



MIAMI BEACH

2024–2025 Retiree Benefits Guide

Welcome

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Benefits Enrollment

KNOW YOUR BENEFITS

Take time to review the available plans. In addition to this benefit summary, you may contact our Cigna onsite representative for any questions relating to your medical and dental plan elections:

Alexandra Alvarado
Office Phone: 305-673-7000 Ext: 26909
Email: Alexandra.Alvarado@Cigna.com
City Email: AlexandraAlvarado@miamibeachfl.gov
Office Hours: Monday-Friday 8:30 am – 5 pm

ENROLLING IN BENEFITS

Once you have made your choices, please complete, sign, and return the enrollment forms which have been provided with this benefit summary. Your enrollment form must be received in the Human Resources Department by **Friday, August 30, 2024** if you are changing or waiving any coverage. **However, if you are satisfied with your current elections and are not making any changes, you are not required to submit any enrollment forms.**

If you are newly enrolling any dependents in your medical and/or dental plan, please provide copies of those documents which are needed in order to prove dependent eligibility (i.e., marriage certificate for a spouse and birth certificate for a child).

How to return your enrollment form:

By mail to:

City of Miami Beach
Attn: HR / Benefits Open Enrollment
1700 Convention Center Drive
Miami Beach, FL 33139

In-person:

Deliver to a staff member at the front desk of the Human Resources Department on the third floor of City Hall (address above).

E-Mail:

Send to openenrollment@miamibeachfl.gov

Fax:

Send documents to **305.673.7529**

ELIGIBILITY

Retirees and eligible dependents may participate in the City sponsored insurance benefit programs. Eligible dependents are your lawful spouse, your registered domestic partner, your dependent child or stepchild who is:

- Less than 26 years old.
- From 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of his own, is a Florida state resident or a student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act.
- 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence may be required to be submitted to the plan as a condition of coverage after the date the child ceases to qualify above.

Proof that your dependents qualify for coverage is required by the City. Examples of this documentation includes a marriage certificate or license, a domestic partner affidavit, birth certificate, adoption certificate, court ordered guardianship or a copy of your divorce decree indicating that you are the parent responsible for health insurance coverage for your claimed dependent.

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Medical Plan Options

www.mycigna.com 800.244.6224	Cigna Open Access	Open Access HDHP Cigna	Cigna Open Access PPO (No NEW enrollees as of 10/1/2019)	Cigna True Choice Medicare Advantage PPO (MAPD) Plan
BENEFIT	In-Network Only	In-Network (Out of Network Available)	In-Network (Out of Network Available)	In-Network (Out of Network Available)
Coinsurance	100% / 0%	90% / 10%	80% / 20%	
Plan Year Deductible: Individual	\$0	\$2,500	\$500	\$0
Out-of-Pocket Maximum: Individual	\$1,500 Medical \$2,500 Rx	\$4,000	\$2,000 Medical \$2,500 Rx	\$0
Preventive Care Adult & Child Preventive Care	No Charge	No Charge	No Charge	\$0 Copay
Outpatient Care Primary Care Physician Office Visits Specialist Office Visits	\$20 Copay \$50 Copay	Deductible, then 10% Deductible, then 10%	\$20 Copay \$50 Copay	\$0 Copay \$0 Copay
Outpatient Surgery	\$200 Copay	Deductible, then 10%	\$100 Copay + ded +20%	\$0 Copay
Lab & X-Ray (Independent Facility) Blood Work X-Ray Advanced Imaging	No Charge No Charge \$200 Copay	Deductible, then 10% Deductible, then 10% Deductible, then 10%	No Charge No Charge Deductible, then 20%	\$0 Copay \$0 Copay \$0 Copay
Emergency Care Ambulance (medically necessary) At hospital emergency room Urgent Care (Walk-In Clinic)	No Charge \$250 Copay \$40 Copay	Deductible, then 10% Deductible, then 10% Deductible, then 10%	Deductible, then 20% \$200 Copay, then 20% \$40 Copay	\$0 Copay \$0 Copay \$0 Copay
Inpatient Hospitalization	\$250 Copay/Day	Deductible, then 10%	\$100 per Admission Copay + DED, then 20%	\$0 Copay per Admission
Routine Eye Exams and Eyewear	N/A	N/A	N/A	\$0 for exams, \$150 annual limit for eye wear
Hearing Aid Evaluation and Fitting	\$0 for testing/fitting of hearing aids. Includes \$2,000 annual max.	20% coinsurance for test- ing / fitting of hearing aids. Includes \$2,000 annual max.		\$0 fitting evaluation per hearing aid every 3 years \$0 copay for hearing aids (\$2,000 max per 3 years)
Mental Health Inpatient Outpatient	\$250 Copay/Day \$50 Copay	Deductible, then 10% Deductible, then 10%	\$100 Copay + DED, + 20% \$50 Copay	\$0 Copay \$0 Copay
Retail Pharmacy (30 day supply) Generic Preferred Brand Non-Preferred Brand	\$15 \$50 \$75	Deductible, then 10%	\$15 \$50 \$75	
Mail Order (90 day supply) Generic/Preferred /Non-Preferred	\$30/\$100/\$150 Copay	Deductible, then 10%	\$45/\$150/\$225 Copay	

