Frequently Asked Questions

This document will be updated as additional questions are posed. Check back for updates. If you have a question that isn't answered, please send it to benefits@charlottenc.gov and it will be answered and added.

Annual Enrollment

1. **What will happen if I miss Annual Enrollment?** If you take no action during Annual Enrollment, you will default to the following coverages.
   - Medical: Coverage will default to PPO Plan D, employee only, non-wellness.
   - Dental: Will default to your current election.
   - Vision: Will default to your current election.
   - Flexible Spending Accounts: You will not be enrolled.
   - Shared Sick Leave: You will not be enrolled.
   - Critical Illness, Accident: Will default to current election and move coverage to Voya. You will need to waive coverage to unenroll.
   - Hospital Indemnity: You will not be enrolled.
   - Other coverages - Aetna (Supplemental Life), Unum (Voluntary Whole Life) and Lincoln Financial (Voluntary LTD): Will default to your current election.

2. **Why is the City make such big changes this year?** The 2018 offering is designed to provide employees choice and flexibility. As an employer, we provide benefits to a multi-generational workforce as well as retirees. One size does not fit all and not all five new plans will work for you as an individual. It's about finding the plan that does. The 2018 line-up provides a variety of choices so employees can choose the benefits that best meet their needs. In addition, the new Health Savings Account plans provide an opportunity for all employees to start saving for future retiree medical expenses which is important whether you are eligible for retiree medical insurance or you aren't.

   The choice of medical plan options also provides you the flexibility to choose how you want to spend your healthcare dollars. Do you want to spend more now in premiums so you spend less at the time of care? Or do you want to spend less now and more later when you access care, but have the opportunity to save some of that money and carry it over into future years? The new plans provide this flexibility.

   The City has not experienced this type of change in benefits in quite some years and we recognize change can be challenging. These new offerings do require you to think about your situation and the benefits that best fit you. The good news is, we've got new offerings for those of you interested in trying them and we are keeping plans that look similar to what we currently have for those of you that aren't interested in changing. Plus we have lots of resources to help you get educated and get your questions answered throughout this process.

3. **If I add a child or a spouse to my plans, how long will I have to provide my dependent verification information?** Your documentation must be submitted by November 20. Send a copy of your documentation along with your Annual Enrollment confirmation page to your department benefits representative by the deadline.

4. **What do I need to do to prepare for Annual Enrollment?**
   - If you've moved, make sure the City has your correct address.
   - Check and read your mail. Benefits information is sent to your home.
   - Get educated on the new medical plan offerings and consider how you intend to use the plan in 2018.

        - You may want to download your HealthCare Summary Report from BCBSNC and Prescription Drug Plan Summary from CVSCaremark to see what benefits you've used in 2017 to get an idea of what you may need in 2018. This will be helpful information if you are considering the Health Savings Accounts or Health Reimbursement Accounts.
    - If you are adding a new dependent, you will want have copies of your dependent verification documents.
    - Take time to contact the benefits vendors to get your specific questions answered.
    - Review your Annual Enrollment booklet for information on all the of the benefits options available to you so when you go to make your elections, you are prepared.
    - Complete your Annual Enrollment elections between October 30 – November 20.
    - **Once you make your elections, review your confirmation page. Your choices are binding until the next Annual Enrollment. You want to make sure you elected what you intended to elect. Print a copy of your Annual Enrollment confirmation form.**

5. **How long can my dependents that are turning 26 stay covered under the plan?** Dependents that are aging out of the plan will end coverage on the last day of the month in which they turn 26.

6. **When will I receive my Annual Enrollment Book?** Books will be mailed to your home the week prior to Annual Enrollment.

7. **I'm going to be out of the country during Annual Enrollment, what are my options?**
   The Annual Enrollment SmartBen system is where you will make your elections. It can be accessed from anywhere there is an internet connection. In addition, you can make your elections over the phone through the SmartBen Call Center. If you have an extenuating circumstance that will prevent you from accessing the internet or telephone between October 30-November 20, please contact Human Resources Benefits Division prior to Annual Enrollment at 704-336-4117 or benefits@charlottenc.gov for alternative options.

