



c/o Amwins Group Benefits
50 Whitecap Drive
North Kingstown, RI 02852

City of Charlotte

Retiree Benefits Program
Your Retiree Health Benefits

City of Charlotte Retiree Medical and Prescription Drug Plan Benefits

As the insurance administrator of the City of Charlotte's Retiree Medical Program, Amwins Group Benefits, LLC, a division of Amwins Group Inc, is pleased to contact you regarding your eligibility for retiree medical and prescription drug insurance. The program is available to qualified City retirees and their dependents, who are age 65, no longer working, eligible for Medicare and enrolled in Medicare Parts A and B. You **must** be enrolled in Medicare Part A and B in order to stay on the City's medical and prescription drug plan. If you have not already done so, please contact your local Social Security office for information on enrolling in Medicare Parts A and B. You can also contact Social Security at 1-800-772-1213 or apply online at: <https://www.ssa.gov/medicare/sign-up>

Plan Options Available

The City of Charlotte offers retirees and their eligible dependents the option to enroll in one of two medical plans paired with a prescription drug program.

Plans offerings are underwritten by the following carriers:

- Retiree Medical Medicare Supplemental Plan is underwritten by Transamerica Life Insurance Company.
- Medicare Advantage Plans is underwritten by Humana.
- Prescription Drug Coverage is underwritten by Express Scripts Medicare and is paired with the medical options above. This plan is a Medicare Part D Plan.

You have the option to enroll in either one of the medical plans above with the prescription drug coverage. These benefits are explained in further detail throughout this enrollment kit. If you have questions, please direct your calls to Amwins Group Benefits, LLC's Customer Care Center by dialing the number provided below.

How to Enroll

- Review the information enclosed in this booklet and decide which coverage option you would like to enroll in.
- Complete and sign the enclosed **2025 City of Charlotte Retiree Health Program Election Form**.
- Return the above form in the **postage-paid return envelope**.
 - Completing and returning this form enrolls you in Transamerica's Retiree Medical plan or Humana MA plan with the Express Scripts Medicare Prescription Drug Plan. **Materials must be received to activate your benefits.**

If you choose to opt out of the City of Charlotte retiree plan, complete the enclosed **Waiver of Coverage** and return in the postage-paid return envelope.

We look forward to serving you and assure you that your retiree health program is in excellent hands with Amwins as your plan administrator.

For questions on your enrollment, contact Amwins:

1-855-483-5988 | Monday - Friday, 8 a.m. to 8 p.m. ET | www.cityofcharlotte.Amwins.com

The above materials must be received prior to your Effective Date to activate your benefits



Retiree Medicare Supplement Medical Option 1

Underwritten by Transamerica Life Insurance Company

Plan summary shown on the following pages reference the City of Charlotte Retiree Medical plan underwritten by Transamerica Life Insurance Company.

Retiree Medicare Supplement Medical Option 1

Retiree Medical Plan underwritten by Transamerica Life Insurance Company

Deductibles & Coinsurance / Copays

	You Pay
Part A Deductible	20%
Part B Deductible	\$28
Part B coinsurance	4%
Part B Out-of-Pocket Max	\$2,500 (includes Part B Deductible)
Lifetime Maximum	Unlimited

Medicare (Part A) - Hospital Services - Per Benefit Period ⁽¹⁾

In general, Medicare Part A covers hospital care, skilled nursing care (even if received in a nursing home) and some health services.

	Plan Pays	You Pay
First 60 days	80% of Part A Deductible	20% of Part A Deductible
61 st through 90 th day	\$400 per day	\$0
91 st through 150 th day (Reserve days)	\$800 per day	\$0
Additional 365 days	100% of Medicare Eligible Expenses	\$0

SKILLED NURSING FACILITY CARE

First 20 days	\$0	\$0
21st through 100th day	80%	20%
101st day and after	\$0	All costs

BLOOD

First 3 pints	80%	20%
Additional amounts	\$0	\$0

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**Once you have been billed the first dollars of Medicare-Approved amounts for covered services (which are noted with two asterisks), your Medicare Part B Deductible will have been met for the calendar year.

