2017 BENEFITS

City of Charlotte Open Enrollment

CHARLOTTE.

EMPLOYEES

Open Enrollment begins October 1, 2016

All changes must be submitted by October 15, 2016

All changes and new elections are effective January 1, 2017

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2017 Highlights

Open Enrollment Period for 2017 Benefits

October 1-15, 2016

Medical Plan

- Basic PPO and Plus PPO have medical and prescription drug plan design changes.
- Non-preferred brand prescription drugs are moving from copay to coinsurance.
- Medical plan premiums for 2017 will be effective on February 4, 2017.

Dental Plan

Third cleaning and exam added to the Dental Plan.

MyClinic

All five MyClinics are open and provide convenient, free medical services to all City medical plan members age 6 and older.

Teladoc

In 2017, access to Teladoc services will be covered under the BlueCross BlueShield plan.

Wellness Works Wellness Incentive Program

The annual wellness incentive for program participation:

- $600 annual savings for employee only or employee/children coverage;
- $1200 annual savings for employee/spouse or employee/family coverage.

Additional Notes:

- Print your Open Enrollment confirmation page and confirm your elections before October 15 to ensure you have enrolled in the plans you intended to enroll.
- Open Enrollment elections are effective on January 1, 2017. Medical plan rate changes are effective February 4, 2017. All other plan rates are effective 1/1/17. You cannot change your benefit elections until the next annual Open Enrollment period, unless you have a qualified family status change.
- Plan details are outlined in the Employee Benefits Handbook and Summary Plan Descriptions, which can be found on the CNet Benefits page.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

MyClinic

- The City of Charlotte partners with OurHealth, an independent, integrated provider of healthcare services, providing near- site clinic services for our employees.
- Employees, spouses, non-Medicare retirees and dependents (ages 6 and up) enrolled in the City's medical plan have access to five MyClinic locations staffed with doctors, nurse practitioners, and health coaches, located throughout the city.

- OurHealth ensures the same level of privacy and confidentiality protections you would receive from any other healthcare provider. This additional benefit is completely voluntary and will not change or affect your current health plan selection or benefits. The partnership with OurHealth is a key component in our efforts to ensure we help you live healthier lives and provide you tools to lower your out-of-pocket medical costs.

MyClinic Locations

City of Charlotte

Locations & Hours

MyClinic @ 4th and McDowell
901 E. 4th St., Ste D
Charlotte, NC 28204
Mon-Th: 7:00AM - 5:00PM
Fri: 7:00AM - 12:00PM

MyClinic @ Wilkinson Blvd
4000 Wilkinson Blvd., Ste A
Charlotte, NC 28208
Mon, Wed, Fri: 8:00AM - 6:00PM
Tu,Th: 8:00AM - 5:00PM

MyClinic @ Northlake
10216 Perimeter Pkwy., Unit C
Charlotte, NC 28216
Mon-Fri: 8:00AM - 6:00PM
Sat: 8:00AM - 12:00PM

MyClinic @ Tower Place
8700 Pineville Matthews Rd., Ste 350
Charlotte, NC 28226
Mon-Th: 10:00AM - 7:00PM
Fri: 10:00AM - 5:00PM

MyClinic @ Albemarle Crossing
9020 Albemarle Rd., Ste E
Charlotte, NC 28227
Mon-Fri: 8:00AM - 5:00PM

Appointments are required.
Contact OurHealth's Member Relations Team at **(866) 451-3467** or visit the portal at **member@ourhealth.org.**

CHARLOTTE. MyClinic

This exciting MyClinic benefit allows for convenient, quality access to healthcare services!

MyClinic Services Overview

Primary & Urgent Care

- Physician-led clinics
- Ages 16+
- Preventive care
- Care of colds/flu, sprained ankle, rashes, etc.
- Suture removal, wound care, minor injuries, etc.

Pediatric Primary & Urgent Care

- Ages 6-15
- Pediatric care by appointment to eliminate long waits
- Minor illness and injuries: cuts, bumps, bruises, sprains
- Sports and camp physicals

Wellness Services

- Annual physicals
- Tobacco cessation
- Diabetes management
- Health coaching

Medications

- 80+ common acute/maintenance medications

General Labs

- On-site general labs
- Hundreds of common blood and urine tests
- Outside lab orders allowed from other providers

Online Tools

- Online member portal for health tools/assessments
- Personalized dashboards
- Access to results
- Wellness information

OurHealth

If You Take No Action During Open Enrollment

Your coverage will default as follows for the entire 2017 plan year:

Medical:
Coverage will default to the Basic PPO Plan, non-wellness premium, **employee-only coverage**, regardless of your 2016 enrollment election.

Important Note:
*If you elected or waived coverage in 2016, you **MUST re-elect** or waive coverage for 2017 or your medical coverage will default to the Basic PPO Plan, non-wellness premium, **employee-only coverage**.*

Dental:
Coverage will default to your current 2016 election.

Vision:
Coverage will default to your current 2016 election.

Flexible Spending Accounts:
You will **not** be enrolled. You must enroll to participate for 2017.

Shared Sick Leave:
You will **not** be enrolled. You must enroll to participate for 2017.

Wellness Incentive:
You will **not** be enrolled in the wellness incentive options unless you actively elect the wellness incentive medical plan option.

Open Enrollment Checklist

Prior to Open Enrollment

- ❑ Review the Open Enrollment booklet and video on the CNet Benefits page or e-Benefits Works to learn about 2017 benefits.
- ❑ Collect the documentation you need to add any dependents.
- ❑ Attend the Benefits Fair on Tuesday, October 4 (10am – 2pm) in CMGC, Room 267 to talk with vendor representatives.

