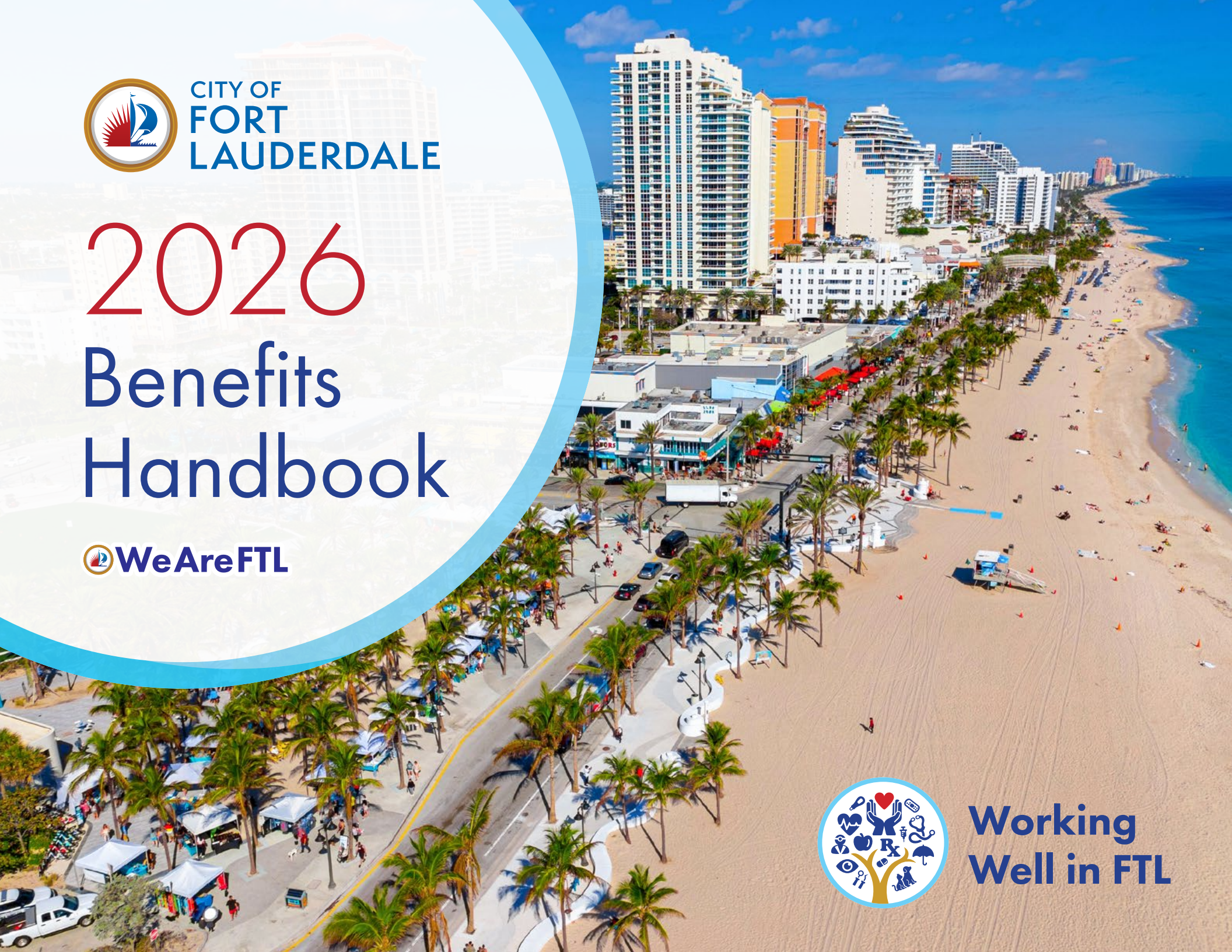
CITY OF FORT LAUDERDALE

2026 Benefits Handbook

WeAreFTL



Working Well in FTL

Welcome

The City of Fort Lauderdale offers eligible employees a comprehensive benefits package that includes medical, dental, vision, life insurance, health care and dependent care flex spending accounts, wellness initiatives, retirement plans and a variety of voluntary benefits. The information included in this handbook is a general summary of available options and also serves to increase your awareness of policies and procedures. If any information in this handbook conflicts with governing plan documents, certificates of coverage, City resolutions, or state/federal laws, the provisions of the governing plan documents, certificates of coverage, City resolutions and state/federal laws will prevail.

Working Well in FTL

Inside

Welcome 2

Eligibility & Enrollment 3

Medical Plans 4

Health & Wellness Center 6

Telehealth (MDLIVE) 7

Employee Assistance Program (EAP) 8

Dental Plans 9

Vision Plans 10

Life and AD&D Insurance 11

Flexible Spending Accounts (FSA) 12

Voluntary Benefits 13

Retirement 14

FAQs 15

Value-Added Benefits 17

Contact Information 18

Eligibility & Enrollment

Full-time employees (both regular full time and temporary full time) are eligible to participate in all group benefits. Variable hour employees, such as part-timers who satisfy the criteria under the Affordable Care Act, are eligible to participate in any of the City's medical plans. Newly eligible employees (i.e. new hires or employees promoted from part time to full time) are eligible for benefits the first day of the month following 30 days from their eligibility date (i.e. date of hire or promotion effective date).

You may also enroll your eligible family members under certain plans you choose for yourself. The type of documentation acceptable, as proof of dependent eligibility, is identified in parentheses below.