Retiree Medicare Supplement Medical Option 1

Medicare (Part B) - Medical Services - Per Calendar Year

In general, Medicare Part B covers services such as lab tests, surgeries, doctor visits and medical supplies considered medically necessary to diagnose or treat a disease or condition.

	Plan Pays	You Pay
First dollars of Medicare-approved amounts ⁽²⁾	Part B Deductible (except \$28)	\$28
Next Medicare-approved amounts	16% until \$2,500 OOP Max is met	4% until \$2,500 OOP Max is met
Outpatient Mental Illness – for most outpatient mental illness services	32%	8%
Part B Excess Charges	0%	100%

BLOOD

First 3 pints	All costs	\$0
Next dollars of Medicare-approved amounts ⁽²⁾	Part B Deductible (except \$28)	\$28
Next Medicare-approved amounts	16% until \$2,500 OOP Max is met	4% until \$2,500 OOP Max is met

CLINICAL LABORATORY SERVICES

Blood tests for Diagnostic Services	\$0	\$0
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Medicare Parts A & B

HOME HEALTH CARE

Medically necessary skilled care services and medical supplies	\$0	\$0
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DURABLE MEDICAL SERVICES

First dollars of Medicare-approved amounts	Part B Deductible (except \$28)	\$28
Next Medicare-approved amounts	16% until \$2,500 OOP Max is met	4% until \$2,500 OOP Max is met

Other Services – Not Covered by Medicare

FOREIGN TRAVEL - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:

First \$250 each calendar year	\$0	\$250
Remainder of charges	80% to a lifetime maximum of \$50,000	20% and amounts over the \$50,000 lifetime max

Benefits are paid only for those expenses which have been approved as eligible by the federal Medicare program.

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.



Medicare Advantage PPO Plan Medical Option 2

Underwritten by Humana

Plan summary shown on the following pages reference the City of Charlotte Medicare Advantage Plan underwritten by Humana.



Monthly Premium, Deductible and Limits

PLAN COSTS

Monthly premium

You must keep paying your Medicare Part B premium.

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

Medical deductible

\$28 per year for some combined in- and out-of-network services

Medical Maximum out-of-pocket responsibility

The most you pay for copays, coinsurance and other costs for medical services for the year.

In-Network Maximum Out-of-Pocket

\$2,500 out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Uniform Flexibility Non-Emergency Medical Transportation; Vision Services (Routine) and the Plan Premium do not apply to the in-network maximum out-of-pocket.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Combined In and Out-of-Network Maximum Out-of-Pocket

\$2,500 out-of-pocket limit for Medicare-covered services.

In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Transportation (Routine); Uniform Flexibility Non-Emergency Medical Transportation; Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket.

Out-of-Network Exclusions: Part D Pharmacy, Hearing Services (Routine); Podiatry Services (Routine); Transportation (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.

Your limit for services received from in-network providers will count toward this limit.

