CITY OF FORT LAUDERDALE RETIREES INSURANCE BENEFITS INFORMATION

This brochure is to provide relevant information to the continuation of medical, dental and/or vision coverage for you and your enrolled dependents through the Retiree Group. Please print and review Important Notices which may be found on the Benefits webpage at www.fortlauderdale.gov/benefits. If you do not have access to a computer, please contact the Benefits Section of HR, to provide you with copies. Upon retirement, if you wish to continue medical, dental and/or vision coverage you must complete the Retiree Enrollment Form and return in person to the Benefits office at 101 NE 3rd Avenue, 16th Floor. Fax to 954-828-5328 or email to healthyliving@fortlauderdale.gov. Please retain proof of fax submission. **Note: Employees who are represented by the Fraternal Order of Police (FOP) should contact the Police and Fire Retirement Systems Pension office directly for assistance with retiree benefits information.**

Coverage through the Retiree Group is not automatic. Your insurance coverage under the Active Group will end the last day of the month in which you retire, providing premium is paid. Coverage under the Retiree Group will become effective the first day of the month after you retire providing you elect coverage and pay the applicable premium.

The information in this brochure is presented in primarily a Questions and Answers format for easy reading. It provides highlights of the current available programs. **Note**: Retirees must consult the Summary Plan Descriptions, which govern the benefits for exact details pertaining to plan coverage, limitations, and exclusions.

Congratulations as you approach or enter retirement! Best wishes for many healthy retirement years!

COBRA

A federal law, the Consolidated Budget Reconciliation Act (COBRA), requires that most group health plans (including this plan) give employees and their covered dependents the opportunity to continue their health coverage through COBRA when there is a "qualifying event" that results in a loss of coverage under the employer's plan. The City of Fort Lauderdale has contracted with P&A Group to administer all aspects of COBRA and to provide you notification of your rights.

Although you are eligible to continue your medical, dental and vision coverage through the City's Retiree Group, you will also receive a Notice from P&A Group of your (and any covered dependents) eligibility to elect COBRA. Your COBRA notice will also include information on other coverage options which may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov and factors, including cost, to consider when choosing coverage options.

You may only maintain COBRA for up to 18 months, whereas you have the option to continue coverage through the Retiree Group indefinitely unless the main policy holder passes, provided timely payments are received. Domestic partners and their dependents, who are not tax- qualified dependents, will be provided the option of electing a COBRA-like continuation of benefits.

Under COBRA (and the COBRA-like benefits, where applicable), you will have the same rights under the medical, dental and/or vision plan as active employees and their covered dependents participating in these plans. However, the choice is entirely up to you and your covered dependents. Therefore, review your options carefully. You have 30 days from your retirement date to elect continuation of coverage through the Retiree Group. You will have 60 days from

the later of the COBRA notice date or retirement date to decide if you wish to elect COBRA. If you elect continuation of coverage, premium is due within 45 days from the date of your election.

For questions relating to COBRA, please contact P&A Group directly at 1-716-852-2611.

Health Insurance Stipend

Employees who retire or separate employment may be eligible for a monthly post-retirement health benefit if they satisfy the eligibility criteria outlined in the labor contracts which cover their job classifications at retirement or separation from employment. The eligibility criteria for Management and Confidential employees, who retire or separate employment, are stipulated in the City's Pay Plan Ordinance.

Please review the eligibility requirements outlined in the labor contracts or Pay Plan Ordinance, if applicable, to determine if you qualify for this monthly benefit. The labor contracts are posted on Laudershare under the resources tab. You may also contact Benefits at 954-828-5160.

FREQUENTLY ASKED QUESTIONS
RETIREES

Q1. Are all retirees eligible to participate in the City's Retiree Group insurance benefits program?

A1. No. Only employees enrolled in medical, dental and/or vision at retirement are eligible to participate.

Q2. May I continue participation for life insurance, Flexible Spending Accounts, and voluntary benefits such as ARAG Legal and AFLAC insurance products through the Retiree Group?

A2. No. You will have the option of purchasing COBRA if you were enrolled for the Healthcare Flexible Spending Account and a conversion policy if enrolled for life insurance at the time of retirement. You must contact the voluntary products providers directly to explore options including portability of those plans that you wish to continue. For more questions regarding voluntary products contact FBMC Benefits Management at 1-800-433-3036.

Q3. Will the City continue to fund a Health Reimbursement Account (HRA) if I enroll for the Consumer Driven Health Plan (CDHP)?

A3. No. The HRA account is not currently available for retirees.

