CITY OF FORT LAUDERDALE
2017 BENEFITS HANDBOOK

WE’RE GREENING OUR ROUTINE!
(No mailed packets this year.)
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City Benefits Office  •  (954) 828-5160  •  Fax (954) 828-5328  •  www.fortlauderdale.gov/benefits
INTRODUCTION

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 resolution or state/federal laws, the provisions of the governing plan documents, certificates of coverage, City resolution and state/federal laws will prevail.

Please also take the time to review the Benefits web page for Frequently Asked Questions (FAQs), important notices, plan certificates of coverage, available forms, any updates subsequent to printing this book and much more at www.fortlauderdale.gov/benefits or on Lauderlink from a City computer. You may also contact the plan administrators directly to discuss your personal situation.
HEALTH AND WELLNESS CENTER (Operated by Marathon Health)
As part of the City’s commitment to wellness, the City of Fort Lauderdale Health and Wellness Center opened in 2013 for exclusive use by City employees and their dependents (ages 6+) enrolled in any of the three Cigna Health Plans - OAPIN1 (HMO1), OAPIN2 (HMO2) and Choice Fund (CDHP). Cigna Plan enrollees may receive professional services from the physician and nurse practitioner at no cost. In a few instances, you may be billed for any lab fees incurred by third party providers such as Quest or Lab Corp. The Center stocks a limited supply of generic prescription medications that the medical staff may dispense at no cost (if indicated) as part of health care they provide. The Health and Wellness Center is not a pharmacy and cannot fill prescriptions written by another physician.

HEALTH AND WELLNESS CENTER SERVICES INCLUDE:
• Acute Care – common illnesses and minor injuries
• Lab and Medication Dispensing – blood draws, lab tests and medications for conditions treated at the Center
• Health Assessments – cholesterol, blood pressure, blood sugar, weight and annual school and sports physicals
• Health Coaching – for personal health issues or concerns including healthy eating, exercise, tobacco cessation and more
• Chronic Condition Management – for conditions such as diabetes, heart problems and high blood pressure
• Biometric Screenings

A list of the services offered at the Health and Wellness Center is available online at www.fortlauderdale.gov/benefits.

To schedule an appointment or to contact the Health and Wellness Center (located at 105 NE 3rd Street), call 754-206-2420 or visit www.marathon-health.com/myphr. The Center is closed on holidays and weekends. The Center’s hours are:
• 7:00 am – 4:00 pm (Monday, Tuesday, Wednesday and Friday)
• 9:00 am – 6:00 pm (Thursdays)
• Closed on holidays and weekends and from 1:00 pm to 2:00 pm daily for lunch

The Health and Wellness Center follows the same rules and privacy regulations that protect your privacy at your personal physician’s office, a hospital or other health provider. In fact, the privacy of your personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

UNDERSTANDING YOUR HEALTH
The medical staff at the Health and Wellness Center will help you understand your health. This includes biometric screenings and a health risk assessment, in which you voluntarily provide information about your health history and status. The medical staff at the Center will help you understand all the aspects of your health, including present risks, and they will answer any questions you have about your health.

MEDICATION DISPENSING
For conditions treated at the Health and Wellness Center, the medical staff can dispense some of the most commonly prescribed generic medications at no additional charge to eligible members. The lists of medications available is online at www.fortlauderdale.gov/benefits.
LAB SERVICES
Many lab tests can be processed at the Health and Wellness Center, including Hemoglobin A1C, lipid panel, stools for occult blood, fasting glucose, random glucose, rapid strep, urinalysis, oxygen saturation levels, influenza A and B, mononucleosis tests, pregnancy tests and more. These tests are at no charge to employees and family members in the City health plan. All other laboratory tests (i.e., urine culture, strep culture, complete blood count, chemistry profile, TSH) can be drawn by Marathon Health providers, but will be sent to an external laboratory for processing. The external laboratory will submit a bill to your health plan for this service; and you may have a “patient responsibility” or payment for a portion of the services.

Visiting the Health and Wellness Center is not just for when you are sick. The medical staff helps employees and their family members improve their health in many ways including:

- **Weight Loss** – Set up a plan to lose weight. The medical staff can work with you on a customized plan based on what you are comfortable with.
- **Smoking Cessation** – Ready to quit? The medical staff can help.
- **Stress Management** – Learn how Mindfulness, Appreciative Inquiry and other simple techniques can help you improve your stress levels, sleep better and feel better.

The medical staff also offers a variety of health promotion programs including Lunch and Learn Workshops on wellness topics such as healthy eating, improving your sleep, heart health and more. New programs are offered regularly, so keep an eye out for notices.

WELLNESS INITIATIVES
To stay healthy, achieve your health goals or manage a chronic condition, the medical staff at the Health and Wellness Center can work with you to create a personalized, step-by-step plan to help you reach your best health. These plans empower people with chronic conditions to be more active and live more fully, and prevent the condition from becoming more serious in the future. Medical staff can also work with you to address your concerns about stress, diet, exercise, smoking and other forces that impact your health and well-being.

**Biometric Screening and Health Risk Assessment (HRA) Questionnaire:** Employees, retirees and covered spouses/domestic partners participating in the City’s medical plans must complete a biometric screening to avoid being charged a post-tax biometric surcharge. The post-tax surcharge will continue until the requirements are completed. Newly eligible employees and their covered spouse/domestic partner (if applicable) have 60 days from the date of their event (i.e., date of hire) to complete the biometric screening and HRA questionnaire. It is recommended that Cigna plan enrollees complete a HRA questionnaire.

The Health and Wellness Center or your personal physician may conduct these biometric screenings and review the data on a personal and confidential basis directly with you to develop an action plan to improve your health.

**Tobacco Use:** This only applies to employees participating in the City’s medical plans. Eligible employees who are tobacco users have 60 days from the date of their event (i.e., date of hire) to complete a City authorized Tobacco Cessation Program (if applicable) to avoid paying a $25 biweekly surcharge. The City’s authorized Tobacco Cessation Programs are:

- One-on-one or group programs through the City’s Health and Wellness Center: Call 754-206-2420
- Online/phone program through Cigna: Register online at www.mycigna.com or call 866-417-7848
- IQuit program with Area Health Education Center (AHEC) at www.ahectobacco.com/calendar
- Broward Health program: Call 954-355-5521
OPEN ACCESS PLUS IN-NETWORK PLANS (OAPIN 1 (HMO1), OAPIN2 (HMO2))

With the Open Access Plus In-Network Plans, you get access to a large network of health care professionals and facilities. So, each time you need care you choose the in-network doctor or facility that works best for you.

Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered health care costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for most services from an in-network doctor or facility. Then, the plan pays the rest. Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.

In-network: For your health care to be covered by the plan, you must choose a health care professional who is in the Cigna Open Access Plus network.

No-referral specialist care: If you need to see a specialist, you do not need a referral to see an in-network doctor.

Out-of-network: If you choose to see a doctor who is not in the network, you will not have coverage except in emergencies.

Emergency and urgent care: When you need care, you have coverage.

Choice Fund (CDHP)

The Cigna Choice Fund (CDHP) provides a health care plan with a Health Reimbursement Account (HRA) funded by the City to help pay for some of the costs of covered expenses, including health care expenses and prescription drugs.

