant must begin at age 70 ½.

401 (k) EMPOWER PRE-TAX AND ROTH POST-TAX

Employee Contributions *Administered by Empower*

Limitations

- Yearly maximum contributions set by the IRS are allowed in addition to contributions to the 401(k) plan.
- Investment and contribution changes can be made any time.
- Suspension of contributions can be done at any time by contacting Empower or the City Payroll division.

Withdrawals

- Participant loans are allowed, but have adverse impacts on your account.
- Withdrawals are only permitted at termination, retirement, death or in the event of a hardship.
- There is an early withdrawal penalty prior to age 59 ½ unless the employee retires at age 50 or on disability.
- Minimum distribution to the participant must begin at age 70 ½.

ANNUAL LEAVE & OTHER LEAVE

The City of Greensboro provides Annual Leave (PTO) for all benefit eligible employees. All benefit eligible employees earn annual leave beginning the first pay period of employment; however, there is a six (6) month waiting period before you can use the earned Annual Leave.

ANNUAL LEAVE

Earned Annual Leave (PTO)

- Annual leave earnings are based on length of continuous service with the City for both Full Time and Part Time Benefit eligible employees.

SICK LEAVE

Earned Sick Leave

- The City of Greensboro provides Earned Sick Leave for all benefit eligible employees.
- All benefit eligible employees earn sick leave beginning the first pay period of employment.
- Sick Leave is available for use as accrued.

Limitations

- Sick leave is to be used for yourself or someone in your immediate family.
- Sick leave may not be used for injuries or illnesses resulting from outside employment.
- Upon termination any unused earned sick leave will not be paid.

Transferred Sick Leave

- New Hires are allowed to transfer an unlimited amount of sick leave time earned during their previous employment if the service time meets the following criteria:
  - Service was with a N.C. State government agency, N.C. Municipality , or N.C. County government.
  - A letter on official letterhead from the previous employer stating the balance of sick leave hours at the time of separation must be received by People & Culture within the employee's first six (6) months of employment.

MEDICAL APPOINTMENT LEAVE

- All benefit eligible employees are eligible for this benefit.
- Medical appointments do not reduce sick leave balances.

LEAVE FOR PARENTAL INVOLVEMENT IN SCHOOLS

- Benefit eligible employees are granted four (4) hours of paid leave per school year (regardless of number of children) for parental involvement in school.
- Non-benefited employees may take a total of four (4) hours of unpaid leave per school year regardless of number of children.

BEREAVEMENT LEAVE

- May be granted to an employee in the event of the death of an immediate family member(s) as defined in Policy F-24). The employee's department may require documentation confirming the death of a family member and/or the relationship to the employee.
- For full time benefit eligible employees a maximum of 40 hours of paid Bereavement Leave may be used if it is an immediate family member. For other family members, a maximum of 16 hours may be used.
- For part time benefit eligible employees the maximum of paid Bereavement Leave for immediate family members depends on the employee classification as follows: PT 20-20 hours, PT 25-25 hours, and PT 30-30 hours. For other family members: PT 20-8 hours, PT 25-10 hours, and PT 30-12 hours.

All benefit eligible employees are granted paid holidays.*

The City observes the following holidays:

- New Year's Day
- Martin Luther King, Jr.'s Birthday
- The Friday before Easter/ Spring Break
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- The Friday after Thanksgiving
- Christmas/Winter Break

*Limitations:

If you are required to work a scheduled holiday you will receive your regular pay plus additional compensation at time and one-half for the additional hours worked. Public Safety personnel may allow employees time off at straight compensatory time.

SERVICE TO OTHERS (STO)

- STO is a paid leave benefit for benefited employees who wish to volunteer with a non-profit organization in the City of Greensboro.
- STO is available to employees that have been employed with the City for at least six months. Review the full policy for more info.

PAID FAMILY CAREGIVER LEAVE

- All benefit eligible employees who have worked for the City for at least twelve (12) months are eligible for six (6) weeks of paid time off for the birth, bonding, and to care for a child, spouse or parent with a serious health condition.

Benefit

- The family-friendly option of Paid Family Caregiver Leave is for the birth of and bonding with a newborn, bonding with a newly placed child for foster care or adoption, and to care for a child, spouse, or parent with a serious health condition.
- Benefit expires twelve (12) months after the date of the qualifying event.
- To receive the benefit, an employee must complete and submit a Family and Medical Leave Act (FMLA) application and other supporting documentation.

Limitations/Requirements

- After Paid Family Caregiver Leave has been exhausted, employees may use all available leave.

FAMILY MEDICAL LEAVE ACT OF 1993 (FMLA)

- Allows time off for any benefit eligible employee who has worked for the City for at least 12 months and at least 1,250 hours during the preceding year.

Benefit

- Up to twelve (12) weeks of paid and/or unpaid leave in any twelve (12) month period to care for a family member with a serious health condition or for your own serious health condition as specified by the FMLA or for military exigency.
- Up to 26 weeks to care for a military person who is injured or becomes ill in the line of duty.
- If the employee giving birth requests FMLA for the birth of a child, they may opt to use the provisions in the Maternity Leave Policy which are less restrictive.
- Before requesting unpaid FMLA leave, all leave for which the employee would otherwise be paid must be exhausted.
- FMLA must be invoked after three (3) business days.
- Unpaid leave does not apply to City years of service.

	Leave Earning Rates			
		Part-Time Benefit Eligible Employees		
	Full-Time Employees	Part-Time 20 *(20-Hour Work Schedule)*	Part-Time 25 *(25-Hour Work Schedule)*	Part-Time 30 *(30-Hour Work Schedule)*
Annual Leave	**Monthly Annual Leave**	**Monthly Annual Leave**	**Monthly Annual Leave**	**Monthly Annual Leave**
0-48 months (0-4 years)	8 hours (96/year)	4 hours (48/year)	5 hours (60/year)	6 hours (72/year)
49-108 months (5-9 years)	10 hours (120/year)	5 hours (60/year)	6.25 hours (75/year)	7.5 hours (90/year)
109-168 months (10-14 years)	12 hours (144/year)	6 hours (72/year)	7.5 hours (90/year)	9 hours (108/year)
169-228 months (15-19 years)	14 hours (168/year)	7 hours (84/year)	8.75 hours (105/year)	10.5 hours (126/year)
229+ months (20+ years)	16 hours (192/year)	8 hours (96/year)	10 hours (120/year)	12 hours (144/year)
Sick Leave	**Monthly Sick Leave**	**Monthly Sick Leave**	**Monthly Sick Leave**	**Monthly Sick Leave**
	8 hours	4 hours	5 hours	6 hours
Medical Appointment Leave	**Monthly Medical Appointment Leave**	**Monthly Medical Appointment Leave**	**Monthly Medical Appointment Leave**	**Monthly Medical Appointment Leave**
	2 hours	1 hour	1.25 hours	1.5 hours

VENDOR CONTACTS

MEDICAL PLAN COVERAGE

WEB
www.myUHC.com

PHONE 1-866-844-4864
Monday - Friday • 7 am - 9 pm CST or call the number on the back of your member ID card
For emergency help, dial 911

DENTAL PLAN COVERAGE

WEB
www.memberportal.com

PHONE
Customer Service 1-800-662-8856
Eligibility and Benefit Information 1-800-524-0149

VISION PLAN COVERAGE

WEB
www.superiorvision.com

PHONE 1-800-507-3800
Monday - Friday • 8 am - 9 pm EST
Saturday • 11 am - 4:30 pm EST

HEALTH SAVINGS ACCOUNT

WEB
www.netbenefits.com

PHONE 1-800-544-3716

FLEXIBLE SPENDING ACCOUNTS

WEB
www.Flores247.com

MOBILE APP
Download from your app store

PHONE
PID & Password Assistance 1-800-840-7684
Fax 1-704-335-0818

MAIL
Flores & Associates, LLC
PO Box 31397, Charlotte, NC 28231

OPTUM LIVE & WORK WELL EMPLOYEE SUPPORT PROGRAM

WEB
www.liveandworkwell.com
Access code: Greensboro

PHONE 1-800-789-3145

STANDARD LIFE INSURANCE

PHONE 1-336-373-2020
For claims and information, contact People & Culture

UNUM ACCIDENT, CRITICAL ILLNESS AND HOSPITAL

WEB
https://services.unum.com

PHONE
Policy Questions 1-866-679-3054

WELLNESS BENEFIT CLAIMS
Telephonic Claim Filing Process 1-800-635-5597

RALLY HEALTH REWARDS

WEB
www.RallyHealth.com

MOBILE APP
Download from your app store

PHONE 1-877-818-5826
7 am - 10 pm CST

NORTH CAROLINA TOTAL RETIREMENT PLANS

WEB
www.myncretirement.com

PHONE
General Questions 1-919-814-4590
Member Fax 1-919-855-5800

EMPOWER NC 401(k), NC 457 & NC 403(b)

WEB
www.myNCplans.com

PHONE 1-866-627-5267

MISSIONSQUARE RETIREMENT

WEB
www.icmarc.org

PHONE 1-800-669-7400

Get Connected
Working Together to Build Health & Financial Wellness
Stronger. Smarter. Better.

City of Greensboro's Health and Welfare Benefits Annual Notice Packet

For the January 1, 2024 to December 31, 2024

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ EEOC Wellness Program Notice
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Should you have any questions regarding the content of the notices, please contact us 336-373-2180.

Medicare Part D
Creditable Coverage Notice

Important Notice from City of Greensboro
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Greensboro and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **City of Greensboro has determined that the prescription drug coverage offered by the United Healthcare plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in City of Greensboro coverage as an active employee, please note that your City of Greensboro coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in City of Greensboro coverage as a former employee.