Q4. How do I elect to continue coverage through the Retiree Group and what are the costs?

A4. Simply contact Benefits at 954-828-5160, complete the Retiree Enrollment Form, and hand deliver to 101 NE 3rd Avenue, Sixteenth Floor, fax to 954-828-5328 or email to healthyliving@fortlauderdale.gov. Please retain proof of submitting your form to Benefits. For employees in the GERS, IAFF and FOP Retirement System, the Pension Board will notify Benefits of your retirement status. The enrollment form may also be obtained from the Benefits webpage by clicking **"Information for Retirees"** at www.fortlauderdale.gov/benefits. Monthly premium rates are included on the enrollment form.

Coverage is not automatic. You must complete a Retiree Enrollment Form if you wish to elect insurance through the Retiree Group.

Q5. May I add dependents, not currently enrolled, to my medical/dental/vision insurance at retirement?

A5. No. You may elect to continue coverage only for the dependents currently enrolled or you may elect to delete dependents.

Q6. What is the deadline to complete the Retiree Enrollment Form?

A6. The completed enrollment form must be received no later than 30 days from your retirement date. If the required paperwork is not submitted in a timely manner, you will **not** have another opportunity to enroll for coverage through the Retiree Group. You and your covered dependent(s) will only be eligible to continue your insurance coverage through COBRA (domestic partners and their dependents would be eligible for a COBRA-like continuation coverage).

Q7. When does medical, dental and vision coverage end through the Active Group and when does it begin under the Retiree Group?

A7. Coverage through the Active Group terminates at the end of the month in which you retire, providing premiums are paid in full. Coverage under the Retiree Group begins the first of the month following your retirement, providing payment is received.

Q8. How do I pay to continue insurance benefits through the Retiree Group?

A8. If you receive a monthly pension check, your insurance deductions will be automatically deducted. Premium payments are due on the first of the month to pay in advance for the month. **If you do not receive a monthly check, arrangements must be made to send a monthly check to Benefits. Payments are due in advance of the beginning of the month.** For example, payment for October is due prior to October 1.

Q9. Is there an annual benefits open enrollment period for retirees?

A9. Yes. The annual retiree open enrollment is conducted in the fall. During that time, you may change medical plans, vision and/or dental plans, add or delete dependents, or cancel coverage.

Q10. What mid-year (outside of the annual benefits open enrollment period) changes in status events allow me to add or delete dependents?

A10.

- A change in your legal status including marriage, divorce, death of your spouse/domestic partner
- A change in the number of dependents due to events such as birth, adoption, placement for adoption or death
- A termination or commencement of employment of your spouse/domestic partner or other enrolled dependent
- An event that causes your dependent child 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 Health Child Support Order
- Entitlement to or loss of Medicare eligibility
- Entitlement to or loss of Medicaid/Children's Health Insurance Program (CHIP) eligibility (60 days allowed to exercise this HIPAA Special Enrollment Rights)
- Differences in the open enrollment periods between the City and another employer affecting your spouse or dependent
- HIPAA Special Enrollment Rights. If you become eligible to exercise any HIPAA Special Enrollment Rights, you 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 HIPAA Special Enrollment Rights, please click on the Cigna image on the Benefits webpage to review the applicable Summary Plan Descriptions.

- Any change in status requests processed must be consistent with the qualifying event. For example, if you get a divorce, it would be a qualifying event to delete your ex-spouse but not to add dependent children who were not on your plan.
- If you would like to change your medical, dental, or vision plan mid year contact the Benefits office at 954-828-5160 for the required paperwork or download from the Benefits webpage under "Forms''.

Q11. May I cancel medical, dental and/or vision coverage during the year?

A11. Yes. However, you cannot rejoin the plan at a later date once coverage is cancelled. The change will become effective the end of the month the request is received. If cancellation is due to other insurance coverage, the cancellation will be done to coincide with the effective date of the new coverage.

Q12. Is there a deadline to submit a request to add a new dependent?

A12. Requests to add a new dependent must be received by Employee Benefits within 30 days of the event (60 days for newborns/adoptions/placement for adoption/entitlement to or loss of Medicaid/CHIP). If the supporting documentation (example marriage certificate, birth certificate etc.) is not readily available, you must provide as soon as it becomes available. The types of documentation required to support the change in status are identified on the Change in Status form on the Benefits webpage "**Forms''**. The change will become effective the first day of the month following receipt of the request, providing supporting documentation is provided.

Q13. Who are my Eligible Dependents and what documentation is required as proof of eligibility of new dependents?