8. **Do I have to enroll in the City's medical plan in order to enroll in other benefits?** No. Employees are able to pick and choose the benefits they want to enroll in.

9. **I'm retiring at the end of the year, what should I do?** If you are retiring before 1/1/18, you do not need to complete Annual Enrollment as an employee. If you are eligible for retiree medical insurance, you will receive information about your options and enrollment during your retirement counseling session.

10. **Is there going to be a benefits fair?** This year you get your own benefits fair. A list of the City's benefit partners and their contact information is available so you can call the providers and get your questions answered at a time that is most convenient for you.

11. **I'm adding a dependent, what information do I need to provide?**
    A copy of the required documents should be attached to your Annual Enrollment confirmation form and sent to your department HR representative or HR Benefits Division by November 20.

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) **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 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)
**Children may be covered up to age 26	

Medical & Prescription Drug Plans

12. **Is the prescription drug provider changing?** No, Caremark will continue to administer the prescription drug plan. Depending on which medical plan you choose, however, how you much you pay for prescription drugs may change.

13. **What medical plans can I enroll**? The new medical plan offering is available to all employees that are eligible for medical plan benefits. You are able to choose any of the plans, regardless of your hire date.

14. **Are the plans increasing in premiums?** Depending on the plan you are currently in, you may experience a decrease in premiums or an increase. The new offering provides a range of plan designs and premiums.

15. **If I choose the HSA this year, can I choose the PPO next year?** Yes, next year during Annual Enrollment you will be able to choose any of the medical plan options

16. **Are the current PPO plans staying the same?** No, the new PPO plans are different than the current plans.

17. **I'm in the Plus Family PPO plan, if I move into Plan E, the premium increase is $89 a week, why?** The 2018 plans are different plans and they are priced according to the level of benefit they provide. Plan E is not the same plan as the current PPO Plus plan, as the plan value is higher. If you have been in the Plus PPO plan and you are considering Plan E, you will see a larger increase than if you chose another plan or tier. For many years the City subsidized the family tier of the Plus PPO plan more than other tiers, meaning employees in that tier were insulated from premium increases that truly reflected the costs of that plan. Over four years ago the City began incrementally shifting the employee cost share for the Plus PPO plan so that it was aligned with the other plan tiers, bringing all of the City's plans in line with industry best practice. The new rates for the 2018 plans reflect the completion of this alignment change. Additionally, the 2018 plans are different plans; they are priced according to the level of benefit they provide, not based on how they correspond to the 2017 plans.

18. **Is the City trying to drive spouses off the medical plans?** The City's intent is not to drive spouses off the medical plans. Spouses do incur more plan costs than employees. Employees that choose to cover a spouse will pay more of the plan premium. If your spouse has access to medical coverage, you are encouraged to compare your spouse's plan to the City's plan so you can make an informed decision about which plan best meet the needs of your family.

19. **Is the most expensive medical plan, the best plan?** Not necessarily. The best plan is the one that meets your needs for the way you use medical and prescription drug services. If you have a lot of prescription drugs or office visits, copays might be important to you. If you don't use many services, copays may not be important. If you anticipate you may meet your out-of-pocket maximum, you may want to consider which plan helps you get to that point as quickly as you can afford to get there, as your expenses are then covered at 100%. So the cost of the plans aren't a single indicator of which plan is best.

20. **What is worst case scenario, the most I'll pay out of my pocket in a year?** Worst case is your total annual premiums plus your out-of-pocket maximum. You'll want to factor in your wellness incentive as it offsets your total costs. The challenge is most people do not hit the out of pocket maximum. People tend to fall somewhere in the middle of no services at all and the out of pocket maximum. That is why this requires some thought into how you use medical plan services, so you can figure out what your expenses may be and what plan best fits those expenses.