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High Deductible Health Plan (HDHP)

High Deductible Health Plans provide comprehensive health care coverage just like a traditional health plan. However, with an HDHP, members are responsible for paying all medical expenses until the deductible is satisfied. HDHPs are also called consumer driven healthcare plans because employees are able to use tools to control both health care decisions and the costs associated with them. A typical consumer-directed plan might include:

- Web-based tools that support the decisions employees make regarding their health plan choices, health savings amounts, and
- Other support features, such as nurse telephone lines, care coaches, and disease management.

WHAT ARE SOME OF THE ADVANTAGES OF AN HDHP PLAN?

- Lower monthly premiums
- Insurance for serious medical conditions
- Access to a broad national network of providers
- Preventive care, including annual exams, women's health services and immunizations are covered at 100% (in-network) before you meet your deductible.
- Allows more control and flexibility for how your dollars are spent.
- Eligibility for a Health Savings Account (HSA) which builds savings with investment options.
- An HSA offers significant tax advantages: contributions to an HSA and any accumulated interest are tax-free.
- **Once on Medicare, you may not contribute to an HSA.**

DO I NEED TO CHOOSE A PRIMARY CARE PHYSICIAN?

No, you may choose any doctor or facility. However, using a Primary Care Physician to manage your overall care and to coordinate specialist care is recommended.

DO I NEED A REFERRAL TO SEE A SPECIALIST?

You don't need a referral but you will save money by choosing an in-network provider. It is your responsibility to ensure that any referrals (even from network providers) to specialists and other provider types are in-network. If the provider you were referred to is not in the plan's network, benefits will be paid at the non-network benefit level.

MEDICARE AND HSA'S

Can I enroll in or contribute to an HSA if I am enrolled in Medicare?

No. Once you enroll in Medicare Part A and/or B, you can no longer setup or contribute pre-tax dollars to an existing HSA.

Can I spend existing HSA funds if I'm enrolled in Medicare?

Yes, if the HSA was in existence prior to Medicare enrollment.

You can spend your HSA money on medical expenses, such as deductibles, premiums, copayments, and coinsurance.

If you use HSA funds for qualified medical expenses, it will continue to be tax-free. qualified medical expenses include Medicare premiums and copays.

Coordination with Medicare

Once eligible for Medicare, retirees and their dependents who participate in the City's health insurance plans are strongly encouraged to enroll in Medicare Part B (Part A is automatic). Part B provides coverage for lab tests, surgeries, doctor visits and some medical supplies.

When you become eligible for Medicare, Cigna will pay your claims as if you were enrolled in Part B even if you are not enrolled in Part B. If you continue on the City's plan, Cigna will pay your claims as the "secondary payer." **This means you will be subject to coordination of benefits and will incur significantly higher out-of-pocket expenses.**

The "primary payer" (Medicare) pays what it owes on your bills first, and then sends the rest to the "secondary payer" (Cigna) to pay in accordance with the summary plan description (SPD). As shown in the City's plan documents and plan summaries, the City's health plan is not free from out-of-pocket expenses.