How the HRA Works

- At the start of the year, the City deposits a specific dollar amount in your HRA.
- Your account is used to pay 100% of eligible health care expenses until the money is used up.
- The health care costs that were paid from your HRA count toward your deductible (the amount you pay before your plan starts to pay), reducing your share.
- When you reach your deductible, you share the costs for covered medical expenses (coinsurance).
- You are protected by an annual limit on how much you pay.
- At the end of the year, any unused HRA funds will roll over to the following year.
- If you switch medical plans or leave your employer, you forfeit your unused HRA funds.
### 2017 MEDICAL PLAN COMPARISON SUMMARY

<table>
<thead>
<tr>
<th>2017 Medical Plan Coverage</th>
<th>2017 OAPIN1 (HMO1)</th>
<th>2017 OAPIN2 (HMO2)</th>
<th>2017 Choice Fund (CDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Reimbursement Account (HRA)*</td>
<td>n/a</td>
<td>n/a</td>
<td>$750=EE, $1,000=EE+1, $1,500=EE+2 or more</td>
</tr>
<tr>
<td><strong>2017 Medical Plan Coverage</strong></td>
<td><strong>You Pay</strong></td>
<td><strong>You Pay</strong></td>
<td><strong>You Pay</strong></td>
</tr>
<tr>
<td>Deductible</td>
<td>No Deductible</td>
<td>$1,000=EE, $2,000=EE+1, $3,000=EE+Family</td>
<td>$2,000=EE, $3,000=EE+1, $4,000=EE+2 or more</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>n/a</td>
<td>n/a</td>
<td>You pay 10%</td>
</tr>
<tr>
<td>Your Out-of-Pocket Maximum</td>
<td>$5,000=EE; $7,000=EE+1; $10,000=EE+2 or more</td>
<td>$6,350=EE; $10,000=EE+1; $12,700=EE+2 or more</td>
<td>$5,000=EE, $7,000=EE+1, $10,000=EE+2 or more (Includes calendar year deductible &amp; coinsurance)</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Preventative Services</td>
<td>No Charge</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$40</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>$60</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>$60</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$500/day, $2,500 Maximum</td>
<td>Deductible then 20%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$500</td>
<td>Deductible then 20%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Diagnostics (X-rays, Ultrasound, etc.)</td>
<td>10%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Outpatient Diagnostics (CAT &amp; PET scans, MRI)</td>
<td>$200 per test</td>
<td>$200 per test</td>
<td></td>
</tr>
<tr>
<td>Routine Lab</td>
<td>10%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$200</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$60</td>
<td>$60</td>
<td></td>
</tr>
<tr>
<td>Mental Health (outpatient)</td>
<td>$40</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>Mental Health (inpatient)</td>
<td>$500 per day for first 5 days</td>
<td>Deductible then 20%</td>
<td></td>
</tr>
<tr>
<td>Allergy Treatments/Injections</td>
<td>$10</td>
<td>$10</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>no charge</td>
<td>$100 copay</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs - Pharmacy, 30-day supply</td>
<td>$20 generic, $40 preferred, $60 non-preferred</td>
<td>$20 generic, $40 preferred, $60 non-preferred</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs - Mail Order, 90-day supply</td>
<td>$40 generic, $80 preferred, $120 non-preferred</td>
<td>$40 generic, $80 preferred, $120 non-preferred</td>
<td></td>
</tr>
<tr>
<td>Prescription for Chronic Conditions &amp; Preventative</td>
<td>Generic prescription provided - waiving copays</td>
<td>Generic prescription provided - waiving copays</td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>(only medical conditions)</td>
<td>(only medical conditions)</td>
<td>(only medical conditions)</td>
</tr>
</tbody>
</table>

*Health Reimbursement Account (HRA)* City annual contributions: The HRA funding is prorated for enrollment after January.

**Cigna’s reimbursement is based on Usual Customary and Reasonable (UCR) charges.**
### CHOICE FUND (CDHP) EXAMPLE

<table>
<thead>
<tr>
<th>Out-of-pocket Max</th>
<th>Deductible</th>
<th>HRA Funded by the Health Plan</th>
<th>100% PREVENTIVE CARE (in network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 100% after out-of-pocket maximum (in-network)</td>
<td>Employee and the City share the cost up to the maximum</td>
<td>Your share of the deductible</td>
<td>Maximum Out-of-Pocket: This is the limit you will pay on an annual basis (each calendar year) for covered expenses regardless of how high your medical bills get. Participants have an out-of-pocket maximum for their eligible in-network medical expenses depending on their tier of coverage. You may be billed for charges in excess of CIGNA’s usual customary and reasonable charges if you use out-of-network providers.</td>
</tr>
</tbody>
</table>

#### Employee

- **$5,000**

#### Employee + 1

- **$7,000**

#### Family

- **$10,000**

#### Coinsurance: This is the percentage of costs you pay for covered healthcare services after you have paid your deductible. **The plan pays the rest.**

- **Employee pays 10% in-network or 30% out-of-network**
- **City pays 90% in-network or 70% out-of-network**

#### Deductible: A deductible is the portion of your covered medical expenses you are responsible for paying during each plan year until you reach the specified amount. Then, your plan will begin to pay a portion of covered medical costs (coinsurance). After the money in the HRA is spent you pay for covered medical expenses until you reach your individual annual deductible.

- **Employee = $2,000** ($1,250 after $750 HRA)
- **Employee + 1 = $3,000** ($2,000 after $1,000 HRA)
- **Family = $4,000** ($2,500 after $1,500 HRA)

#### Health Reimbursement Account (HRA): At the start of the year, the City deposits a specific contribution in your HRA. Your account automatically pays eligible medical expenses until the money is used up. The health care costs that were paid from your HRA count toward your deductible, reducing your share. At the end of the year, any unused HRA funds will roll over to the following year. If you switch medical plans or leave the City, you forfeit your unused HRA funds.

- **2017 City Annual HRA Contributions:**
  - **Employee = $750**
  - **Employee + 1 = $1,000**
  - **Family = $1,500**

#### Note: HRA funding is prorated for enrollment after January.
Meet the Smiths: A family of five
The Smiths are an active family of five. All family members get their yearly wellness exams. Mrs. Smith has high cholesterol that requires her to take prescription medication daily. She also suffers from severe low back pain and sees her chiropractor regularly. The Smiths are enrolled in family coverage with $1,500 in their HRA.

<table>
<thead>
<tr>
<th>Service</th>
<th>Discounted Provider Charge</th>
<th>The Smith’s HRA Account $1,500</th>
<th>The Smith’s Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Annual preventive exams</td>
<td>Plan pays direct</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6 Chiropractic visits</td>
<td>$510</td>
<td>-$510</td>
<td>$0</td>
</tr>
<tr>
<td>2 Urgent care visits</td>
<td>$260</td>
<td>-$260</td>
<td>$0</td>
</tr>
<tr>
<td>2 Primary doctor visits</td>
<td>$124</td>
<td>-$124</td>
<td>$0</td>
</tr>
<tr>
<td>Cholesterol prescription</td>
<td>$252</td>
<td>-$252</td>
<td>$0</td>
</tr>
<tr>
<td>Year-end balance</td>
<td>$1,146</td>
<td>$354</td>
<td>$0</td>
</tr>
</tbody>
</table>

Meet the Davidsons: Married couple, late 50s
Mr. Davidson was in a severe auto accident. As a result, he was hospitalized and his recovery consisted of rehabilitation and many visits to specialists. The Davidsons are enrolled in the Employee + 1 with $1,000 in their HRA account.