	HSA Plan A		HSA Plan B		PPO W/ HRA Plan C		PPO Plan D		PPO Plan E	
	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
Out of Pocket Maximum	$6,550	$13,100	$3,000	$6,000	$6,600	$13,200	$6,000	$12,000	$4,000	$8,000
Annual Employee Premiums	$416	$4,160	$1,924	$10,660	$676	$5,148	$676	$5,200	$1,924	$12,480
Wellness Savings	$1,000	$2,000	$500	$1,000	$500	$1,000	$500	$1,000	$500	$1,000
Maximum Annual Cost	$5,966	$15,260	$4,424	$15,660	$6,776	$17,348	$6,676	$17,200	$5,924	$20,480

21. **If I am in the HSA plan, can I change my contributions throughout the year?** Yes, you can change your payroll deduction amount and/or send your contribution directly to Health Equity. You will want to ensure you remain within the IRS limits for the annual HSA contribution.

22. **The HSA plans reference a generic preventive list, what is that?** There is a list of preventive generic medications which are covered by Plan A and Plan B before you must meet the deductible. This list is on CNet. All other medications in Plan A and Plan B are subject to the deductible and coinsurance.

23. **Why are the generic copays increasing in the PPO Plans?** Over the past several years, the City reduced the generic copays for chronic conditions, such as diabetes and high cholesterol, to make it easier for employees to be compliant with their medications to aid in health improvement. Since MyClinic is now operational, they offer a selection of generic medications at no cost. Since employees can receive these generics for free at MyClinic and that is more cost effective for the employee, the City has adjusted the generic copays in the 2018 PPO plans to be more in line with industry standards.

24. **Will there still be a front end deductible on prescription drugs?** No, the prescription drug plan design is different based on which medical plan you choose. There is no front end deductible for 2018. Be sure to review the prescription drug benefit when you make your medical plan election. Some plans have copays and coinsurance. Other plans you pay the cost of the drug up to the deductible and then you pay coinsurance.

25. **Is there still a 90 day maintenance medication provision?** Yes, this provision will operate the same as 2017.

26. **How do I get medication from MyClinic?** A formulary is available on CNet. If your medications are on the list and you would like to switch to MyClinic, you may schedule a medication consult visit with MyClinic and they will get you set up to receive them through the clinic.

27. **Can I still go to Teladoc or MinuteClinic?** Yes. Depending on which medical plan you choose, will depend on how you pay for that service.

    - Plans A & B– you pay the cost of the visit, up to the deductible and then subject to coinsurance.
    - Plans C, D & E – you will pay a copay

28. **Am I paying the negotiated rate when I go for medical care or the actual cost of the care?** When you go to an in-network provider, there is an allowed amount. This is the amount in-network doctors and health care facilities have agreed to accept as full payment on covered services for Blue Cross NC members. It's usually

lower than their normal charge. Out-of-network providers don't have a negotiated rate with Blue Cross NC. You pay on the allowed amount. How much of the allowed amount you pay, will depend if you have copays in your plan and where you are to your deductible and out of pocket maximum.

29. **How do I find out how much a service costs?** You can ask your provider how much a service will cost before receiving the service.

30. **What are the differences in the new plans?** All of the medical plans have the same building blocks, the differences between the plans is where you want to spend your money.

    Premiums – Amount you pay to the City weekly for your medical/prescription drug plan.
    Deductible – Money you pay until the insurance plan start to pay.
    Copay – Fixed amount you pay for office visits and prescriptions.
    Coinsurance - % you pay for services after you pay your deductible.
    Out of Pocket Max– Most you will pay out of your pocket for medical and prescription drug expenses. Once met, the plan will pay the rest of your covered expenses at 100%.

31. **What is the difference between embedded and collective deductibles?** There are two types of deductibles. Individual and Family.

    Individual deductible – This applies to Employee Only Coverage. This is the amount you must pay for services other than copays, before the plan will start to pay. Once you meet this deductible you move to the coinsurance phase.

    Family deductible – This applies to Employee/Spouse, Employee/Child(ren) and Family coverage. This is the amount the family must pay for services other than copays, before the plan will start to pay. Once this deductible is met, the whole family moves to the coinsurance phase. There are two types of family deductibles: Embedded and Collective.

    Embedded Family Deductible - An embedded deductible means that each family member has an individual deductible within a family deductible.
    - When a family member has a health care expense, the money he/she pays toward the individual deductible is also credited toward the family deductible.
    - When one person in the family meets the individual deductible, he/she starts paying coinsurance.
    - The rest of the family must continue to pay deductibles until the family deductible is met before paying coinsurance.
    - The City's plan requires that at least one person in the family meet the individual deductible before the family deductible can be satisfied. After that one person meets the individual deductible, the remaining family deductible can be satisfied by any combination of expenses from the other family members.