If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	\$320 per admit	\$320 per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	4% of the cost	4% of the cost
Diagnostic mammography	4% of the cost	4% of the cost
Observation services	4% of the cost	4% of the cost
Surgery services	4% of the cost	4% of the cost
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	4% of the cost	4% of the cost
Surgery services	4% of the cost	4% of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	4% of the cost	4% of the cost
Specialists	4% of the cost	4% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
This plan covers all Medicare preventative services including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening • Cardiovascular disease behavioral therapy • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes self-management training • Diabetes screening • Glaucoma screening • Hepatitis C screening • HIV screening • Kidney disease education services • Lung cancer screening • Medical nutrition therapy • Obesity screening and therapy • Physical exams (routine) • Prostate cancer screening exam • Smoking and tobacco use cessation • STI screening and counseling • "Welcome to Medicare" preventative visit	Covered at no cost	Covered at no cost
• Immunizations • Medicare diabetes prevention program (MDPP) Any additional preventative services approved by Medicare during the contract year will be covered.	Covered at no cost	Covered at no cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	4% of the cost for Medicare-covered emergency room visit(s)	4% of the cost for Medicare-covered emergency room visit(s)
Urgently needed services - Primary care provider (PCP) - Specialist's office - Urgent care center Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	4% of the cost 4% of the cost 4% of the cost	4% of the cost 4% of the cost 4% of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT Scan) - Primary care provider (PCP) - Specialist's office - Freestanding radiological facility - Outpatient Hospital	4% of the cost 0% of the cost 4% of the cost 4% of the cost	4% of the cost 0% of the cost 4% of the cost 4% of the cost
Diagnostic mammography - Primary care provider (PCP) - Specialist's office - Freestanding radiological facility - Outpatient Hospital	4% of the cost 4% of the cost 4% of the cost 4% of the cost	4% of the cost 4% of the cost 4% of the cost 4% of the cost
Diagnostic procedures and tests - Primary care provider (PCP) - Specialist's office - Urgent care center - Freestanding radiological facility - Outpatient Hospital	4% of the cost 4% of the cost 4% of the cost 4% of the cost 4% of the cost	4% of the cost 4% of the cost 4% of the cost 4% of the cost 4% of the cost
EKG screening - Primary care provider (PCP) - Specialist's office	0% of the cost 0% of the cost	0% of the cost 0% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
- Freestanding radiological facility - Outpatient Hospital	0% of the cost 0% of the cost	0% of the cost 0% of the cost
Lab services		
- Primary care provider (PCP) - Specialist’s office - Urgent care center - Freestanding laboratory - Outpatient Hospital	0% of the cost 0% of the cost 0% of the cost 0% of the cost 0% of the cost	0% of the cost 0% of the cost 0% of the cost 0% of the cost 0% of the cost
Nuclear medicine services		
- Freestanding radiological facility - Outpatient Hospital	4% of the cost 4% of the cost	4% of the cost 4% of the cost
Outpatient x-rays		
- Primary care provider (PCP) - Specialist’s office - Urgent care center - Freestanding radiological facility - Outpatient Hospital	4% of the cost 4% of the cost 4% of the cost 4% of the cost 4% of the cost	4% of the cost 4% of the cost 4% of the cost 4% of the cost 4% of the cost
Radiation therapy		
- Specialist’s office - Freestanding radiological facility - Outpatient Hospital	4% of the cost 0% of the cost 0% of the cost	4% of the cost 0% of the cost 0% of the cost
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	4% of the cost	4% of the cost
Routine hearing TruHearing Provider must be used. Contact Customer Service to locate a provider.	\$0 copay for routine hearing exams up to 1 per year. \$2,000 maximum benefit coverage amount for hearing aid(s) (all types) up to 2 per year. Note: Includes 80 batteries per aid and 3 year warranty.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
DENTAL SERVICES		
Medicare-covered dental	4% of the cost	4% of the cost
VISION SERVICES		
Medicare-covered vision services	0% of the cost	0% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered diabetic eye exam (1 per year)	0% of the cost	0% of the cost
Medicare-covered glaucoma screening (1 per year)	0% of the cost	0% of the cost
Medicare-covered eyewear (post-cataract)	0% of the cost	0% of the cost
Routine vision EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	\$0 copay for routine exam (includes refraction) up to 1 per year. \$250 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	\$175 combined maximum benefit coverage amount per year for routine exam (includes refraction). \$0 copay for routine exam (includes refraction) up to 1 per year. \$250 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

