pompano beach®

Florida's Warmest Welcome

2025–2026
EMPLOYEE BENEFIT HIGHLIGHTS

Contact Information

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	Online Benefit Enrollment	Bentek Support	Customer Service: (888) 5-Bentek (523-6835) app.mybentek.com/copbfl Email: support@mybentek.com
	Medical Insurance	Florida Blue	Customer Service: (800) 352-2583 www.floridablue.com
	Prescription Drug Coverage	Prime Therapeutics	Customer Service: (877) 794-3574 www.myprime.com
	Mail Order Program	Amazon Pharmacy	Customer Service: (855) 965-7539 www.amazon.com
	Telehealth	Teladoc Health	Customer Service: (800) 835-2362 www.teladochealth.com
	Dental Insurance	Florida Combined Life	Customer Service: (888) 223-4892 www.floridabluedental.com
FSA	**Flexible Spending Accounts**	HealthEquity	Customer Service: (877) 924-3967 www.healthequity.com
	Voluntary Life and AD&D Insurance	The Standard	Customer Service: (800) 628-8600 www.standard.com
	Employee Assistance Program	Health Advocate	Customer Service: (877) 240-6863 www.healthadvocate.com/members Email: answers@healthadvocate.com
	Behavioral Health Access Program	City of Pompano Beach	Contact: Nina Taxis Phone: (954) 786-7865 Email: nina.taxis@copbfl.com
	Supplemental Benefits	Aflac	Customer Service: (800) 992-3522 www.aflac.com
		LegalShield	Customer Service: (888) 807-0407 Agent: Barry Olfern | Phone: (954) 655-2446 Email: barryolfern@legalshieldassociate.com
	Claims, Billing and Benefit Assistance	Gehring Group	Customer Service: (800) 244-3696 Email: pompanobeach@gehringgroup.com

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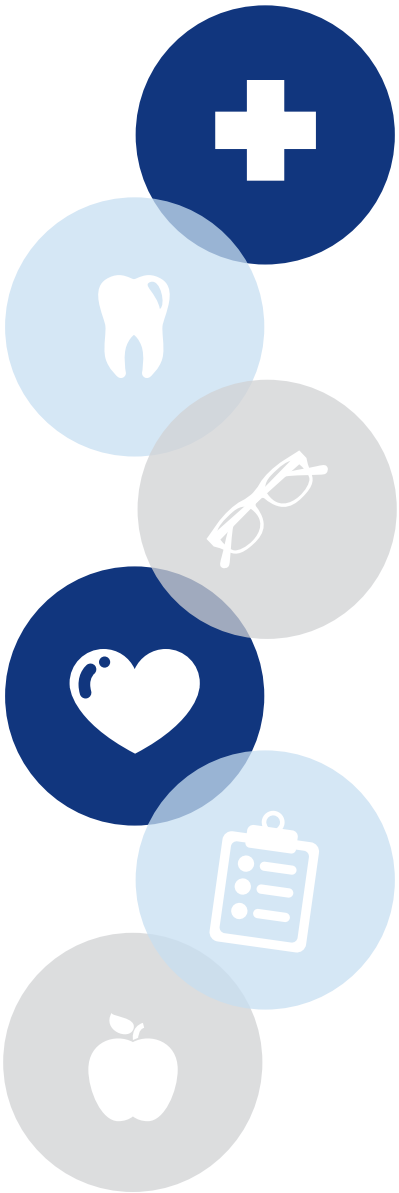

This booklet is merely a summary of employee benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. The City of Pompano Beach reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

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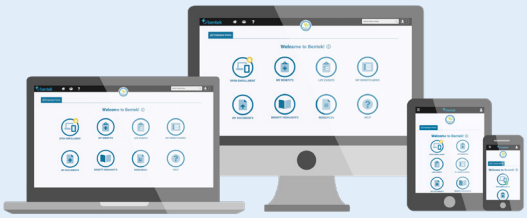
Introduction

The City of Pompano Beach provides group insurance benefits to eligible employees. The Employee Benefit Highlights Booklet provides a general summary of the benefit options as a convenient reference. Please refer to the City's Personnel Policies and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If employee requires further explanation or needs assistance regarding claims processing, please refer to the customer service phone numbers under each benefit description heading or contact Human Resources/Risk Management.