Collective Family Deductible - A collective family deductible means the entire family deductible must be met prior to coinsurance benefits for **any** individual plan member. If one person in the family meets the individual deductible, that person does not move to coinsurance until the full family deductible is met.

Plan *A, C, D & E*

- Individual deductible and for employee only coverage.
- Individual deductible and embedded family deductible for employee-sp, employee-children, or employee-family coverage.

Plan B

- Individual deductible for employee only coverage.
- Collective family deductible for employee-sp, employee-children, or employee-family coverage.

*****This provision also applies to the Out-of-Pocket Maximum on these plans.****

32. **Why is the Out-of-Pocket Maximum important?** The Out-of-Pocket Maximum is important if you use a lot of medical and prescription drug benefits or if something catastrophic happens. This is the magic number - when you pay this amount out of your pocket, the plan pays all of your expenses at 100% for the remainder of the year. All of the prescription drugs and medical plan services (copays, deductibles, coinsurance) you pay for contribute to this out-of-pocket maximum. This is your protection in the event something catastrophic occurs, as this is the most you will pay.

33. **Is preventive care still covered in the new plans?** At MyClinic, preventive care and preventive medications are free to all medical plan members in all five plans. Preventive care is covered by BCBS at 100% in network in all five medical plans. The US Preventive Services Task Force, a federal agency, determines what services are preventive. See BlueCross Blue Shield's Preventive Care pages for a list of typically covered services. To be covered with no out-of-pocket costs, the service must be:
    - Provided by an in-network doctor or facility
    - Filed by your doctor as a preventive care visit
    - Identified as preventive care under the Affordable Care Act (ACA)

34. **What if my doctor requests additional procedures during my annual physical?** Additional procedures or diagnostic services may be subject to copayment, deductible or coinsurance. Below are examples of common services your doctor may provide that are not identified as preventive care by the ACA so they are not 100% covered. These services may cost you money at your doctor's office or lab:

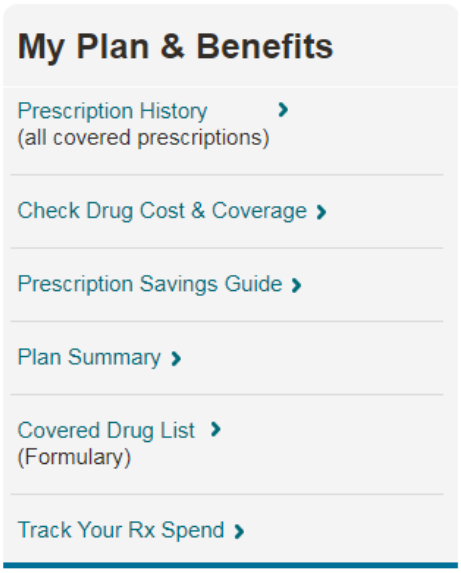
    Urinalysis, hormone tests, vitamin D tests, chest x-rays, thyroid tests, EKGs (electrocardiograms)

    ***NOTE:** You should feel free to ask questions about your health. Tell your doctor that you are on a preventive care visit when you want to ask about a problem you are having. If you do not, your doctor may label the discussion as diagnostic (and not preventive), which may cost you money.

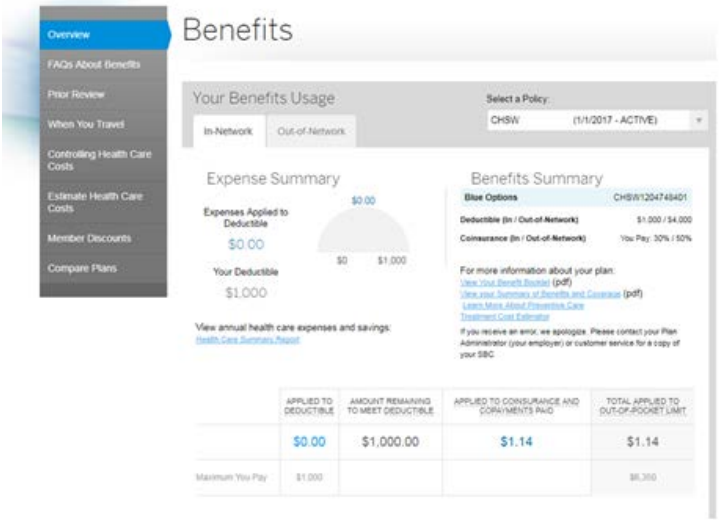
35. **How can I tell what my medical and prescription drug costs are?**

