

City of Fort Lauderdale

Section 125 Plan

Summary Plan Description

Effective Date: January 01, 2026

101 NE 3rd Avenue, 16th Floor,
Fort Lauderdale, FL 33301

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I. INTRODUCTION

The City's Flexible Benefit Plan ("Plan") has been established to allow Eligible Employees to pay for certain benefits on a pre-tax basis. There are specific benefits that you may elect, and they are outlined in this Summary Plan Description. You will also be informed about other important information concerning the Plan, such as the conditions you must satisfy before you can join and the laws that protect your rights.

Read this Summary Plan Description ("SPD") carefully so that you understand the provisions of the Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the Plan document, which governs the operation of the Plan. The Plan document is written in much more technical language. Please note that if the non-technical language in this SPD and the legal language of the Plan document conflict, the Plan document will always govern the Plan. Also, if there is a conflict between any of the insurance contracts and either the Plan document or this Summary Plan Description, the insurance contracts will control the respective insurance policies. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan is subject to the Internal Revenue Code and other federal and state laws and regulations that may affect your rights under this plan. This SPD explains the current details of the Plan in order to comply with all applicable legal requirements. From time to time, the Plan may be revised due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. This Plan may be amended or terminated by the City. If the Plan is ever amended or changed, the City will notify you.

This SPD was designed to provide you with information regarding the City Flexible Benefit Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other assigned person). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About our Plan."

II. ARTICLE - ELIGIBILITY

01. How can I participate in the Plan?

Before you can become a Participant in the Plan, there are certain conditions that you must satisfy. First, you must be an active employee working 30 or more hours per week and meet the eligibility requirements.

After that, you must enroll in the Plan on the "entry date" that has been established for all employees. The "entry date" is defined in Question 3 below. However, in certain limited situations, you may enroll in the Plan at other times as well. See the Article titled: "Contributions".

02. What are the eligibility requirements for our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan and the other eligibility requirements established by the City as defined in Question 1.

03. When can I enter the plan?

You can enter the Plan on the first of the month following the date you met the eligibility requirements.

04. How do I enroll in the Plan?

Before you can join the Plan, you must complete an enrollment to select which benefits you want to participate in under the Plan. This will authorize the City to redirect some of your earnings in order to pay for the benefits you select.

05. Who is eligible under the Plan?

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the governing documents for each Benefit Program. Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- a. Your legal spouse;
- b. Your child(ren) until the end of the calendar year in which the child reaches age 26 regardless of financial dependency, residency with you, marital status, or student status;
- c. Your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan.

A “child” is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

Domestic partners and children of domestic partners are not eligible for reimbursements from Health Flexible Spending Accounts.

06. Who is eligible under the Dependent Care?

An eligible dependent is someone for whom you can claim expenses on your Federal Income Tax. Children, as previously defined, must be under age 13. Other dependents must be physically or mentally unable to care for themselves.

III. ARTICLE - OPERATION

01. How does this Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your earnings contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your earnings that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under this Plan, you cannot claim a Federal income tax credit or deduction on your return. Participation in this plan is completely voluntary.

IV. ARTICLE - CONTRIBUTIONS; ELECTIONS

01. How much of my pay may the City redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year on a per payroll basis.

02. What happens to contributions made to the Plan?

Prior to the Plan start date each year, you must decide on the amount of pre-tax dollars you want to contribute to the Plan. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, those dollars will be used to pay those expenses as they arise during the Plan Year. Unused funds remaining in your Health Flexible Spending Account after the grace period described in the Article titled: "Benefits" will be forfeited to the City.

For information regarding the administration of contributions in specific accounts under this Plan, please refer to the Article titled: "Benefits".

03. When must I decide which accounts I want to use?

You are required by Federal regulations to decide during the enrollment period (defined below). You must decide which accounts you want and how much you want to contribute to each account.

04. When is the enrollment period for our Plan?

You will make your initial enrollment on or before your entry date. (Please review the Article titled: "Eligibility" to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the enrollment period is established by the City and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The City will inform you each year about the enrollment period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

05. May I change my benefits during the Plan Year?

Generally, you cannot change any benefits after the beginning of the Plan Year or eligibility date. However, there are certain limited situations when you can change your benefits.