During Open Enrollment

- ❑ Log on to e-Benefits Works to make your elections for 2017.
- ❑ Review your personal information, including your home or mailing address, phone number, and/or email address.
- ❑ Review social security numbers for all covered dependents.
- ❑ Add or remove dependents.
- ❑ If you added dependents, send appropriate documentation along with a copy of your confirmation page to your department HR Representative by October 1-15, 2016.
- ❑ Make your elections in e-Benefits Works: Medical, Dental, Vision, Flexible Spending Accounts, Supplemental and Dependent Life Insurance, Shared Sick Leave, Voluntary Accident & Critical Illness.
- ❑ Meet with a Mark III representative if you wish to enroll in Voluntary Long-Term Disability and/or Voluntary Whole Life Insurance.
- ❑ **Print and review your confirmation page by October 15 to confirm you elected the correct benefit options. Changes cannot be made after October 15.**

After Open Enrollment

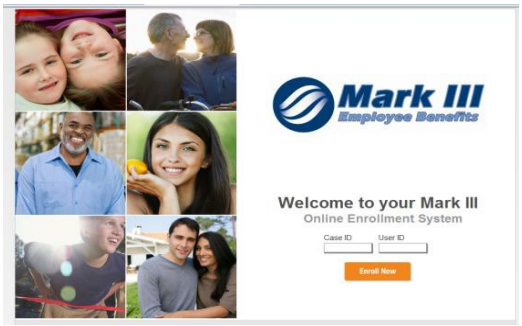
- ❑ **Review your first 2017 paycheck for your benefit deductions and your February 17, 2017 check for your new medical plan deduction.**
- ❑ Complete the wellness incentive requirements if you elected the wellness incentive option.

As you prepare for Open Enrollment and make your elections, remember that your department HR Representatives can assist you with questions and issues.

How To Enroll

Between October 1-15, 2016 go to e-Benefits Works:

- **CNet or https://www.mywecarebenefits.net/markiii**
- **Enter Case ID and Online ID**
  Case ID = M167
  Online ID = Your 5-digit employee number
- **Click Sign In**
- **Enter your password**
  Password = Last 5 digits of your SS #
- **Retype the security code that will appear**
- **Click Enroll Now**



Documentation for Adding Dependents

For employees adding dependents during Open Enrollment who are not currently covered under the plans, documentation will be required as outlined below. Documentation must be provided to your department HR Representative by October 15, 2016.

If your dependent has not previously been enrolled in a City plan, you are required to provide his/her social security number at the time of enrollment.

Dependent	Required Documents
Spouse	Proof of marriage – Copy of marriage certificate or Dependent Spouse Affidavit AND Proof of current spousal relationship status (e.g. federal income tax return, joint bank/credit account statement, joint mortgage/lease agreement, property tax document, loan obligation). These documents must be current and provide employee and spouse's name and address. **Black out confidential information.**
Natural Child(ren)*	Proof of birth – Copy of birth certificate with parent's name listed
Child(ren) with disability(ies)*	Proof of birth (copy of birth certificate with parent's name listed), AND disability certification from medical professional)
Adopted Child(ren)*	Proof of adoption or adoption placement (copy of legal adoption paper or papers indicating adoption petition has been filed)
Step Child(ren)*	Proof of birth (copy of birth certificate with parent's name listed), AND proof of marriage (copy of marriage certificate, dependent spouse affidavit or tax return showing dependency status of spouse). **Black out confidential information.**
Other Child(ren)*	Proof of legal custody or guardianship (copy of custody papers or legal guardian papers)
*Child(ren) may be covered up to age 26	

Medical Plans

The City's medical plans are administered by BlueCross BlueShield of NC (BCBSNC). The City pays a portion of the premium. Your portion of the premium will depend on which plan you choose.

Medical Plan Options:

- Blue Options BASIC PPO – Wellness Incentive or Non-Wellness
- Blue Options PLUS PPO* – Wellness Incentive or Non-Wellness

2017 Medical Plan Rates are effective on 2/4/2017. In January 2017, you will pay the 2016 rates for the plan option you chose during Open Enrollment. In February, you will pay the 2017 rates. Please visit CNet to view the 2016 rate chart.

Rates effective 2/4/2017 through 12/31/2017:

	Basic PPO Plan	
Coverage Level:	Wellness Incentive Weekly Rates	Non-Wellness Weekly Rates
Employee Only	$17.17	$28.71
Employee & Spouse	$94.67	$117.75
Employee & Child(ren)	$75.13	$86.67
Employee & Family	$106.48	$129.55

	Plus PPO Plan	
Coverage Level:	Wellness Incentive Weekly Rates	Non-Wellness Weekly Rates
Employee Only	$32.08	$43.62
Employee & Spouse	$141.45	$164.53
Employee & Child(ren)	$112.27	$123.81
Employee & Family	$151.40	$174.48

Annual Physicals & Preventive Care – Covered at 100% in-network

Visit BCBSNC Online at www.bcbsnc.com/members/coc to:

- View your claims & check your benefits;
- Plan for healthcare costs, find in-network providers, find and compare providers, facilities; and
- View discount programs and services.

Additional plan details can be found on the CNet Benefits page or by contacting BCBSNC at 1-877-275-9787.

*All employees not currently enrolled in the City's health insurance plan and new hires with a hire date of 7/4/15 or later are only permitted to enroll in the Basic PPO Plan option.

Wellness Works Incentive Program

Healthy Targets

- Hemoglobin A1c in optimal range
- Waist Circumference in optimal range
- Blood pressure >/=130/85
- Cholesterol ratio in optimal range

Employees/Spouses who completed the screening by February 28, 2017 and achieve the healthy targets will maintain the wellness incentive for 2017, with health coaching optional. Those that do not achieve the healthy targets can still maintain the wellness incentive by completing onsite health coaching.

The Wellness Works Incentive Program provides an annual medical premium savings for employees and spouses that participate. It is only available to elect during Open Enrollment. When you make your medical plan election you have two choices: Wellness Incentive Option or Non-Wellness Option.

Wellness Incentive Option

By completing the participation requirements, you will receive:

- **$600** annual savings for employee only or employee/children coverage;
- **$1200** annual savings for employee/spouse or family coverage.

Participation Requirements

✓ Wellness Screening - Complete a wellness screening at one of the MyClinic locations or annual physical with your primary care provider.

✓ Health Coaching – If you meet the healthy targets, health coaching is optional. Participants that do not achieve the healthy targets will engage in face-to-face health coaching. Frequency of health coaching is based on individual health risks.

Wellness WORKS CHARLOTTE

EMPLOYEE+SPOUSE or EMPLOYEE + FAMILY COVERAGE:
If you elect the wellness incentive, you AND your spouse must meet the participation requirements in order to receive the full incentive.

Incentive Program Timeline

Elect Wellness Incentive Option during Open Enrollment	10/1/16 - 10/15/16
Complete a Wellness Screening at a MyClinic or submit your physician-completed annual physical results	1/1/17- 2/28/17
Complete your initial health coaching visit*	By 5/15/17
Complete ongoing Health Coaching*	Throughout 2017

* If healthy targets are not met

Non-Wellness Option

Adult medical plan members enrolled in the non-wellness premium option may utilize MyClinic services and are eligible to participate in health coaching, however, are you are not eligible to receive the incentive.