In order to properly coordinate benefits, the City's health plan will assume that all retirees and dependents who are eligible are enrolled in Medicare Parts A and B. **Retirees who are ineligible for Medicare coverage are required to communicate this information to the City in writing.**

If you have any questions on how the City's health plan has coordinated a benefit with Medicare for one of your claims, please contact Cigna customer service at **800.244.6224**.

For additional information, you may also contact the City's Onsite Cigna Representative:

Alexandra Alvarado
Client Account Support Specialist for The City Of Miami Beach
Office Phone: 305-673-7000 Ext: 26909
Email: Alexandra.Alvarado@Cigna.com
City Email: AlexandraAlvarado@miamibeachfl.gov
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Medicare Advantage Plan

The City of Miami Beach will continue to offer a group Medicare Advantage PPO plan option is available to Medicare-eligible retirees and their Medicare–eligible dependents.

This Cigna Healthcare plan has been customized exclusively for City of Miami Beach retirees and combines Medicare Parts A, B, and D into one easy-to-use plan.

The plan option is the **Cigna® True Choice Medicare (PPO)**.

Cigna’s Medicare Advantage PPO plans are designed to support the specific needs of Medicare beneficiaries. The City of Miami Beach plan includes extra benefits such as routine hearing and vision coverage, in-home support, fitness, and more.

In addition to the new plan, the City of Miami Beach has retained RetireeFirst, a retiree benefits management solutions and advocacy service provider. With RetireeFirst, you can rest assured that you have a dedicated team of experts on your side for assistance with understanding and using your benefits.



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Advantage PPO Snapshot

Cigna Healthcare Medicare Advantage PPO benefits snapshot.

Medical benefits	In-network and out-of-network	Additional plan features
Annual deductible	\$0	<ul style="list-style-type: none"> • Yearly health check-up • Wellness incentives • 24 Hour Health Information Line • Retiree-focused clinical programs • Silver&Fit fitness • Caregiver support • Home Delivered Meals • Vision • Hearing • In-home support
Lifetime coverage maximum	No maximum	
Inpatient/Outpatient hospital	\$0	
Emergency care	\$0	
Ambulatory surgery center	\$0	
Doctor visit	\$0	
Specialist visit	\$0	
Preventive care	\$0	
Urgent care	\$0	
Lab services	\$0	
Prescription drug benefits	Integrated medical and prescription drug coverage	
Deductible	\$0	
Initial Coverage Limit and Coverage Gap	Retail (30-day supply)	Home delivery (90-day supply)
• Tier 1 generic	\$15	\$30
• Tier 2 preferred brand	\$50	\$100
• Tier 3 non-preferred brand	\$75	\$150
• Tier 4 specialty	\$75	N/A
Catastrophic phase	\$0, brand or generic	

With a Cigna Healthcare Medicare Advantage PPO plan, you can see any In-network or out-of-network provider with no referrals, as long as they accept Medicare and the plan. Accepting the plan means the doctor is willing to treat you and bill Cigna Healthcare, even if they are not contracted with us as an In-network Medicare Advantage provider. Unlike many other PPO plans, you pay the same cost-share to see an In-network provider or out-of-network provider.



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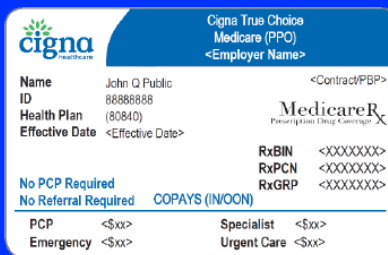
Medicare ID Card

Here's what you can expect after you enroll.

You'll receive a **Welcome Kit** in the mail.



Your **ID card** will arrive in a separate mailing.



Your **Cigna Healthy Today** card will arrive in a separate mailing.



Note: These examples are for illustrative purposes only. Depending on your plan, your welcome kit and cards may look different than the one shown here.