- Spouse (official marriage certificate). An ex-spouse is not eligible for coverage under your insurance.
- Domestic partner as established by the City (Affidavit of Domestic Partnership). A domestic partner who is a benefits eligible employee cannot be covered by another benefits eligible employee.
- Your biological child, legally adopted child or a child placed in the home for adoption in accordance with applicable state and federal laws (official birth certificate or copy of official legal documents proving the status such as proof of placement by the Department of Children and Families or the foster care program of a licensed agency).
- Child(ren) of domestic partner (copy of official birth certificate showing the domestic partner as the parent and Domestic Partner Affidavit).
- Your child, if permanently physically and/or mentally disabled may be covered indefinitely beyond the limiting age as long as acceptable proof of the disability is provided to the plans.
- A grandchild up to age 18 months if born while your child is covered under the plan (Florida Statute 627.6575) and the parent remains covered under the plan (copy of birth certificate).

Required Information: When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the City to report this information to the IRS each year. This information will be securely submitted to the IRS and will remain confidential.

Dependent documentation may be uploaded in Selerix BenSelect or by submitting the document(s) to Benefits Section, HR. If the documentation is not readily available, please complete the online enrollment (active employees) and follow-up with the documentation as soon as it becomes available. Your enrollment request will not be processed without the supporting documentation.

Dependent Age Requirements

Medical Coverage: The Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans until the last day of the calendar year that they reach the age of 26.

An overage dependent may continue to be covered under the medical plan until the last day of the calendar year that they reach the age of 30 if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student; and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Dental and Vision Coverage: Dependent children enrolled for dental, vision and life insurance coverage are eligible until the last day of the calendar year that they reach the age of 26.

When Coverage Begins

New Hires: You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following 30 days of employment. If you fail to enroll on time, you will NOT have benefits coverage (except for City-paid benefits).

Open Enrollment: Changes made during Open Enrollment are effective for the following calendar year.

Cost of Benefits

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend upon the plan you select and if you choose to cover eligible family members. Please refer to the separate rate sheet for your contributions.

Health Insurance Imputed Income

The Internal Revenue Code (IRC) allows employees to pay "tax-free" health insurance subsidies for themselves and their eligible dependents as defined under IRC provisions but generally excludes the amount attributable to dependent children after the end of the year in which they turn age 26, domestic partners and children of domestic partners. This excluded amount is referred to as imputed income. Please see the life insurance section for imputed income related to City paid life insurance. The monthly Imputed income is applied to the second paycheck of each month.

How to enroll

To enroll in your benefits, go to benselect.com/FTL. There, you will find detailed information about the plans available to you and instructions for enrolling.

Medical Plans

We are proud to offer you a choice among three different medical plans that provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. The following is a brief description of each plan.

Cigna OAPIN1 Plan and Cigna OAPIN2 Plan

The OAPIN1 and OAPIN2 plans are similar to an HMO, in that you may only visit physicians and hospitals within the OAPIN network. Services received outside the network are not covered, except in the case of emergency medical care. With the OAPIN plans, you are not required to select a Primary Care Physician (PCP). The OAPIN1 plan does not have a calendar year deductible and provides copays for more services than the OAPIN2 plan.

Cigna CDHP with HRA Plan

The Health Reimbursement Account (HRA) allows for in-network and out-of-network coverage. With an HRA, money is funded by the employer, non-taxable to the employee, and can be used for any qualified medical expense incurred under the medical plan, such as deductibles and coinsurance for physician services and hospital expenses. HRA funding is prorated for coverage that is effective after January 1st.

For more information about the medical plans, visit fortlauderdale.gov/benefits.

Medical Plans

Medical Plan Coverage	OAPIN1 (HMO1)	OAPIN2 (HMO2)	Consumer Driven Health Plan (CDHP)	
	In-Network Only	In-Network Only	In-Network	Out-of-Network
City Contribution to Health Reimbursement Account (HRA) (For Active Employees and their Tax Qualified Dependents ONLY)				
Individual / Employee + 1 / Employee + 2 or more	N/A	N/A	$1,200 / $1,800 / $2,400	
Deductible (per calendar year)				
Individual / Employee + 1 / Employee + 2 or more	No deductible	$1,000 / $2,000 / $3,000	$2,000 / $3,000 / $4,000	$2,000 / $3,000 / $4,000
Coinsurance	Varies See Below	Varies See Below	You pay 10%	You pay 30%
Your Out-of-Pocket Maximum (Includes deductible, copays & coinsurance)				
Individual / Employee + 1 / Employee + 2 or more	$5,000 / $7,000 / $10,000	$6,350 / $10,000 / $12,700	$5,000 / $7,000 / $10,000	$5,000 / $7,000 / $10,000
Preventative Services	No Charge	No Charge	No Charge	30% Coinsurance
Hospital and Mental Health (inpatient)	$250/day, $2,500 Annual Max.	Deductible then 20% Coinsurance	Subject to calendar year deductible & coinsurance (HRA applies)	Subject to calendar year deductible & coinsurance (HRA applies)
Primary Care Physician, Specialist Physician, Mental Health (outpatient), and Telehealth	$35	$35		
Maternity	$35 Initial Visit	$35 Initial Visit		
Outpatient Surgery	$500	Deductible then 20% Coinsurance		
Outpatient Diagnostics (X-rays, Ultrasound, etc.)	10% Coinsurance	10% Coinsurance		
Outpatient Diagnostics (CAT & PET scans, MRI)	$200 per test	$200 per test		
Routine Lab	10% Coinsurance	10% Coinsurance		
Emergency Room / Urgent Care	$200 / $50	$200 / $50		
Allergy Treatments / Injections	$10	$10		
Ambulance	No charge	$100 copay		
Prescription Drugs Pharmacy, 30-day supply	$10 generic / $30 preferred $50 non-preferred	$10 generic / $30 preferred $50 non-preferred	Subject to calendar year deductible & coinsurance of 20% generic 30% preferred 50% non-preferred (HRA applies)	Not Covered
Prescription Maintenance Drugs Retail or Mail Order, Mandatory 90-day supply	$20 generic / $60 preferred $100 non preferred	$20 generic / $60 preferred $100 non preferred		
Prescription for Chronic Conditions & Preventative	Generic prescription provided - waiving copays	$50 non-preferred	Generic prescription provided - waiving copays	Not Covered
Vision	Only covers medical conditions; LASIK excluded			