You may also choose to drop your City of Greensboro coverage. If you do decide to join a Medicare drug plan and drop your current City of Greensboro 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 City of Greensboro and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information at 336-373-2180. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Greensboro changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2024

Name of Entity/Sender: City of Greensboro
Contact--Position/Office: Deborah A. Stephens, Human Resources
Address: PO Box 3136, Greensboro, NC 27401
Phone Number: 336-373-2180

HIPAA Special Enrollment Rights Notice

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Deborah A. Stephens, Human Resources at 336-373-2180.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

City of Greensboro, Inc. ("City of Greensboro") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of City of Greensboro, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by City of Greensboro, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the City of Greensboro HIPAA Privacy Officer:

City of Greensboro, Inc.
Attention: HIPAA Privacy Officer
Deborah A. Stephens, Human Resources
PO Box 3136
Greensboro, NC 27401
336-373-2180

Effective Date

This Notice as revised is effective January 1, 2024

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; 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 & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information 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. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, 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
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period City of Greensboro has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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 your plan administrator at 336-373-2180
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Newborns' and Mothers' Health Protection Act (NMHPA) 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 vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

Plan contact information
Deborah A. Stephens, Human Resources
PO Box 3136, Greensboro, NC 27402
336-373-2180

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 336-373-2180 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Wellness Program Notice

Notice Regarding Wellness Program

City of Greensboro Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol, glucose, blood pressure, height and weight. You are not required to complete the HRA or to participate in the blood test or other medical examinations.
However, employees who choose to participate in the wellness program will receive an incentive of $160 gift cards for participating in variety of wellness activities that the employee selects: Biometrics, annual physical, other preventive care, health survey, missions, and challenges. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive $160 gift cards.

Additional incentives of up to a PTO day off may be available for employees who participate in certain health-related activities including participating in lunch and learns and other wellness activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Deborah A. Stephens at 336-373-2180.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of Greensboro may use aggregate information it collects to design a program based on identified health risks in the workplace, City of Greensboro wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. No one will receive your personally identifiable health information in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Deborah A. Stephens at 336-373-2180.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (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" describes 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 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 the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles 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 believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.

Paquete de avisos de beneficios de salud y bienestar de Ciudad de Greensboro

Para Año del plan 1/1/2024 – 12/31/2024

Estimado Empleado,

Adjunto encontrará un paquete de notificaciones y divulgaciones que pertenecen a los planes de salud y bienestar patrocinados por su empleador, según lo exige la ley federal.

Anexos

- ☐ Aviso de cobertura acreditable Medicare Parte D
- ☐ Aviso de derechos de inscripción especial HIPAA
- ☐ Aviso de prácticas de privacidad HIPAA
- ☐ Aviso sobre el Programa de Seguro de Salud Infantil (CHIP)
- ☐ Aviso sobre la Ley de Derechos Sobre la Salud y el Cáncer de la Mujer (WHCRA)
- ☐ Aviso sobre la Ley para la Protección de la Salud de las Madres y Recién Nacidos (NMHPA)
- ☐ Aviso General sobre Derechos de Continuación de Cobertura COBRA
- ☐ Aviso del Programa de Bienestar HIPAA Reasonable Alternative Standards (RAS) - Planes médicos con programas de bienestar que ofrecen incentivos contingentes de salud
- ☐ Aviso del Programa de Bienestar EEOC
- ☐ Aviso de facturación médica sorpresa – “Sus derechos y protecciones contra las facturas médicas sorpresa”

Si tiene alguna pregunta sobre el contenido de los avisos, póngase en contacto con nosotros en 336-373-2180.

Medicare Parte D
AVISO DE COBERTURA ACREDITABLE

Aviso Importante de CIUDAD DE GREENSBORO
sobre su Cobertura de Medicamentos con Receta Médica y Medicare

Sírvase leer este aviso cuidadosamente y conservarlo a la mano. Este Aviso contiene información sobre su cobertura actual de medicamentos con receta con CIUDAD DE GREENSBORO y sobre sus opciones en virtud de la cobertura de medicamentos recetados de Medicare. Esta información puede ayudarle a decidir si desea inscribirse o no en un plan de medicamentos de Medicare. Si está considerando inscribirse, le recomendamos comparar su cobertura actual, incluso qué medicamentos tienen cobertura a qué costo, con la cobertura y los costos de los planes que ofrecen cobertura de medicamentos con receta de Medicare en su localidad. Al final de este aviso se incluye información sobre dónde puede obtener ayuda para tomar decisiones respecto a su cobertura de medicamentos con receta.

Existen dos aspectos importantes que usted debe conocer acerca de su cobertura y de la cobertura de medicamentos con receta de Medicare:

1. **En 2006, la cobertura de medicamentos recetados de Medicare se volvió disponible para todos los inscritos en Medicare. Usted puede obtener esta cobertura si se inscribe en un Plan de medicamentos con receta de Medicare o se inscribe en un Plan Advantage de Medicare (como una HMO o PPO) que ofrezca cobertura de medicamentos con receta. Todos los planes de medicamentos de Medicare ofrecen al menos un nivel estándar de cobertura establecido por Medicare. Además, algunos planes pueden ofrecer más cobertura sujeta a primas mensuales más altas.**
2. **CIUDAD DE GREENSBORO ha determinado que la cobertura de medicamentos con receta que le ofrece United Healthcare se espera que, en promedio, pague a todos los participantes del plan una cantidad equivalente a lo que paga la cobertura estándar de medicamentos con receta de Medicare y por lo tanto se considerará como cobertura acreditable. Debido a que su cobertura existente es Cobertura acreditable, usted puede conservar esta cobertura y no pagar una prima más alta (penalización) si posteriormente decide inscribirse en un plan de medicamentos de Medicare.**

¿Cuándo puede unirse a un plan de medicamentos recetados de medicare?

Usted se puede inscribir en un plan de medicamentos de Medicare al obtener la elegibilidad inicial para Medicare cada año entre el 15 de octubre y el 7 de diciembre. Sin embargo, si pierde su cobertura

acreditable actual de medicamentos con receta, mientras no sea por su culpa, también calificará para un Período de Inscripción Especial (SEP) de dos (2) meses para participar en el plan de medicamentos de Medicare.

¿Qué le ocurre a su cobertura actual si decide inscribirse en un plan de medicamentos de Medicare?

Si decide inscribirse en un plan de medicamentos de Medicare mientras está inscrito en la cobertura de CIUDAD DE GREENSBORO como empleado activo, tenga en cuenta que su cobertura de CIUDAD DE GREENSBORO será el pagador primario de sus beneficios de medicamentos con receta y Medicare el pagador secundario. Como resultado, el valor de sus beneficios de medicamentos con receta de Medicare podría disminuir significativamente. Por lo general, Medicare será el pagador primario de sus beneficios de medicamentos con receta si usted participa en la cobertura de CIUDAD DE GREENSBORO como exempleado.

Además, puede optar por cancelar su cobertura de CIUDAD DE GREENSBORO. Tenga presente que si decide inscribirse en un plan de medicamentos con receta de Medicare y cancela su cobertura actual de CIUDAD DE GREENSBORO, tenga presente que ni usted ni sus dependientes podrán recuperar esta cobertura.

Si decide participar en un plan de medicamentos de Medicare mientras está inscrito en la cobertura de CIUDAD DE GREENSBORO como empleado activo, tenga en cuenta que por lo general Medicare será el pagador primario de sus beneficios de medicamentos con receta, y su cobertura de CIUDAD DE GREENSBORO pagará en segundo lugar. Como resultado, el valor de sus beneficios de medicamentos con receta de CIUDAD DE GREENSBORO podría disminuir considerablemente.

También puede optar por cancelar su cobertura de CIUDAD DE GREENSBORO. Si decide participar en un plan de medicamentos de Medicare y cancela su cobertura de CIUDAD DE GREENSBORO actual, tenga en cuenta que es posible que usted y sus dependientes no puedan recuperar esta cobertura.

¿Cuándo pagará usted una prima más alta (penalización) para inscribirse en un plan de medicamentos de Medicare?

También debe saber que si cancela o pierde su cobertura actual con CIUDAD DE GREENSBORO y no se une al plan de medicamentos de Medicare durante los siguientes 63 días continuos después de que termine su cobertura actual, podría pagar una prima más alta (penalización) para unirse más tarde a un plan de medicamentos de Medicare.

Si usted pasa 63 días continuos o más sin cobertura acreditable de medicamentos con receta, su prima mensual puede aumentar un mínimo de 1% de la prima mensual básica de beneficiario de Medicare por cada mes que usted no haya tenido dicha cobertura. Por ejemplo, si usted pasa diecinueve meses sin cobertura acreditable, su prima será consecuentemente al menos 19% mayor que la prima base que pagan los beneficiarios de Medicare. Quizá tenga que pagar esta prima más alta (penalización)

siempre que usted tenga cobertura de medicamentos con receta de Medicare. Además, quizá tenga que esperar hasta en octubre próximo para inscribirse.

Si desea más información acerca de este Aviso o sobre su cobertura actual de medicamentos con receta…

Comuníquese con la persona que se indica a continuación para obtener más al 336-373-2180. **NOTA:** Usted recibirá este aviso cada año. Además, lo recibirá antes del próximo período en el que puede inscribirse en un plan de medicamentos de Medicare, y también si esta cobertura a través de CIUDAD DE GREENSBORO cambia. Usted puede solicitar una copia de este aviso en cualquier momento.