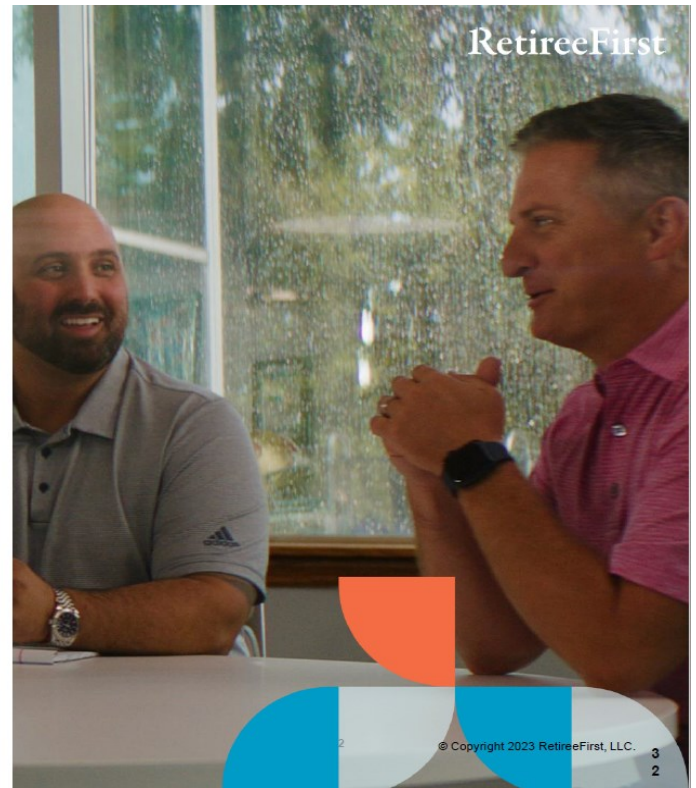
About RetireeFirst

Who We Are

RetireeFirst was founded in 2006 with a mission to simplify retiree healthcare for both plan sponsors and retirees.

How We Help

You have access to a team of Retiree Advocates who are US-based and available to help you navigate your retiree healthcare benefits and serve as a liaison between the insurance carrier, provider's office, and pharmacy.



How RetireeFirst Supports You

How can we help?

- Outreach to providers
- Medical prior authorizations
- Medical reimbursements
- Medical billing/Benefits questions
- Pharmacy outreach
- Mail order assistance
- Formulary lookup
- Prescription prior-authorization and/or step therapy
- Prescription billing/benefits questions

Some common questions

- "I received a bill, and I'm unsure if these services should be covered."
- "I need help finding a specialist"
- "I need help making an appointment"
- "What does this benefit mean for me and how can I take advantage of it?"
- "I need to know if a specific drug my doctor prescribed is covered"
- "I'm at the pharmacy and my medication costs more than normal"

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Retiree First



Retiree**First**

How to reach us!

City of Miami Beach Dedicated Retiree Line:

Toll free 1-855-460-6970 (TTY 711)

Monday-Friday, 8am-5pm EST

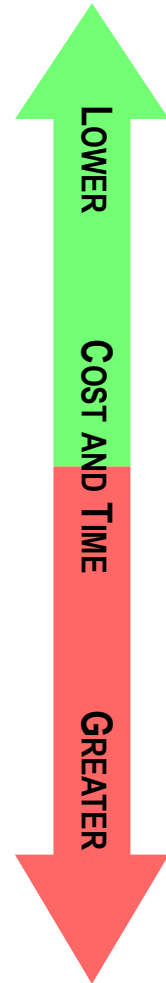
Know Before You Go!

GETTING THE RIGHT CARE

With so many options for getting care, sometimes it's difficult to make the right choice. The chart below can help you decide where to go and how you can save time and money.



WHERE TO GO	WHAT IT IS	TYPE OF CARE	
Cigna Telehealth Connection	Connect with a board-certified doctor via video or phone when where and how it works best for you.	<ul style="list-style-type: none"> • Colds and flu • Rashes • Sore throats 	<ul style="list-style-type: none"> • Stomachaches • Fever • Allergies
Convenience Care Clinic	Treats minor medical concerns. Staffed by Nurse Practitioners and Physician Assistants. Located in retail stores and pharmacies. Often open nights and weekends.	<ul style="list-style-type: none"> • Colds and flu • Rashes or skin conditions • Sore throat, earaches 	<ul style="list-style-type: none"> • Minor cuts or burns • Pregnancy testing • Vaccines • Sinus pain
Primary Care Physician	The best place to go for routine or preventive care, to keep track of medications, or for a referral to a specialist.	<ul style="list-style-type: none"> • General health issues • Routine Checkups 	<ul style="list-style-type: none"> • Preventive care • Immunizations and screenings
Urgent Care	For conditions that aren't life threatening. Staffed by nurses and doctors; usually have extended hours.	<ul style="list-style-type: none"> • Sprains • Minor cuts • Burns 	<ul style="list-style-type: none"> • Minor respiratory symptoms • Urinary tract infections
Emergency Room	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening call 911 or go to the nearest emergency room.	<ul style="list-style-type: none"> • Sudden numbness, weakness • Uncontrolled bleeding • Seizure / loss of consciousness 	<ul style="list-style-type: none"> • Chest pain • Shortness of breath • Head injury/major trauma • Blurry or loss of vision • Overdose