<table>
<thead>
<tr>
<th>Service</th>
<th>Discounted Provider Charge</th>
<th>The Davidsons’ HRA Account</th>
<th>The Davidsons’ Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Annual preventive exams</td>
<td>Plan pays direct</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$25,000</td>
<td>-$1,000</td>
<td>-$2,000 remaining deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-$2,200 (10% coinsurance on $22,000 hospital)</td>
</tr>
<tr>
<td>2 Radiology visits</td>
<td>$2,500</td>
<td>$0</td>
<td>-$4,200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-$250 (10% coinsurance)</td>
</tr>
<tr>
<td>20 Rehabilitation visits</td>
<td>$2,500</td>
<td>$0</td>
<td>-$250 (10% coinsurance)</td>
</tr>
<tr>
<td>Year-end balance</td>
<td>$32,500</td>
<td>$0</td>
<td>-$4,950</td>
</tr>
</tbody>
</table>
USEFUL CIGNA TOOLS
How to register on myCigna.com

Register on myCigna.com and you will be able to find all your coverage information online. My Cigna.com provides you with the following navigation tools:

- Find doctors and medical services
- Manage and track claims
- See cost estimates for medical procedures
- Compare quality of care ratings for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Review My Coverage
- Home Delivery Pharmacy

myCigna.com – Easy to Register, Easy to Use

Register today. It is this easy:

- Go to myCigna.com and select “Register.”
- Enter your personal details (i.e., name, address and date of birth).
- Confirm your identity with secure information such as your Cigna ID, social security number or complete a security questionnaire. This will make sure only you can access your information.
- Create a user ID and password
- Review and submit
FIND A CIGNA DOCTOR OR FACILITY:
One Cigna network of providers for everyone: OpenAccessPlus

- OpenAccessPlus is the Cigna Network used for all three plans: OAPIN1 (HMO1), OAPIN2 (HMO2) and Choice Fund (CDHP).
- To search for a participating provider in the Cigna network, select “Find a Doctor or Facility” by logging into www.myCIGNA.com or by calling 1-800-244-6224.

Cigna’s Cost Comparison Tool: Medical Cost Estimator

- The more you know about the cost and quality of doctors and hospitals, the easier it is to make the best choices for you and your family. After all, no one wants to pay too much for health care.
- The myCigna health care professional directory allows you to see integrated cost and quality information throughout the directory, helping you compare doctors and control health care spending.
- To help you make the most confident, cost-effective decisions about your care it is wise to compare costs and to understand how much your plan will pay and how much you will need to cover.
MYCIGNA MOBILE APP
Use the myCigna Mobile App to log in anytime, anywhere to:

- Manage and track claims
- View, fax or email ID card information
- Find doctors and compare cost and quality ratings
- Review your coverage
- Track your account balances and deductibles
- Refill your Cigna Home Delivery PharmacySM prescriptions online and view order history
- Compare prescription drug prices at thousands of pharmacies in Cigna’s network

** The downloading and use of myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.
For benefit eligible employees other than International Associations of Fire Fighters (IAFF)
The City offers two dental plan choices – DHMO and DPPO. Please go to www.humanadental.com and select Humana for DHMO (HS195) or PPO (Traditional Preferred) for DPPO. Humana will mail new dental plan participants identification cards.

1. Humana Dental Prepaid DHMO plans focus on maintaining oral health, prevention and cost containment. Members are required to select a participating primary care dentist and may see the dentist as often as necessary. There are no deductibles to meet and no waiting periods. Copayments for listed procedures are applicable at either a participating general dentist or participating specialist.

   A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist.

   Specialists services: Should members need a specialist (i.e., endodontist, oral surgeon, periodontist, or pediatric dentist), they may be referred by a participating general dentist, or members can self-refer to any participating specialist. For DHMO plans, copayment amounts are applicable when treatment is performed by participating specialists.

2. Humana Dental PPO plans feature schedules of benefits for Preventive (100%), Basic (100%), Major (60%) and Orthodontic services all subject to exclusions and limitations.

Below is a very brief summary of the dental plan offered by the City of Fort Lauderdale. For further information, please refer to the Humana plan documents at www.fortlauderdale.gov/benefits, or contact Humana directly at 1-800-233-4013 (PPO Plan) or 1-800-979-4760 (DHMO Plan).

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>Participant Maximum</th>
<th>Preventive Services</th>
<th>Basic Services</th>
<th>Major Services</th>
<th>Orthodontia</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTAL HMO</td>
<td>No Maximum</td>
<td>$0 copayments</td>
<td>Refer to Plan Copayments</td>
<td>Refer to Plan Copayments</td>
<td>Go to <a href="http://www.humanadental.com">www.humanadental.com</a></td>
</tr>
<tr>
<td>DENTAL PPO</td>
<td>$1,500 Maximum/year</td>
<td>100% (no deductibles)</td>
<td>100% (no deductibles)*</td>
<td>60% (no deductibles)*</td>
<td>60% (no deductibles)</td>
</tr>
</tbody>
</table>

*Please note if a non-network PPO dentist is used, there will be a $100 individual/$300 family deductible and 60% coverage for Basic and Major Services. Non-participating dentists may bill you for charges above the amount covered by your Humana Dental Plan. Visit www.humanadental.com to check out participating dentists.

**Humana DPPO Plan offered to IAFF members only:**
Visit www.humanadental.com for a list of participating dentists. Non-participating dentists may bill you for charges above the amount covered by your Humana Dental Plan. Humana will mail dental cards to new plan participants before January 1, 2017.
VOLUNTARY VISION PLAN (EYE EXAMS, EYEGLASSES AND CONTACTS)

The Vision Plan is a voluntary stand-alone benefit. Broader vision coverages are provided by UnitedHealthcare for all employees and their dependents. UnitedHealthcare also offers a larger network of national and independent vision providers and even provides substantial savings on hearing aids.

In-Network Benefits Summary

(Visit www.fortlauderdale.gov/benefits for more details)

1. Once every 12 months employees are able to get a comprehensive exam, spectacle lenses and contact lenses in lieu of eye glasses. Once every 24 months employees are able to get frames.

2. $130 retail frame allowance for private practice or retail chain providers

3. Standard scratch resistant coating is covered in full. Other optional lens upgrades may be offered at a discount (discounts varies by provider).

4. CONTACT LENS BENEFIT:

Elective contact lenses: The fitting/evaluation fees, contact lenses and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to four boxes are included when obtained from a network provider.

A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply).

<table>
<thead>
<tr>
<th>In-Network</th>
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<td>Frames and one of the following:</td>
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<tr>
<td>Single vision lenses</td>
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<tr>
<td>Bifocal lenses</td>
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<td>Trifocal lenses</td>
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<td>Lenticular lenses</td>
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<td>Elective contact in lieu of eye glasses</td>
<td>$105 allowance</td>
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<tr>
<td>Necessary contact in lieu of eye glasses</td>
<td>$25 (then covered in full)</td>
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</table>
TERM LIFE INSURANCE FOR THE FAMILY

Because life insurance should be part of every employee’s benefit package, the City provides various life insurance options depending on his or her individual needs. The City provides and pays for $10,000 of life insurance for Management, Confidential, Professional and Supervisory employees.

VOLUNTARY GROUP TERM LIFE INSURANCE (Standard Insurance Company): Newly eligible employees (i.e., new hires) may purchase life insurance coverage, without evidence of insurability (EOI), of up to $300,000 at the rates indicated below (for their age bracket). Eligible employees may apply for life insurance coverage not to exceed $400,000. Employees must be actively at work for coverage to become effective. The voluntary group term life insurance includes Accidental Death and Dismemberment (AD&D) for both employees and spouses/domestic partners. Please refer to Standard Insurance Company’s certificates of coverage for complete information about your benefits.