Para obtener más información acerca de sus opciones en virtud de la cobertura de medicamentos con receta de Medicare…

El manual "Medicare & You" (Medicare y usted) contiene información más detallada sobre los planes de Medicare que ofrecen cobertura de medicamentos con receta. Medicare le enviará por correo un ejemplar del manual todos los años. Además, los planes de medicamentos de Medicare quizá se comuniquen directamente con usted.

Si desea más información sobre la cobertura de medicamentos con receta de Medicare:

- Visite www.medicare.gov
- Llame al Programa estatal de ayuda para seguros de salud (State Health Insurance Assistance Program), al número de teléfono que se indica en el interior de la contraportada de su manual "Medicare & You", para obtener ayuda personalizada
- Llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.

Si tiene ingresos y recursos limitados, hay disponible ayuda adicional para pagar la cobertura de medicamentos recetados de Medicare. Si desea información sobre esta ayuda adicional, visite el Seguro Social en la Web en www.socialsecurity.gov, o llámeles al 1-800-772-1213 (TTY 1-800-325-0778).

Recuerde: Conserve este aviso de Cobertura Acreditable. Si decide inscribirse en uno de los planes de medicamentos de Medicare, quizá se le solicite presentar una copia de este aviso en el momento de la inscripción para demostrar que usted ha mantenido o no su cobertura acreditable y, por lo tanto si deberá usted pagar o no una prima más alta (penalización).

Fecha: 1 de Enero de 2024

Nombre de la entidad/remitente: Ciudad de Greensboro
Contacto--Cargo/Oficina: Deborah A. Stephens, Recursos Humanos
Dirección: PO Box 3136, Greensboro, NC 27401
Número de teléfono: 336-373-2180

Aviso sobre inscripción especial HIPAA

Si declina la inscripción en Ciudad de Greensboro a cobertura de salud de grupo para usted o sus dependientes (incluido su cónyuge) debido a la existencia de otro seguro de salud o cobertura de plan de salud de grupo, podrán inscribirse usted y sus dependientes en este plan si usted o sus dependientes pierden la elegibilidad para la cobertura antedicha (o si el empleador deja de contribuir para dicha cobertura de usted o de sus dependientes). Sin embargo, es necesario solicitar inscripción en un plazo de 30 días después de que termine la otra cobertura de usted o de sus dependientes (o después de que el empleador cese sus contribuciones para dicha cobertura).

Además, si usted obtiene un nuevo dependiente como resultado de matrimonio, nacimiento, adopción o colocación para adopción, podrán inscribirse usted y sus dependientes. Sin embargo, es necesario solicitar la inscripción en un plazo de 30 días después del matrimonio, nacimiento, adopción o colocación para adopción.

Finalmente, usted y/o sus dependientes pueden tener derechos especiales de inscripción si se pierde la cobertura bajo Medicaid o de un programa de seguro de salud estatal (“CHIP”), o cuando usted y/o sus dependientes obtengan la elegibilidad para recibir asistencia para las primas estatales. Usted dispone de 60 días a partir de la ocurrencia de uno de estos eventos para notificar a la compañía e inscribirse en el plan.

Para solicitar una inscripción especial u obtener más información, comuníquese con Deborah A. Stephens, Recursos Humanos at 336-373-2180.

Notificación sobre las prácticas de privacidad HIPAA

ESTE AVISO DESCRIBE CÓMO SU INFORMACIÓN MÉDICA PUEDE SER UTILIZADA Y DIVULGADA, Y CÓMO USTED PUEDE TENER ACCESO A ESTA INFORMACIÓN. POR FAVOR REVÍSELA CUIDADOSAMENTE.

Ciudad de Greensboro, Inc. (“Ciudad de Greensboro”) patrocina ciertos planes de salud de grupo (colectivamente, el “Plan” o “Nosotros”) para proporcionar beneficios a nuestros empleados, sus dependientes y otros participantes. Proporcionamos esta cobertura mediante varias relaciones con terceros que establecen redes de proveedores, coordinan su atención y procesan las reclamaciones de reembolso por los servicios que usted recibe. Este Aviso de prácticas de privacidad (el “Aviso”) describe las obligaciones legales de Ciudad de Greensboro, el Plan y sus derechos legales con respecto a su información de salud protegida en poder del Plan bajo HIPAA. Entre otras cosas, este Aviso describe cómo su información de salud protegida puede ser utilizada o divulgada para realizar tratamientos, pagos, gestiones de cuidado de salud o para cualquier otro propósito que esté permitido o sea requerido por la ley.

Estamos obligados a proporcionarle este Aviso en cumplimiento con la ley HIPAA. La Regla de privacidad de HIPAA protege solamente cierta información médica designada como “información de salud protegida”. Generalmente, la información de salud protegida es información de salud individualmente identificable, incluyendo información demográfica, recopilada de usted o creada o recibida por un proveedor de atención médica, un centro de información de atención médica, un plan de salud o de su empleador en nombre de un plan de salud de grupo, que se relaciona con:

(1) su salud, condición física o mental pasada, presente o futura;
(2) la prestación de atención médica para usted; o
(3) el pago pasado, presente o futuro por la prestación de atención médica a usted.

Nota: Si usted está cubierto por uno o más planes de salud de grupo totalmente asegurados que le ofrece Ciudad de Greensboro, recibirá una notificación por separado con respecto a la disponibilidad de un aviso sobre las prácticas de privacidad aplicables a esa cobertura y cómo obtener una copia de la notificación directamente de la compañía de seguros.

Información de contactos

Si tiene alguna pregunta sobre este Aviso o sobre nuestras prácticas de privacidad, por favor comuníquese con el Oficial de Privacidad de HIPAA Ciudad de Greensboro o Deborah A. Stephens, Recursos Humanos:

Ciudad de Greensboro, Inc.
A la atención de: HIPAA Privacy Officer (Oficial de Privacidad de HIPAA)
Deborah A. Stephens, Recursos Humanos
PO Box 3136
Greensboro, NC 27401
336-373-2180

Fecha de vigencia

Este aviso y sus revisiones entrará en vigor a partir del 1 de Enero 2024.

Nuestras responsabilidades

La ley estipula que debemos:

- mantener la privacidad de su información médica protegida;
- proporcionarle ciertos derechos con respecto a su información médica protegida;
- proporcionarle una copia de esta Notificación de nuestras obligaciones legales y prácticas de privacidad con respecto a su información de salud protegida; y
- cumplir las cláusulas del Aviso que esté actualmente en vigencia.

Nos reservamos el derecho de modificar los términos de este Aviso y de establecer nuevas provisiones con respecto a su información de salud protegida que mantenemos, según lo permita o requiera la ley. Si realizamos cualquier cambio material a este Aviso, le proporcionaremos una copia de nuestro Aviso de Prácticas de Privacidad revisado. También puede obtener una copia de la última versión revisada del Aviso a través del contacto con nuestro Oficial de Privacidad en la información de contactos proporcionada anteriormente. Con excepción de lo dispuesto en este Aviso, no podemos divulgar su información de salud protegida sin su autorización previa.

Cómo podemos usar y divulgar su información de salud protegida

Según la ley, en ciertas circunstancias podemos usar o revelar sin su permiso su información de salud protegida. Las siguientes categorías describen las diferentes maneras en que podemos usar y divulgar su información de salud protegida. Para cada categoría de usos o divulgaciones explicaremos lo que queremos decir y presentaremos algunos ejemplos. No se enumerarán todos los usos o divulgaciones de una categoría. Sin embargo, todas las formas en que se nos permite usar y divulgar información de salud protegida se incluirán en una de las categorías.

Para el tratamiento
Podemos usar o revelar su información médica protegida para facilitar el tratamiento o servicios médicos por parte de los proveedores. Podemos divulgar su información médica a proveedores, incluso médicos, enfermeras, técnicos, estudiantes de medicina u otro personal del hospital que esté involucrado en el cuidado de su salud. Por ejemplo, podríamos divulgar información sobre sus recetas anteriores a un farmacéutico para determinar si una receta pendiente es inapropiada o peligrosa para que usted la use.

Para el pago
Podemos usar o divulgar su información de salud protegida para determinar su elegibilidad para los beneficios del Plan, para facilitar el pago del tratamiento y los servicios que usted recibe de los proveedores de atención médica, para determinar la responsabilidad de los beneficios bajo el Plan o para coordinar la cobertura del Plan. Por ejemplo, podemos informar a su proveedor de atención médica sobre su historial médico para determinar si un tratamiento en particular es experimental, de investigación o médicamente necesario, o para determinar si el Plan cubrirá el tratamiento. También podemos compartir su información de salud protegida con un proveedor de servicios de revisión de utilización o de precertificación. De igual manera, podemos compartir su información de salud protegida con otra entidad a fin de ayudar con la adjudicación o subrogación de reclamaciones de salud o con otro plan de salud para coordinar el pago de los beneficios.

Para gestiones de cuidados de salud
Podemos usar y divulgar su información de salud protegida para otras gestiones del Plan. Estos usos y divulgaciones son necesarios para el funcionamiento del Plan. Por ejemplo, podemos utilizar información médica en relación con la realización de actividades de evaluación y mejora de la calidad; suscripción de aseguramiento, clasificación de primas y otras actividades relacionadas con la cobertura del Plan; presentación de reclamaciones para la cobertura de limitación de pérdidas (o exceso de pérdidas); realización u organización de revisiones médicas, servicios legales, servicios de auditoría y programas de detección de fraudes y abusos; planificación y desarrollo empresarial, como la gestión de costos; y gestión empresarial y actividades administrativas generales del Plan. El Plan tiene prohibido usar o divulgar información de salud protegida que sea información genética sobre un individuo con fines de suscripción de aseguramiento.