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SURPRISES ARE FOR BIRTHDAYS, NOT MEDICATION COSTS.

Use Price a Medication to see how much it will cost to fill your medication.

When it comes to medication costs, nobody likes surprises. That's why Cigna created the Price a Medication tool on the myCigna® App or website. You can easily compare the price of a medication before you get to the pharmacy counter – or, even before you leave the doctor's office.

The Price a Medication tool lets you:

- › Compare the price of your medication at retail pharmacies in your plan's network, as well as through Express Scripts Pharmacy®, our home delivery pharmacy^{1,2}
- › View lower-cost alternatives, if available.¹
- › See which medications your plan covers.
- › View your costs for a 30-day and 90-day supply, depending on what your plan allows.
- › Find out if your medication needs approval before your plan will cover it.



Shop wisely.

Did you know that your medication could cost you less at a different pharmacy?

Not all pharmacies charge the same amount for medications. When you and your doctor are considering the right medication for your treatment, knowing how much the medication costs and which pharmacies offer the best prices can help you avoid surprises when you fill it.



Start using the Price a Medication tool on the myCigna App today.



Together, all the way.®



1. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.

2. Not all plans offer home delivery as a covered pharmacy option. Please log in to the myCigna app or website, or check your plan materials, to learn more about the pharmacies in your plan's network. All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including ESI Mail Pharmacy Service, Inc. and Express Scripts Pharmacy, Inc. All pictures are used for illustrative purposes only.

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PAY \$0 FOR SELECT SPECIALTY MEDICATIONS



Participate in the SaveonSP program

Specialty medications can cost a lot of money. That's why your plan offers a program called SaveonSP,¹ which can help lower your out-of-pocket costs to \$0. And there's no extra cost to participate.²

Enroll in SaveonSP and save.

Certain specialty medications are eligible for the SaveonSP program.³ If you're filling an eligible medication, a representative from SaveonSP will call you to talk about enrolling in the program.

If you choose to participate, you'll pay \$0 for your medication. If you choose not to participate in SaveonSP, you'll pay a higher copay when you fill your medication.

Conditions supported by SaveonSP include, but are not limited to:

- › Hepatitis C
- › Multiple Sclerosis
- › Psoriasis
- › Inflammatory Bowel Disease
- › Rheumatoid Arthritis
- › Oncology

1. SaveonSP is an Express Scripts program, and Express Scripts is now a Cigna company. SaveonSP, Express Scripts and Cigna are working together to better serve you and all of your pharmacy, health and wellness needs.

2. SaveonSP is only available to non-Health Savings Account (HSA) plans. If your plan offers multiple plan options and you'd like to participate, you'll need to select a non-HSA plan during open enrollment. If you select a HSA plan during open enrollment, you won't be eligible for the SaveonSP program.

3. The drug classes, medications and associated copays included in this program are subject to change. Check your plan materials to see which medications are eligible for the SaveonSP program.

4. For illustrative purposes only. Plans may vary.



Here's an example of how it works.⁴

John's taking a specialty medication that's eligible for the SaveonSP program. His copay is currently \$70. His new copay will be \$1,000.

- › **If he participates in SaveonSP, he won't pay anything (\$0) out-of-pocket.** His full copay will be paid through a manufacturer copay assistance program, and the copay won't count toward his deductible or out-of-pocket maximum.
- › **If he decides not to participate in SaveonSP, he'll pay his full copay of \$1,000 out-of-pocket.** And the copay John pays won't count toward his deductible or out-of-pocket maximum.