A13. The types of documentation acceptable, as proof of dependent eligibility, are identified in parenthesis. Documentation must be provided at the time the change in status or election form is submitted to the Benefits Office or as soon as available. The dependent will not be added without proof of eligibility.

- Spouse/Domestic Partner **(Official Marriage Certificate or Affidavit of Domestic Partnership).**
- Your biological child, legally adopted child or child placed in the home for adoption in accordance with applicable state and federal laws (**Birth Certificate**, **copy of official legal documents proving the status).**
- Child(ren) of your spouse/domestic partner (**copy of official Birth Certificate showing the spouse/domestic partner as the parent).**
- Your child, if permanently physically and/or mentally disabled, may be covered indefinitely beyond the limiting age as long as acceptable proof of the disability is provided to the plans **(medical proof of disability).**
- Court order for the 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 and the parent remains covered under the plan **(copy of Birth Certificate).**
- The Patient Protection and Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans to 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 Statute are

satisfied. Dependent children enrolled for dental and/or vision coverage are eligible to the end of the year turning 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**).

Q14. What are the criteria for dependent children ages 26 - 30 to be eligible for group medical coverage?

A14. 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 or part-time student and c) is not provided coverage or is not a covered person under any other group health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

- Retirees 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.

Q15. What happens to the medical, dental and/or vision coverage for my covered dependents if I should die?

A15. Your covered dependents will be offered continuation coverage under the provisions of COBRA.

Q16. What happens when I, my spouse/domestic partner approach eligibility for Medicare?

A16. Medicare is managed by the Centers for Medicare and Medicaid Services (CMS). It is recommended that you, your spouse/domestic partner contact Medicare at 1-800-Medicare or go online at Medicare.gov at least three months in advance of attaining Medicare eligibility to obtain guidance on how to apply for

Medicare Part B. Enrollment in Medicare Part A (Hospital Insurance) is automatic and becomes effective the first day of the month in which you turn age 65, providing you have satisfied the eligibility requirement. Enrollment in Medicare Part B (Medical Insurance) is not automatic. You must apply and pay a monthly premium for Part B coverage.

You should be aware that there are many insurance companies that offer approved Medicare Advantage Health Plans, generally at no premium cost to enrollees other than their Part B premium. There are also many Medicare approved supplements/Medigap policies offered in the market and Part D prescription drug programs at competitive prices.

After exploring your options, if you prefer, you may continue coverage through the City's Retiree Groups. Be aware, after you become Medicare eligible, the City's medical plans will be considered secondary coverage.

Q17. Does the City offer Medicare Supplement/Medigap plans?

A17. No

Q18. Will there be a penalty if I delay enrolling in Medicare Part D Prescription Drug or Medicare Part B after becoming eligible?

A18. If you provide proof that you were enrolled in a group health plan with Creditable Part D coverage without a break of more than 63 days, there will be no penalty. It has been determined that the City's medical plans currently provide prescription drug benefits as good as the prescription drug benefits offered under Medicare Part D. Please review the Notice of Creditable Part D Prescription Drug Coverage found in the Retiree Open Enrollment Newsletter on the Benefits webpage. If you decline Part B coverage upon eligibility, you will pay a penalty

unless you provide proof of continued coverage through the Retiree Group.

Q19. When is the Medicare annual open enrollment period?

A19. The Medicare annual open enrollment period generally takes place from October 15th through December 7th. Please contact the Social Security Administration to confirm the actual dates.

Q20. Where may I obtain information on my 457(b) Deferred Compensation plan?

A20. You may contact the City's Deferred Compensation Representatives, Miguel Hidalgo, MissionSquare at 202-759-7075 or email mhidalgo@missionsq.org; and/or Al Pinzon, Nationwide Retirement Solutions, at 954-232-7615 or email pinzona@nrsforu.com. Customer Service Representatives for MissionSquare and Nationwide may be reached at 1-800-669-7400 or 1-877-677-3678, respectively.

Q21. How may I report changes of address to the City?

A21. Changes of address must be reported, in writing, to the Pension Board and Employee Benefits.

Q22. Where may I obtain more information on the medical, dental and vision plan benefits, limitations and exclusions?

A22. Please visit the Benefits webpage at www.fortlauderdale.gov/benefits for the Summary of Plan Descriptions for the medical, dental and vision plans. The benefits provided when you click the Cigna and UnitedHealthcare Insurance buttons on the webpage are also applicable to retirees. You may also contact the plans directly.

Disclaimer: The provisions of insurance certificates of coverage, collective bargaining agreements, and federal/state law, City Commission legislation governs if it conflicts with any of the information presented in this document.

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