A asociados empresariales
Podemos suscribir contratos con personas o entidades conocidos como asociados empresariales para realizar diversas funciones en nombre del Plan o para proporcionar ciertos tipos de servicios. Con el fin de realizar estas funciones o de proporcionar estos servicios, los asociados empresariales recibirán, crearán, mantendrán, utilizarán y/o divulgarán su información de salud protegida, pero solo después de que acuerden por escrito con nosotros implementar las medidas de seguridad apropiadas con respecto a su información de salud protegida. Por ejemplo, podemos divulgar su información de salud protegida a un asociado empresarial para administrar reclamaciones o para proporcionar servicios de apoyo, tales como la gestión de la utilización, gestión de beneficios de farmacia o subrogación, pero solo después de que el asociado empresarial suscriba un Acuerdo de asociado empresarial con nosotros.

Según lo estipule la ley
Divulgaremos su información de salud protegida cuando así lo exija la ley federal, estatal o local. Por ejemplo, podemos divulgar su información de salud protegida cuando así lo exijan las leyes de seguridad nacional o las leyes de divulgación de salud pública.

Para prevenir una amenaza grave a la salud o a la seguridad
Podemos usar y divulgar su información de salud protegida cuando sea necesario para prevenir una amenaza grave a su salud y seguridad, o a la salud y seguridad del público o de otra persona. Sin embargo, cualquier divulgación, solo se haría a alguien capaz de ayudar a prevenir la amenaza. Por ejemplo, podemos revelar su información de salud protegida en un procedimiento relacionado con la autorización de licencia de un médico.

A los patrocinadores del Plan
Para el propósito de administrar el Plan, podemos divulgar a información sobre la salud protegida a ciertos empleados del Empleador. Sin embargo, estos empleados únicamente utilizarán o divulgarán dicha información según sea necesario para realizar funciones administrativas para el Plan o de otra manera que lo requiera la ley HIPAA, a menos que usted haya autorizado divulgaciones adicionales. Su información de salud protegida no se puede utilizar para fines de empleo si no se cuenta con su autorización específica.

Situaciones especiales

Además de las situaciones antedichas, las siguientes categorías describen las diferentes maneras en que podemos usar y divulgar su información de salud protegida. Para cada categoría de usos o divulgaciones explicaremos lo que queremos decir y presentaremos algunos ejemplos. No se enumerarán todos los usos o divulgaciones de una categoría. Sin embargo, todas las formas en que se nos permite usar y divulgar información de salud protegida se incluirán en una de las categorías.

Donación de órganos y tejidos
Si usted es un donante de órganos, podemos divulgar su información de salud protegida a organizaciones que manejan la obtención y trasplante de órganos, ojos o tejidos o a un banco de donación de órganos, según sea necesario, para realizar la donación y trasplante del órgano o tejido.

Militares y veteranos
Si usted es miembro de las fuerzas armadas, podemos divulgar su información de salud protegida según lo requieran las autoridades del comando militar. Además, podemos divulgar información de salud protegida acerca de personal militar extranjero a la autoridad militar extranjera correspondiente.

Seguro de compensación a los trabajadores
Podemos divulgar su información de salud protegida para los fines del seguro de compensación a los trabajadores o programas similares. Estos programas proporcionan beneficios por lesiones o enfermedades relacionadas con el trabajo.

Riesgos de salud pública
Podemos divulgar su información de salud protegida para acciones de salud pública. Estas acciones por lo general incluyen lo siguiente:

- prevenir o controlar enfermedades, lesiones o incapacidades;
- reportar nacimientos y fallecimientos;
- reportar abuso o abandono infantil;
- reportar reacciones a medicamentos o problemas con productos;
- notificar a personas sobre la retirada del mercado de productos que puedan estar consumiendo;
- para notificar a una persona que pueda haber estado expuesta a una enfermedad o que pueda estar en riesgo de contraer o propagar una enfermedad o afección;
- notificar a la autoridad gubernamental pertinente si creemos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. Solo haremos esta divulgación si usted está de acuerdo, o cuando así lo requiera o lo autorice la ley.

Actividades de supervisión de la salud
Podemos divulgar su información de salud protegida a una agencia de supervisión de salud para actividades autorizadas por la ley. Por ejemplo, estas actividades de supervisión pueden incluir auditorías, investigaciones, inspecciones y otorgamientos de licencias. El gobierno necesita estas actividades para supervisar el sistema de atención de salud y los programas gubernamentales, y para velar por el cumplimiento de las leyes de derechos civiles.

Demandas judiciales y disputas
Si usted está involucrado en una demanda judicial o en una disputa, podemos divulgar su información de salud protegida en respuesta a una orden judicial o administrativa. También podemos divulgar su información de salud protegida en respuesta a una citatorio, solicitud de descubrimiento u otro proceso judicial por parte de otra persona involucrada en la disputa, pero solo si se han hecho esfuerzos para informarle sobre la solicitud o para obtener una orden que proteja la información solicitada.

Cumplimiento de la ley
Podemos divulgar su información de salud protegida si así lo solicita un funcionario del orden público,

- en respuesta a una orden judicial, citatorio, requerimiento judicial, emplazamientos o procesos legales similares;
- para identificar o localizar a un sospechoso, fugitivo, testigo material o persona desaparecida;
- sobre la víctima de un delito si, en ciertas circunstancias limitadas, no podemos obtener el acuerdo de la víctima;
- acerca de una muerte que consideramos que puede ser el resultado de una conducta delictiva;
- acerca de una conducta delictiva; y
- en circunstancias de emergencia para reportar un delito; la ubicación del delito o de las víctimas; o la identidad, descripción o ubicación de la persona que cometió el delito.

Jueces de instrucción, médicos forenses y directores funerarios
Podemos divulgar información de salud protegida a un juez de instrucción o a un médico forense. Esto puede ser necesario, por ejemplo, para identificar a una persona fallecida o para determinar la causa de la muerte. Además, podemos divulgar la información de salud de pacientes para ayudar a un director funerario según sea necesario para llevar a cabo sus obligaciones.

Actividades de seguridad nacional y servicios de inteligencia
Podemos divulgar su información de salud protegida a funcionarios federales autorizados para actividades de inteligencia, contrainteligencia y otras actividades de seguridad nacional autorizadas por la ley.

Internos o reclusos
Si usted es un recluso de una institución correccional o está bajo la custodia de un oficial de cumplimiento de la ley, podemos divulgar su información de salud protegida a la institución correccional o al oficial de cumplimiento de la ley si es necesario (1) para que la institución le brinde atención médica; (2) para proteger su salud y seguridad o la salud y seguridad de otros; o (3) para la seguridad y protección de la institución correccional.

Investigación
Podemos divulgar su información de salud protegida a investigadores cuando:

(1) se haya eliminado los identificadores individuales; o
(2) cuando una junta de revisión institucional o junta de privacidad haya (a) revisado la propuesta de investigación; y (b) establecido protocolos para asegurar la privacidad de la información solicitada, y aprueba la investigación.

Divulgaciones necesarias

La siguiente es una descripción de las divulgaciones de su información de salud protegida que estamos obligados a realizar.

Auditorías gubernamentales
Estamos obligados a divulgar su información de salud protegida al Secretario del Departamento de Salud y Servicios Humanos de los Estados Unidos cuando el Secretario está investigando o determinando nuestro cumplimiento de la regla de privacidad de la HIPAA.

Divulgaciones a usted
Cuando usted lo solicite, estamos obligados a divulgarle la parte de su información de salud protegida que contiene registros médicos, registros de facturación y cualquier otro registro utilizado para tomar decisiones con respecto a sus beneficios de atención médica. También estamos obligados, cuando se nos solicite, a proporcionarle un informe de la mayoría de las divulgaciones de su información médica protegida si la divulgación se hizo por razones que no fueran de pago, tratamiento u gestiones de atención médica, y si la información de salud protegida no fue divulgada de conformidad con su autorización individual.

Notificación de una infracción
Estamos obligados a notificarle en caso de que nosotros (o uno de nuestros asociados empresariales) descubra una infracción a su información de salud protegida no segura, según lo define la HIPAA.

Otras divulgaciones

Representantes personales
Divulgaremos su información de salud protegida a las personas que usted autorice, o a una persona designada como su representante personal, apoderado, etc., siempre y cuando usted nos proporcione un aviso/autorización por escrito y cualquier documento de apoyo (por ejemplo, un poder notarial). Nota: En virtud de la regla de privacidad de HIPAA, no estamos obligados a divulgar información a un representante personal si tenemos una sospecha razonable de que:

(1) usted ha sido, o puede ser, víctima de violencia doméstica, abuso o negligencia por parte de dicha persona;
(2) tratar a dicha persona como su representante personal podría ponerlo en peligro a usted; o
(3) en el ejercicio o juicio profesional, no resulta en su mejor interés tratar a la persona como su representante personal.

Cónyuges y otros familiares
Salvo excepciones limitadas, enviaremos todo correo al empleado. Esto incluye el correo relacionado con el cónyuge del empleado y otros miembros de la familia que están cubiertos por el Plan, e incluye el correo con información sobre el uso de los beneficios del Plan por el cónyuge del empleado y otros miembros de la familia e información sobre la denegación de cualquier beneficio del Plan al cónyuge del empleado y otros miembros de la familia. Si una persona cubierta por el Plan ha solicitado Restricciones o Comunicaciones Confidenciales (ver más adelante bajo "Sus derechos"), y si hemos aceptado la solicitud, le enviaremos un correo electrónico según lo estipulado en la solicitud de Restricciones o Comunicaciones Confidenciales.