Together, all the way.™



Para obtener ayuda en español llame al número en su tarjeta de Cigna.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Accredo Health Group, Inc., Express Scripts, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. "Accredo" refers to Accredo Health Group, Inc. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. "Accredo" is a trademark of Express Scripts Strategic Development, Inc.

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EASY TO REGISTER. EASY TO USE.

Get to know the full value of myCigna.



From programs that help improve your health to tools that help manage your health spending, there's so much you can do on myCigna.com or the myCigna® app.



Find in-network doctors, hospitals and medical services



Manage and track claims



See cost estimates for medical procedures



Compare quality of care information for doctors and hospitals



Access a variety of health and wellness tools and resources



The myCigna website and app both have an easy, interactive health assessment to help you learn more about your health and what you can do to improve it.



Register today

You can register online or through the app.

1. Go to the **myCigna.com** website or launch the **myCigna app** and select "Register Now"
2. **Enter** your requested information
3. **Confirm** your identity
4. **Create** your security information and provide your primary email address
5. **Review** and submit



Feel better-protected

Cigna is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on the myCigna website and app.

- › **Enhanced registration**
- › **Two-step authentication**

Together, all the way.®





Enhanced registration

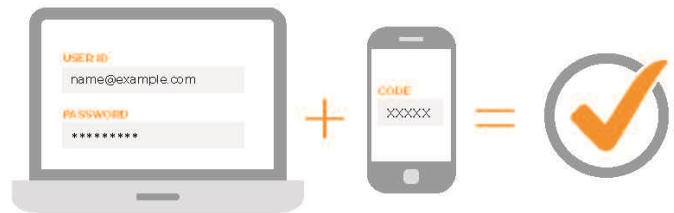
When you register for the first time on the myCigna website or app, you'll be required to provide a primary email address. Having an email address helps Cigna better protect the information in your myCigna account. We can send automatic alerts when you update your email or password. Your email address also can be used when you need help recovering your myCigna user ID or password.



Two-step authentication

With two-step authentication, you have the option of adding an extra layer of security to your myCigna account to further protect your claim, health and account information.

1. First, you'll be encouraged **to add, update and verify contact information – email addresses and mobile phone numbers.**
2. Once you enable two-step authentication and log in to your myCigna account, you'll be asked **to enter your user ID and password, as well as a six digit code that will be sent to either your email address or mobile phone number.** You'll also be offered to select "Remember this Device." If this choice is selected, you won't be prompted for a code each time you log in to your myCigna account from that device.



Questions?

If you have any questions about your myCigna account or your plan benefits, call the number on the back of your Cigna ID card. Customer service representatives are ready to speak with you 24/7/365.



Now compatible with iPhone® X devices

The Apple® Face ID® feature for iPhone X devices is a new way to unlock and authenticate your myCigna app. It's even more convenient than the Touch ID® tool, and makes authenticating fast and easy. Other iPhone users can still use Touch ID to log in to the app.*

Together, all the way.®



* Please refer to your phone's manufacturer for your phone's specific capabilities. The downloading and use of the myCigna app is subject to the terms and conditions of the app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

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All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. All pictures are used for illustrative purposes only.

Dental

DENTAL COVERAGE

Cigna's PPO dental plan is designed to allow you to seek care from the dentist of your choice, but you will incur lower out-of-pocket costs if you utilize in-network providers because of the negotiated discount rates.

Cigna's DHMO dental plan offers flexibility and savings with covered services subject to a copay schedule.