MENTAL HEALTH SERVICES

Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	\$320 per admit	\$320 per admit
Partial Hospitalization	4% of the cost	4% of the cost
Intensive Outpatient Services	4% of the cost	4% of the cost
Outpatient group and individual therapy visits - Primary care provider (PCP) - Specialist's office - Urgent care - Outpatient Hospital	4% of the cost 0% of the cost 4% of the cost 0% of the cost	4% of the cost 0% of the cost 4% of the cost 0% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays \$0 after 100 days.	\$0 copay per day for days 1-20 \$40 copay per day for days 21-100	\$0 copay per day for days 1-20 \$40 copay per day for days 21-100
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	4% of the cost	4% of the cost
TRANSPORTATION		
Routine Transportation	\$0 copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges
Uniform Flexibility Non-Emergency Medical Transportation	\$0 copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip.	The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	4% of the cost	4% of the cost
• Outpatient Hospital	4% of the cost	4% of the cost
Medicare Part B covered drugs		
• Primary care provider (PCP)	4% of the cost	4% of the cost
• Specialist's office	4% of the cost	4% of the cost
• Outpatient Hospital	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost
Medicare Part B insulin drugs		
• Primary care provider (PCP)	4% of the cost	4% of the cost
• Specialist's office	4% of the cost	4% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
• Outpatient Hospital	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost

You will pay no more than \$35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to Part B insulin.

ACUPUNCTURE SERVICES

Medicare-covered acupuncture visit(s) for chronic low back pain	4% of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	4% of the cost for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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ALLERGY

Allergy shots & serum

• Primary care provider (PCP)	4% of the cost	4% of the cost
• Specialist's office	4% of the cost	4% of the cost

CHIROPRACTIC SERVICES

Medicare-covered chiropractic visit(s)	4% of the cost	4% of the cost
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DIABETES SERVICES AND SUPPLIES

Continuous glucose monitor (CGM)

• Durable medical equipment provider	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost

Diabetes management training

• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Outpatient hospital	0% of the cost	0% of the cost

Diabetes monitoring supplies

• Durable medical equipment provider	4% of the cost	4% of the cost
• Pharmacy	0% of the cost	0% of the cost
• Preferred diabetic supplier	\$0 copay	Not Covered

Diabetes screening

• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
FOOT CARE (PODIATRY)		
Medicare-covered foot care	4% of the cost	4% of the cost
Routine foot care	\$0 copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	\$0 copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
HOME HEALTH CARE		
	0% of the cost	0% of the cost
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment		
• Durable medical equipment provider	4% of the cost	4% of the cost
• Pharmacy	4% of the cost	4% of the cost
Medical supplies (includes but not limited to: catheters, IV set-up and supplies)		
• Medical supply provider	0% of the cost	0% of the cost
• Pharmacy	0% of the cost	0% of the cost
Prosthetics (artificial limbs or braces)		
• Prosthetics provider	4% of the cost	4% of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits		
• Primary care provider (PCP)	4% of the cost	4% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Urgent care	4% of the cost	4% of the cost
• Outpatient hospital	0% of the cost	0% of the cost
REHABILITATION SERVICES		
Audiology Therapy		
• Specialist's office	4% of the cost	4% of the cost

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Cardiac rehabilitation		
• Specialist's office	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Occupational therapy		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Physical therapy		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Pulmonary rehabilitation		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Speech therapy		
• Specialist's office	4% of the cost	4% of the cost
• Comprehensive outpatient rehab facility	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
RENAL DIALYSIS		
Renal dialysis services		
• Dialysis center	4% of the cost	4% of the cost
• Outpatient hospital	4% of the cost	4% of the cost
Kidney disease education services		
• Primary care provider (PCP)	0% of the cost	0% of the cost
• Specialist's office	0% of the cost	0% of the cost
• Outpatient hospital	0% of the cost	0% of the cost
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	\$0 copay	Not Covered
Specialist	4% of the cost	Not Covered

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Urgent care services	\$0 copay	Not Covered
Substance abuse or behavioral health services	\$0 copay	Not Covered

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Additional Benefits

FITNESS AND WELLNESS

Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

HEALTH EDUCATION SERVICES

Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

POST-DISCHARGE SERVICES

\$0 copay for the following benefits per discharge event following each inpatient or skilled nursing facility stay:

- Assistance from a qualified aid to help perform activities of daily living within the home. Minimum of 4 hours per day, up to a maximum of 8 hours. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.
- 2 meals per day for 14 days, up to 28 meals delivered to your door.
- Transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle.