Teladoc

All medical plan members have access to Teladoc which provides access to U.S. board-certified doctors and pediatricians via phone or online video consultations 24/7/365.

You can use Teladoc for a variety of *non-emergency* medical issues rather than taking expensive and time-consuming trips to the ER and urgent care.

Teladoc offers telehealth services for when you...	
Have a non-emergency medical issue	If you're having trouble getting in to see your doctor, Teladoc doctors can diagnose, recommend treatment, and prescribe medication for many basic medical issues, including: **Cold and flu symptoms** **Allergies** **Pink eye** **Respiratory infection** **Ear infection** **Bronchitis** **Poison ivy** **Urinary tract infection** **Sinus problems**
Need a short-term prescription	If appropriate, the Teladoc doctor will write a short-term prescription and have it sent to the pharmacy of your choice. Some common prescriptions include: **Amoxicillin™** **Bactrim DS™** **Cipro™** **Flonase Nasal Spray™** **Prednisone™** **Azithromycin™** **Augmentin™** **Tessalon Perles™** **Pyridium™** **Diflucan™**
Need a specialist	Teladoc doctors can advise you on whether you need a specialist and the type of specialist you should see - saving you guesswork, time and money.
Need a pediatrician	Teladoc is the only telehealth provider with a national network of U.S. board-certified pediatricians who are able to treat children from 0-17 years old.
Travel frequently	Whether on vacation, traveling for work, or traveling internationally, Teladoc is there for you 24/7 wherever you may be.

- Plan members receiving services by a Teladoc provider will have a $10 copay.
- Members may pay by credit card or with an FSA debit card.

Fun Facts:

- 90% of Teladoc members report that the Teladoc physician resolved their medical issue.
- 95% member satisfaction
- 24-minute average doctor call-back time
- No time limit to your consult

2017 Medical Benefits

	Blue Options Basic PPO	
Amounts listed are what YOU pay. Coinsurance percentages are after any required deductible. Unlimited lifetime maximum on both plans.		
	In-Network	**Out-of-Network**
Deductible	$1,000	$4,000
Coinsurance Percentage	30%	50%
Out-of-Pocket Maximum	$6,350	$19,050
Family		
Deductible	$4,000	$16,000
Coinsurance Percentage	30%	50%
Out-of-Pocket Maximum	$13,700	$41,100
Preventive Care Services		
Routine physical, colonoscopy, preventive mammogram, PSA test, routine gynecological exam, well child care, routine immunizations	Covered at 100%	Not Covered
Diagnostic Mammogram	Covered at 100%	50%
Office & Outpatient Services		
MyClinic - All services	No Charge	N/A
Primary Care Physician Visit	$30 copay	50%
Specialists (including chiropractors)	$50 copay	50%
Minute Clinic	$10 copay	N/A
Teladoc	**$10 copay**	N/A
Urgent Care	$50 copay	50%
Emergency Room* *	30% & $250 copay	30% & $250 copay
Ambulance (no deductible)	30%	30%
X-ray & Lab	With office visit - covered 100% * Outpatient—30%	50%
Surgery *	30%	50%
Physical, Speech, Occupational Therapy (up to 60 visits combined)	$30 PCP copay/$50 Specialist copay	50%
Durable Medical Equipment, Orthotics, & Prosthetic Devices *	30%	50%
Inpatient Services		
Hospital Services *	30% & $100 admission copay	50% & $200 admission copay
Physician & Surgeon Fees *	30%	50%
Maternity		
Initial Physician Visit	$50 copay	50%
Hospital Services *	30% & $100 admission copay	50% & $200 admission copay
Delivery (includes professional services for prenatal, postnatal & delivery charges) *	30%	50%
Chemical Dependency Treatment		
Inpatient/Outpatient Facility *	30% & $100 per admission copay	50% & $200 per admission copay
Office	$50 copay	50%
Mental Health		
Inpatient/Outpatient Facility *	30% & $100 per admission copay	50% & $200 per admission copay
Office	$50 copay	50%

*Charges are subject to deductible unless otherwise indicated.

** Emergency Room—(copay waived if admitted) After 2 visits, the copay increases in $100 increments up to a maximum of $450. Copays are included in the out-of-pocket maximum.

at a Glance

Blue Options Plus PPO	
In-Network	**Out-of-Network**
$750	$3,000
20%	50% U & P
$5,000	$15,000
$3,000	$12,000
20%	50% U & P
$10,000	$30,000
Covered at 100%	Not Covered
Covered at 100%	50%
No Charge	N/A
$30 copay	50%
$40 copay	50%
$10 copay	N/A
$10 copay	N/A
$40 copay	50%
20% & $200 copay	20% & $200 copay
20%	20%
With office visit - covered 100% Outpatient—20%	50%
20%	50%
$30 PCP copay/$40 Specialist copay	50%
20%	50%
20% & $100 admission copay	50% & $200 admission copay
20%	50%
$40 copay	50%
20% & $100 admission copay	50% & $200 admission copay
20%	50%
20% & $100 per admission copay	50% & $200 per admission copay
100% after $40 copay	50%
20% & $100 per admission copay	50% & $200 per admission copay
100% after $40 copay	50%

Note: All employees and retirees not currently enrolled in the City's health insurance plan and new hires with a hire date of 7/4/15 or later will only be permitted to enroll in the PPO Basic Plan and any future plan additions.

This guide is a summary of coverage levels and copay amounts for services covered under the medical plans. See the Summary Plan Descriptions on the CNet Benefits page for full plan details.

Glossary of Terms

Copay: The member's share of the charge that must be paid directly to the provider at the time of treatment.

Deductible: The individual dollar amount of covered services the member must pay before the plan begins reimbursement. Under family coverage a minimum of one individual must meet the individual deductible before the family deductible begins.

Coinsurance: Percentage of eligible charges the plan and member will pay in accordance with the plan benefit.

Out-of-Pocket (OOP) Maximum: The individual OOP maximum is a limit on the amount you must pay out-of-pocket for eligible covered services in a calendar year. The OOP maximum includes medical and prescription drug copays, deductibles and coinsurance if applicable. Once this maximum is met, eligible-covered services are paid at 100% for the remainder of the calendar year. The family OOP may be satisfied by any covered member's contribution towards the family OOP.