Employees who have a qualifying life event (QLE) may apply for new or additional coverage, but will be subject to evidence of insurability (EOI) and must complete an EOI form (regardless of the amount). The completed EOI form may be downloaded from the Benefits web page at www.fortlauderdale.gov/benefits and must be submitted or faxed directly to Standard Insurance Company or may be submitted via the online process found on the Benefits web page using Group ID #754544.

All eligible employees enrolling in group term life insurance must complete a life insurance beneficiary designation form that may be obtained on the Benefits web page. To complete the beneficiary designation, the date of birth for each beneficiary listed will be required. Please submit the completed form to the Benefits Section, HR.

You may elect to take this coverage with you when you terminate your City employment.

BI-WEEKLY VOLUNTARY TERM LIFE RATES BELOW

Voluntary Standard Insurance Company group term life insurance automatically includes AD&D. If you die from natural causes your beneficiary receives the term amount. If you die as a result of an accident your beneficiary will receive term amount plus AD&D (equal to term amount).

Newly hired employees may secure up to $300,000 guaranteed issue voluntary group term life insurance and up to $400,000 with EOI. Life Insurance coverage reduces to 65% of coverage beginning at age 70. The premium will be adjusted to reflect the reduced coverage.

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Bi-weekly voluntary term life rates continued on following page.
## Bi-Weekly Voluntary Term Life Rates (continued)

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**SPOUSE/DOMESTIC PARTNER COVERAGE:** Spouse/domestic partner coverage is available in $5,000 increments as long as the employee is enrolled in voluntary group term life insurance. Amounts more than $50,000 are subject to EOI. Spouse/domestic partner coverage cannot exceed half of the employee’s coverage. Spouse/domestic partner rates are based on the employee’s age. Employees adding a spouse/domestic partner outside of their initial eligibility period must provide EOI. The employee must be enrolled in voluntary group term life insurance to select spouse/domestic partner coverage.

**CHILDREN COVERAGE:** Children may be enrolled for $10,000 of coverage through the end of the calendar year they turn age 26 for a biweekly rate of $0.23 (covers all children at one price). Employees adding coverage for children outside of their initial eligibility period must provide EOI and be approved by Standard Insurance Company. The employee must be enrolled in voluntary group term life insurance to select coverage for their child(ren).

**BENEFICIARY DESIGNATIONS**
You are encouraged to update your life insurance beneficiaries when you experience a change in family status such as marriage, death, divorce, etc. You may change your beneficiaries at any time by downloading the Group Term Life Beneficiary Designation Form from the benefits web page at www.fortlauderdale.gov/benefits and submitting the completed form to Benefits Section, HR.
FLEXIBLE SPENDING ACCOUNTS (FSAs)
The employer-sponsored Flexible Spending Accounts (FSA) program offered by City of Fort Lauderdale is administered by Benefits Outsource, Inc. (BOI), located in Davie, Florida. Employees have the option of participating in the Health Care or Dependent Care account, or both.

An FSA allows an employee to reduce their taxable income by setting aside pre-tax dollars to pay for eligible health care and dependent care expenses approved by the Internal Revenue Code (IRC). Eligible expenses covered are for you and all of your dependents, even if they are not covered under your primary health plan. It is important that you only allocate dollars for predictable medical and dependent care expenses. Any unused FSA funds at the end of the grace period, March 15, 2018 (for 2017 Plan Year) will be forfeited, also called the use-it-or-lose-it rule.

HEALTH CARE FSA (ANNUAL MAXIMUM ELECTION $2,550)
The maximum election for Health Care FSA is $2,550. This is an annual benefit that allows participation when an election is made during the open enrollment period. Nonetheless, newly hired employees may also participate and enroll within the initial enrollment eligibility period. A big perk with the Healthcare FSA is that it is pre-funded, meaning that the full annual election amount is accessible at the beginning of the plan year. Eligible out-of-pocket expenses for reimbursement relate to any health plan (i.e., medical, dental and vision). Eligible expenses include copays, deductibles, co-insurance, eyeglasses, dental care and certain medical supplies. (Over-the-counter (OTC) medications are eligible with a doctor’s prescription. View the full list of eligible expenses at www.irs.gov/publications/p502/.) The benefits debit card provided upon enrollment lets you easily access all of your account so there are no out-of-pocket costs.

DEPENDENT CARE FSA (ANNUAL MAXIMUM ELECTION $5,000)
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 to $5,000 annually if “married filing joint tax returns” or “single head of household” or $2,500 for “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, nursery school or a private sitter
- Late pick-up fees
- Summer of holiday day camp (not sleepover)
ANNUAL MINIMUM ELECTION $260 – HEALTH AND DEPENDENT CARE FSA
Effective January 1, 2017, the minimum employee annual contribution for Health and/or Dependent Care FSA is $260. The minimum election tempers the employee risk and allows you to experience the pre-tax savings of this worthwhile employer-sponsored benefit.

CLAIM REIMBURSEMENT
Your benefits debit card lets you easily access the Healthcare FSA and Dependent Care FSA funds. Payments are automatically withdrawn from your account(s). One card can access all of your benefit accounts. In the event that manual submission of a claim is required, an employee may submit itemized receipts to BOI via email, fax, mail and online portal upload. Disbursements of weekly claim reimbursements are done via ACH/direct deposit or manual check.

The Convenient Way to Pay
The benefits debit card lets you easily access all of your benefits.
Participants in tax-advantaged benefit accounts can pay for eligible products and services with their benefits debit card. Payments are automatically withdrawn from your benefit account, so there are no out-of-pocket costs and many purchases won’t require receipt submission. One card can access all of your benefit accounts:
► Healthcare flexible spending account
► Dependent care FSA

Real-time access to your benefit account funds – real world convenience!
Your benefits debit card provides immediate access to your benefit funds to pay for qualified expenses without having to pay anything out-of-pocket. Most major pharmacy chains have a point-of-sale system in place that auto-substantiates eligible items at the register. Swipe your benefits debit card to subtract the eligible items from your total, then offer a second form of payment for any ineligible items that remain. Though the need for documentation is infrequent, you should save your receipts in the rare instance documentation is requested by your administrator.

Advantages of the Card
► No out-of-pocket expenses
► No waiting for reimbursement
► Convenient access to funds reduces end-of-year forfeitures
► Single card for multiple accounts

Online Access
Get account information from our easy-to-use online portal at https://www.mywealthcareonline.com/boi. See your account balance, check on a claim status and view your transaction history.

FSA ADMINISTRATIVE SERVICES INFORMATION
Benefits Outsource, Inc.
5599 South University Drive, Suite 201
Davie, FL 33328

To contact BOI with any questions, please call their customer service department Monday – Friday from 9:00 a.m. to 5:30 p.m. at 954-680-7626 or 1-888-877-2780 (toll free).

For 24/7 online access to your account, logon to www.mywealthcareonline.com/boi. To submit manual claims, you may upload documentation using BOI’s online portal, email benefits@boibenefits.com or fax to 954-680-7630.
DEFERRED COMPENSATION
City of FORT LAUDERDALE

457(b) DEFERRED COMPENSATION

The 457(b) Deferred Compensation Plan is tax deferred and may be used to supplement your defined contribution or defined benefit plan and social security benefits during retirement. The 457(b) Deferred Compensation Plan allows for both pre-tax and after-tax contributions. Employees can select which option best suits their long-term financial needs. The City offers two deferred compensation plan providers, ICMA-RC and Nationwide Retirement Solutions. Contributions to the plans lower your current year taxes and all income. All income taxes are deferred until you withdraw or receive a distribution after separation from service. You may contribute to either or both providers. Both ICMA-RC and Nationwide offer a wide selection of investment options ranging from conservative to aggressive. Neither ICMA-RC nor Nationwide provide tax advice.