You are permitted to change benefits if you have a "Qualifying Life Event" and you make an election change. Currently, Federal law considers the following to be Qualifying Life Events:

- a. Marriage, divorce, death of a spouse, legal separation or annulment;
- b. Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- c. Any of the following events for you, your spouse or dependent: termination or commencement of employment or any other change in employment status that affects eligibility for benefits;
- d. One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- e. A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you certain other rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your enrollment under the Plan. If any of these conditions apply to you, you should contact the Benefits Division. You should report a status change as soon as possible, but no later than 30 days following the QLE, or 60 days with a birth or loss of Medicaid. If notification is not timely due to extenuating circumstances or you have questions about when you can change your benefits, you should contact the Benefits Division.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if the City adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan.

For Dependent Care Accounts eligible enrollment changes include changes in the hours for which care is provided and changes in the fee charged by a provider. You may not change your enrollment under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

06. May I make new elections in future Plan Years?

Yes. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the enrollment period before a new Plan Year begins, the City will not roll over existing benefits.

V. ARTICLE - BENEFITS

01. What benefits are offered under the Plan?

You may choose to receive your entire compensation or use a portion to pay for benefits under this plan.

02. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for out-of-pocket medical, dental and/or vision expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code and that are not covered by the City's medical plan, and to save taxes at the same time.

Drug costs may be reimbursed. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Benefits Division.

The most that you can contribute to your Health Flexible Spending Account for the Plan Year is the maximum limit which may increase from year-to-year pursuant to Section 125 of the Internal Revenue Code. The minimum amount you contribute for the Plan Year is \$260.00.

In order to be reimbursed for a health care expense, you may be required to submit an itemized bill from the service provider. The City's Third Part Administrator (TPA) will also provide you with a debit card to use to pay for qualified health expenses and further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Expenses under this Plan are based on the date the service was incurred.

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact the City's TPA for more information.

03. Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your

spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

The most that you can contribute to your Dependent Care Flexible Spending Account for the Plan Year is the

maximum limit which may increase from year-to-year pursuant to Section 125 of the Internal Revenue Code. The minimum amount you can contribute to the Dependent Care Flexible Spending Account for the plan year is \$260.00.

Dependent Care arrangements which qualify include:

- a. A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- b. An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- c. An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan.

Limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account may not exceed the amount determined by the IRS.

Also, in order to be able to exclude from your income the reimbursements made to you from this account, you must provide on your tax form for the year the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Consult with your tax adviser for further information.

VI. ARTICLE - BENEFIT PAYMENTS

01. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred through the online portal, or the Benefits Division will provide you with acceptable forms. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax, social security or withholding. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Health Flexible Spending Account or Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

02. What happens if I don't spend all Plan contributions during the Plan Year?

If you have unused contributions in your account at the end of the current Plan Year, those monies will be forfeited to the City.

If you have unused contributions in your Health Flexible Spending Account or Dependent Care Flexible Spending Account at the end of the current Plan Year, you can continue to receive

reimbursement for expenses incurred during the first 2.5 months or 105 days immediately following the end of the Plan year, until such unused funds are depleted.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins.

03. Family and Medical Leave Act (FMLA)

If you take a leave under the Family and Medical Leave Act, you may continue, revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage for these benefits terminates, due to your revocation of the benefit to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. You can resume your coverage at its original level and make payments for the time that you are on leave. Alternatively, your maximum amount will be reduced proportionately for the time that you were gone.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and the City may arrange a schedule for you to "catch up" your payments when you return.

04. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage through your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected, ask the Benefits Division for further details.

05. What happens if my employment terminates?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- a. You will remain covered by insurance through the end of the month following termination of employment.
- b. You will still be able to request reimbursement for qualifying dependent care expenses up to 60 days after the end of the month from the balance remaining in your Dependent Care Account or Health Flexible Spending Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after termination.
- c. For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA."

06. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as the City contributions to Social Security on your behalf.

VII. ARTICLE - HIGHLY COMPENSATED AND KEY EMPLOYEES

01. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or are highly paid. You will be notified by the Benefits Division each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

VIII. ARTICLE - PLAN ACCOUNTING

01. Periodic Statements

Periodically during the Plan Year, The City's TPA will provide you with a statement of your account that shows your account balance. It is important to read these statements carefully so you understand the balance remaining. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

IX. ARTICLE - GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

01. General Plan Information

City of Fort Lauderdale FSA Plan is the name of the Plan. Your City has assigned Plan Number 501 to your Plan.

The City has adopted this Plan effective January 01, 2022

Your Plan's records are maintained on a twelve-month period of time known as the Plan Year. The Plan Year begins on January 01 and ends on December 31.