Network: A group of physicians and hospitals that provide medical services under a contracted agreement. Members receive greater benefits for using in-network providers.

Out-of-Network: Benefits for covered services rendered by non-contracted physicians and hospitals. Members receive lower or no benefits for these services.

Smart Tip – MyClinic dispenses over 100 medications. Check their formulary to see if any of your prescriptions can be dispensed there. All MyClinic medications are free to you.

A full drug list can be found on Caremark's website at www.caremark.com or by calling member services at 1-888-850-8130.

Additional plan details can be found on the CNet Benefits page or visit www.caremark.com or call 1-888-850-8130.

Prescription Drug Plan

Prescription drug coverage is administered by CVS Caremark and is included in the medical plan premiums. You may not elect the prescription drug coverage without participating in the City's medical plan.

Prescription Drug Copays

Tiers	Network Retail Pharmacy (30-day supply, up to 2 refills)	90-Day Maintenance Medications (fill through mail-order or local CVS)
Generic Drugs	$12	$30
Preferred Brand-Name Drugs	$40	$100
Non-Preferred Brand-Name Drugs	50% Coinsurance $0 Minimum & $125 Maximum	50% Coinsurance $0 Minimum & $250 Maximum

Plan Highlights

- $100 front-end deductible for preferred and non-preferred brand prescription drugs for each covered individual. Not applicable to generic medications.
- Specialty drugs are limited to a 30 Day Maximum Supply.
- Mandatory Maintenance Provision for drugs taken regularly or on a long-term basis. Prescriptions must be filled as a 90-day maintenance prescription.
- Generic step therapy provision for some classes of drugs. This requires that cost-effective generic alternative drugs are tried before targeted brand drugs are covered for some drug classes.

Note: All prescription drug copays and the deductible (if applicable) will be applied to your medical out-of- pocket maximum.

Dental Plans

The dental plans are administered by Ameritas. Two plan options are offered:

- Dental Basic
- Dental Plus (includes orthodontia benefits for eligible dependent children up to the age of 19)

	Dental Basic	
	In-Network	**Out-Of-Network**
Calendar Year Deductible	$50 Individual / $150 Family	$75 Individual / $225 Family
Calendar Year Maximum	$750 (applies to all services including preventive)	
Preventive	100%	100%
Basic	80%	50%
Major	50%	50%
Orthodontia	Not covered	Not covered

	Dental Plus	
	In-Network	**Out-Of-Network**
Calendar Year Deductible	$50 Individual / $150 Family	$75 Individual / $225 Family
Calendar Year Maximum	$1,500 (applies to all services including preventive)	
Preventive	100%	100%
Basic	80%	80%
Major	80%	50%
Orthodontia	50%	50%
Ortho Lifetime Maximum	$2,000	

Rates effective 1/1/2017 through 12/31/2017		
Coverage Level:	**Dental Basic**	**Dental Plus**
Employee Only	$0.17	$4.39
Employee & Spouse	$7.27	$15.26
Employee & Child(ren)	$5.67	$15.01
Employee & Family	$12.77	$25.88

Plan Highlights

- New for 2017, members may receive a third preventive cleaning and exam. Discuss with your dentist if this is an option you may benefit from.
- Both plan options include Dental Rewards. With this feature, members are able to carry over $250 of their unused Calendar Year Maximum if they have had at least one covered procedure during the year and the total paid claims have not exceeded $500.
- **Orthodontic benefits are only included in the Dental Plus plan for eligible dependent children up to the age of 19.** Orthodontic treatment that is started before coverage is effective under this plan is not covered. The Orthodontia Lifetime Maximum is separate from the Calendar Year Maximum. Dental Rewards accumulation amounts cannot be used towards the Orthodontia Lifetime Maximum.

Clean Your Smile

Routine dental exams and cleanings three times a year are covered benefits!

Dental PPO Network

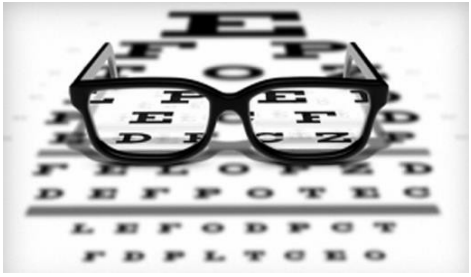
- Ameritas has a PPO network of dentists that have agreed to accept negotiated fees for services, which often help you save and make your dental benefits go farther.
- Out-of-network claims are subject to the usual and customary charges for the dentist's zip code area.

Additional plan details can be found on the CNet Benefits page or visit www.ameritasgroup.com/coc or by contacting Ameritas at 1-877-495-5581.

Begin to see clearly

Additional plan details can be found on the CNet Benefits page or visit VSP at www.vsp.com or contacting VSP at 1-800-877-7195.

Vision Plan



The vision plan is administered by VSP. There's a network of participating optometrists and ophthalmologists from which to choose care for the highest level of benefit.

Vision Plan	Benefit	Copays
Exam	100%	$15 copay
Prescription Glasses	Lenses - 100% Frames - 100% up to $170	$20 copay Covered lenses include: single vision, lined bifocal and lined trifocal lenses, polycarbonate. Additional covered lens options include: anti-reflective coating, blended bifocal and progressive.
Contact Lens	100% up to $170	No copay Benefit applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts and member cost will never exceed $60.

Vision Plan	Weekly Rates
Employee Only	$3.03
Employee & Spouse	$4.79
Employee & Child(ren)	$4.89
Employee & Family	$7.88

Additional Benefits:

- To use your vision coverage, no ID card is necessary - simply tell your eye care provider that you are covered under the VSP Choice Plan.
- VSP offers extra discounts and savings, including an average of 20-25% savings on all non-covered lens options.
- You may register on www.vsp.com to view a complete description of your benefits.

Flexible Spending Accounts (FSA)

The Flexible Spending Accounts (FSA) are administered by Flexible Benefit Administrators (FBA).

There are two options:

- **Healthcare Spending Account** – You may contribute up to $2,550 for the year. This account is pre-funded with the employee's annual election amount on January 1, 2017.
- **Dependent Care Spending Account** – You may contribute up to $5,000 for the year. This account is funded as the deductions are taken from the weekly paycheck.