Autorizaciones
No se harán sin su autorización por escrito otros usos ni divulgaciones de su información de salud protegida no descritos anteriormente, incluyendo el uso y divulgación de notas de psicoterapia y el uso o divulgación de información de salud protegida para propósitos de recaudación de fondos o comercialización. Usted puede revocar su autorización escrita en cualquier momento, siempre que dicha revocatoria se haga por escrito. Una vez que el Plan reciba su revocatoria de autorización por escrito, esta causará efecto únicamente en las divulgaciones y usos futuros. No será aplicable a ninguna otra información que haya sido utilizada o divulgada en función de la autorización escrita y antes de recibir su revocatoria por escrito. Usted puede optar por no recibir comunicaciones de recaudación de fondos de nuestra parte en cualquier momento.

Sus derechos

Usted tiene los siguientes derechos con respecto a su información de salud protegida:

Derecho de inspeccionar y copiar
Usted tiene derecho de inspeccionar y copiar cierta información de salud que se pueda utilizar para tomar decisiones acerca de sus beneficios de atención médica. Para inspeccionar y copiar su información de salud protegida, envíe su solicitud por escrito al Oficial de Privacidad a la dirección proporcionada anteriormente bajo el título Información de contactos. Si usted solicita una copia de la información, podemos cobrarle una tarifa razonable por los costos de copiado, envío por correo u otros materiales relacionados con su solicitud. Podemos denegar su solicitud de inspeccionar y copiar su información de salud protegida en muy limitadas circunstancias. Si se le niega el acceso a su

información de salud, puede tener derecho a solicitar que se revise la denegación y se le proporcionarán detalles sobre cómo hacerlo.

Derecho de enmienda
Si usted considera que la información de salud protegida que tenemos sobre usted es incorrecta o incompleta, puede solicitarnos que enmendemos la información. Usted tiene el derecho de solicitar una enmienda siempre que la información sea mantenida por o para el Plan. Para solicitar una enmienda, debe presentar su solicitud por escrito y enviarla al Oficial de Privacidad a la dirección proporcionada anteriormente bajo el título Información de contactos. Además, usted deberá proporcionar al menos un motivo que respalde su solicitud. Podemos rechazar su solicitud de enmienda si no se efectúa por escrito o si no incluye un motivo para respaldar la solicitud. Además, podemos rechazar su solicitud si usted nos solicita enmendar información que:

- No es parte de la información de salud conservada por, o para el plan;
- No fue creada por nosotros, a menos que la persona o entidad que creó la información ya no esté disponible para efectuar la enmienda;
- No es parte de la información a la que usted se le permitiría inspeccionar y copiar; o
- ya es exacta y completa.

Si denegamos su solicitud, usted tiene el derecho de presentar una declaración de desacuerdo con nosotros y cualquier divulgación futura de la información en disputa incluirá su declaración.

Derecho de ver el registro de las divulgaciones
Usted tiene el derecho de solicitar un "listado" o reporte de ciertas divulgaciones de su información personal de salud protegida. El listado no incluirá (1) divulgaciones para fines de tratamiento, pago o gestiones de atención médica; (2) divulgaciones hechas a usted; (3) divulgaciones hechas de conformidad con su autorización; (4) divulgaciones hechas a amigos o familiares en su presencia o debido a una emergencia; (5) divulgaciones para fines de seguridad nacional; y (6) divulgaciones incidentales a divulgaciones que de otra manera serían permisibles.

Para solicitar este listado o informe de divulgaciones, usted debe presentar su solicitud por escrito al Oficial de Privacidad en la dirección proporcionada anteriormente bajo el título Información de contactos. Su solicitud debe indicar un periodo de tiempo no mayor de seis años (tres años para expedientes médicos electrónicos) o el periodo que Ciudad de Greensboro haya estado sujeta a las reglas de privacidad HIPAA, si es menor.

Su solicitud debe indicar en qué forma desea el listado (por ejemplo: impreso o en formato electrónico). Intentaremos proporcionar el listado en el formato que usted lo solicitó o en otro formato acordado mutuamente si el formato solicitado no es razonablemente factible. El primer listado que solicite dentro de un período de 12 meses se le proporcionará sin costo alguno. Para listados adicionales, podemos cobrarle los costos para suministrar cada listado. Le informaremos sobre el costo involucrado y usted podrá retirar o modificar su solicitud en ese momento antes de incurrir en algún costo.

Derecho a solicitar restricciones
Usted tiene derecho a solicitar una restricción o limitación sobre cuánta de su información de salud protegida podemos usar o divulgar para gestiones de tratamiento, pago o atención de salud. Además, tiene el derecho de solicitar un límite sobre su información de salud protegida que divulgamos a alguien que esté involucrado en su atención de salud o en el pago de esta, tal como un familiar o un amigo. Por ejemplo, usted podría solicitarnos que no usemos ni divulguemos información acerca de una cirugía que usted tuvo.

No estamos obligados a aceptar su solicitud. Sin embargo, si estamos de acuerdo con la solicitud, respetaremos la restricción hasta que usted la revoque o se lo notifiquemos de manera diferente. Para solicitar restricciones, usted debe hacer su solicitud por escrito al Oficial de Privacidad en la dirección proporcionada anteriormente bajo el título Información de contactos. En su solicitud, debe decirnos (1) qué información desea limitar; (2) si desea limitar nuestro uso, divulgación o ambos; y (3) a quién desea que se apliquen los límites, por ejemplo, divulgaciones a su cónyuge.

Derecho de solicitar comunicaciones confidenciales
Usted tiene el derecho de solicitar que, para asuntos médicos, nos comuniquemos con usted de cierta manera o en cierta localidad. Por ejemplo, usted puede solicitar que solo nos comuniquemos con usted en el trabajo o por correo. Para solicitar comunicaciones confidenciales, usted debe hacer su solicitud por escrito al Oficial de Privacidad en la dirección proporcionada anteriormente bajo el título Información de contactos. No le preguntaremos el motivo de su solicitud. Su solicitud deberá especificar cómo o dónde desea que se le contacte. Nos acomodaremos a todas las solicitudes razonables si usted proporciona claramente información de que la divulgación parcial o total de su información protegida podría ponerlo en peligro a usted.

Derecho a recibir copia impresa de este aviso
Usted tiene derecho a recibir una copia impresa de este aviso. En cualquier momento, puede solicitarnos que le entreguemos una copia de este aviso. Incluso si usted ha aceptado recibir este aviso electrónicamente, tiene derecho a recibir una copia impresa de este aviso. Para obtener una copia impresa de este aviso, llame por teléfono o escriba al Oficial de Privacidad según se indica en la sección Información de contactos.

Si desea obtener más información, consulte Sus derechos en virtud de HIPAA.

Quejas
Si usted considera que sus derechos de privacidad han sido infringidos, puede presentar una queja ante el Plan o ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. Puede presentar una reclamación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. por medio de una carta dirigida a 200 Independence Avenue, S.W., Washington, D.C. 20201, puede llamar al 1-877-696-6775, o visitar www.hhs.gov/ocr/privacy/hipaa/complaints/.

Para presentar una queja ante el Plan, llame por teléfono y escriba al Oficial de Privacidad según se indica más arriba en Información de contactos. Usted no recibirá penalización alguna, ni represalias de ningún tipo, por presentar una queja ante la Oficina de Derechos Civiles o ante el Plan. Le sugerimos conservar para sus registros una copia de cualquier notificación que envíe al Administrador del Plan o al Oficial de Privacidad.

Asistencia para primas bajo Medicaid y el Programa de Seguro Médico Infantil de California (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura de salud a través de su empleador, el estado donde usted reside puede tener un programa de asistencia de primas para ayudarle a pagar la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, no podrán ser elegibles para estos programas de ayuda para el pago de primas, pero quizá pueda adquirir cobertura de seguro individual a través del Mercado de Seguros de Salud. Si desea obtener más información, visite **www.healthcare.gov**.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y residen en uno de los estados que se indican más adelante, comuníquese con la oficina estatal de Medicaid o CHIP para determinar si está disponible la ayuda de primas.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes podría ser elegible para cualquiera de estos programas, comuníquese con la oficina estatal de Medicaid o de CHIP, o bien, marque el **1-877-KIDS NOW** o visite **www.insurekidsnow.gov** para enterarse de cómo solicitar su inscripción. Si usted califica, pregunte si el estado tiene un programa que pudiese ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para recibir ayuda para el pago de primas en virtud de Medicaid o CHIP, así como también son elegibles en virtud del plan de su empleador, su empleador deberá permitirle inscribirse en su plan de empleador si aún no estuviese inscrito. Esto se llama una oportunidad de "inscripción especial", y **usted debe solicitar la cobertura en un plazo no mayor de 60 días después de determinarse su elegibilidad para la ayuda de primas.** Si tiene preguntas acerca de cómo inscribirse en su plan del empleador, comuníquese con el Departamento de Trabajo en **www.askebsa.dol.gov** o llame al **1-866-444-EBSA (3272)**.

Si usted reside en uno de los estados siguientes, quizá sea elegible para recibir ayuda para el pago de las primas del plan de salud de su empleador. La lista de estados a continuación está en vigor desde el 31 de enero de 2023. Comuníquese con la oficina en su estado para obtener más información sobre elegibilidad.