457(b) Deferred Compensation Features

- If you experience an unforeseeable emergency, you may be able to withdraw funds from your account as permitted by Internal Revenue Code Section.
- The plan allows participants to apply for loans of up to 50% of their account balance, not to exceed $50,000.
- Does not include a 10% tax penalty for early distributions/withdrawals upon separation of employment prior to age 59½, as is typical in 401(a) plans.
- Upon separation from employment, you may keep the funds invested in the accounts or roll them over to another tax-qualified retirement plan. You are required to begin receiving minimum distributions the latter of April 1 following the calendar year in which you turn 70½ or April 1 following the year in which you retire (if 70½).

457(b) Maximum tax year contributions (as of printing) - up to:

- $18,000 normal limit
- $24,000 if age 50 or older as year-end
- $36,000 if you qualify for pre-retirement catch-up contributions

Benefits that Go Together

A Roth IRA and 457(b) Deferred Compensation Plan go together; use both to reach your savings goals with added tax benefits and flexibility.

- For different savings goals: Additional retirement income, health care, a home purchase, college education, emergencies
- For different tax benefits: You can get a tax benefit now when you contribute to your 457(b) plan and a tax benefit later when you withdraw from your Roth IRA. And, if you retire early you can withdraw from your 457(b) plan without penalties.

MATCH YOUR ROTH IRA WITH YOUR 457(b) PLAN

Tax-free withdrawals/distributions, including earnings, are tax- and penalty-free if you have:

- Owned a Roth IRA for at least five years, as defined by the IRS; and
- A qualifying event, such as age 59½, a “first-time” home purchase, disability or death.

Otherwise, income and penalty taxes may apply to the withdrawal of earnings, but contributions can be withdrawn at any time without taxes or penalties. There are no IRS required minimum distributions, so loved ones can receive money you do not need tax free.

Maximum annual Roth contributions:
Up to $5,500, or $6,500 if age 50 or older, as of the current year-end and if your IRS Modified Adjusted Gross Income is less than:

- $116,000 for individual filers ($116,000 - $131,000 to make partial contributions)
- $183,000 for married joint filers ($183,000 - $193,000 to make partial contributions)

LEARN MORE

ICMA-RC:
IRA: www.icmarc.org/ira
457(b) plan: www.icmarc.org/457
Contact your ICMA-RC representative at yflores@icmarc.org

NATIONWIDE RETIREMENT SOLUTIONS
Contact your Nationwide Retirement solutions representative at pinzona@nationwide.com
www.nrsforu.com
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, not available to individuals on their own, and the convenience of paying premiums through payroll deduction.

- **Medical GAP Insurance** (a.k.a. Major Medical Complement), Allstate (pre-tax): Only participants in the City’s three Cigna Medical Plans, [OAPIN1 (HMO1), OAPIN2 (HMO2) and Choice Fund (CDHP)] may enroll in a GAP insurance policy to supplement their medical plan enrollment.
- **Legal Insurance, ARAG** (post-tax): Provides attorney fees for most covered legal matters within the plan limits.
- **Accident Insurance, Trustmark** (pre-tax): Provides financial benefits for eligible covered accidents.
- **Disability Insurance, Trustmark** (post-tax): Provides financial benefits in the event of a qualified disability.
- **Critical LifeEvents℠ Insurance, Trustmark** (pre-tax): Provides benefit payout for covered diagnosed conditions.

Please see the Voluntary Benefits Guide online at www.fbmclearningcenter.com/flauderdale2017py for more detailed information on each of these benefits and plans.

**If you wish to enroll in any of these voluntary benefits you must speak with a Professional Benefits Counselor/Enroller.** Professional Benefits Counselors/Enrollers will be available telephonically by appointment. During your telephonic appointment, your Professional Benefits Counselor/Enroller will:

- Provide education on voluntary benefits offered and assist you with making benefits decisions to best meet your needs
- Answer any questions you may have about offered voluntary benefits
- Assist you with making your voluntary benefits elections

A Professional Benefits Counselor/Enroller will contact newly eligible employees. You may also schedule a telephonic appointment at http://www.myenrollmentschedule.com/lauderdale or by calling 1-866-998-2915.

**FLORIDA PRE-PAID COLLEGE TUITION**: Allows you to save for your dependent’s college education through payroll deductions. You may obtain more information about the program online at www.myfloridaprepaid.com or by calling 1-800-552-4723.

**LOANS AT WORK**: A voluntary loan program will provide City employees with the opportunity to apply for unsecured loans for health care expenses or any other needs up to $5,000 (capped at 20% of net take-home pay) to be repaid through payroll deductions. The Employee Access Code for Fort Lauderdale employees is Fort2013.
WHO IS ELIGIBLE TO PARTICIPATE IN GROUP COVERAGE?

EMPLOYEES

- 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/GAP for the 2017 plan year.

- New hires are eligible for benefits the first day of the month following their hire date. However, coverage is effective the first day of the month following or coincident to receipt of the enrollment paperwork by Benefits Section, HR. Enrollment paperwork must be received by the Benefits Section, HR no later than 30 days from hire date for selected benefits to be effective (must be actively working for life insurance to be effective). The required paperwork may be downloaded from the Benefits web page. You may contact Benefits Section, HR at 954-828-5160 if you do not have access to a computer. Social Security numbers and documentation to support dependent status must be provided to Benefits Section, HR for all dependents. Please visit www.fortlauderdale.gov/benefits.

- Police employees represented by the Fraternal Order of Police (FOP) are eligible for medical, dental and vision benefits through the FOP ONLY and may participate in the City's life, Health Care and Dependent Care Flex Spending Accounts and voluntary benefits (excluding GAP). **NOTE: Remove the last sentence in this paragraph. Please also remove the last bullet item that follows this one.**

DEPENDENTS

Who are my eligible dependents and what documentation is required as proof of eligibility?

If you enroll for medical, dental, vision or GAP insurance you may also enroll your eligible dependents (identified below). The type of documentation acceptable, as proof of dependent eligibility, is identified in parenthesis. Documentation must be provided at the time you enroll by submitting the document(s) to Benefits Section, HR. If the documentation is not readily available, please complete the online enrollment (active employees) or change request form (retirees) and follow-up with the documentation as soon as it becomes available. **Your enrollment request will not be processed without the supporting documentation.** Please remember to write your employee id number on each document submitted. If both parents are enrolled for benefits through the City, children may not be enrolled for coverage under both parents.

- Spouse, if she/he is not also a benefits eligible City of Fort Lauderdale employee (official marriage certificate)
  - Ex-spouse is not eligible for coverage under your insurance
  - Domestic partner (if she/he is not also a City of Fort Lauderdale employee eligible for benefits) as established by the City (Affidavit of Domestic Partnership)
  - 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, copy of official legal documents proving the status)
  - Children (of your domestic partner, unless covered by a spouse/domestic partner who also works for the City of Fort Lauderdale (copy of official birth certificate showing the domestic partner as the parent)
  - Your child, if permanently physically and/or mentally disabled (and not an eligible City employee), may be covered indefinitely beyond the limits age as long as acceptable proof of the disability is provided to the plans. (The health plan will request medical proof of the disability.)
  - Specified dependent child or foster child placed in your home (copy of the executed court order)
  - 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)
  - The Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans to the last day of the calendar year that they reach the age of 26. An unmarried dependent child may be covered for medical beyond age 26 to age 30, if the criteria established by Florida Statutes is satisfied. Dependent children enrolled for dental coverage are eligible to the end of the calendar year in which they turn age 26.