All participants will receive a Flexible Spending Account debit card.

Important Information: **Prior to enrolling, you should read the Flexible Spending Account Plan Summary**. This can be found on the CNet Benefits page. IRS guidelines may require supporting documentation for your expenses. It is important to keep your receipts and submit upon request to avoid suspension of your FBA debit card.

If you are covered under a spouse's high deductible health plan, you may not enroll in the City's FSA plan, per IRS guidelines. The City's FSA is not a limited FSA plan.

To help you add up your anticipated out-of-pocket health care expenses to determine how much you should contribute to your Health FSA, visit the FBA Portal/FSA resources at https://www.mywealthcareonline.com/fba/ or link to the FBA portal from the CNet Benefits page.

FSA Store

Flexible Benefit Administrators partners with the FSA store to make it easy to use your flexible spending dollars on FSA eligible products. Visit https://fsastore.com to learn more or start shopping.

2016 FSA Deadlines

You have until March 15, 2017 to incur claims for the 2016 FSA plan year. You have until April 15, 2017 to submit those claims against your 2016 FSA balance. Any remaining funds in your FSA account after April 15, 2017 will be forfeited. These claims should be submitted to Flexible Benefit Administrators with a claim form or you may use your FSA debit card. For questions about your Flexible Spending Account, contact Flexible Benefit Administrators at 1-800-437-3539.

Shared Sick Leave Program

This program provides paid leave for catastrophic situations for enrolled employees. Shared Sick Leave may be used after all accrued leave has been exhausted. If you are a current Shared Sick Leave participant, you MUST re-enroll to participate for calendar year 2017. To participate, employees must donate the following amount of sick time:

- Full-time: 8 hours
- Part-time (30 hrs/week): 6 hours
- Part-time (20 hrs/week): 4 hours
- Firefighters: 12 hours

Have You Received Your Reimbursement?

Voluntary Accident Health Screening benefit pays up to $60 per calendar year for:

- Annual physical exams
- Mammograms
- Pap Smears
- Eye examinations
- Immunizations
- Flexible Sigmoidoscopy
- PSA
- Ultrasounds
- Blood screenings

Critical Illness Health Screening benefit pays up to $100 per calendar year for:

- Mammogram
- Pap Smear
- Flexible Sigmoidoscopy
- Stress test on a bicycle or treadmill
- Fasting blood glucose test; blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- Chest X-ray
- Colonoscopy
- Physical exams

Accident and Critical Illness

Aflac Voluntary Accident Insurance

Accident insurance pays a benefit for the treatment of injuries suffered as the result of a covered accident.

Plan features:

- 24-hour coverage on and off the job
- Coverage available for spouse and children
- $60 health screening benefit
- Guaranteed issue coverage during open enrollment
- Scheduled benefits vary based on the type and nature of the accident
- Plan is portable
- Premiums are paid by pre-tax payroll deduction

Aflac Voluntary Critical Illness Insurance

Critical illness insurance can help with the treatment costs of illnesses and health events. You receive cash benefits directly, giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Plan features:

- Pays a lump sum benefit in the event of a covered critical illness, including but not limited to heart attack, stroke, end-stage renal failure, cancer and major organ transplants
- Coverage available for spouse and children (no additional cost to cover dependent children)
- $100 health screening benefit
- Guaranteed issue coverage during open enrollment
- Plan is portable
- Premiums are paid by pre-tax payroll deduction
- Benefits may be taxable

Pre-existing Conditions Limitations may apply

For weekly payroll deduction rates and additional plan details, please refer to the Aflac Accident & Critical Illness booklet which can be found on the CNet Benefits page or e-Benefits Works.

Long-Term Disability (LTD) Plan

The Voluntary LTD program is offered through Lincoln Financial. All active, regular employees who are scheduled to work at least thirty (30) hours per week are eligible to participate in this plan, regardless of whether or not you are vested in the North Carolina or Charlotte Firefighters' Retirement System.

- Plan will pay 60% of your monthly salary to a $10,000 maximum. It will pay in addition to any disability retirement benefit you receive not to exceed 100% of your income.
- There is an 180-day waiting period before benefits begin.
- There are two maximum benefit duration periods from which to choose:
  - 5 years / or to age 70, but not less than one year
  - Social Security Normal Retirement Age

- Employees hired on or after September 2, 2015 through September 1, 2016 have the opportunity to enroll during Open Enrollment with no medical questions.

- All other eligible employees may apply during Open Enrollment, however, you will be subject to medical questions.

Note: A pre-existing clause applies on the Long-Term Disability Plan. You may not be eligible for benefits if you have received treatment for a condition within the past 3 months until you have been covered under the plan for 12 months.

To drop LTD coverage, complete the LTD Cancellation Form found on CNet.

Employees interested in obtaining a premium estimate or enrolling in the LTD and/or Voluntary Whole Life Insurance plan must meet with a Mark III representative during Open Enrollment.

Voluntary Whole Life Insurance

The Voluntary Whole Life Insurance benefit is offered through Unum.

- Employees hired on or after September 2, 2015 through September 1, 2016 have the opportunity to enroll during Open Enrollment with no medical questions.

- All other eligible employees may apply during Open Enrollment, however, you will be subject to medical questions.

Whole Life Insurance features:

- Builds cash value
- Living benefit
- Accidental death benefit rider
- Long-term care feature

To drop Voluntary Whole Life coverage, contact Unum at 1-800-635-5597.

If you don't elect coverage during Open Enrollment and wish to enroll at a later time, you'll need to provide evidence of good health for any amount of Supplemental Term Life coverage for yourself or Dependent Term Life coverage for your spouse unless you have a qualifying event.

Review & update your beneficiary for life insurance, retirement, 401(k) and 457. Go to the CNet Benefits page to learn how.

Life Insurance

Basic Term Life and Accidental Death & Personal Loss (AD&PL) Insurance

The City provides eligible employees with Basic Term Life Insurance coverage equal to two (2) times annual salary, up to a maximum of $200,000. Employees are also provided Basic AD&PL for a matching amount.