Online Benefit Enrollment

The City of Pompano Beach provides employees with an online benefits enrollment platform through Bentek's Employee Benefits Center (EBC). The EBC provides benefit-eligible employees the ability to select or change insurance benefits online during the annual Open Enrollment Period, New Hire Orientation, or for Qualifying Events.

Accessible 24 hours a day, throughout the year, employee may log in and review comprehensive information regarding benefit plans, and view and print an outline of benefit elections for employee and dependent(s). Employee also has access to important forms and carrier links, can report qualifying events and review and make changes to Life insurance beneficiary designations.



To Access the Employee Benefits Center:

- ✓ Log on to **app.mybentek.com/copbfl**
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate using the Launchpad to review current enrollment, learn about benefit options, and make any benefit changes or update beneficiary designations.

For technical issues directly related to using the EBC, please call (888) 5-Bentek (523-6835) or email Bentek Support at support@mybentek.com, Monday through Friday during regular business hours 8:30am - 5:00pm.

To access Bentek using a mobile device, scan code.

Group Insurance Eligibility

The City's group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in the City's insurance plans if they are full-time employees. Coverage will be effective the first of the month following date of hire if hired on or before the 10th of the month proceeding. For example, if hired on April 5th, then the effective date of coverage will be May 1. If hired on the 11th of the month or later, coverage will be effective first day of the month following 30 days of employment. For example, if hired on April 20, then the effective date of coverage will be June 1.

Separation of Employment

If employee separates employment from the City on the 19th of the month or before, insurance for medical and dental will continue through the end of the month in which separation occurred. If employee separates employment from the City on the 20th of the month or later, insurance for medical and dental will continue through the end of the following month. For example, if separation occurs on August 12th, coverage terminates on August 31st. If separation occurs on August 21st, coverage terminates on September 30th. Other coverage may terminate on the last date of employment. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse/domestic partner and/or dependent child(ren) of the participant or spouse/domestic partner. The term "child" includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A newborn child (up to the age of 18 months) of a covered dependent (Florida State Statute)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 26. An over-age dependent (taxable dependent) may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

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

Dental Coverage: A dependent child may be covered through the end of the calendar year in which the child turns age 30.

Disabled Dependents

Coverage for a dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group's insurance plans; and
- The dependent has been continuously insured.

Proof of disability will be required upon request. Please contact Human Resources/Risk Management if further clarification is needed.

Domestic Partner Coverage

Domestic partners may be eligible to participate in the City's group insurance plans if the partner is officially registered as a domestic partner with the City. The IRS guidelines state that employee may not receive a tax advantage on any portion of premiums paid related to domestic partner coverage. Employees insuring domestic partners and/or child dependent(s) of a domestic partner are required to pay imputed income tax on subsidy amounts and should consult a tax advisor. Please contact Human Resources/Risk Management for more information.

Qualifying Events and Section 125

Section 125 of the Internal Revenue Code

Premiums for medical, dental, contributions to Flexible Spending Accounts (FSA), and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment Period unless the employee or qualified dependent(s) experience(s) a Qualifying Event and the request to make a change is made within 30 days of the Qualifying Event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year if the event affects the employee, spouse or dependent's coverage eligibility. An "eligible" Qualifying Event is determined by Section 125 of the Internal Revenue Code. Any requested changes must be consistent with and due to the Qualifying Event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Loss or gain of coverage due to employee, employee's spouse and/or dependent(s) termination or start of employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with other parent or legal guardian
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing or becoming eligible for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)

IMPORTANT NOTES

If employee experiences a Qualifying Event, **Human Resources/Risk Management must be contacted within 30 days of the Qualifying Event** to make the appropriate changes to employee's coverage. Employee may be required to furnish valid documentation supporting a change in status or "Qualifying Event". If approved, changes may be effective the date of the Qualifying Event or the first of the month following the Qualifying Event. Newborns are effective on the date of birth. Qualifying Events will be processed in accordance with employer and carrier eligibility policy. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements.

Medical Insurance

The City offers medical insurance through Florida Blue to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plans, please refer to the carrier's Summary of Benefits and Coverage (SBC) document or contact Florida Blue's customer service.