Services must be provided by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

SMOKING CESSATION (ADDITIONAL)

A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.

The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Note: This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: [Humana.com/PAL](https://www.humana.com/PAL).



Prescription Drug Plan

Underwritten by Express Scripts Medicare

This plan will be combined with the medical plan option of your choice

Plan summary shown on the following pages reference the City of Charlotte Prescription Drug Plan underwritten by Express Scripts Medicare.

Benefit Overview

Express Scripts Medicare® (PDP)

YOUR 2026 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Deductible Stage	Your yearly deductible is \$100			
MOP	\$2,100 Maximum Out of Pocket			
Initial Coverage Stage	After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reaches \$2,100:			
	Tier	Retail One-Month (31-day) Supply	Retail Three-Month (90-day) Supply (Standard)	Home Delivery Three-Month (90-day) Supply
	Tier 1: Generic Drugs	\$12 copay	\$30 copay	\$30 copay
	Tier 2: Preferred Brand Drugs	\$40 copay	\$100 copay	\$100 copay
	Tier 3: Non- Preferred Brand	50% (\$125 Max)	50% (\$250 Max)	50% (\$250 Max)
	Tier 4: Specialty	50% (\$125 Max)	50% (\$125 Max – 30 Day Only)	50% (\$125 Max – 30 Day Only)
	If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive. You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts PharmacySM. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.			
Non-part D Drugs	Covered; Excluding lifestyle.			
Compound	Compound Management Solution applies. Compound Management Solution is in place to mitigate compound drug abuse by means of inclusion and exclusion lists			
Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs reach \$2,100.00, you will pay \$0.00 .			

IMPORTANT PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **www.Express-Scripts.com**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- To access your plan's list of covered drugs, visit our website at **www.Express-Scripts.com**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you may need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is \$0.00.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract. Enrollment in Express Scripts Medicare depends on contract renewal.

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2026 Retiree Medical Insurance Monthly Premiums

Level of Coverage	Amwins Supplement Plan (Transamerica / Express Scripts)	Amwins Advantage Plan (Humana / Express Scripts)	BCBS Plan D Options PPO & Amwins Plan	BCBS Plan E Options PPO & Amwins Plan	High Performance Network
20+ years of City service & hired before 1/1/2002 OR Disability Retirement prior to 11/1/2010 OR Retired Prior to 1-1-1991					
Medicare Supplement Retiree Only	\$194.97				
Medicare Supplement Retiree & Medicare Spouse	\$433.26				
Medicare Advantage Retiree Only		\$142.12			
Medicare Advantage Retiree & Medicare Spouse		\$315.83			
Retiree no Medicare & Spouse Medicare			\$727	\$1,068	\$534
Retiree/Child(ren) no Medicare & Spouse Medicare			\$913	\$1,338	\$666
Medicare Retiree & Spouse no Medicare			\$727	\$1,068	\$534
Medicare Retiree & Child(ren) no Medicare			\$511	\$771	\$384
Medicare Retiree & Family no Medicare			\$913	\$1,338	\$666
Medicare Retiree/Spouse & Child(ren) no Medicare			\$913	\$1,338	\$666
15<20 years of City service & hired before 7/1/2009 or 20 years of City service & hired between 1/1/2002-6/30/2009					
Medicare Supplement Retiree Only	\$194.97				
Medicare Supplement Retiree & Medicare Spouse	\$628.23				
Medicare Advantage Retiree Only		\$142.12			
Medicare Advantage Retiree & Medicare Spouse		\$457.95			
Retiree no Medicare & Spouse Medicare			\$1,681	\$2,950	\$1,245
Retiree/Child(ren) no Medicare & Spouse Medicare			\$2,288	\$4,046	\$1,696
Medicare Retiree & Spouse no Medicare			\$1,681	\$2,950	\$1,245
Medicare Retiree & Child(ren) no Medicare			\$1,021	\$1,763	\$755
Medicare Retiree & Family no Medicare			\$2,288	\$4,046	\$1,696
Medicare Retiree/Spouse & Child(ren) no Medicare			\$2,288	\$4,046	\$1,696
10<15 years of City service & hired before 7/1/2009					
Medicare Supplement Retiree Only	\$433.26				
Medicare Supplement Retiree & Medicare Spouse	\$866.52				
Medicare Advantage Retiree Only		\$315.83			
Medicare Advantage Retiree & Medicare Spouse		\$631.66			
Retiree no Medicare & Spouse Medicare			\$2,418	\$4,366	\$1,796
Retiree/Child(ren) no Medicare & Spouse Medicare			\$3,025	\$5,462	\$2,247
Medicare Retiree & Spouse no Medicare			\$2,418	\$4,366	\$1,796
Medicare Retiree & Child(ren) no Medicare			\$1,758	\$3,179	\$1,306
Medicare Retiree & Family no Medicare			\$3,025	\$5,462	\$2,247
Medicare Retiree/Spouse & Child(ren) no Medicare			\$3,025	\$5,462	\$2,247