ALABAMA – Medicaid	ALASKA – Medicaid
Sitio web: http://myalhipp.com/ Teléfono: 1-855-692-5447	El Programa de Pagos de la Prima de Seguros Médicos de AK (AK Health Insurance Premium Payment Program) Sitio web: http://myakhipp.com/ Teléfono: 1-866-251-4861 Correo electrónico: CustomerService@MyAKHIPP.com Elegibilidad de Medicaid: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Sitio web: http://myarhipp.com/ Teléfono: 1-855-MyARHIPP (855-692-7447)	Sitio web: Programa de Pago de las primas del seguro médico (Health Insurance Premium Payment, HIPP) http://dhcs.ca.gov/hipp Teléfono: 916-445-8322 Fax: 916-440-5676 Correo electrónico: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Programa Medicaid de Colorado) y Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Sitio web de Health First Colorado: https://www.healthfirstcolorado.com/ Centro de Contacto con el Miembro de Health First Colorado: 1-800-221-3943/ Retransmisión estatal 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus Servicio al cliente de CHP+: 1-800-359-1991/ Retransmisión estatal 711 Programa Buy-In de Seguro Médico (HIBI): https://www.mycohibi.com/ Servicio al cliente de HIBI: 1-855-692-6442	Sitio web: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Teléfono: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
Sitio web de GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Teléfono: 678-564-1162, presione 1 Sitio web de GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Teléfono: 678-564-1162, presione 2	Plan Healthy Indiana para adultos de bajos ingresos 19-64 Sitio web: http://www.in.gov/fssa/hip/ Teléfono: 1-877-438-4479 Todos los demás de Medicaid Sitio web: https://www.in.gov/medicaid/ Teléfono: 1-800-457-4584
IOWA – Medicaid y CHIP (Hawki)	**KANSAS – Medicaid**
Sitio web de Medicaid: https://dhs.iowa.gov/ime/members Teléfono de Medicaid: 1-800-338-8366 Sitio web de Hawki: http://dhs.iowa.gov/Hawki Teléfono de Hawki: 1-800-257-8563 Sitio web de HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Teléfono de HIPP: 1-888-346-9562	Sitio web: https://www.kancare.ks.gov/ Teléfono: 1-800-792-4884 Teléfono de HIPP: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Sitio web del Programa Integrado de Pago de las Primas del Seguro médico de Kentucky (Kentucky Integrated Health Insurance Premium Payment Program, KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Teléfono: 1-855-459-6328 Correo electrónico: KIHIPP.PROGRAM@ky.gov Sitio web de KCHIP: https://kidshealth.ky.gov/Pages/index.aspx Teléfono: 1-877-524-4718 Sitio web de Kentucky Medicaid: https://chfs.ky.gov	Sitio web: www.medicaid.la.gov o www.ldh.la.gov/lahipp Teléfono: 1-888-342-6207 (Línea directa de Medicaid) o 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid y CHIP**
Sitio web de inscripciones: https://www.mymaineconnection.gov/benefits/s/?language=en_US Teléfono: 1-800-442-6003 TTY: Servicio de retransmisión de Maine 711 Página web de la prima del seguro médico privado: https://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-977-6740 TTY: Servicio de retransmisión de Maine 711	Sitio web: https://www.mass.gov/masshealth/pa Teléfono: 1-800-862-4840 TTY: 617-886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Sitio web: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Teléfono: 1-800-657-3739	Sitio web: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Teléfono: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Sitio web: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Teléfono: 1-800-694-3084 Correo electrónico: HHSHIPPProgram@mt.gov	Sitio web: http://www.ACCESSNebraska.ne.gov Teléfono: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Sitio web de Medicaid: http://dhcfp.nv.gov Teléfono de Medicaid: 1-800-992-0900	Sitio web: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Teléfono: 603-271-5218 Número sin costo para el programa HIPP: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid y CHIP	**NEW YORK – Medicaid**
Sitio web de Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Teléfono de Medicaid: 609-631-2392 Sitio web de CHIP: http://www.njfamilycare.org/index.html Teléfono de CHIP: 1-800-701-0710	Sitio web: https://www.health.ny.gov/health_care/medicaid/ Teléfono: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Sitio web: https://medicaid.ncdhhs.gov/ Teléfono: 919-855-4100	Sitio web: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Teléfono: 1-844-854-4825
OKLAHOMA – Medicaid y CHIP	**OREGON – Medicaid**
Sitio web: http://www.insureoklahoma.org Teléfono: 1-888-365-3742	Sitio web: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Teléfono: 1-800-699-9075
PENNSYLVANIA – Medicaid y CHIP	**RHODE ISLAND – Medicaid y CHIP**
Sitio web: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Teléfono: 1-800-692-7462 Sitio web de CHIP: Children's Health Insurance Program (CHIP) (pa.gov) Teléfono de CHIP: 1-800-986-KIDS (5437)	Sitio web: http://www.eohhs.ri.gov/ Teléfono: 1-855-697-4347, o 401-462-0311 (Línea directa RIte Share)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Sitio web: https://www.scdhhs.gov Teléfono: 1-888-549-0820	Sitio web: http://dss.sd.gov Teléfono: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid y CHIP**
Sitio web: http://gethipptexas.com/ Teléfono: 1-800-440-0493	Sitio web de Medicaid: https://medicaid.utah.gov/ Sitio web de CHIP: http://health.utah.gov/chip Teléfono: 1-877-543-7669
VERMONT – Medicaid	**VIRGINIA – Medicaid y CHIP**
Sitio web: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Teléfono: 1-800-250-8427	Sitio web: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Teléfono de Medicaid/CHIP: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid y CHIP
Sitio web: https://www.hca.wa.gov/ Teléfono: 1-800-562-3022	Sitio web: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Teléfono de Medicaid: 304-558-1700 Línea telefónica sin costo de CHIP: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid y CHIP	**WYOMING – Medicaid**
Sitio web: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Teléfono: 1-800-362-3002	Sitio web: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Teléfono: 1-800-251-1269

Para ver si otros estados han agregado un programa de ayuda de primas desde el 31 de enero de 2023, o para obtener más información sobre derechos especiales de inscripción, puede comunicarse con cualquiera de los siguientes:

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

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

Aviso sobre la Ley de Derechos Sobre la Salud y el Cáncer de la Mujer (WHCRA)

¿Sabe usted que su Plan, según lo estipula la Ley de Derechos Sobre la Salud y el Cáncer de la Mujer de 1998 (WHCRA), proporciona beneficios para los servicios relacionados con la mastectomía, que incluyen todas las etapas de reconstrucción y cirugía para lograr la simetría entre los senos, prótesis y las complicaciones resultantes de una mastectomía, incluyendo el linfedema? Llame al administrador del Plan: al [inserte número de teléfono] para obtener más información.

Estos beneficios se suministrarán sujetos a los mismos deducibles y coseguros aplicables a otros beneficios médicos y quirúrgicos suministrados en virtud de este plan. Si desea más información sobre los beneficios de la WHCRA, comuníquese con su administrador del plan en 336-373-2180.

Aviso sobre la ley para la Protección de la Salud de las Madres y los Recién Nacidos (NMHPA)

En virtud de las leyes federales, los emisores de planes de salud de grupo y de seguros de salud generalmente no pueden restringir beneficios pertinentes al tiempo de hospitalización en relación con un parto, para la madre o para el recién nacido, a menos de 48 horas después de un parto vaginal ni a menos de 96 horas después de un parto por cesárea. Sin embargo, la ley Federal generalmente no prohíbe que el proveedor de atención médica que atiende a la madre o al recién nacido, después de consultarlo con la madre, pueda dar el alta hospitalaria a la madre o a su recién nacido antes de transcurridas 48 horas (o 96 horas según corresponda). En cualquier caso, los planes de salud y los emisores no pueden, en virtud de la ley federal, requerir que un proveedor obtenga autorización del plan o del emisor del seguro para recomendar un tiempo de hospitalización que no exceda 48 horas (o 96 horas).

Modelo de Aviso general de derechos de continuación de cobertura COBRA

** Derechos de continuación de cobertura en virtud de COBRA**

Introducción

Usted está recibiendo esta notificación porque ha obtenido recientemente la cobertura en virtud de un plan de salud de grupo (el Plan). Este aviso contiene información importante acerca de su derecho a la continuación de cobertura COBRA, la cual es una extensión temporal de la cobertura en virtud del Plan. **Este aviso explica la continuación de cobertura COBRA, cuando puede estar disponible para usted y su familia, y qué necesita usted para proteger su derecho de obtenerla.** Cuando usted es elegible para COBRA, también puede ser elegible para otras opciones de cobertura que pueden costar menos que la continuación de cobertura COBRA.

El derecho a la continuación de cobertura COBRA fue creado por una ley federal: la Ley Omnibus de Reconciliación Presupuestaria Consolidada de 1985 (Consolidated Omnibus Budget Reconciliation Act of 1985, COBRA). La continuación de cobertura COBRA puede estar disponible para usted y otros miembros de su familia cuando la cobertura de salud de grupo de otra manera hubiese terminado. Para obtener más información acerca de sus derechos y obligaciones en virtud del Plan y en virtud de la ley federal le recomendamos consultar la descripción resumida de su Plan o comunicarse con el Administrador del Plan.

Puede haber otras opciones disponibles para usted cuando pierde la cobertura de salud de grupo. Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros de salud. Al inscribirse en la cobertura a través del mercado de seguros de salud, puede calificar para menores costos en sus primas mensuales y menores gastos de su propio bolsillo. Además, puede calificar para un período de inscripción especial de 30 días para otro plan de salud de grupo para el cual usted sea elegible (tal como un plan de su cónyuge), incluso si dicho plan por lo general no acepta inscripciones tardías.