How the HRA Works for Non-Tax Qualified Dependents:

Per IRS Section 125, only tax qualified dependents are eligible to use HRA funds. Non-tax qualified dependents (i.e. adult child dependents (ages 26-30), domestic partners and domestic partner's child(ren)) are not eligible to use HRA funds.

- Non-tax qualified dependents will be enrolled in their own medical plan that is separate from the employee and tax qualified dependents.
- Non-tax qualified dependents will share their own deductible and out-of-pocket maximum that is separate from the employee and tax qualified dependents.
- When non-tax qualified dependents reach their deductible, they share the costs for covered medical expenses with the City (coinsurance) until they reach their out-of-pocket maximum.
- The funding is prorated for coverage effective after January 1.

Health & Wellness Center

The Employee Health & Wellness Center, operated by Marathon Health, is available to all City of Fort Lauderdale employees and dependents ages 6 and up covered on the City's medical plan at no cost.[1]

Known nationally as a trusted health care provider, Marathon Health treats both acute and chronic health conditions. The center also dispenses more than 40 generic medications, provides annual physicals, health coaching, lab work, a registered dietician, and more.

Health care services include:

- Common Illness
- Chronic Conditions
- Women's Health & Men's Health
- Minor Injuries
- Suture Removal
- Allergies
- EKG
- Health Coaching
- Health Assessments
- Nutrition

[1] All tests processed at the Center are at no charge. All other laboratory tests (i.e., urine culture, strep culture, complete blood count, chemistry profile, TSH) will be sent to an external laboratory for processing. The external laboratory will submit a claim to your medical plan for this service, and you may be responsible for a portion of the bill.

Location & Hours of Operation

City of Fort Lauderdale Health and Wellness Center

4750 North Federal Highway, Suite 300
Fort Lauderdale, FL 33308

Telephone: 754-206-2420

Fax: 1-954-867-5583 (must dial 1 in front)

- Monday - Wednesday: 7 am – 4 pm
- Thursday: 7 am – 6 pm
- Friday: 7 am – 4 pm
- Saturday: 8 am – Noon
- Closed on Sundays and City-observed holidays
- Closed daily for lunch 1 pm – 2 pm

To schedule an appointment, call 754-206-2420 or visit the Marathon Health secure website at my.marathon-health.com or use the Marathon Health app. Get the app from Google Play or the App Store. The Center is also offering virtual (video) and telephone visits for many of their regular services, including medical visits, comprehensive health reviews and health coaching.

Telehealth (MDLIVE)

Cigna provides access to MDLIVE telehealth services as part of the City's medical plans.

Telehealth is a convenient phone and video consultation company that provides immediate medical assistance for many conditions. This benefit is provided to all enrolled members. Registration is required and should be completed ahead of time.

This program allows members 24 hours a day, seven days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues.

Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- Sore throat
- Fever
- Rash
- Headache
- Stomach ache
- Cold and flu
- Allergies
- Acne
- UTIs
- And more

MDLIVE Customer Service:
888-726-3171 | MDLIVEforCigna.com

MDLIVE® for Cigna Healthcare

Employee Assistance Program (EAP)

As a City of Fort Lauderdale employee, you and your household members have access to the valuable Cigna Employee Assistance Program (EAP) at no cost.

For a confidential EAP appointment or questions, contact:

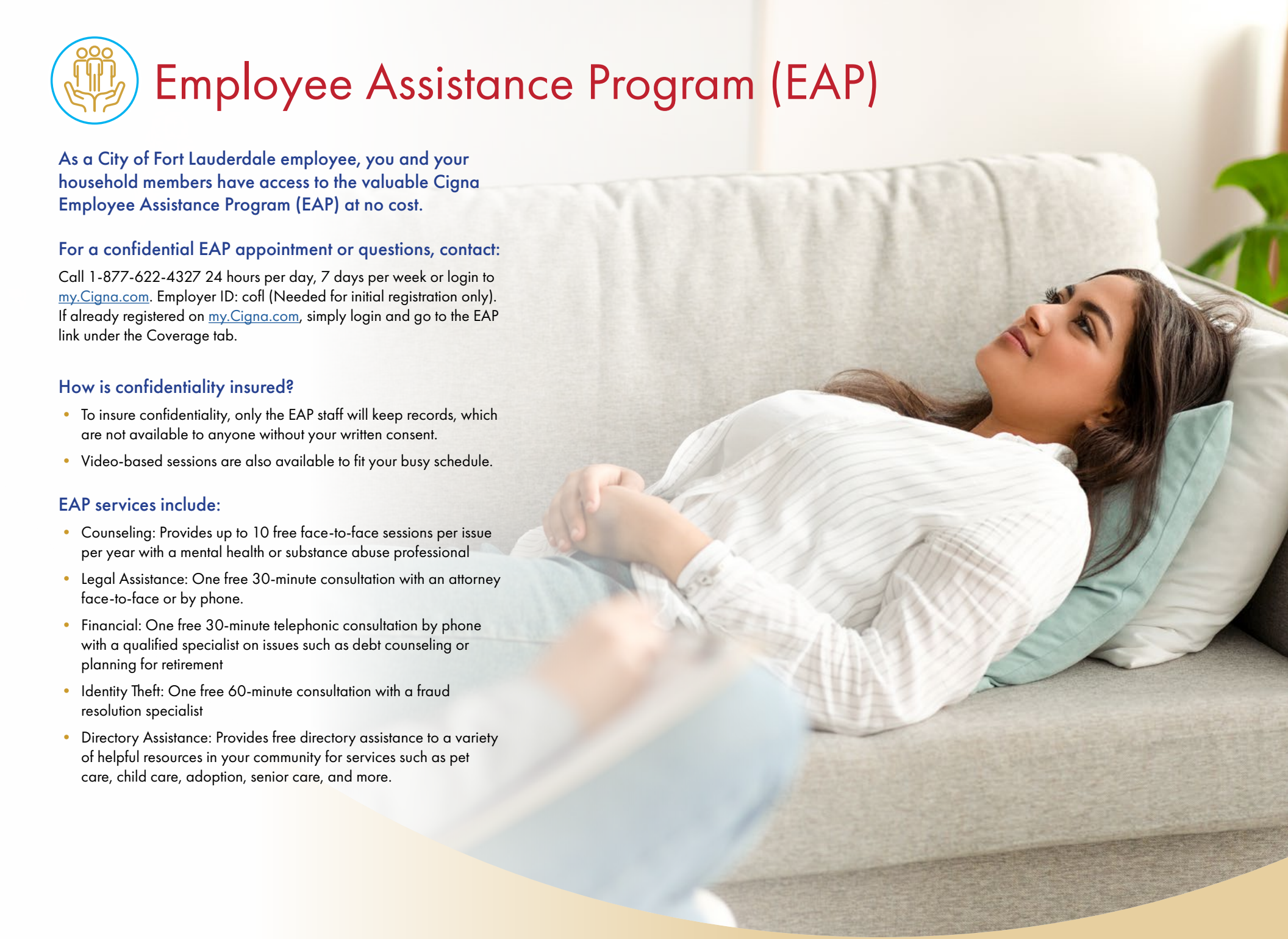
Call 1-877-622-4327 24 hours per day, 7 days per week or login to my.Cigna.com. Employer ID: cofl (Needed for initial registration only). If already registered on my.Cigna.com, simply login and go to the EAP link under the Coverage tab.

How is confidentiality insured?

- To insure confidentiality, only the EAP staff will keep records, which are not available to anyone without your written consent.
- Video-based sessions are also available to fit your busy schedule.

EAP services include:

- Counseling: Provides up to 10 free face-to-face sessions per issue per year with a mental health or substance abuse professional
- Legal Assistance: One free 30-minute consultation with an attorney face-to-face or by phone.
- Financial: One free 30-minute telephonic consultation by phone with a qualified specialist on issues such as debt counseling or planning for retirement
- Identity Theft: One free 60-minute consultation with a fraud resolution specialist
- Directory Assistance: Provides free directory assistance to a variety of helpful resources in your community for services such as pet care, child care, adoption, senior care, and more.



Dental Plans

Cigna Dental DHMO

With this plan, you choose a primary dental provider to manage your care. There are no charges for most preventive services, no claim forms and no deductibles. Reduced, pre-set charges apply to other services.

Cigna Dental DPPO

This plan offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a dentist who participates in the Cigna Dental network. Benefit includes 4 cleanings per year.

The following is a high-level overview of the coverage available.

Key Plan Features	DHMO[1]	DPPO[1]
Participant Maximum	No Maximum	$1,500 Maximum annual benefit per person combined in or out of network
Preventive Services Exam, cleaning, fluoride, x-rays, sealants	$0 Copayments	100% (no deductibles)[1]
Basic Services Fillings, periodontics, endodontics	Refer to Plan	100% (no deductibles) [1]
Major Services Crowns, bridges, dentures	Refer to Plan Copayments	60% (no deductibles)[2]
Orthodontia Up to 24 month treatment, children or adult braces	Refer to Plan Copayments	60% (no deductibles) / $2,500 lifetime maximum
DHMO Participants must select a primary care dentist at cigna.com.		

Cigna DPPO Plan offered to IAFF members only:

Visit www.cigna.com for a list of participating dentists. Non-participating dentists may bill you for charges above the amount covered by your Cigna Dental Plan. Benefit includes 2 cleanings per year.

Below is a very brief summary of the dental plan offered by the City of Fort Lauderdale for IAFF members. For further information, please refer to the Cigna plan documents at www.fortlauderdale.gov/benefits, LauderShare, or contact Cigna.

Key Plan Features	DPPO[1]
Participant Maximum	$1,500 Maximum annual benefit per person combined in or out of network
Preventive Services (Exam, cleaning, fluoride, x-rays, sealants)	100% (no deductibles)
Basic Services (Fillings, periodontics, endodontics)	80% (after $100 deductible)
Major Services (Crowns, bridges, dentures)	50% (after $100 deductible)
Orthodontia (Up to 24 month treatment, children or adult braces)	50% (no deductible) / $1,500 lifetime maximum

[1] Teeth missing prior to coverage under the Cigna Dental plans are not covered.
[2] Please see the applicable summary plan description at www.fortlauderdale.gov/benefits or Laudershare for all limitations and exclusions.