Medical Insurance
Florida Blue BlueCare HMO Plan 55

24 Payroll Deductions - Per Pay Period Cost - Includes Medical and Dental Coverage

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Family	$333.47

Medical Insurance
Florida Blue BlueChoice PPO Plan 0727

24 Payroll Deductions - Per Pay Period Cost - Includes Medical and Dental Coverage

Tier of Coverage	Employee Cost
Employee Only	$0.00
Employee + Family	$376.62

****Please Note:** Medical and dental coverage is offered to all benefit-eligible employees as a package.*

Florida Blue | Customer Service: (800) 352-2583 | www.floridablue.com

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the Medical Plan(s) is provided as a supplement to this booklet being distributed to new hires and existing employees during the Open Enrollment Period. The summary is an important item in understanding employee's benefit options. A free paper copy of the SBC document may be requested or is also available as follows:

From: Human Resources/Risk Management
Address: 100 W. Atlantic Blvd., Suite 219
Pompano Beach, FL 33060
Phone: (954) 786-7945
Website: app.mybentek.com/copbfl

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting Human Resources/Risk Management.

If there are any questions about the plan offerings or coverage options, please contact Human Resources/Risk Management at (954) 786-7945.

Medical Plan Resources

Florida Blue offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other medical plan resources, please contact Florida Blue's customer service at (800) 352-2583 or visit www.floridablue.com.

Mobile App

Mobile app provides on-the-go access to the medical benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Blue365

Blue365 is a health and wellness discount program for products and services available to all Florida Blue members including:

- Eye Exam, Glasses, and Contact Lenses
- Hearing Care and Aids
- Fitness Club Memberships, Exercise Footwear and Apparel
- Weight Loss Management
- Alternative Medicine
- Elder Care Advisory Services
- Hotel Rooms and Travel Information

For more information, please contact Florida Blue at (800) 352-2583 or visit www.blue365deals.com/BCBSFL.

Telehealth

Florida Blue provides access to telehealth services as part of the medical plan. Teladoc Health is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergency medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with telehealth, such as:

- ✓ Acne
- ✓ Allergies
- ✓ Cold and Flu
- ✓ Fever
- ✓ Headache/Migraine
- ✓ Rash
- ✓ Sore Throat
- ✓ Stomachache
- ✓ UTIs and More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please contact Florida Blue.

Florida Blue
Teladoc Health | Customer Service: (800) 835-2362 | www.teladochealth.com

Florida Blue BlueCare HMO 55 Plan At-A-Glance

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueCare network.

Plan References

**Individual deductible and Out-of-Pocket limit does not apply if enrolled in the family plan.*

**Value Choice Providers (VCP): Additional cost savings available when choosing a designated VCP listed on the Florida Blue online provider directory.*

****Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please confirm they are contracted with Florida Blue's BlueCare (HMO) network prior to receiving services.*

Important Notes

Services received by providers or facilities not in the BlueCare (HMO) network, will not be covered.

Network	BlueCare
Calendar Year Deductible (CYD)	**In-Network**
Single	$250
Family*	$500
Coinsurance	
Member Responsibility	10%
Calendar Year Out-of-Pocket Limit	
Single	$2,500
Family*	$5,000
What Applies to the Out-of-Pocket Limit?	Deductible, Copays and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit *(PCP Election Required)*	$20 Copay/No Charge**
Specialist Office Visit *(No Referral Required)*	$35 Copay/No Charge**
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Bloodwork)****	$50 Copay
X-rays	$50 Copay
Advanced Imaging *(MRI, PET, CT)*	$75 Copay
Outpatient Surgery at Surgical Center	$75 Copay
Physician Services at Surgical Center	No Charge
Urgent Care *(Per Visit)*	$50 Copay/No Charge for Visits 1-2, then $20 Copay*
Hospital Services	
Inpatient Hospital *(Per Admission)*	$150 Copay Per Day/$450 Maximum
Outpatient Hospital *(Per Visit)*	$100 Copay
Physician Services at Hospital	No Charge
Emergency Room *(Per Visit)*	$75 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospital Services *(Per Admission)*	No Charge
Outpatient Services *(Per Visit)*	No Charge
Outpatient Office Visit	No Charge
Prescription Drugs *(Rx)*	
Generic	$10 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$50 Copay
Mail Order Drug *(90-Day Supply)*	2x Retail Copay