¿Qué es la continuación de cobertura COBRA?

La continuación de cobertura COBRA es una continuación de cobertura del plan, que de otra manera terminaría, en virtud de un evento de vida. Esto se conoce como un “evento calificado”. Los eventos calificados específicos se enumeran más adelante en este aviso. Después de un evento calificado, la continuación de cobertura COBRA deberá ofrecerse a cada persona que sea un “beneficiario calificado”. Usted, su cónyuge y sus hijos dependientes podrían ser beneficiarios calificados si se pierde la cobertura en virtud del Plan debido al evento calificado. En virtud del Plan, los beneficiarios calificados que eligen la continuación de cobertura de COBRA la continuación de cobertura de COBRA.

Si usted es empleado, será beneficiario calificado si pierde su cobertura en virtud del Plan debido a los siguientes eventos calificados:

- Se reducen sus horas de empleo, o
- Termina su empleo por alguna razón que no sea por faltas graves.

Si usted es el cónyuge de un empleado, usted será beneficiario calificado si pierde su cobertura en virtud del Plan debido a los siguientes eventos calificados:

- Fallece su cónyuge;
- Se reducen las horas de empleo de su cónyuge;
- Termina el empleo del cónyuge por alguna razón que no sea por faltas graves;
- Su cónyuge se vuelve elegible para recibir beneficios de Medicare (en virtud de la Parte A, Parte B, o ambas); o
- Usted se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes serán beneficiarios calificados si pierden la cobertura en virtud del Plan debido a los siguientes eventos calificados:

- Fallece el padre/empleado;
- Se reducen las horas de empleo del padre-empleado;
- Termina el empleo del padre-empleado por cualquier razón que no sea por faltas graves;
- El padre-empleado obtiene elegibilidad para los beneficios de Medicare (Parte A, Parte B o ambas);
- Los padres se divorcian o se separan legalmente; o
- El menor deja de ser elegible para cobertura en virtud del Plan como “hijo dependiente”.

¿Cuándo está disponible la continuación de cobertura COBRA?

El Plan ofrecerá la continuación de cobertura COBRA a los beneficiarios calificados únicamente después de que el Administrador del Plan haya sido notificado de que se ha producido un evento calificado. El empleador debe notificar al Administrador del Plan los siguientes eventos calificados:

- El cese de empleo o la reducción de horas de empleo;
- Fallecimiento del empleado;
- El empleado es ahora elegible para recibir beneficios de Medicare (en virtud de la Parte A, Parte B, o ambas).

Para todos los otros eventos calificados (divorcio o separación legal del empleado y del cónyuge o si un hijo pierde la elegibilidad de cobertura como hijo dependiente), usted debe notificarlo al Administrador del Plan dentro de los 60 días después de ocurrido el evento calificado. Usted debe proporcionar esta notificación a: Deborah A. Stephens, Recursos Humanos.

¿Cómo se proporciona la continuación de cobertura COBRA?

Una vez que el Administrador del Plan reciba la notificación que ha ocurrido un evento calificado, se ofrecerá la continuación de cobertura COBRA a cada uno de los beneficiarios calificados. Cada beneficiario calificado tendrá un derecho independiente para elegir la continuación de cobertura COBRA. Los empleados cubiertos pueden elegir la continuación de cobertura COBRA en nombre de sus cónyuges, y los padres pueden elegir la continuación de cobertura COBRA en nombre de sus hijos.

La continuación de cobertura COBRA es una continuación de cobertura temporal que dura por lo general 18 meses debido al cese de empleo o a la reducción de horas de trabajo. Algunos eventos calificados, o un segundo evento calificado durante el período inicial de cobertura, pueden permitir a un beneficiario recibir un máximo de 36 meses de cobertura.

También hay formas en las que este período de 18 meses de continuación de cobertura COBRA pueda ser prorrogado:

Prórroga por incapacidad del período de 18 meses de la continuación de cobertura COBRA
Si usted o alguien en su familia, cubiertos en virtud del Plan, recibe una determinación de incapacidad por parte del Seguro Social y usted lo notifica al Administrador del Plan en forma oportuna, usted y toda su familia pueden tener derecho a obtener hasta 11 meses adicionales de continuación de cobertura COBRA, hasta por un máximo de 29 meses. La incapacidad debe haber comenzado en algún momento antes del día 60 de la continuación de cobertura Cobra y debe durar al menos hasta el final del período de 18 meses de continuación de cobertura COBRA.

Segundo evento calificado para la prórroga del período de 18 meses de continuación de cobertura
Si su familia tiene otro evento calificado durante los 18 meses de la continuación de cobertura COBRA, el cónyuge y los hijos dependientes en su familia pueden obtener hasta 18 meses adicionales de continuación de cobertura COBRA, hasta un máximo de 36 meses, si el Plan recibe la notificación correspondiente del segundo evento calificado. Esta prórroga puede estar disponible para el cónyuge y para cualesquier hijos dependientes que estén recibiendo la continuación de cobertura COBRA si el empleado o exempleado fallece, adquiere el derecho a recibir beneficios de Medicare (en virtud de la Parte A, Parte B, o ambas) se divorcia o se separa legalmente; o si el hijo dependiente deja de ser elegible en virtud del Plan como hijo dependiente. Esta prórroga está disponible únicamente si el segundo evento calificado habría provocado que el cónyuge o el hijo dependiente perdiesen la cobertura en virtud del Plan si el primer evento calificado no hubiese ocurrido.

¿Existen otras opciones a parte de la continuación de cobertura COBRA?
Sí. En vez de inscribirse en la continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del Mercado de Seguros de Salud, Medicare, Medicaid, el Programa de Seguro de Salud Infantil (CHIP), u otras opciones de cobertura de un plan de salud de grupo (como el plan de un cónyuge) a través de lo que se denomina "período de inscripción especial". Algunas de estas opciones pueden costar menos que la continuación de cobertura COBRA. Puede conocer más sobre muchas de esas opciones en **www.HealthCare.gov**.

¿Puedo inscribirme en Medicare en lugar de continuar la cobertura de COBRA después de que termine la cobertura de mi plan de salud de grupo?
En general, si no se inscribe en la Parte A o B de Medicare cuando es elegible por primera vez porque todavía está empleado, después del período de inscripción inicial de Medicare, dispone de un período de inscripción especial de 8 meses1 para inscribirse en la Parte A o B de Medicare, que comienza en la más temprana de las fechas siguientes:

- El mes siguiente a la terminación de su empleo; o
- El mes siguiente a la terminación de la cobertura del plan de salud de grupo basado en el empleo actual.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

Si no se inscribe en Medicare y en su lugar elige la continuación de cobertura de COBRA, es posible que tenga que pagar una multa por inscripción tardía en la Parte B y además tenga un lapso de cobertura si decide que quiere inscribirse en la Parte B posteriormente. Si elige la continuación de cobertura de COBRA y luego se inscribe en la Parte A o B de Medicare antes de que termine la continuación de cobertura de COBRA, el Plan puede terminar su continuación de cobertura. Sin embargo, si la Parte A o B de Medicare entra en vigor en la fecha de la elección de COBRA o antes, la cobertura COBRA no podrá interrumpirse a causa del derecho a Medicare, incluso si se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura COBRA.

Si está inscrito en la continuación de cobertura de COBRA y en Medicare, Medicare generalmente pagará primero (pagador primario) y la continuación de cobertura de COBRA pagará segundo. Ciertos planes pueden pagar como si fueran secundarios a Medicare, incluso si usted no está inscrito en Medicare.

Para obtener más información visite https://www.medicare.gov/medicare-and-you.

Si tiene preguntas
Las preguntas respecto a su Plan o a sus derechos de continuación de cobertura COBRA deben dirigirse a la persona o personas de contacto que se identifican más adelante. Para obtener más información acerca de sus derechos en virtud de la Ley de Seguridad de Beneficios de los Empleados (ERISA), incluida la continuación de cobertura COBRA, y la Ley de Protección al Paciente y de Cuidado de Salud de Precio Bajo, y otras leyes que afectan los planes de salud de grupo, comuníquese con la Oficina Regional o de Distrito más cercana de la Labour's Employee Benefits Security Administration (EBSA) del Departamento de Trabajo de EE. UU. en su región o visite **www.dol.gov/agencies/ebsa**. (Las direcciones y números de teléfonos de las oficinas regionales y de Distrito de EBSA están disponibles a través del sitio web de EBSA). Para obtener más información sobre el Mercado, visite **www.HealthCare.gov**.

Mantenga informado a su Plan sobre los cambios de dirección
Con el fin de proteger los derechos de su familia, comuníquele al Administrador del Plan cualquier cambio en las direcciones de sus familiares. Además, le sugerimos conservar una copia, para sus registros, de cualesquier avisos que usted envíe al Administrador del Plan.

Información de contactos del Plan
Deborah A. Stephens, Recursos Humanos
PO Box 3136
Greensboro, NC 27401
336-373-2180

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Aviso de HIPAA sobre normativas alternativas razonables del programa de bienestar

Su plan de salud de grupo está comprometido en ayudarle a lograr su mejor estado de salud. Las recompensas por participar en un programa de bienestar están disponibles para todos los empleados elegibles. Si usted considera que no puede cumplir con un estándar para una recompensa en virtud de este programa de bienestar, podría calificar para una oportunidad de ganar la misma recompensa por diferentes medios. Contáctenos en 336-373-2180 y trabajaremos con usted (y, si lo desea, con su médico) para encontrar un programa de bienestar con la misma recompensa que sea adecuada para usted en función de su estado de salud.