Vision Plans

Vision Service Plan (VSP)

Vision insurance is provided by Vision Service Plan (VSP). Both VSP plans give you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the VSP network.

The following is a high-level overview of the available coverage.

Key Vision Benefits	VSP Core Plan		VSP Buy-Up Plan	
	In-Network Only	Out-of-Network Reimbursement	In-Network Only	Out-of-Network Reimbursement
Exam (once every 12 months)	$10 copay	Up to $40	$0 copay	Up to $40
Lenses (once every 12 months) Single Vision Bifocal Trifocal	 $25 $25 $25	 Up to $30 Up to $50 Up to $60	 $25 $25 $25	 Up to $30 Up to $50 Up to $60
Frames (once every 24 months)	Up to $130	Up to $50	Up to $260	Up to $50
Contact Lenses (once every 12 months in lieu of glasses)	Up to $130 or up to 4 boxes for medically necessary lenses	Up to $100	Up to $260 or up to 8 boxes for medically necessary lenses	Up to $100

vsp VISION

Life and AD&D Insurance

Life insurance[1]

Life insurance provides your named beneficiary(ies) with a benefit in the event of your death. Accidental Death and Dismemberment (AD&D) insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the Life and the AD&D benefit would be payable.

The City provides all active full-time, senior management fellows, and temporary full-time employees with group term life insurance through The Standard at no cost.

Benefit Amount

1x annual salary rounded up to the next $1,000 increment with a minimum of $50,000 and up to a maximum of $300,000.

The amount of coverage will be updated to reflect the employee's base salary as of January 1 of each year or the benefit effective date for new hires. Life Insurance coverage reduces to 65% of coverage beginning at age 70.

Voluntary Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage through The Standard for yourself and your eligible family members.

	Benefit Option	Guaranteed Issue[2]
Employee	$5,000 increments up to a maximum of $400,000	$300,000
Spouse/Domestic Partner	$5,000 up to a maximum equal to employee's voluntary coverage in increments of $500	$50,000
Child(ren)	$10,000 (covers all enrolled children)	Not Applicable

Any new enrollment or coverage increase requested during Open Enrollment from $5,000 - $20,000 of additional coverage will be approved up to the guaranteed issue amount without Evidence of Insurability (EOI). Any increase over the Guaranteed Issue amount will be subject to EOI and requires a completed Medical History Statement. The Medical History Statement form may be completed at myeoi.standard.com/754544 using Group ID #754544.

Spouse/Domestic Partner Coverage

The employee must be enrolled in voluntary group term life insurance to select spouse/domestic partner coverage. A spouse/domestic partner who is a benefits-eligible employee cannot be covered by another benefits-eligible employee.

Child(ren) Coverage

The employee must be enrolled in voluntary group term life insurance to select coverage for their child(ren). If both parents are City employees, they cannot both cover the same child through their insurance plan. A member may not be enrolled as an employee and a child.

[1] Life insurance is a tax-free benefit for amounts up to $50,000. The Internal Revenue Service (IRS) requires you to pay income tax on the value of any amount exceeding $50,000. The IRS-determined value is called imputed income and is applied to the second paycheck of each month.

[2] During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

Flexible Spending Accounts (FSA)

We provide you with an opportunity to participate in up to two different FSAs administered through TASC. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

Health Care FSA

Contribute starting from $260 up to the maximum allowed by the IRS to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions
- Dental treatment
- Orthodontia
- Eye exams/ eyeglasses
- LASIK eye surgery

You MUST re-enroll annually during open enrollment.

New FSA enrollees will be provided with a new benefits debit card from TASC for use for eligible expenses incurred in plan year 2026. Claims incurred through the grace period, which ends March 15, 2027, must be submitted to TASC no later than April 15, 2027. Eligible expenses covered are for you and all of your dependents, even if they are not covered under your primary health plan(s). Any unused FSA funds at the end of the grace period, will be forfeited, also called the use-it-or-lose-it rule.

Dependent Care FSA[1]

A Dependent Care FSA is also a pre-tax account established for employees to benefit tax-wise while paying for eligible daycare expenses in order to work. The IRS limits annual contributions based upon "married filing joint tax returns" or "single head of household" or "married filing separately." Qualified dependents are:

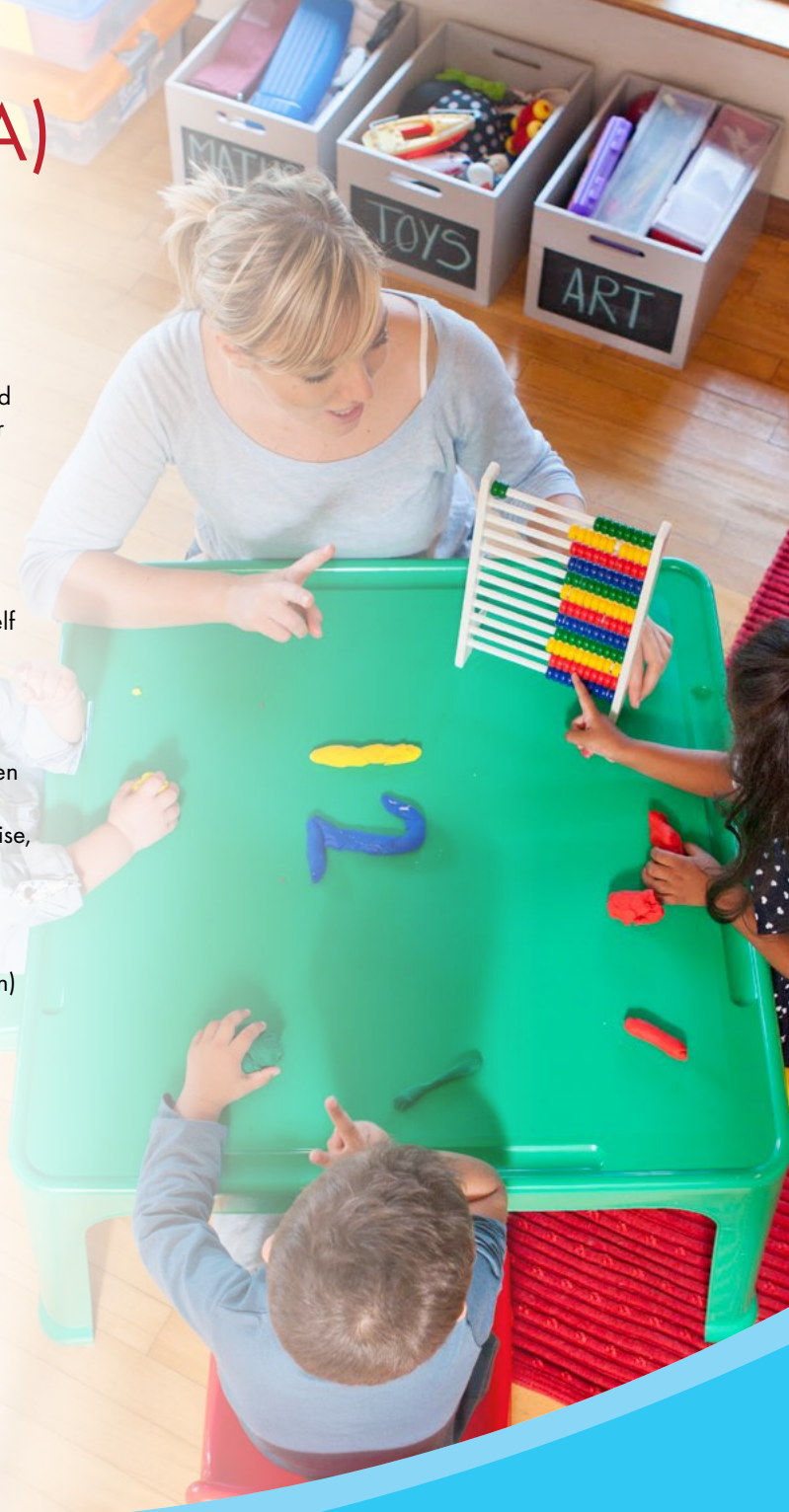
- Children under the age of 13 who share the same residence with you, or
- Your spouse or qualifying child or relative who is physically or mentally unable to care for him/herself who shares the same residence with you whose income is less than the federal exemption amount

Unlike the Health Care FSA, with the Dependent Care FSA, you can only spend up to the amount that has been deducted from your paycheck. With the swipe of your benefits debit card, you can access your funds; otherwise, you can submit manual claims for reimbursement.

Eligible Expenses Include:

- Before school or after school care (other than tuition)
- Custodial care for dependent adults
- Licensed day care centers
- Nursery schools or preschools
- Placement fees for a provider, such as au pair
- Day camp or a private sitter
- Late pick-up fees
- Summer or holiday day camp (not sleepover)

[1] Employee and spouse both MUST work to enjoy the tax benefits of the Dependent Care FSA



Voluntary Benefits

Voluntary Benefits

The City offers Voluntary Benefits that are administered by FBMC Benefits Management to all eligible active employees. These are optional benefit plans that are paid 100% by employees and typically have the advantage of preferred rates.

Aflac Plans

- **Group Hospital Indemnity Insurance (Post-Tax)**
  Provides financial assistance when you are confined to a hospital.
- **Group Accident Insurance (Pre-Tax)**
  Provides financial benefits for covered accidents.
- **Group Short-Term Disability Insurance (Post-Tax)**
  Provides financial benefits in the event of a qualified disability.
- **Group Critical Illness Insurance (Pre-Tax)**
  Provides benefits when diagnosed with a covered critical illness.

ARAG Legal Insurance Plans (Post-Tax)

ARAG provides legal advice and counsel for most covered legal matters within the plan limits.

Beneficiary Designations

You are encouraged to update your Hospital Indemnity, Accident, and Critical Illness insurance beneficiaries when you experience a change in family status such as marriage, death, divorce, etc. You may change your beneficiaries at any time online through Selerix BenSelect at benselect.com/FTL.

Pet Discount Bundle (Post-Tax)

Pet Benefits Solutions service includes 25% discounts on in-house medical services for network vets, up to 40% discounts on pet prescriptions and products, 24/7 pet telehealth with vets and lost pet recovery service.

Cancer Guardian (Post-Tax)

The Genomic Life service includes onsite nurse navigator, cancer support specialists, second opinion pathology review, cancer information phone line, advanced DNA cancer testing and medical records platform.

BeyondMed (Post-Tax)

BeyondMed is a licensed discount plan offering up to 20% savings on elective procedures not covered by insurance, like spa treatments or elective surgeries. Discounts also apply once annual benefit limits (e.g., 20 chiropractic visits) are reached.

To learn more about your voluntary benefits, please visit cofl.fbmcbenefits.com or call 1-866-849-COFL (2635).