- Your foster child, if placed in your home prior to age 18 (proof of placement by the Department of Children and Families or the foster care program of a licensed agency)

What are the criteria for dependent children ages 26-30 (end of calendar year) to be eligible for group medical coverage?

- Florida Statute Chapter 627.6562 stipulates that the child must be (a) unmarried without any dependents, (b) a resident of the state of Florida or a full-time/part-time student and (c) is not entitled to benefits under Title XVIII of the Social Security Act.

- Employees enrolling a new dependent child age 26+ must provide supporting documentation that the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.
**PRE-TAX PREMIUM/IMPUTED INCOME**

**What is pre-tax premium?**

Pre-tax premium is an insurance contribution deducted from your paycheck before you pay any taxes. Premium contributions for medical, dental, vision, supplemental life (up to $50,000), health care and dependent care FSAs are deducted through a Cafeteria Plan established under Internal Revenue Code (IRC) Section 125 and the City’s Flexible Benefits Plan document. Due to IRC Section 125 rules, mid-year pre-tax premium changes may only be processed if the employee satisfies a qualifying event as permitted by the IRC Section 125, and the City’s Plan document, or exercises a HIPAA Special Enrollment Right and submits a timely request.

**Are premiums for adult children ages 26 to 30 and domestic partners/dependent children of domestic partners deducted pre-tax?**

Generally, no. Premiums attributable to dependent children ages 26 to 30 is deducted post-tax unless they meet the definition for tax-qualified dependent under Internal Revenue Code Section 152. Premiums attributable to domestic partners, and the children of domestic partners, are deducted post-tax unless it is established that they are qualified tax dependents as defined by Section 152 of the Internal Revenue Code. To have premiums payroll deducted pre-tax, the employee must also complete the Domestic Partner Certification of Dependent Status Form included under Forms on the Employee Benefits web page.

**What is 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. The City does not subsidize premiums for adult children ages 26-30.

**IRC SECTION 125 CHANGE IN STATUS QUALIFYING AND OTHER PERMITTED EVENTS**

**What mid-year (outside of the annual open enrollment period) qualifying events allow me to add or delete dependents?**

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 (example to add or delete dependents) 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:

- A change in the participant’s legal status, including marriage, divorce, death of the participant’s spouse, domestic partnership status (post-tax, unless a qualified tax dependent as defined by the Internal Revenue Code and the employee completes a Domestic Partner Certification of Dependent Status Form)
- A change in the number of dependents that the participant has for federal income tax purposes due to events such as birth, adoption, placement for adoption or death
- A termination or commencement of employment of the participant, spouse, domestic partner (post-tax unless a qualified tax dependent under the Internal Revenue Code) or dependent of the participant
- A reduction or increase in the hours of employment such as a switch between part-time and full-time status, going on an approved unpaid leave of absence (LOA)/Family Medical Leave Act (FMLA) or returning from an approved LOA/FMLA
- An event that causes the participant’s dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age
- A court order or judgment, decree or change in legal custody, including a qualified medical child support order
- Entitlement to/or loss of Medicare eligibility, entitlement to Medicaid
- Entitlement to Premium Assistance under State Medicaid or Children’s Health Insurance Program (CHIP), OR loss of eligibility for State Medicaid or CHIP (60 days allowed to exercise special enrollment rights after termination of Medicaid or CHIP coverage)
- Differences in the open enrollment periods between the City and another employer affecting the participant’s spouse or dependent
- Significant increases in plan costs
- Significant curtailment in plan benefits
- Special Enrollment Rights: If an employee becomes eligible to exercise any Special Enrollment Rights, he/she may change election for the balance of the plan year and file a new election which corresponds with the exercise of those rights. For more information on Special Enrollment Rights, please click on the Cigna image on the Benefits web page to review the certificates of coverage.
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 delete 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 delete 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 change to my medical/dental/vision/life insurance plan outside of the annual open enrollment and what is the time frame?
To make a change in your medical, dental or vision plan or life insurance outside of the annual open enrollment, ACTIVE employees must complete a Benefits Election Change Form and Flex Change in Status Form and submit it to the Benefits Section, HR 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). Retirees must complete a Benefits Election Change Form and a Flex Change in Status Form and submit them to Benefits Section, HR. These forms may be downloaded from www.fortlauderdale.gov/benefits or obtained from the Benefits Section, HR. Do not delay submitting the completed change forms while you gather the supporting documentation. Change requests must be completed within the specified time frames. You must then follow up with submitting the supporting documentation to Benefits Section, HR as soon as it becomes available, but no later than 30 days after the event. The types of documentation required to support the change in status are on the Change in Status Form. Changes between health plans are generally not allowed.

When do requested changes become effective?
Open enrollment changes become effective January 1 of the following year with the exception of life insurance increases, above guaranteed issue, which are effective subject to approval from Standard Life Insurance Company. Outside of the open enrollment period, changes generally become effective the first day of the month following receipt of the change request if provided within 30 days from the date of the event (60 days for newborns/adoptions/placement for adoption/entitlement to State Medicaid/CHIP or entitlement to CHIP).

When do changes to add a new dependent become effective?
Changes to add a new dependent become effective the first day of the month following, or coincident to, timely receipt by Benefits Section, HR, of the 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.
Payroll changes to add newborn child(ren) are processed in accordance with Florida Statute 641.31(9). If the change request is completed within 30 days of birth, the premium is waived for the first 30 days from birth. If the change request is completed after the first 30 days, but within 60 days of the qualifying event (birth, adoption or, placement for adoption), the new premium will be charged retroactive to the date of the qualifying event.

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 processed. If the request is to delete an ineligible dependent, you will be responsible financially for any claims incurred by that ineligible dependent but the premium changes, if applicable, will not be processed. Late requests to add new dependents will not be processed. You will need to make the change during the annual benefits open enrollment or if you exercise an allowable HIPAA Special Enrollment Right.

CANCELLATION
May I cancel coverage outside the annual benefits open enrollment?
Employees may request cancellation of coverage during the year as permitted by Florida Statute. However, for pre-tax benefits, if there is not an IRC Section 125 qualifying event, pre-tax premium payroll deductions will continue through the end of the current plan year. If you opt out or cancel your coverage you may not reapply (a) until the annual benefits open enrollment period, which takes place in the fall of each year, or (b) if you may exercise a HIPAA Special Enrollment Right. Requests to cancel post-tax benefits during the year will be processed prospectively without a penalty. Applications to re-enroll for life insurance benefits are subject to evidence of insurability.
**BENEFICIARY DESIGNATIONS**

**May I update my beneficiaries at any time?**
Yes. If enrolled for life insurance, you are strongly encouraged to review your beneficiaries and update, if necessary, when you experience a change in status such as divorce, marriage, death or any other changes. You are also encouraged to list contingent/secondary beneficiaries in the event your primary beneficiary(ies) predeceases you. Simply download the Group Term Life Beneficiary Designation Form from the City’s Employee Benefits web page, complete it and drop it off or mail to Benefits Section, HR.

**Where may I find information on life insurance benefits and provisions?**
Review the certificates of coverage at www.fortlauderdale.gov/benefits or contact Standard Life Insurance Company at 1-888-937-4783.

**HEALTH REIMBURSEMENT ACCOUNT (HRA)**

**What is an HRA?**
An HRA is an employer-funded, tax-qualified spending account that may be used to pay for qualified health expenses such as deductibles and coinsurance for covered medical expenses and prescription drugs.