Aviso del Programa de Bienestar EEOC

Aviso respecto del programa de bienestar

El programa de bienestar de la ciudad de Greensboro es un programa de medicina preventiva y bienestar que está disponible para todos los empleados. El programa es administrado de acuerdo con las normativas federales que permiten programas de salud patrocinados por empleadores que procuran mejorar la salud del empleado o prevenir enfermedades, incluida la Ley de Estadounidenses con Discapacidades de 1990, la Ley de NO Discriminación por Información Genética de 2008 y la Ley de Portabilidad y Responsabilidad de los Seguros de Salud, según corresponda, entre otros. Si decide participar en el programa de bienestar se le pedirá que complete una evaluación voluntaria de salud conocida como “HRA” con una serie de preguntas acerca de sus actividades y comportamientos relacionadas con su salud, y si usted tiene o ha tenido ciertas condiciones médicas (por ejemplo: cáncer, diabetes o enfermedades del corazón). También se le pedirá que complete una prueba biométrica, que incluirá un análisis de sangre para colesterol, glucosa, presión arterial, altura y peso. No es obligatorio completar el HRA ni hacerse la prueba de sangre u otros exámenes médicos.

Sin embargo, los empleados que decidan participar en el programa de bienestar recibirán un incentivo de tarjetas de regalo de $160 por participar en una variedad de actividades de bienestar que el empleado selecciona: biometría, examen físico anual, otros cuidados preventivos, encuestas de salud, misiones y desafíos.. Aunque no es obligatorio completar la HRA o participar en la evaluación biométrica, únicamente los empleados que lo hagan recibirán tarjetas de regalo de $160.

Pueden existir incentivos adicionales de hasta un día libre de PTO para los empleados que participan en ciertas actividades relacionadas con la salud, , incluida la participación en el almuerzo y aprendizaje y otras actividades de bienestar o que logran ciertos resultados de salud. Si no puede participar en alguna de las actividades relacionadas con la salud o lograr alguno de los resultados de salud necesarios para ganar un incentivo, quizá pueda tener derecho a una adaptación razonable o a un estándar alternativo. Usted puede solicitar una adaptación razonable o un estándar alternativo contactando a través de Deborah A. Stephens, Recursos Humanos en 336-372-2180.

La información de su evaluación HRA y los resultados de su evaluación biométrica se utilizarán para brindarle información que le ayudará a entender su salud actual y los riesgos potenciales. Además, le alentamos a compartir sus resultados o dudas con su propio médico.

Protecciones contra la divulgación de información médica

Estamos obligados por ley a mantener la privacidad y seguridad de su información de salud identificable personalmente. Aunque el programa de bienestar y Ciudad de Greensboro pueden utilizar información resumida que se recolecta, para diseñar un programa basado en riesgos de salud identificados en el lugar de trabajo, el programa de bienestar de la ciudad de Greensboro nunca divulgará su información personal de manera pública o al empleador, salvo según sea necesario para responder a una solicitud suya para una modificación razonable y necesaria para participar en el programa de bienestar, o según lo expresamente permitido por la ley. La información médica que le identifica a usted personalmente, que se proporcione en relación con el programa de bienestar no será proporcionada a sus supervisores o gerentes y nunca podrá utilizarse para tomar decisiones acerca de su empleo.

Su información de salud no se venderá, intercambiará, transferirá ni se divulgará excepto en la medida permitida por la ley para llevar a cabo actividades específicas relacionadas con el programa de bienestar, y no se le pedirá ni obligará a renunciar a la confidencialidad de su información de salud como condición para participar en el programa de bienestar o recibir un incentivo. Toda persona que reciba su información con el fin de ofrecerle servicios a usted como parte del programa de bienestar cumplirá los mismos requisitos de confidencialidad Nadie recibirá su información médica identificable personalmente..

Además, toda la información médica obtenida a través del programa de bienestar se mantendrá separada de su expediente de personal, la información almacenada electrónicamente será cifrada y ninguna información que usted proporcione como parte del programa de bienestar podrá ser utilizada para la toma de ninguna decisión de empleo. Se tomarán las precauciones pertinentes para evitar cualquier divulgación indebida de datos, y en caso de ocurrir una divulgación accidental de datos que involucre la información que usted proporcione en relación con el programa de bienestar, se lo le notificaremos inmediatamente.

Usted no puede ser discriminado en el empleo debido a la información médica que usted haya proporcionado como parte de su participación en el programa de bienestar, ni puede ser objeto de represalias si decide no participar.

Si tiene alguna pregunta o dudas respecto de este aviso, o sobre la protección contra la discriminación y las represalias, le sugerimos comunicarse con Deborah A. Stephens, Recursos Humanos en 336-373-2180.

Sus derechos y protecciones contra las facturas médicas sorpresa

Cuando recibe atención de emergencia o tratamiento de un proveedor fuera de la red en un hospital o centro de cirugía ambulatoria dentro de la red, usted está protegido contra la facturación médica sorpresa (también llamada facturación de saldos). En estos casos, no le deben cobrar una cantidad que exceda los copagos, el coseguro y/o el deducible del plan.

¿Qué es la "facturación de saldos" (algunas veces llamada "facturación médica sorpresa")?

Cuando consulta a un médico o a otro proveedor de atención médica, es posible que deba ciertos gastos de su bolsillo, como un copago, el coseguro o un deducible. Si consulta a un proveedor o visita una instalación de atención médica que no se encuentra en la red de su plan médico, podría tener gastos adicionales o tener que pagar toda la factura.

"Fuera de la red" describe a los proveedores y a las instalaciones que no han firmado un contrato con su plan médico para proporcionar servicios. Es posible que se permita a los proveedores fuera de la red que le facturen la diferencia entre lo que su plan paga y la cantidad total que se cobra por un servicio. A esto se le llama **"facturación de saldos"**. Esta cantidad es posiblemente mayor que los costos dentro de la red por el mismo servicio, y podrían no contar para el deducible o límite anual de gastos del bolsillo de su plan.

La "facturación médica sorpresa" es una factura inesperada. Esto puede suceder cuando usted no puede controlar quién está involucrado en su atención, como cuando tiene una emergencia o cuando programa una visita en una instalación dentro de la red pero inesperadamente recibe tratamiento de un proveedor fuera de la red. Las facturas médicas del saldo podrían costar miles de dólares dependiendo del procedimiento o del servicio.

Usted está protegido contra la facturación de saldos en los siguientes casos:

Servicios de emergencia

Si tiene una situación médica de emergencia y recibe servicios de emergencia de un proveedor o de una instalación fuera de la red, lo más que pueden facturarle es la cantidad de los costos compartidos dentro de la red de su plan (como los copagos, el coseguro y los deducibles). **No se le puede** facturar el saldo por estos servicios de emergencia. Esto incluye servicios que puede recibir cuando se encuentre en una condición estable, a menos que usted dé su consentimiento por escrito y renuncie a sus protecciones contra la facturación de saldos de estos servicios que se le brindan después de su estabilización.

Ciertos servicios en un hospital o en un centro de cirugía ambulatoria dentro de la red

Cuando recibe servicios de un hospital o en un centro de cirugía ambulatoria dentro de la red, ciertos proveedores podrían estar fuera de la red. En estos casos, la cantidad mayor que estos proveedores pueden facturarle es la cantidad de costos compartidos dentro de la red de su plan. Esto aplica a los servicios de medicina, anestesia, patología, radiología, laboratorio, neonatología, de un cirujano asistente, un hospitalista o un especialista en pacientes críticamente enfermos. Estos proveedores **no pueden** facturarle el saldo y **no** le pueden pedir que renuncie a sus protecciones contra la facturación de saldos.

Si recibe otros servicios en estas instalaciones fuera de la red, los proveedores fuera de la red **no pueden** facturarle el saldo, a menos que usted dé su consentimiento por escrito y renuncie a sus protecciones.

Nunca se le requerirá que renuncie a sus protecciones contra la facturación de saldos. Tampoco requiere recibir atención fuera de la red. Usted puede elegir a un proveedor o instalación que pertenezca a la red de su plan.

Cuando no se permite la facturación de saldos, usted también cuenta con las siguientes protecciones:

- Usted es el único responsable de pagar sus costos compartidos (como los copagos, el coseguro y los deducibles que pagaría si el proveedor o la instalación perteneciera a la red). Su plan médico pagará directamente cualesquier gastos adicionales a los proveedores y a las instalaciones fuera de la red.

- Por lo general, su plan debe:

    - Cubrir los servicios de emergencia sin requerirle obtener la aprobación anticipada de los servicios (también conocida como "autorización previa").
    - Cubrir los servicios de emergencia proporcionados por proveedores fuera de la red.
    - Basar lo que usted debe al proveedor o a la instalación (costos compartidos) en lo que pagaría a un proveedor o en una instalación dentro de la red, y mostrarle esta cantidad en su explicación de los beneficios.
    - Considerar cualquier cantidad que usted pague por servicios de emergencia o servicios fuera de la red para su deducible y su límite de gastos del bolsillo dentro de la red.

Si cree que lo facturaron erróneamente, tiene disponibles los siguientes información y recursos que lo ayudarán a entender sus derechos:

Asistencia por teléfono – Puede comunicarse con el Departamento de Salud y Servicios Humanos de EE. UU. al (800) 985-3059 para preguntar si tiene derechos de protección contra la facturación del saldo en su situación.

Asistencia disponible en línea – También puede visitar el sitio web de los Centros de Servicios de Medicare y Medicaid de EE. UU. para obtener más información sobre las protecciones contra las facturaciones médicas del saldo.