The City requires documentation to add dependents who are not currently covered under the City's plans.

Dependent	Required Documentation
Adopted Child	Proof of adoption or adoption placement – Copy of legal adoption papers indicating adoption petition has been filed
Child(ren) (Natural)	Proof of birth – Copy of birth certificate with parent's name listed
Disabled Child	Proof of birth – Copy of birth certificate with parent's name listed AND Handicap certification – from medical professional
Grandchild	Proof of legal custody or guardianship – Copy of custody papers or legal guardian papers
Other Child	Proof of legal custody or guardianship – Copy of custody papers or legal guardian papers
Stepchild	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
Spouse	Proof of marriage – Copy of marriage certificate AND Secondary Proof of Current Spousal Relationship Status (must show employee's and spouses names and current address) Secondary Documentation MUST be Current: • Federal income tax return or • Joint bank/credit account statement or • Joint mortgage/lease agreement or • Mortgage statement or • Property tax document or • Rental/lease agreement or • Homeowners/renters insurance policy or • Loan obligation

***NOTE:** New Dependents can only be added at Open Enrollment or with a Family Status Change

2026 CITY OF CHARLOTTE RETIREE HEALTH PROGRAM ELECTION FORM
Plans Underwritten by Transamerica Life Insurance Company or Humana, and Express Scripts Medicare

Retiree Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Gender	Phone Number
State	Zip Code	Medicare ID# <i>(From Medicare ID card):</i>	
Hospital (Part A) effective date <i>(From Medicare ID card):</i>		Medical (Part B) effective date <i>(From Medicare ID card):</i>	
Email Address			
Spouse Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Gender	Phone Number
State	Zip Code	Medicare ID# <i>(From Medicare ID card):</i>	
Hospital (Part A) effective date <i>(From Medicare ID card):</i>		Medical (Part B) effective date <i>(From Medicare ID card):</i>	
Email Address			
Please Choose Your Coverage			
Retiree or Spouse Only		Retiree & Spouse	
☐ Transamerica Retiree Medical Supplement & Express Scripts Prescription Drug Coverage		☐ Transamerica Retiree Medical Supplement & Express Scripts Prescription Drug Coverage	
☐ HUMANA Medicare Advantage PPO & Express Scripts Prescription Drug Coverage		☐ HUMANA Medicare Advantage PPO & Express Scripts Prescription Drug Coverage	
Please complete the following information:			
Do you currently have any Medicare Supplement policies or Medicare Advantage Policies in force?			
Retiree/Surviving Spouse (if enrolling):		Spouse (if enrolling):	
If YES, with which company?			