Life Insurance Options During Open Enrollment

Employees currently enrolled in Supplemental Term Life coverage	• May increase coverage one (1) level, not to exceed level three (3) or $600,000 • Amounts greater will require evidence of good health
Spouses and Children currently enrolled in Dependent Term Life coverage	• May increase coverage on your dependents by one (1) level without evidence of good health • Increases by more than one (1) level will require evidence of good health for the spouse

Eligible Employees, Spouses and Children not currently enrolled	• Employee Supplemental Term Life – you may elect coverage up to level four (4) with evidence of good health
	• Dependent Life –
	  • Spouse – evidence of good health is required for any level of coverage
	  • Dependent Child(ren) – can be enrolled for any level. Evidence of good health is not required.

If you or a dependent have previously been denied coverage, evidence of good health will be required for the full coverage amount requested.	

Additional Life Insurance Benefits

Accelerated Death Benefit: You can receive up to 75% of your Basic and Supplemental Term Life Insurance coverage to a maximum of $500,000 if you become terminally ill and your doctors determine your life expectancy will likely not exceed 24 months.

Aetna Life Essentials℠: Provides access to legal information regarding identity theft, wills and estate planning and financial advice through Merrill Edge. Vision and fitness programs discounts are offered. Visit www.aetna.com/group/aetna_life_essentials

Everest Funeral Planning and Concierge Services: Pre-funeral planning services include online tools and access to advisors 24/7 to discuss funeral planning, and get detailed local funeral home price comparisons. At-need services provide family support and negotiation assistance. Visit www.everestfuneral.com/aetna and enter your email address and enrollment identification AETNA0006.

Supplemental Term Life Insurance

Employees can buy Supplemental Term Life Insurance coverage from 1 to 4 times their annual salary, rounded to the next higher $1,000, not to exceed $600,000. The combined coverage amounts of Basic and Supplemental Term Life Insurance are subject to a maximum of $800,000.

Employee Monthly Premium Rate per $1,000 of Coverage	Age
$0.047	Under 30
$0.055	30-34
$0.066	35-39
$0.091	40-44
$0.137	45-49
$0.208	50-54
$0.350	55-59
$0.419	60-64
$0.561	65-69
$1.121	70 and above

Example:

Employee age 35, salary $41,275, wants to purchase 2 times basic annual salary.

$41,275 x 2 = $82,555 rounded to the next higher $1,000 = $83,000

$83,000 ÷ 1,000 = 83

83 units x $0.066 per unit = $5.48 monthly

$5.48 x 12 months = $65.76 annually

Annual cost ÷ 52 weeks = $1.26 weekly

Dependent Term Life Insurance

Employees have 5 options from which to choose. Evidence of good health may be required on your spouse.

Monthly Cost	Coverage Options
$0.38	Option 1: Spouse: $1,000 Dependent Child(ren): $1,000
$1.32	Option 2: Spouse: $5,000 Dependent Child(ren): $2,000
$2.77	Option 3: Spouse: $10,000 Dependent Child(ren): $5,000
$3.92	Option 4: Spouse: $20,000 Dependent Child(ren): $10,000
$6.28	Option 5: Spouse: $30,000 Dependent Child(ren): $15,000

Example:

Employee elects Option 5.

$6.28 x 12 months =

$75.36 annual cost ÷

52 weeks = $1.45 weekly

Seasonal Flu Shots

Onsite -

- Free flu shots will be available onsite for all employees. The full calendar of onsite flu clinics is on CNet.

MyClinic –

- Free flu shots are available for all adult medical plan members. Contact OurHealth MyClinic at (866) 451-3467 to schedule an appointment.

Physician's office –

- Medical plan members may either schedule an appointment for a flu shot or visit a physician's flu shot clinic. Members who receive other services in addition to the flu shot will be required to pay any applicable copayment, coinsurance or deductible amounts.

Pharmacy

- Eligible members ages 18 and older may go to an in-network pharmacist to receive a flu shot. A limited number of pharmacists have contracted with BCBSNC to administer BCBSNC-covered vaccines, such as the flu shot. To find in-network pharmacists, visit the Doctors, Rx and Hospitals section on the BCBSNC website (www.BCBSNC.com/members/coc), and search for "Pharmacist (Flu & Other Limited Injections)" under Search By Specialty.

CVS MinuteClinic

- To find a participating CVS MinuteClinic, search for "Convenience Care Center" under "Specialty" at www.BCBSNC.com.

Wellness WORKS CHARLOTTE.

Your health matters. It matters not only to you, but also to your family and to the City. The City of Charlotte is committed to offering a comprehensive wellness program that helps encourage good health. Whether you want to take a big step toward improved well-being or just a small step in the right direction, find support with Wellness Works.

Programs offered by Wellness Works:

- Health Coaching
- Exercise Consults
- Life Coaching
- Health Condition Management
- Annual Flu Shots
- Diabetes Management Program
- Tobacco Cessation Resources and Prescription Cessation Medication Coverage
- Employee Fitness Centers & Group Exercise Classes
- Wellness Challenges
- Onsite Wellness Education Programs
- Blood Pressure Management Education
- Lactation Rooms

Contact your Department's Wellness Ambassador for additional Wellness Works information.

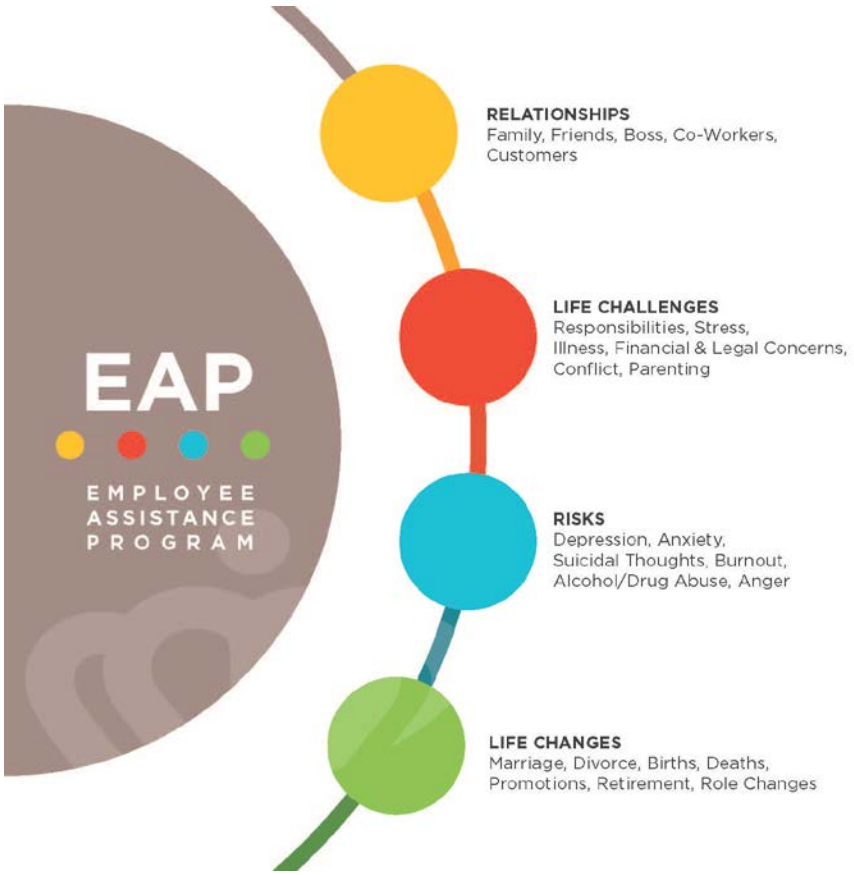
Employee Assistance Program (EAP)