**Do all employees enrolled in the medical plans have an HRA account funded by the City?**
No. HRA funding is only available to employees/dependents enrolled for the Cigna Choice Fund Plan (CDHP). Employees may not access funds remaining in the account upon separation of employment since the account is not portable. Retirees are not eligible for HRA funding.

**How much HRA funding does the City provide for Choice Fund (CDHP) participants for the plan year?**
- Employee only = $750
- Employee + one dependent = $1,000
- Employee + two or more dependents = $1,500
- Adult child = $750
- The funding is prorated for enrollments after January 1.

**Is there a separate ID card for the HRA?**
No. The Cigna ID card is presented to access the HRA funding.

**How do I keep track of the funds remaining in my HRA or obtain more information?**
You may keep track of your HRA balance by reviewing Explanation of Benefits (EOB) statements received, by logging on to www.myCigna.com, reviewing quarterly HRA statements received or by contacting Cigna’s customer service 24/7 toll-free at 1-800-244-6224. You may also review the Cigna summary plan descriptions on the Employee Benefits web page.

**May the funds in my HRA be rolled over to another calendar year?**
Yes; however, this is subject to changes in IRS guidelines and City policy.

**MEDICAL GAP INSURANCE**
(a.k.a. Major Medical Complement Insurance)

**What is GAP coverage and what company administers it?**
- This benefit helps pay the out-of-pocket expenses an insured individual incurs due to injury or sickness. GAP coverage for enrolled children ends at the end of the month he/she turns age 26. Coverage may be extended to the end of the month the child turns age 30 if the eligibility criteria under Florida Statute 627.6562 is satisfied.
- Fidelity Security Life Insurance Company underwrites the product for Allstate. The ID card issued to enrollees indicates Special Insurance Services (SIS) as administrator.

**Must I enroll for GAP coverage if I enroll in Cigna Medical Plans?**
No. It is an optional benefit.

**What types of covered medical expenses may GAP coverage be used for?**
Expenses include (a) hospital confinement due to injury or illness, (b) medically necessary outpatient treatment of an injury or sickness, (c) outpatient benefits, including treatment under the regular care of a physician at a hospital, (d) expenses at a physician’s office (except those expenses allocated as a physician’s office visit expense), or (e) outpatient surgical, emergency or diagnostic testing facility or a similar facility licensed to provide outpatient treatment. Benefits are limited to the difference between the benefit paid by your major medical plan and actual outpatient expenses incurred.
FREQUENTLY ASKED QUESTIONS (FAQS)

What are the maximum GAP limits for the CIGNA plans?
- Choice Fund (CDHP) - $4,000 hospital confinement and $2,000 outpatient benefit
- OAPIN1 (HMO1) and OAPIN2 (HMO2) - $2,500 hospital confinement and $1,250 outpatient benefit

If I enroll for GAP coverage, will I receive a separate ID card in addition to the Cigna ID card?
Yes. The card will be from administrator, Special Insurance Services (SIS).

Upon accessing health expenses, must I present the GAP ID card along with my Cigna ID card?
Yes. By submitting both cards at the same time it may eliminate the need to file a separate claim. For example, if you are enrolled in either of the CIGNA OAPIN1 (HMO1) OR OAPIN2 (HMO2) plan, you are responsible for a $200 copayment for an MRI at a participating outpatient diagnostic facility. If you enrolled for the GAP coverage, just present your Cigna ID card along with the GAP card and the $200 copay will be deducted from your GAP balance (providing the funds were not depleted prior to this visit).

How will I and my qualified beneficiaries be notified of my COBRA rights?
The City has contracted with a Third Party Administrator (TPA), currently Benefits Outsource, Inc. (BOI), to administer the COBRA provisions, provide notification within the time frames specified by the federal law and to perform the accounts receivable functions for qualified beneficiaries who elect continuation. The City provides the TPA with information pertaining to new enrollees and employees losing group coverage due to termination of employment and other known qualifying events.

Where may I obtain more information on COBRA?
Go to the BOI posting at www.fortlauderdale.gov or contact the City’s COBRA Administrator, BOI, at 954-680-7626 or toll free at 1-888-877-2780.

APPROVED UNPAID LEAVES OF ABSENCE (LOA)/THE FAMILY AND MEDICAL LEAVE ACT FMLA

How do I maintain my group benefits while on unpaid leave and FMLA?
Going on an approved unpaid LOA or FMLA leave is considered a qualifying event that allows you to make changes to your coverage consistent with the event. For example, you may delete dependents or cancel coverage within 30 days of being in an unpaid LOA or FMLA leave. Since you will not receive a paycheck while on unpaid leave, the premiums to cover your plan elections cannot be payroll deducted. You must take steps to ensure there is no disruption in your coverage. Before you miss your first paycheck, please contact Benefits Section, HR for instructions on how much to pay, the frequency of payments and other pertinent information.
2017 IMPORTANT NOTICE FROM THE CITY OF FORT LAUDERDALE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE TO ACTIVE EMPLOYEES, RETIREES AND DEPENDENTS PARTICIPATING IN THE FOLLOWING CITY-SPONSORED HEALTH PLANS:

Cigna Open Access Plus In-Network 1 (OAPIN1, aka HMO1) and
Cigna Open Access Plus In-Network 2 (OAPIN2, aka HMO2) and
Choice Fund (CDHP)

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

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

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Fort Lauderdale has determined that the prescription drug coverage under OAPIN1 (HMO1), OAPIN2 (HMO2) and Choice Fund (CDHP) are, on average, expected to pay out as much as standard Medicare prescription drug coverage pays for all plan participants and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you may keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

What happens to your current coverage if you decide to join a Medicare drug plan?
If you decide to join a Medicare drug plan, your current City of Fort Lauderdale coverage will not be affected. Coverage under the City’s plan will be primary.

For those individuals who elect Part D coverage and elect to drop coverage under the City of Fort Lauderdale’s plan, coverage will end for the individual and all covered dependents, etc. See pages 7-9 of the Centers for Medicare and Medicaid Services (CMS) Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

Your current City of Fort Lauderdale coverage pays for other medical expenses in addition to prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current City of Fort Lauderdale medical plan, which includes prescription drug benefits, please be aware that you (if actively employed) and your dependents may not be able to get this coverage back until the next annual benefits open enrollment period, which has an upcoming effective date of January 1. Retirees who drop their current City of Fort Lauderdale plan, which includes prescription drug coverage, must be aware that they will not be able to get this coverage back at a later date.
When will you pay a higher premium (penalty) to join a Medicare drug plan?
You should also know that if you drop or lose your current coverage with the City of Fort Lauderdale and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage:
Contact the office listed below for further information and refer to the certificates of coverage issued by the prescription drug provider. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the City of Fort Lauderdale changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number)
- For personalized help, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date: October 14, 2016
Name of Entity/Sender: City of Fort Lauderdale
Contact-Position/Office: Employee Benefits, Human Resources
Address: 100 North Andrews Avenue, 3rd Floor
Fort Lauderdale, FL 33301
Phone Number: 954-828-5160
**PART A: General Information**

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact **BENEFITS SECTION, HR**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
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<td>59-6000319</td>
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<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
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</thead>
<tbody>
<tr>
<td>100 N. ANDREWS AVENUE</td>
<td>954-828-5160</td>
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</table>

<table>
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<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
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</thead>
<tbody>
<tr>
<td>FORT LAUDERDALE</td>
<td>FL</td>
<td>33301</td>
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</tbody>
</table>

10. Who can we contact about employee health coverage at this job?

BENEFITS MANAGER

11. Phone number (if different from above) 12. Email address

healthyliving@fortlauderdale.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - □ All employees. Eligible employees are:
    - ☒ Some employees. Eligible employees are:
      - All full-time employees and part-time employees who satisfy the criteria under the Affordable Care Act (ACA).