Retirement

Florida Retirement System

Eligible employees are enrolled in the Florida Retirement System (FRS). As an employer, the City contributes to this plan on behalf of the employee. In addition, the employee must contribute three percent (3%) of gross pay to FRS. There are two plans offered by FRS: the Defined Pension Plan and the Investment Plan.

Contact: 866-446-9377 | www.myFRS.com

Note: Employees who are represented by the Fraternal Order of Police (FOP)or International Association of Fire Fighters (IAFF) should contact the Police and Fire Retirement Systems Pension office directly for assistance with retiree benefits information ftlaudpfpension.com.

Note: Employees who are participants in the City's 401(a) retirement plan should visit their 401(a) plan site: www.missionsq.org/fortlauderdale or contact the MissionSquare Retirement Representative at MHidalgo@missionsq.org

The City offers a 457 Deferred Compensation program and a Roth IRA to all benefit-eligible employees:

457 Plan through Nationwide or MissionSquare

Employees may set aside a pre-tax or post-tax dollar amount toward retirement savings through automatic payroll deductions. The money contributed to this type of account, including earnings, accumulates on a tax-deferred basis. Employees can change or stop contribution at any time. Employees cannot withdraw money as long as they are employed by the City.

Roth IRA through MissionSquare

Employees may set aside after-tax dollars toward retirement savings through automatic payroll deductions, which does not affect their current taxable income. Withdrawals of contributions will not be subject to income taxes as long as the employee is at least 59 1/2 years of age, and their first Roth contribution was made five years prior to withdrawal. These contributions cannot be converted to pre-tax contributions once made.

There is no employer matching for either of these programs, and both are subject to minimum and maximum participation amounts.

For additional information, employee may contact

MissionSquare Retirement:

- IRA: www.missionsq.org/fortlauderdale
- 457(b) plan: www.missionsq.org/fortlauderdale
- Contact your MissionSquare Retirement Representative at MHidalgo@missionsq.org.

Nationwide Retirement Solutions:

- www.nrsforu.com
- Contact: pinzona@nationwide.com or aaron.schwartz@nationwide.com.

FAQs

IRC Section 125 Change in Status and Qualifying Life Events

What mid-year qualifying events allow me to change benefits outside of Open Enrollment?

The health plans are governed by Internal Revenue Code Section 125 rules and the City's Flexible Benefits Plan document, which permits mid-year plan changes only if certain qualifying events are experienced by the employee or dependent. Therefore, a participant may not revoke any elections made, outside of the annual benefits open enrollment period, except as illustrated in the following qualifying events or Special Enrollment Rights:

Permitted Qualifying Life Events (Mid-Plan Year Changes)	Required Documentation
Loss of coverage for (dependent) child or spouse/domestic partner (DP)	Letter of explanation from Employer or insurance company with cancellation date of coverage/ discharge paper
Gain of coverage for (dependent) child or spouse/DP	Letter of explanation from Employer or insurance company with start date of coverage/ enlistment papers.
Marriage/New Domestic Partnership	Marriage Certificate or Domestic Partner Affidavit
Divorce/Termination of Domestic Partnership (DP)	Divorce decree or Letter from employee stating they are terminating their Domestic Partnership with the name of their DP and the termination effective date included
Death (dependent) child or spouse/DP	Death certificate
Adoption/ Birth of a child (60 days for newborns)	Birth certificate (when it becomes available) / Finalized Adoption agreement or letter from placement agency
Significant change in health coverage due to spouse's, DP's or dependent's employment	Letter of explanation from employer or insurance company
Court Order	Court Order
Medicare (self and/or spouse/DP)	Copy of Medicare card showing effective date or another form of
Medicaid/CHIP (self, spouse/DP and/or dependent)	Copy of Medicaid/CHIP card or relevant letter indicating effective date

What is the consistency rule governing change in status requests?

IRC Section 125 requires that any change in status requests processed must be consistent with the qualifying event. For example, if the employee gets a divorce, it would be a qualifying event to remove the ex-spouse, but not to add existing dependent children who were not on the employee's plan. Another example is the event of a deceased spouse. It would be a qualifying event to remove the deceased spouse and add the existing dependents, if they were enrolled under the spouse's health plan, within 30 days from the date of death.

How do I make a Qualified Life Event (QLE) change to my benefits outside of the annual open enrollment and what is the time frame?

To make a change to your benefits outside of the annual open enrollment, ACTIVE employees must submit the Benefits Change Form and supporting documentation no later than 30 days from the event (60 days for newborns/adoptions/placement for adoption/ entitlement or loss of Medicaid/CHIP and other events noted in IRC section 125). This form may be downloaded from www.fortlauderdale.gov/benefits or obtained from the Benefits Section, HR.

When do requested changes become effective?

Open enrollment changes become effective January 1 of the following year. Outside of the open enrollment period, changes generally become effective the first day of the month following receipt of the change request with the exception of birth, adoption or placement for adoption which become effective as of birth or the earlier of (a) adoption or (b) placement for adoption.

What if I submit a late request for a change in status qualifying event?

If the request is submitted beyond the required time frames, the change will not be

FAQs

processed unless the dependent becomes ineligible (e.g. divorce).

Separation from the City or Loss of Benefits Eligibility and COBRA

What happens to my benefits if I separate from the City or lose eligibility?

Benefits coverage and payroll deductions will continue through the end of the month in which you separate from the City or lose eligibility. You are responsible for payment of employee deductions for the entire month in which you separate or lose eligibility.