Florida Blue BlueChoice PPO 0727 Plan At-A-Glance

Network	BlueChoice	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Single	$500	
Family	$750	
Coinsurance		
Member Responsibility	20%	30%
Calendar Year Out-of-Pocket Limit		
Single	$2,000	
Family	$4,000	
What Applies to the Out-of-Pocket Limit?	Deductible, Coinsurance, Copays and Rx	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$25 Copay/No Charge**	30% After CYD
Specialist Office Visit	$35 Copay/No Charge**	30% After CYD
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Bloodwork)****	20% Coinsurance	30% Coinsurance
X-rays	20% After CYD	30% After CYD
Advanced Imaging *(MRI, PET, CT)*	20% After CYD	30% After CYD
Outpatient Surgery at Surgical Center	No Charge	30% After CYD
Physician Services at Surgical Center	20% After CYD	30% After CYD
Urgent Care *(Per Visit)*	$50 Copay/No Charge for Visits 1-2, then $25 Copay**	$50 Copay After CYD
Hospital Services		
Inpatient Hospital *(Per Admission)*	$100 PAD + 20% After CYD	$250 PAD + 30% After CYD
Outpatient Hospital *(Per Visit)*	No Charge	30% After CYD
Physician Services at Hospital	20% After CYD	20% After CYD
Emergency Room *(Per Visit)*	20% After CYD	20% After INN-CYD
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospital Services *(Per Admission)*	No Charge	30% Coinsurance
Outpatient Services *(Per Visit)*	No Charge	30% Coinsurance
Outpatient Office Visit	No Charge	30% Coinsurance
Prescription Drugs *(Rx)*		
Generic	$10 Copay	50% Coinsurance
Preferred Brand Name	$30 Copay	50% Coinsurance
Non-Preferred Brand Name	$50 Copay	50% Coinsurance
Mail Order Drug *(90-Day Supply)*	2x Retail Copay	50% Coinsurance

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridablue.com. When completing the necessary search criteria, select BlueChoice network.

Plan References

***Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by out-of-network providers, please refer to the Summary of Benefits and Coverage (SBC) document.*

***Value Choice Providers (VCP): Additional cost savings available when choosing a designated VCP listed on the Florida Blue online provider directory.*

****Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please confirm they are contracted with Florida Blue's BlueChoice (PPO) network prior to receiving services.*

Dental Insurance

Florida Combined Life BlueDental Choice Plan

The City offers dental insurance through Florida Combined Life to benefit-eligible employees. The cost per pay period for coverage is included in the medical premium deductions and a brief summary of benefits is provided on the following page. For more detailed information about the dental plan, please refer to the carrier's summary plan document or contact Florida Combined Life's customer service.

In-Network Benefits

The BlueDental Choice plan provides benefits for services received from in-network and out-of-network providers. It is also an open-access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Florida Combined Life BlueDental Choice. These participating dental providers have contractually agreed to accept Florida Combined Life's contracted fee or "allowed amount." This fee is the maximum amount a Florida Combined Life dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when member receives services by a non-participating Florida Combined Life BlueDental Choice provider. Florida Combined Life reimburses out-of-network services based on what it determines as the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member may be responsible for balance billing. Balance billing is the difference between Florida Combined Life's MRC and the amount charged by the out-of-network dental provider. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Calendar Year Deductible

The BlueDental Choice plan requires a $50 individual or a $100 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Calendar Year Benefit Maximum

The maximum benefit (coinsurance) the BlueDental Choice plan will pay for each covered member is $2,000 for in-network and out-of-network services combined. All services, including preventive, accumulate towards the benefit maximum. Once the plan's benefit maximum is met, the member will be responsible for future charges until next plan year.

Mobile App

Mobile app provides on-the-go access to the dental benefit account. Download the mobile app from the iPhone or Android app store. Using the mobile app, members are able to:

- View Benefits
- Download Member ID Cards
- Locate a Provider
- View Claims

Florida Combined Life
Customer Service: (888) 223-4892 | www.floridabluedental.com

Florida Combined Life BlueDental Choice Plan At-A-Glance

Network	BlueDental Choice	
Calendar Year Deductible (CYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$100	
Waived for Class I Services?	Yes	
Calendar Year Benefit Maximum		
Per Member	$2,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings		
Complete X-rays		
Bitewing X-rays		
Class II Services: Basic Restorative Care		
Fillings	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD *(Subject to Balance Billing)*
Simple Extractions		
Oral Surgery		
Periodontal Services		
Anesthetics		
Endodontics *(Root Canal Therapy)*		
Class III Services: Major Restorative Care		
Crowns	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD *(Subject to Balance Billing)*
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Florida Blue's customer service or visit www.floridabluedental.com. When completing the necessary search criteria, select BlueDental Choice network.