*Please note: a permanent U.S. residence address is required to participate in a Medicare Supplement Plan or Medicare Advantage Plan. Medicare Advantage plan participants cannot use a PO Box or Foreign Address.

2026 CITY OF CHARLOTTE RETIREE HEALTH PROGRAM ELECTION FORM

Please complete the following information:

A couple of questions to help us manage your plan:

**If you answered "yes" to this question and you don't need regular dialysis anymore or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.*

Do you have End-Stage Renal Disease (ESRD)?*

☐ Yes ☐ No

If yes, how long have you been Medicare for ESRD?

Start Date: ___/___/___ End Date: ___/___/___

FRAUD WARNING

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Warning:

AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

MD Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD.

DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Release of Information:

By joining this medical plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled.

I understand that my signature (or that of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare.

2026 CITY OF CHARLOTTE RETIREE HEALTH PROGRAM ELECTION FORM

Date:	Retiree Signature:
Date:	Spouse/Surviving Spouse Signature:
If you are an authorized representative, you must sign above and provide the following information: Name: _____ Address: _____ Phone Number: _____ Relationship to Retiree: _____	

**Please return signed election form to:
Amwins Group Benefits
50 Whitecap Drive, North Kingstown, RI 02852**

**For Customer Service, please call: 1-855-483-5988
Monday through Friday, 8:00 AM to 8:00 PM EST**

WAIVER of COVERAGE

If you DO NOT wish to enroll in the City of Charlotte Plan(s), please complete, sign and return this Waiver of Coverage form.

Retiree		Spouse (or Surviving Spouse)	
Name:		Name:	
Address:		Address:	
City:		City:	
State:	Zip Code:	State:	Zip Code:

Please Sign & Date Below:	
NO, DO NOT ENROLL ME (us) in the City of Charlotte Plan(s). I (we) understand that by choosing this option, I am (we are) declining medical and prescription drug coverage. I also understand that I cannot re-enroll until the next Open Enrollment period unless I have a qualified family status change. I must complete the enrollment form within 31 days of the qualified family status change.	
Retiree:	Date:
Spouse (or Surviving Spouse):	Date:
All applicable signatures are required for individuals declining coverage in the Plan.	

[illegible]

ANSWERS to YOUR QUESTIONS

Q: Who can I call if I have questions?

A: Please contact the Amwins Group Benefits Customer Care Center toll-free at 1-855-483-5988, Monday through Friday, from 8 a.m. to 8 p.m. EST or visit cityofcharlotte.amwins.com.

Q: Can my age 65 spouse enroll if I am not yet age 65?

A: Yes. As long as your spouse is eligible to participate in the Program and is age 65 or over. As soon as you become Medicare eligible, you can enroll on the first day of the month in which you reach your 65th birthday.

Q: My spouse is not yet 65. What will happen to coverage for my spouse after I enroll in this plan?

A: Your spouse will continue coverage under the pre-Medicare early retiree plan. Two months prior to your spouse attaining age 65, a Medicare enrollment packet will be mailed. At that time, your spouse should contact Social Security to enroll in Medicare Parts A and B in order to be eligible to enroll in the group Retiree Medicare Supplement Plan.

Q: Will I have to re-enroll in the Plan next year?

A: No, once you enroll, you remain in the plan until you elect or terminate coverage.

Q: When will I receive my ID Cards?

A: ID cards will be sent once we process your enrollment materials. Medical and Prescription Drug ID cards will arrive in two separate packages.

Q: How are my medical claims paid?

A: As long as your physician accepts Medicare you will not have to send in any claim forms. Present your ID card along with your Medicare card to your doctor. Medicare pays the provider of the Medicare portion of your claim and forwards the balance due to the claims administration department. Remaining amounts will be billed to you.