Regardless which plan you choose, it's important to know what your plan costs are, as you are responsible for copays, deductibles and coinsurance. If you are considering the Health Savings Account Plans A or B this information is important since you will be responsible for the costs of services and prescription drugs up to the deductible. In Plan C you will be responsible for the costs of medical services up to the deductible. In all plans you are responsible for the deductible and coinsurance expenses. To find out what you have paid in 2017 and determine what expense you may have in 2018, visit BCBSNC or CVS/Caremark.

CVSCaremark
www.cvscaremark.com
Log in or create your account



BlueCross BlueShield North Carolina
www.bcbsnc.com
Log in or create your account



Health Savings Account

36. **How do I use the money in my HSA account?** You will be sent a Health Equity Welcome Kit which will include instructions on setting up your HSA account and a debit card that you can use to pay your qualified medical expenses. Please be aware of the following:

    - You can spend up to the available balance in your HSA; no overdraft is available.
    - The card will not work at ATMs and will typically only work at appropriate medical facilities.
    - The card has a daily spending limit of $2,500.

37. **Do I need to keep my receipts?** The balance in your health savings account is yours and rolls over every year. It is important to treat the record keeping of your HSA as you would your retirement plan, any other savings account or a credit card. Here are some record keeping tips:
    - Make sure you review all of your account transactions. If you see charges you don't understand or that don't belong to you, contact the provider or Health Equity right away.
    - Keep records that allow you to reconstruct how you have spent your money. Disputes or questions about billing and payments can arise even a year or two after a procedure or office visit.
    - Stay prepared for an IRS audit by saving HSA receipts for up to 7 years. You'll also want to maintain records of any deductions claimed on your tax return.

38. **Can I roll my current HSA into the new HSA?** Yes. When you receive your Health Equity HSA Welcome Kit you will be provided with information on how to roll a current HSA account into your 2018 HSA account with Health Equity. It will also be available on the Heath Equity website or by giving them a call directly.

39. **What are the HSA contribution limits for 2018?**
    Employee Only - $3,450
    Family - $6,900
    Catch-up Contribution (age 55 or older) - $1,000
    *This includes employer and employee contributions to the HSA.

40. **Can I use HSA funds for medical expenses incurred out of the country?** Yes, but the card may not work abroad so you may have to pay out of pocket and then be reimbursed from your HSA.

41. **What is a Qualified Medical Expense (QME)?** Qualified medical expenses are designated by the IRS. They include medical, dental, vision and prescription expenses. These are the items you may pay for with your HSA money. To learn more or about QME, please visit: https://learn.healthequity.com/qme/.

42. **Can I elect the Health Savings Account and the PPO?** No, the Health Savings Account is attached to Plan A and Plan B. You cannot be in a PPO plan and contribute to a Health Savings Account per the IRS.

43. **Are there any eligibility requirements to be in a Health Savings Account?** Yes.
    - You cannot be covered by any other health plan that is not a qualified high deductible plan. This also includes your spouse's health insurance.
    - You cannot be enrolled in any part of Medicare.
    - You cannot be enrolled in TriCare.
    - You cannot be claimed as dependent on another person's tax return.
    - Provisions regarding VA medical benefits in the past 90 days.

    Health Equity will be available to answer all of your HSA questions prior and during Annual Enrollment

44. **Can I invest my Health Savings Account?** Just like a traditional savings account, your HSA earns interest which is not taxed. This makes your HSA an effective component of your retirement strategy. Once your account meets a certain threshold, you can invest in mutual funds to maximize your HSA earning potential. You may contact Health Equity for specifics around HSA investment questions.