02. City and Plan Administrator Information

Your City's name, address, and tax identification number are:

City of Fort Lauderdale - Benefits Division
101 NE 3rd Avenue, 16th Floor
Fort Lauderdale, FL 33301
954-828-5160
healthyliving@fortlauderdale.gov
FEIN: 59-6000319

The Benefits Division keeps the records for the Plan and is responsible for the administration of the Plan. The Benefits Division will also answer any questions you may have about our Plan.

03. Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the Plan.

The Plan's Agent of Service is:

City of Fort Lauderdale
1 East Broward Blvd, Suite 1605
Fort Lauderdale, FL 33301
954-828-5436

04. Claims Submission

Claims for expenses should be submitted to TPA directly.

X. ARTICLE - ADDITIONAL PLAN INFORMATION

01. Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addition Equity Act of 2008, PPACA, HITECH, Michelle's Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

02. Claims Process

It is recommended that you submit all reimbursement claims during the Plan Year.

Claims for insured benefits will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Benefits Division.

If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure.

Within 60 days after denial, you or your beneficiary may submit to the TPA a written request for reconsideration of the denial.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The TPA will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the TPA will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The TPA has the exclusive right to interpret the appropriate plan provisions. Decisions of the TPA are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the claim:

Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The TPA will provide written or electronic notification of any claim denial. The notice will state:

- a. The specific reason or reasons for the denial;
- b. Reference to the specific Plan provisions on which the denial was based;
- c. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- d. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- e. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- f. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- a. was relied upon in making the claim determination;
- b. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- d. constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

03. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the City, if the order is determined to be "qualified." You may contact the Benefits

XI. ARTICLE - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") beyond the time when coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Benefits Division or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the TPA to Plan Participants who become Qualified Beneficiaries under COBRA. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

01. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

02. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- a. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- b. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the City sponsoring the Plan. However, this provision does

not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's City no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

03. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provides that the Plan participant will lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- a. The death of a covered Employee.
- b. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- c. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- d. A covered Employee's enrollment in any part of the Medicare program.
- e. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

04. What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. You should be aware that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which

you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

05. What is the election period and how long must it last?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

06. Is a covered Employee or Qualified Beneficiary responsible for informing the Benefits Division of the occurrence of a Qualifying Event?

The Benefits Division will offer COBRA continuation coverage to Qualified Beneficiaries only after timely notification that a Qualifying Event has occurred. The City will notify the TPA of the Qualifying Event within 30 days following the:

- a. end of employment or reduction of hours of employment,
- b. death of an employee,
- c. commencement of a proceeding in bankruptcy with respect to the City, or
- d. entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must complete and submit the Benefits Change Form to the Benefits Division within 30 days after the Qualifying Event occurs. If the form is not submitted, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES: You must email, mail, fax 954-828-5328 or hand-deliver your Benefits Change Form, at the following address:

City of Fort Lauderdale
101 NE 3rd Avenue, 16th Floor, Fort Lauderdale, FL 33301
healthyliving@fortlauderdale.gov

Once the Benefits Division receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage.

For each Qualified Beneficiary who elects COBRA, coverage will begin on the date that plan coverage would otherwise have been lost. If COBRA is not elected within the 60-day election period described above, the right to elect continuation coverage will be lost.

07. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need

not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the TPA, as applicable.

08. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

09. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- a. The last day of the applicable maximum coverage period.
- b. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- c. The date upon which the City ceases to provide any group health plan (including a successor plan) to any employee.
- d. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- e. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- f. The last day of the applicable disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, the Plan is not obligated to make coverage available to the individual once the Qualified Beneficiary is no longer eligible.

10. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- a. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- b. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- c. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee, the maximum coverage period is applicable to the original Qualifying Event.
- d. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

11. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The TPA must be notified of the second qualifying event within 60 days of the second qualifying event.

12. How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the TPA with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the TPA in accordance with the procedures above.

13. Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The City's TPA will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

15. What is Timely Payment for COBRA continuation coverage?

Your initial COBRA payment must be paid within 45 days of the time you elect COBRA coverage. All other premium payments must be made within 30 days after that.

16. Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

18. How is my participation in the Health Flexible Spending Account affected?

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$750 and, at the time you terminate employment, you have contributed \$400 but only claimed \$200, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to \$750. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

XII. ADDITIONAL INFORMATION

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the TPA. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Benefits Division informed of any changes in the addresses of family members.