The City offers an Employee Assistance Program for employees and their household members, administered by Business Health Services. You will receive these free, confidential benefits:

- Short-term counseling to help you cope with family, personal or work-related issues. Up to 6 sessions per person, per separate issue, per year.
- Unlimited legal consultation with an attorney by phone or in person.
- Unlimited financial consultation with a financial advisor by phone.
- Resources and referrals for childcare and eldercare needs.

Some situations are difficult no matter how you look at them but other times, our stress comes from dealing with multiple issues at once. Talking to an objective professional can help broaden your perspective on the issue(s) or can provide insight on additional resolutions to the problem. Sometimes you may just need new tools to deal with a situation. That is where the EAP can help.

Call Business Health Services at 1-800-327-2251 or visit www.bhsonline.com username: CHAR.



Life Happens, but Help is Available

Personal
- Stress Management
- Family Problems
- Childcare & Parenting
- Substance Abuse
- Marital & Relationship Problems
- Grief & Loss
- Work-Related Issues
- Communication
- Time Management

Legal
- Domestic or Family Matters
- Estate Planning
- Wills & Power of Attorney
- Separation or Divorce
- Custody Issues
- Motor Vehicle Violations
- Real Estate Concerns
- Landlord & Tenant Disputes
- IRS Matters
- Criminal Charges
- Business Matters

Financial
- Debt Management & Consolidation
- Tax Planning & Preparation
- Credit Counseling
- Budgeting
- College Funding
- Retirement Funding

Childcare
- Emergency & Back-up Childcare
- Nanny & Au Pair Services
- Summer Camps
- Before & After School Programs
- Adoption & Special Needs

Eldercare
- In-Home Care
- Home-based Services
- Nursing Home
- Assisted Living Facilities
- Transportation Services
- Support/Advocacy Groups
- Adult Day Care

Notifications

Participation in any of the City's benefits plans should not be viewed as a contract of employment. While the City of Charlotte intends to provide these benefits for an indefinite period of time, it reserves the right to terminate, suspend, withdraw, amend or modify the plans at any time. Any such change or termination of benefits will be based solely on the decision of the City and may apply to active employees, future retirees and current retirees as either separate groups or as one group.

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 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 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 31 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a State CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and State CHIP. As described above, a 31-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Human Resources, Benefits Division at 704-336-5211.

Women's Health and Cancer Rights Act (WHCRA) Notice

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of mastectomy

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

If you have questions about this or any medical coverage, call the BCBS Member Services Department at 1-877-275-9787.

Notice of the City of Charlotte Medical Plan
Health Information 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.

The effective date of this Notice of the City of Charlotte Medical Plan Health Information Privacy Practices (the "Notice") is January 1st, 2017.

The City of Charlotte Medical Plan (the "Plan") provides health benefits to eligible employees of the **City of Charlotte** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, retirees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and retirees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, retiree or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor's or other health care provider's privacy practices with respect to your PHI that they maintain.

RECEIPT OF YOUR PHI BY THE COMPANY AND BUSINESS ASSOCIATES

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Plan provide health benefits. These third parties are known as the Plan's "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

- Obtaining payments required for coverage under the Plan
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
- Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
- Planning and development, such as cost-management analyses
- Conducting or arranging for medical review, legal services, and auditing functions
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

Limited Data Set: The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

Legally Required: The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

Health or Safety: When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Law Enforcement: The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

Lawsuits and Disputes: In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

Workers' Compensation: The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

Emergency Situation: The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

Personal Representatives: The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.

Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

Organ Donation: The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

AUTHORIZATION TO USE OR DISCLOSE YOUR PHI

Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

THE PLAN MAY CONTACT YOU

The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

COMPLAINTS

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the end of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

The Plan has designated the City of Charlotte Benefits Manager as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: 700 E. 4th St., Ste. 200, Charlotte, NC 28202 or 704-336-6509.

Patient Protection Disclosure

The City of Charlotte Medical Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, or for a list of the participating primary care providers, or for information on how to select a primary care provider, contact the BCBS Member Services Department at 1-877-275-9787.

Medicare Prescription Drug Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Charlotte 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. The City of Charlotte has determined that the prescription drug coverage offered by the City of Charlotte 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?

As an active employee, if you or a covered dependent qualify to enroll in Medicare prescription drug coverage, you have the following options:

a) Keep your existing coverage through the City of Charlotte and not enroll in a Medicare prescription drug plan; or

b) Enroll in a Medicare prescription drug plan in which case the Medicare prescription drug coverage will be supplemental to the prescription drug coverage provided by the City of Charlotte's group plan. In making your decision, you should consider the extra premium you will pay to enroll in a Medicare plan and you should understand that prescription drug claims paid by the City's group plan do NOT count as true out-of-pocket expenses.

Your current coverage pays for other healthcare expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug benefit, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current City of Charlotte coverage, under current City guidelines, you and your dependents will be able to get this coverage back due to a change in family status or during Open Enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Charlotte plan 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 Human Resources Department Benefits Division at the number listed below.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through the City of Charlotte changes. You may also request a copy of this notice at any time.

Human Resources Department Benefits Division
700 E. 4th St.
Charlotte, NC 28202
704-336-5211

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 numbers) 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).

Wellness Incentive Program Overview

Purpose: The purpose of the Wellness Works wellness incentive program is to assist our employees and their spouses with early detection of personal health risks that may lead to the prevention or delay of certain chronic diseases or illnesses.