Plan References

***Out-of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the Out-of-Network Benefits section on the previous page.*

Important Notes

- *For any dental work expected to cost $200 or more, the plan will provide a "Pre-Determination of Benefits" upon the request of the dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.*
- *Waiting periods and age limitations may apply.*
- *Benefit frequency limitations may apply to certain services.*

Flexible Spending Accounts

The City offers Flexible Spending Accounts (FSA) administered through HealthEquity/EZ Receipts. The FSA plan year is from October 1 to September 30.

If employee or family member(s) has predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year. There are two (2) types of FSAs:

Health Care FSA

This account allows participant to set aside up to an annual maximum of $3,300. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participant to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and dependent adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from participant's paycheck for the Dependent Care FSA.

A sample list of qualified Health Care expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Prescription/Over-the-Counter Medications
- ✓ Menstrual Products
- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees
- ✓ Diagnostic Tests/Health Screenings
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses
- ✓ Hearing Aids and Exams
- ✓ Injections and Vaccinations
- ✓ LASIK Surgery
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees
- ✓ Sunscreen SPF 15 or Greater
- ✓ Wheelchairs

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Accounts *(Continued)*

FSA Guidelines

- Employee may carry over up to $660 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed (only if the employee re-enrolls the next year). Dependent Care funds cannot be carried over.
- The Health Care FSA has a 92 day run out period at the end of the plan year (until December 31st) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year.
- Employee can enroll in an FSA only during the Open Enrollment Period, New Hire Orientation, or Qualifying Life Events.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners healthcare expenses are not eligible for reimbursement in the employee FSA as Federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail, fax, online or through the HealthEquity/EZ Receipts mobile app. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. HealthEquity may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to the City. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

An employee earning $50,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.66 based on a 24 pay period schedule. As a result, health care expenses are paid with tax-free dollars, giving the employee a tax savings of $197.

	With a Health Care FSA	Without a Health Care FSA
Salary	$50,000	$50,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$49,000	$50,000
Estimated Tax 19.65% = 12% + 7.65% FICA	- $9,628	- $9,825
After Tax Expenses	- $0	- $1,000
Spendable Income	$39,372	$39,175
Tax Savings	**$197**	

Please Note: *Be conservative when estimating health care and/or dependent care expenses. IRS regulations state that any unused funds remaining in an FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $660 carry over that may be allowed for the Health Care FSA.* ***This rule is known as "use-it or lose-it."***

Using a Smartphone or Mobile Device

With EZ Receipts mobile app from HealthEquity/EZ Receipts, employees can file and manage reimbursement claims and receipts with a click of a smartphone or mobile device camera, from anywhere.

Use EZ Receipts:

- **Download the app from www.WageWorks.com, Apple App Store or Google Play Store.**
- **Log into account.**
- **Choose the type of receipt from the simple menu.**
- **Enter required information regarding the transaction.**
- **Use a smartphone camera or device to capture the documentation.**
- **Submit the image and details to HealthEquity/WageWorks.**

HealthEquity
Phone: (877) 924-3967 | www.healthequity.com

Voluntary Life and AD&D Insurance

Voluntary Employee Life and AD&D Insurance

Eligible employee may elect to purchase Voluntary Life and AD&D insurance through The Standard. Voluntary Life insurance offers coverage for employee, spouse and/or dependent child(ren) at different benefit levels.