Q: Do I still need my Medicare ID Card?

A: Yes. You will continue to use your Medicare ID card with this plan in conjunction with your Plan ID card.

Q: Do my prescription drug co-payments count toward my medical plan deductible?

A: No. Any co-payments you make for prescription drugs do not count toward deductibles or out of pocket maximum amounts for your medical plan.

Q: How do I get my prescriptions filled?

A: Simply present your ID card and prescription to a participating pharmacy in the plan network. You will also receive information about mail order prescriptions when you enroll. You can find more information about your prescription coverage by visiting www.Express-Scripts.com or by calling Amwins Group Benefits at 1-855-483-5988.

Q: Where can I get information on using Mail Order Services?

A: Once you enroll in the plan, you will receive a fulfillment kit in the mail which will include mail order through the Express Scripts Pharmacy. Please be aware that you will need to obtain new prescriptions from your Doctor before ordering prescriptions from this new mail order program. The necessary forms and instructions on how to order prescriptions through the mail order service will be included in your fulfillment packet. Please expect your package and materials to arrive shortly before your plan effective date.

ANSWERS to YOUR QUESTIONS

Q: How can I find out if my drugs are covered on the new plan?

A: You will receive a copy of the formulary (List of Covered Drugs) in your fulfillment packet once you enroll. Some covered drugs may have additional requirements or limits on coverage. You can find out if your drug has any additional requirements or limits by reviewing the formulary. If your drug is not included on the formulary, you should first contact us and ask if your drug is covered. Please contact Amwins Group Benefits Customer Care toll-free at **1-855-483-5988** or visit **cityofcharlotte.Amwins.com** for more information about your prescriptions.

Q: How can I lower my drug expenses?

A: Generic medications often cost less than brand-name counterparts. Talk to your doctor to determine if a generic is available. You may also have the option of mail order, where you can receive up to a 90-day supply for one mail order co-payment.

Q: What services are not covered?

A: Services not covered by Medicare are not covered by the Retiree Medicare Supplement plan. Please contact us for the Medicare exclusion list. You may also call 1-800-MEDICARE or visit www.medicare.gov.

Q: If I choose not to enroll this year, can I enroll next year?

A: Yes, you will have the opportunity to enroll in the group plan at the next open enrollment, or if you have a qualified family status change.

Q: Do I have the option to enroll in just medical or prescription drug coverage or do I have to enroll in both plans?

A: The City's health benefit plan combines two separate plans into one package which includes both medical and prescription drug coverage. You may not elect the prescription drug coverage without participating in the City's medical plan, or vice versa. The premium for medical insurance includes the prescription drug benefit.

Q: How do I pay for my coverage?

A: Your premium is deducted from your retiree benefit check.

Q: Can I enroll in a separate Medicare Part D plan and the City's medical and prescription plan?

A: No. You cannot enroll in two Medicare Part D plans. If you enroll in a separate Medicare Part D plan, you are not eligible to enroll in the City's medical plan and prescription drug plan with Transamerica and Express Scripts.

Q: How do I obtain a replacement ID card for my plans through Transamerica and Express Scripts?

A: Call Amwins Group Benefits at 1-855-483-5988, Monday through Friday, from 8 a.m. to 8 p.m. EST.

Q: What happens to coverage for a spouse if the City retiree dies?

A: The spouse or family member of the City retiree should notify City Human Resources as soon as possible. The City will inform Amwins Group Benefits. The Surviving Spouse will remain on the Transamerica and Express Scripts plans. Amwins will direct bill the surviving spouse for the monthly premium due.



Disclaimer: The benefit information contained in this brochure is subject to change at any time, and the City of Charlotte reserves the unlimited right to make benefit plan changes at any time. Any changes to the benefit plans implemented by the City will be considered effective, regardless of whether notice has been given, on the date set by the City. If you are ever in doubt about your retiree medical benefits, please contact Amwins Group Benefits at 1-855-483-5988.