Retirement:

- You have the option to continue medical, dental, and vision coverage through the Retiree Group. Coverage is not automatic. You must complete a Retiree Enrollment Form if you wish to elect insurance through the Retiree Group. You will also receive a notice from the City's third-party vendor of your eligibility to elect Consolidated Omnibus Budget Reconciliation Act (COBRA). As a retiree, you also have the option to continue your health care flexible spending account and EAP through COBRA through the end of the calendar year.

COBRA:

- When employees separate from the City or employees and/or their covered dependents lose eligibility, benefits coverage and payroll deductions typically continue through the end of the month. Employees and dependents have the option to continue group coverage (medical, dental, vision, and EAP) after the end of the month. Information about electing COBRA will be sent by mail from the City's third-party vendor.
- Under the Affordable Care Act, there may be less expensive coverage options available other than COBRA. For more information go to the Federal Market Place website www.HealthCare.gov or call 1-800-318-2596.

City Paid Group Term Life Insurance and Voluntary Group Term Life Insurance:

- The coverage can be ported, in this case meaning the coverage will stay the same as it is now (Term Life), but you will have to pay the insurance company (The Standard) directly. You can keep your current coverage amount or elect a lower coverage amount.
- The coverage can be converted, meaning the coverage will change to a whole life policy, which provides a cash value at a certain point. This coverage premium will also have to be paid directly to The Standard.
- The Standard provides an application to complete for either option.
- Employees who port or convert their life insurance coverage will continue their coverage directly with The Standard and will no longer be affiliated with the City Group Life Insurance.

Voluntary Group Aflac Benefits

- The Accident, Short Term Disability, Critical Illness and Hospital Indemnity coverages through Aflac can be ported, in this case meaning the benefit will stay the same as it is now but you will have to pay Aflac directly. The contact number for Aflac is 1-800-433-3036. Upon your request, Aflac will mail you information on how to port your coverage(s).

Voluntary Group ARAG Legal Plan

- ARAG Legal offers two conversion plans that an employee can enroll in. The premium is subject to change and paid directly to ARAG. The contact number for ARAG is 1-800-247-4184. Upon your request, ARAG will mail you information on how to convert your coverage.

Who is eligible for COBRA?

- The following individuals do not have the right to independently elect COBRA: domestic partners, grandchildren and/or stepchildren (unless adopted by the employee). However, if the employee elects COBRA continuation coverage for themselves, they may also cover their dependents even if they are not considered qualified beneficiaries under COBRA. Such individuals' coverage will terminate when the employee's COBRA continuation coverage terminates.
- The employee or family member must provide written notice to Benefits Section, HR within 60 days of the event when a covered spouse loses eligibility due to divorce or a dependent child loses eligibility.

Value-Added Benefits

Travel Assistance through City Paid Life Insurance

The Standard provides free access to emergency travel assistance when members experience travel or health emergencies more than 100 miles (150 km) from home or internationally for up to 180 days for business or pleasure. Some of the benefits available are medical consultation, lost luggage or document assistance, emergency medical evacuation, prescription assistance, pre-trip information and legal and interpreter referral.

www.standard.com/eforms/14684.pdf

Identity Force through City's Medical Plans

As our digital footprint expands, fraud and scams increase exponentially, along with vulnerabilities that result from having sensitive personal information exposed. IdentityForce is here to provide you with award-winning identity theft protection built to proactively monitor, alert, and help fix any identity theft compromises.

1. Visit cigna.identityforce.com/starthere or call 833-580-2523.
2. Once you complete the registration, you can access your dashboard. Your dashboard displays the monitoring scans that IdentityForce is doing to protect you.

Discounts at Work

TicketsatWork is an employee benefit program that offers exclusive discounts on entertainment, travel, and everyday purchases. Members can access deals on theme parks, movie tickets, hotels, car rentals, events, and more.

www.ticketsatwork.com/tickets/about-us.php

Contact Information

Coverage	Provider	Phone #	Website/Email
Medical and Dental	Cigna	800-244-6224	my.Cigna.com
Employee Assistance Program (EAP)	Cigna	877-622-4327	my.Cigna.com (Employer ID: cofl)
Well-Being Coordinator	Cigna	689-231-8035	Adam.Clawson@CignaHealthcare.com
Vision	VSP	800-877-7195	vsp.com
City Health and Wellness Center	Marathon Health	754-206-2420	my.marathon-health.com/login
Life Insurance	Standard Insurance Company	800-628-8600	standard.com
Voluntary Group Products (Group Accident, Group Critical Illness Advantage, Group Short-Term Disability and Group Hospital Indemnity Insurance)	Aflac	800-433-3036	cofl.fbmcbenefits.com
Health Care and Dependent Care Flexible Spending Accounts (FSA)	TASC	800-422-4661	tasconline.com
Legal Services	ARAG	800-247-4184	cofl.fbmcbenefits.com
Retirement Plan	FRS (Florida Retirement System)	866-446-9377	myfrs.com
Deferred Compensation	MissionSquare	800-669-7400	missionsq.org/fortlauderdale
Deferred Compensation	Nationwide	877-677-3678	nrsforu.com
Pet Discount Bundle	Pet Benefits Solutions	800-891-2565	petbenefits.com/land/fortlauderdale
Cancer Support	Genomic Life	844-694-3666	genomiclife.com
Elective Health Discounts	BeyondMed	844-267-6192	beyondmedplans.com

Benefits Website

Find additional information on our programs and links to mobile apps at www.fortlauderdale.gov/benefits.

Questions?

If you have any questions, contact the Benefits Section, HR at 954-828-5160 or healthyliving@fortlauderdale.gov.

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