New Hires may purchase Voluntary Employee Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $150,000.**

- Units can be purchased in increments of $10,000 to the maximum of $500,000.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 70
  - Reduces to 45% of the benefit amount at age 75
  - Reduces to 30% of the benefit amount at age 80
  - Reduces to 20% of the benefit amount at age 85
  - Reduces to 15% of the benefit amount at age 90
  - Reduces to 10% of the benefit amount at age 95

Voluntary Spouse Life and AD&D Insurance

New Hires may purchase Voluntary Spouse Life and AD&D insurance without being subject to Medical Underwriting, also known as Evidence of Insurability (EOI), **up to the Guaranteed Issue amount of $50,000.**

- Employee must participate in the Voluntary Employee Life and AD&D plan for spouse to participate.
- Units can be purchased in increments of $5,000 to a maximum of $250,000 not to exceed 100% of the employee's Voluntary Life coverage amount.
- Benefit amounts are subject to the following age reduction schedule:
  - Reduces to 65% of the benefit amount at age 70
  - Reduces to 45% of the benefit amount at age 75
  - Reduces to 30% of the benefit amount at age 80
  - Reduces to 20% of the benefit amount at age 85
  - Reduces to 15% of the benefit amount at age 90
  - Reduces to 10% of the benefit amount at age 95

Voluntary Life and AD&D Insurance Rate Table

Monthly Premium

Age Bracket	Employee/Spouse *(Rate Per $1,000 of Benefit)*
< 30	$0.106
30-34	$0.112
35-39	$0.129
40-44	$0.186
45-49	$0.275
50-54	$0.411
55-59	$0.638
60-64	$0.821
65-69	$1.172
70-74	$1.885
>75	$5.791

Voluntary Dependent Child(ren) Life and AD&D Insurance

- Employee must participate in Voluntary Employee Life and AD&D plan for dependent child(ren) to participate.
- Coverage may be purchased for dependent child(ren) from birth up to the date in which the dependent child reaches age 26 in the amount of $10,000 not to exceed 100% of the employee's Voluntary Life coverage amount.
- Monthly cost for Voluntary Dependent Child(ren) Life and AD&D coverage elected is $0.230 per $1,000 for any eligible dependent child(ren) enrolled.

Always remember to keep beneficiary information updated. Beneficiary information may be updated at anytime through Bentek.

The Standard | Customer Service: (800) 628-8600 | www.standard.com

Employee Assistance Program

The City cares about the well-being of all employees on and off the job and provides, at no cost, a comprehensive Employee Assistance Program (EAP) through Health Advocate. EAP offers employee and each family member access to licensed mental health professionals through a confidential program protected by State and Federal laws. EAP is available to help employee gain a better understanding of problems that affect them, locate the best professional help for a particular problem, and decide upon a plan of action. EAP counselors are professionally trained and certified in their fields and available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program (EAP)?

An Employee Assistance Program offers covered employees and family members/domestic partners free and convenient access to a range of confidential and professional services to help address a variety of problems that may negatively affect employee or family member's well-being. Coverage includes five (5) visits with a specialist, per person, per issue, per year, online material/tools and webinars. EAP offers counseling services on issues such as:

- ✓ Child Care Resources
- ✓ Legal Resources
- ✓ Grief and Bereavement
- ✓ Stress Management
- ✓ Depression and Anxiety
- ✓ Work Related Issues
- ✓ Adult & Elder Care Assistance
- ✓ Financial Resources
- ✓ Family and/or Marriage Issues
- ✓ Substance Abuse

Are Services Confidential?

Yes. Receipt of EAP services are completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), we will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor/manager will not receive specific information regarding the referred employee's case. The supervisor/manager will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Health Advocate | Customer Service: (877) 240-6863
Email: answers@healthadvocate.com
www.healthadvocate.com/members | Code: D8YVUGB

Behavioral Health Access Program

The Behavioral Health Access Program (BHAP) is here to help employees and their dependent family members by providing cost free mental health resources, education, guidance, and crisis intervention. Participation in the program can assist employees and families:

- Reduce stress symptoms
- Returning to feeling more productive
- Increase in job satisfaction
- Boost in confidence
- Support your longevity

The program includes important services such as:

- ✓ Training
- ✓ Critical Incident Stress Management
- ✓ Chaplaincy
- ✓ Counseling/EAP
- ✓ Leadership
- ✓ Peer Support
- ✓ Family Support
- ✓ Recovery Centers
- ✓ Appropriately Trained Clinicians

In addition, the City offers free access to a Health & Wellness coach to assist with exercising which promotes mental and physical wellness. For more information on BHAP, please visit the following websites:

Outreach Resources
https://wellness.pompanobeachfl.gov/wellness/resources

Guidance Support
https://wellness.pompanobeachfl.gov/wellness/support

Employees can also contact Nina Taxis, Nina.taxis@copbfl.com (954) 786-7865 if you would like to connect to a Peer Support Team member, learn more about becoming a Peer Support Team Member, or nominate someone who you feel possesses empathy and is trustworthy.