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    - Spouses, domestic partners, dependent children of employees up to age 26 and those who satisfy the guidelines under Florida Statute (FS627.6562)
  - □ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

  ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
CITY OF FORT LAUDERDALE NOTICE REGARDING COLLECTION, USE, AND DISCLOSURE OF SOCIAL SECURITY NUMBERS

The collection of social security numbers by the City of Fort Lauderdale ("City") is either specifically authorized by law or imperative for the performance of the City’s duties and responsibilities as prescribed by law and the Florida Constitution. The following list identifies the purposes for which social security numbers may be collected, used, or disclosed, the relevant legal authority, and whether collection of the social security number for the stated purpose is mandatory or authorized.

- For reports to the Social Security Administration. [Disclosure: 26 C.F.R. §31.6051-2, §119.071(5)(a)6, Fla. Stat.];
- For administration of the City’s health benefits, pension fund, deferred compensation plan, and defined contribution plan, [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- For income deduction notices for child support, alimony, and child support enforcement. [Collection authorized by §§61.1301(2)(e) and 61.13, Fla. Stat. Disclosure: 42 U.S.C. §653(a)(b), §119.071(5)(a)6, Fla. Stat.];
- For unemployment compensation benefits. [Disclosure: §119.071(5)(a)6, Fla. Stat.];
- For reports of worker’s compensation injury or death. [Disclosure: §§440.185, and 119.071(5)(a)6, Fla. Stat.];
- For worker’s compensation petitions for benefits and responses. [Collection authorized by §60Q-6.103, Florida Administrative Code. Disclosure: §60Q-6.103, Florida Administrative Code, and §119.071(5)(a)6, Fla. Stat.];
- For notices of tort claim. [Collection mandated by §768.28(6), Fla. Stat.];
- For verification of identity, background investigations and criminal history checks. [Disclosure: §119.071(5)(a)6, Fla. Stat.];
  - The social security number may be disclosed to facilitate the direct deposit of funds to a payee’s account. [§119.071(5)(a)6, Fla. Stat.]
  - The social security number may be disclosed if it is expressly required by federal or state law or a court order. [§119.071(5)(a)6, Fla. Stat.]
  - The social security number may be disclosed if the individual expressly consents in writing to the disclosure of his or her social security number. [§119.071(5)(a)6, Fla. Stat.]
  - The social security number may be disclosed if the disclosure is necessary for the City to perform its duties and responsibilities. [§119.071(5)(a)6, Fla. Stat.]
  - The social security number may be disclosed if the disclosure is made to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224. [§119.071(5)(a)6, Fla. Stat.]
  - The social security number may be disclosed if the disclosure is made to a commercial entity for the permissible uses set forth in the federal Driver’s Privacy Protection Act of 1994, 18 U.S.C. ss. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. ss. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. ss. 6801 et seq., provided that the authorized commercial entity complies with the requirements of Fla. Stat. § 119.071(5). [§119.071(5)(a)6, Fla. Stat.]
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

For further information on eligibility in Florida:

FLORIDA - Medicaid & KidCare
Website: www.floridakidcare.org
Phone: 1-888-540-5437
SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision.” Special enrollment rights apply when you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program) - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll your self and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program - If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption - If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children’s Health Insurance Program - If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact:

City of Fort Lauderdale
Benefits Section, 3rd Floor
Human Resources
100 North Andrews Avenue
Fort Lauderdale, FL 33301
### BENEFITS DIRECTORY

#### MEDICAL / DENTAL / VISION

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<tbody>
<tr>
<td>CIGNA</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
<td>1-800-244-6224</td>
</tr>
<tr>
<td>Personal CIGNA Web Portal</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td><a href="http://www.cignabehavioral.com">www.cignabehavioral.com</a> (Employer ID: cofl)</td>
<td>1-877-622-4327 (24/7)</td>
</tr>
<tr>
<td>Kerri Holden, CIGNA Onsite Wellness Coordinator</td>
<td></td>
<td>954-652-1306</td>
</tr>
<tr>
<td>Fax: 1-860-847-5126</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allstate Medical GAP Insurance</td>
<td><a href="http://www.fbmclearningcenter.com/ftlauderdale2017py">www.fbmclearningcenter.com/ftlauderdale2017py</a></td>
<td>1-800-767-6811</td>
</tr>
<tr>
<td>United Healthcare Vision</td>
<td><a href="http://www.myuhcvision.com">www.myuhcvision.com</a></td>
<td>1-800-638-3120</td>
</tr>
<tr>
<td>Fax: 1-248-733-6060</td>
<td></td>
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#### CITY HEALTH AND WELLNESS CENTER

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marathon Health (Administrator)</td>
<td><a href="http://www.marathon-health.com/MyPhr/login">www.marathon-health.com/MyPhr/login</a></td>
<td>1-754-206-2420</td>
</tr>
<tr>
<td>Fax: 954-867-5583</td>
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#### LIFE INSURANCE

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax: 1-971-321-5994</td>
<td></td>
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#### INCOME PROTECTION (disability, accident, critical life events)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustmark</td>
<td><a href="http://www.fbmclearningcenter.com/ftlauderdale2017py">www.fbmclearningcenter.com/ftlauderdale2017py</a></td>
<td>1-877-201-9373, Option 2</td>
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#### FSA ADMINISTRATOR

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care FSA</td>
<td><a href="http://www.mywealthcareonline.com/boi">www.mywealthcareonline.com/boi</a></td>
<td>954-680-7626</td>
</tr>
<tr>
<td>Fax: 954-680-7630</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td><a href="http://www.mywealthcareonline.com/boi">www.mywealthcareonline.com/boi</a></td>
<td></td>
</tr>
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</table>

#### LEGAL SERVICES

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
<th>Phone</th>
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<tbody>
<tr>
<td>ARAG Legal</td>
<td><a href="http://www.araglegalcenter.com">www.araglegalcenter.com</a> (Access code 18107cfl)</td>
<td>1-800-247-4184</td>
</tr>
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</table>

#### FLORIDA PRE-PAYED COLLEGE TUITION

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
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<tbody>
<tr>
<td>Florida Prepaid College Tuition</td>
<td><a href="http://www.myfloridaprepaid.com">www.myfloridaprepaid.com</a></td>
<td>1-800-552-4723</td>
</tr>
<tr>
<td>Fax: 1-850-309-1766</td>
<td></td>
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#### DEFERRED COMPENSATION / LOANS

<table>
<thead>
<tr>
<th>Provider</th>
<th>Website</th>
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</thead>
<tbody>
<tr>
<td>ICMA-RC</td>
<td><a href="http://www.icmarc.org">www.icmarc.org</a></td>
<td>1-800-669-7400</td>
</tr>
<tr>
<td>Fax: 1-202-682-6439, Attn: WMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nationwide</td>
<td><a href="http://www.nrsforu.com">www.nrsforu.com</a></td>
<td>1-877-677-3678</td>
</tr>
<tr>
<td>BMG Loans at Work</td>
<td><a href="http://www.loansatwork.com">www.loansatwork.com</a></td>
<td>1-800-316-8507</td>
</tr>
</tbody>
</table>