Participation: Participation is voluntary. Employees and spouses who choose to participate in the wellness incentive medical plan option will have the opportunity to earn a premium savings by participating in the wellness incentive program. Premium savings is awarded by the completion of the wellness activities below. Both employees and their spouses (if enrolled in the medical plan as employee + spouse or family plan) must complete all activities by the deadlines to qualify for the full incentive:

1. Participate in a MyClinic screening or submit a Physician Health Screening Form by February 28, 2017 (form must be received by OurHealth by this date).
2. Participants that do not meet the healthy targets, must complete the initial face-to-face health coaching session by May 15, 2016. Face-to-face health coaching is offered in City worksites and at MyClinic locations. Participants must then engage in ongoing health coaching as prescribed by your Health Coach to maintain incentive compliance. They will work with you to develop an individualized Care Plan; and, as long as you continue to meet your coach at your scheduled appointment times to discuss your care plan you will be compliant. Ongoing health coaching may include telephonic coaching sessions, if appropriate.
3. Participants that meet the healthy targets are not required to engage in health coaching, however health coaching is available to you at any time during the year, in City worksites and at MyClinic locations.

Plan Changes: The program details may be changed at any time by giving employees 30 days written notice at their last known address. The program may be changed without notice in order to comply with existing or new legislation governing wellness programs.

Funding-Deposits: Each calendar year, the City will determine the participation and/or requirement-based wellness program criteria as well as the frequency of incentive awards. For 2017, incentive premium savings will begin with the first January payroll.

Spouses & Adult Dependents: We understand that healthy changes require support which is why the City of Charlotte is makes wellness services available to all adult dependents age 18 and older who are on the City's medical plan. This will enable the entire family to work on healthy choices together. Spouses enrolled in the Wellness Incentive Plan are eligible for an incentive and must complete all activities to qualify. Adult dependents age 18 and older who are on the City's medical plan are not eligible to receive an incentive for participation. However, adult dependents are offered the OurHealth Member Portal, MyClinic services and Health Coaching to assist them in achieving their health goals.

Non-Plan Members: For the 2017 plan year, employees, spouses, adult dependents age 18 or older and Non-Medicare eligible retirees not enrolled in the City of Charlotte PPO medical plan or who waived coverage are not eligible to participate in the program. Employees that are not enrolled in the City of Charlotte's wellness incentive medical plan option are not eligible to receive an incentive.

Appeals Process: Employees have the right to an appeals process. Alternative standards and waiver opportunities may apply for all similarly situated members. If you feel that your results are inaccurate, it is unreasonably difficult to meet the program criteria to earn your incentive due to a medical condition or you would like to appeal your results due to a specific issue that prevents you from being able to meet the criteria as outlined, please call OurHealth at 1.866.451.3467 to initiate an appeal. OurHealth will proactively work with you and your physician to certify the issue and, if applicable, develop another way for you to qualify for the award.

MyClinic Services: All medical plan members have access to all MyClinic services, regardless of incentive eligibility or compliance status.

Premium Savings: 2017 Medical Plan Rates are effective on 2/4/2017. In January 2017, you will pay the 2016 medical plan premiums for the plan option you chose during Open Enrollment and the incentive amount will be the 2016 incentive amount. Beginning February 4, 2017 you will pay the 2017 medical plan premiums and receive the 2017 premium incentive amount. The total amount of your annual premium savings is dependent on the premiums you pay and program compliance.

Benefit Plan Description for City of Charlotte Employees: The above information describes the components and criteria of the standards based wellness program that must be met in order to qualify for the premium savings toward your cost to the health care plan sponsored by the City of Charlotte. Employees enrolled in the Wellness Incentive Plan who successfully complete the actions outlined are eligible to earn the following:

Plan	Incentive Amount	Annual Total
Employee or Employee/Child	$50/month	**$600**
Employee/Spouse* or Employee/Family	$100/month	**$1200**

* If enrolled in Employee/Spouse or Family plan, both employees and spouses must complete all activities by the stated deadlines to receive the full incentive.

Contact Information

Medical
BlueCross BlueShield of North Carolina
1-877-275-9787 · www.bcbsnc.com/members/coc

Teladoc
1-800-Teladoc(835-2362) · www.teladoc.com

MyClinic
(866) 451-3467 · member.ourhealth.org

Prescription Drugs
CVS Caremark
1-888-850-8130 · www.caremark.com

Flexible Spending Accounts
Flexible Benefit Administrators
1-800-437-3539 · www.flex-admin.com

Dental
Ameritas Group
1-800-487-5553 · www.ameritasgroup.com/coc

Vision
Vision Service Plan (VSP)
1-800-877-7195 · www.vsp.com

Voluntary Long Term Disability
Lincoln Financial
1-800-423-2765

Voluntary Whole Life Insurance
Unum
1-800-635-5597

Accident & Critical Illness
Aflac
1-800-433-3036

Basic & Supplemental Term Life Insurance
Aetna Life Insurance
1-800-523-5065

Wellness
Wellness Works
704-336-6005

Employee Assistance Program (EAP)
Business Health Services
1-800-327-2251 · www.bhsonline.com

City of Charlotte Human Resources
Benefits Division
704-336-5211 · benefits@charlottenc.gov

CNet Benefits page
http://cnet/kbus/hr/benefits/Pages

Upcoming Meetings

Benefits Fair/Flu Shots

CMGC Rooms 267 & 270/271:

Tuesday, October 4th 10:00am – 2:00pm

Interested in enrolling in Voluntary LTD and/or Whole Life Insurance?

A Mark III representative will be in CMGC Room 270/271:

Thursday, October 6 10:00am – 2:00pm

Thursday, October 13 10:00am – 2:00pm

Have questions about the Flexible Spending Accounts?

Flexible Benefit Administrators will be in CMGC Room 274:

Monday, October 3 12:00pm – 3:00pm

Wednesday, October 5 8:00am – 11:00am

Check with your HR Representative for other informational Open Enrollment sessions that may be offered in your department.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers health coverage options. Choosing a health coverage option is an important decision. As required by Healthcare Reform, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the CNet Benefits page beginning October 1, 2016 at http://cnet/kbus/hr/benefits/Pages/Medical.aspx . A paper copy is also available, free of charge, by calling Human Resources Benefits Division at 704-336-5211.