Scan to access the City's Wellness page using mobile device

Supplemental Benefits

Aflac

Aflac offers a variety of voluntary supplemental benefit plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction. Aflac pays money directly to employee, regardless of what other insurance plans they may have. Available Aflac plans include:

- ✓ Hospital Confinement Indemnity
- ✓ Critical Care Protection
- ✓ Short Term Disability
- ✓ Accident Advantage
- ✓ Cancer Protection Assurance
- ✓ Dental
- ✓ Group Term and Whole Life

To learn more about these Aflac plans contact customer service or the City's Human Resources/Risk Management.

Aflac | Customer Service: (800) 992-3522 | www.aflac.com

LegalShield

The City offers employee the opportunity to participate in a voluntary pre-paid legal program offered through LegalShield. By enrolling in the legal plan, participant and family member(s) will have direct access to a nationwide network of law firms for a variety of situations. Dependents are covered up to age 26, if living at home or a student. The plan provides assistance, but is not limited to the following benefits:

- ✓ Civil Litigation
- ✓ Bankruptcy
- ✓ Name Changes
- ✓ Civil Litigation
- ✓ Gender Rights
- ✓ Wills & Living Trusts
- ✓ Power of Attorney
- ✓ Real Estate
- ✓ Immigration Assistance
- ✓ Contract Review
- ✓ Adoption

IDShield

The City also offers employee the opportunity to participate in an identity theft plan called IDShield through LegalShield which protects employee, spouse and child(ren). IDShield can provide:

- ✓ Anti-Malware Protection
- ✓ Cyberbullying Protection
- ✓ Mobile Security
- ✓ Password Manager
- ✓ 3 Million Identity Fraud Protection
- ✓ Social Media Monitoring
- ✓ Reputation Management
- ✓ VPN Proxy One

There are many additional features offered along with the plan benefits such as licensed investigators being available 24 hours a day, seven (7) days a week, lost wallet assistance and fraud alerts.

Plan benefits include unlimited phone consultations. For additional information, please contact the City's dedicated Agent Barry Olfern as listed below, or visit the following website: https://www.shieldbenefits.com/copbfl

Legal Services and/or IDShield

	Employee Cost Per Pay Period	Employee Cost Per Month
Legal Shield	$10.15	$22.00
IDShield - Employee Only	$2.68	$5.80
IDShield - Employee + Family	$4.94	$10.70
Legal Shield & IDShield - Employee Only	$12.37	$26.80
Legal Shield & IDShield - Employee + Family	$14.17	$30.70

LegalShield | Customer Service: (888) 807-0407
Agent: Barry Olfern | Phone: (954) 655-2446
Email: barryolfern@legalshieldassociate.com

Claims, Billing & Benefit Assistance

If employees have questions on claims, receive bills from providers which they do not understand or would like general information on any of the employee benefits provided, please contact the Gehring Group Service Team.

The Gehring Group Service Team works directly with City of Pompano Beach and its employees to provide claims and benefits service and will assist employees with their concerns. Please remember this is in addition to the City's Human Resources/Risk Management and is not replacing assistance employee may need from Human Resources/Risk Management.

Employee may contact a claims specialist by:

1. Email: pompanobeach@gehringgroup.com

Please include your name, contact information and a brief description of the issue. A Gehring Group Claims Specialist will respond via email or phone call to gather additional information.

OR

2. Call: (800) 244-3696

When calling, please identify yourself as an employee of the City of Pompano Beach and ask to speak to a Claims Specialist or another member of the City of Pompano Beach's designated team to assist with questions or concerns.

Office hours are Monday through Friday, 8:30am – 5:00pm. If calling after office hours, please leave a message indicating you are a City of Pompano Beach employee who would like to speak to a Claims Specialist. Please leave full name, contact information and a brief message and a Claims Specialist will be in contact with you the following business day.

At the Gehring Group, our goal is to be your advocate and ensure issues are resolved as quickly as possible.

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctors' names and addresses or prescription medications.

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A RISK STRATEGIES COMPANY

3500 Kyoto Gardens Drive, Palm Beach Gardens, Florida 33410
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