45. **I'm eligible for retiree medical insurance when I retire, why would I consider a HSA plan?** The City offers retiree medical insurance to employees hired before 7/1/2009. The City does not offer dental and vision insurance to retirees. Another benefit of the HSA is that you can use this money to pay for qualified medical expenses in retirement – that includes medical plan expenses, dental, vision and more. Even if you are eligible for retiree medical insurance, that benefit isn't going to pay all of your expenses, this provides you an opportunity to save for those expenses.

Health Reimbursement Account

46. **Do my HRA dollars roll over from year to year?** HRA dollars do not rollover to the next plan year.

47. **When is my HRA money available?** If you choose the wellness option, half of your HRA money will be in your account in January and the other half in July once you've completed the screening requirement. You can use this money to offset your medical expenses after you have met your deductible.

48. **Can I add money to my HRA?** No, the only money that can go into this account is the money provided to you by the City for your wellness incentive.

Wellness

49. **Are there changes to My Clinic?** The medical plan you choose will determine your MyClinic benefit.
    - If you choose PPO Plan C, D or E – there will be no change for you. All MyClinic services will be free to you and your covered dependents.

    - If you choose Health Savings Account Plan A or B –Preventive care and medications will continue to be free. If you go to the clinic for sick care, you will be charged a $30.00 fee. If you get an acute/sick/non-preventive medication you will be charged $4.00. The IRS rules require you to pay the cost of non-preventive services up to the deductible in these plans, so we are required to charge for those services at the clinic and have set the fair market value at $30 and $4. You can use your HSA funds to pay for these services.

50. **Are there changes to the wellness incentive program?** During Annual Enrollment you will have the choice the elect the wellness incentive or opt out when you make your medical plan election. The medical plan you choose will determine how you receive your incentive.

    - If you choose Health Savings Account Plan A or B – Incentive will be a contribution to your HSA. You will receive half of the incentive in January and the other half in July if you complete the criteria. You can begin using the money in your HSA as soon as it is in the account to offset your expenses. This will provide you with funding early in the year as a start in this new plan.
    - If you choose PPO with Health Reimbursement Account Plan C – Incentive will be a contribution to your HRA, which you can use to offset your medical plan expenses after you meet the deductible.
    - If you choose PPO Plan C, D or E - you will get a savings on your medical plan premium weekly.

51. **What do I have to do to get the incentive?**
    1. Elect the wellness incentive option during Annual Enrollment when you make your medical plan election.
    2. Complete a health screening at your doctor or at MyClinic between 1/1/2018-5/15/2018.

    We have simplified the wellness requirements so that you only have to do a health screening. Health Coaching is available, but optional.

52. **Will MyClinic change to a walk in clinic?** No it's not their model. One of the great benefits of the clinic is that providers only book one person at a time, so they have time to spend with you and deliver the care you need in the amount of time it takes. They are not shuffling patients in and out every 10 minutes and double booking

appointments. For this reason, they are not able to take walk-ins. They can accommodate most same day appointments if you call ahead.

53. **I can't get into the clinic as fast as I want to get into the clinic.** Most appointment requests are scheduled within 2-3 days. If you have a specific request, location, provider, time of day, it may take longer to accommodate your request. Same day appointments are held at the clinics for sick and urgent care. These do require appointments, so if you need sick or urgent care, call MyClinic and they will direct you to the clinic with the earliest opening. If it is taking more than 3-4 days for you to get an appointment, please notify the HR Benefits Division at benefits@charlottenc.gov.

54. **What should I do if I need to cancel my appointment?** Please call and cancel. Too many employees are not canceling their appointments; they are just not showing up. This is taking appointments away from other employees, including much needed sick and urgent care visits. Please be responsible with this free benefit and courteous of fellow employees and cancel any appointment you cannot attend.

55. **Can I use my previous physical for my wellness incentive health screening?** If your physical is between January 1 – May 15, 2018, yes. Otherwise, you will need to visit MyClinic or your provider during the screening period to complete the screening.

Flexible Spending Accounts

56. **How will the new medical plans affect my Flexible Spending Account?** There is no impact on your dependent care flexible spending, remember though this account is for childcare (daycare) expenses only.

    - If you choose Health Savings Account Plan A or B – you will only have the option of a limited healthcare FSA account. You may only use the limited FSA for dental and vision expenses only. You would use your HSA account for medical and prescription drug expenses. Because these are both tax advantaged accounts, the rules are set by the IRS.

    - If you choose PPO with Health Reimbursement Account Plan C, PPO Plan D or PPO Plan E – There is no change to how you would use the healthcare flexible spending account. You would enroll in the full healthcare flexible spending account and use it for medical, dental and vision expenses.

    Before enrolling in any Flexible Spending Account, be sure to read the benefit documents so you understand how these plans work.

57. **Is the Flexible Spending Account Grace Period Changing?** Yes.
    Currently, the Healthcare Flexible Spending Account has a grace period. You have until March 15 of the following year to incur expenses for the previous year. You have until April 15, to file for reimbursement. In 2018, the grace period is being removed. You may only incur expenses between January 1 – December 31 for your 2018 healthcare flexible spending account money.

58. **If I enroll in the HSA plans, but I have a healthcare FSA right now, what happens?** If you are currently in the health care flexible spending account and you have money in your account after 12/31/17, you may elect the Blue Options Health Savings Account A or B during Annual Enrollment, however, per IRS guidelines, you will not be able to contribute to your HSA until after the grace period runs out on your 2017 FSA. If you spend all of your 2017 FSA money by 12/31/17, there is no limitation on your 2018 HSA contributions.

59. **Can I use my dependent care flexible spending money immediately?** No, the money is only available as you contribute to dependent care flexible spending account.

60. **How will I file dependent care and health care flexible spending accounts in 2018?** Once enrolled in the plans with Health Equity you will receive a welcome packet which will outline how to file claims.

61. **Since the vendors are changing, how will I file my 2017 flexible spending account claims?** Claims submitted after 12/31/2017 must be submitted by a paper claim form, your debit card will no longer work. For questions about your 2017 Flexible Spending Account, contact Flexible Benefit Administrator at 800-437-3539.

62. **Can I enroll in the FSA plans if I am not on City medical insurance?** Yes.

Voluntary Benefits

63. **Why is the City moving from Aflac to VOYA?** Every 3-5 years, the City undergoes a competitive bid process for benefit partners. After completion of the voluntary benefit process in 2017, Voya offered enhanced benefits with competitive rates and was chosen to be the benefit provider for the accident, critical illness and hospital indemnity products.

64. **If I participate in the current AFLAC Critical Illness or Accident Plan, what will happen to my coverage?** You will automatically be enrolled in the new plan through Voya at your current benefit amount during Annual Enrollment. If you cover a spouse or dependent, you will NEED TO list your spouse and/or dependents in SmartBen during Annual Enrollment in order to continue the coverage on them. If you do not want the Voya plans, you will need to waive these benefits during Annual Enrollment.

65. **What do I need to do if I want to keep my Aflac plan?** Aflac mailed letters to current plan participants in early October with instructions on how to transfer your current coverage directly through Aflac. You can contact AFLAC directly to transition your policy directly with AFLAC. You will NEED TO waive the Voya coverage in SmartBen during Annual Enrollment if you do not want the Voya coverage.

66. **What do I need to do if I want to switch to VOYA?** This will happen automatically. You will just need to list your dependents during Annual Enrollment if you cover any.

67. **I don't have any of these plans, can I get them during Annual Enrollment?** Yes, all of the voluntary benefits are available for you to enroll in during Annual Enrollment.

Other Benefits

68. **Are there changes to sick leave?** No. There aren't any changes to Sick Leave.

69. **Will the view of my paycheck stub details change?** You will no longer be able to tell by your paycheck, what medical plan and tier you have, you will only see your medical plan election and deduction amount on your pay advice in 2018. You will need to log into SmartBen to see the plan you enrolled in and who you cover.

70. **Are there any changes to the dental plan?** There are no changes to the dental plan coverage. The Basic Dental Plan rates are increasing by $2 per month. There is no change to the Plus Dental Plan rates.

Additional Questions Asked

This section will be updated when additional questions are asked that are not addressed above. Check back for updates.