BENEFIT	CIGNA DHMO	CIGNA PPO	
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
www.MyCigna.com 800.244.6224	Must use participating providers. Plan pays 100% after fixed copayment for service	Must use participating providers. Plan payment is based on providers contracted fees	You may choose any licensed dental provider. Payment is based on a maximum reimbursable charge.
Annual Deductible	None	Individual: \$ 50 Family: \$150	Individual: \$ 50 Family: \$150
Benefit Maximums Annual Orthodontia Lifetime Maximum	None		\$2,500 \$1,500
Diagnostic & Preventive Services Prophylaxis (Cleanings); Oral Examinations; Topical Fluoride; Bitewing X-rays	Copay Schedule	Plan Pays 100%	Plan Pays 100%*
Basic Services Fillings; Minor Oral Surgery; Periodontics; Sealants; Space Maintainers	Copay Schedule	Plan Pays 80% After Deductible	Plan pays 80%* After Deductible
Major Services Bridges and Dentures; Crowns, Inlays, Onlays; Endodontics; Major Oral Surgery, Anesthesia	Copay Schedule	Plan Pays 50% After Deductible	Plan Pays 50%* After Deductible
Orthodontic Services	Copay Schedule (Adults & Children)	Plan Pays 50% (No deductible) (Dependent children up to age 26)	

*When using out-of-network providers balance billing may apply.

For new enrollees on the Cigna Dental PPO plan, no coverage is available for Major Services, Orthodontic Services and Implants for the first 12 months on the plan.

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Vision

VISION COVERAGE

Properly caring for your eyesight is of the utmost importance. As part of keeping up with maintaining your overall health, routine eye exams should be scheduled on a regular basis.

The cost of Vision coverage is included in your medical premium.
You must participate in one of the City's medical plans in order to enroll in vision coverage

www.eyemedvisioincare.com
866.299.1358

EYEMED SELECT VISION

BENEFIT	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
Eye Exam	\$0 Copay	\$0 Copay	Up to \$28
Frequency			
Exam	Once every plan year	Once every plan year	Once every plan year
Lenses	Once every plan year	Once every plan year	Once every plan year
Frames	Once every plan year	Once every plan year	Once every plan year
Frames	\$200 Allowance + 20% off amount over allowance	\$150 Allowance + 20% off amount over allowance	Up to \$75
Lenses			Up to
Single Vision Lenses	\$10 Copay	\$10 Copay	\$18
Bifocal Vision Lenses	\$10 Copay	\$10 Copay	\$32
Trifocal Vision Lenses	\$10 Copay	\$10 Copay	\$56
Lenticular Vision Lenses	\$10 Copay	\$10 Copay	\$56
Medically Necessary Contact Lenses	\$0 Copay	\$0 Copay	Up to \$200
Elective Contact Lenses (in lieu of frames and lenses)	\$150 Allowance	\$150 Allowance	\$120



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MEMBERSHIP PERKS: PLUS PROVIDERS

This PLUS can really add up

YOUR INROADS TO EXTRA BENEFITS

It's the little extras that make life fun – the icing on the cake, the sauce on the steak, and of course, the cash you keep when you visit a PLUS Provider.

Choosing an in-network eye doctor already helps you save on annual exams, frames and other perks. But to save even more, visit a PLUS Provider. Getting more without paying more? Now, that's a benefit.

A BIGGER DEAL IS A BIG DEAL

Visit a PLUS Provider and you get access to a supersized set of benefits – for starters, try a \$0 exam copay and more to spend on frames.* That's on top of everyday savings and other discounts from your EyeMed vision benefits.

YOUR PLUS PROVIDER BENEFITS

- \$0 exam copay
- Extra cash to spend on frames



LOOK FOR THE PLUS PROVIDER MARK

See exactly where you can boost your benefits on the Provider Locator at eyemed.com. With thousands of PLUS Providers across the country – retail, independent and online – finding one nearby is a snap.

SIMPLY SHOW UP AND SAVE

All PLUS Provider perks are built right into your vision benefits – no promo codes, no coupons, no paperwork. Simple, streamlined and stress-free.

Look for a PLUS Provider at eyemed.com



LENSCRAFTERS



 OPTICAL

*Frame allowance may vary by plan.

PDF-2005-M-278



Monthly Premiums

No Increase in Retiree Premium for the 2024-2025 Plan Year

Medical—Cigna Monthly Rates

	Cigna Open Access	Open Access HDHP Cigna	Cigna Open Access PPO (No NEW enrollees as of 10/1/2019)	Cigna True Choice Medicare Advantage PPO (MAPD) Plan
Coverage Tier	Standard	HDHP	PPO	Advantage
PRE-MEDICARE				
Single	\$354.00	\$228.00	\$772.00	N/A
Retiree + 1	\$742.00	\$476.00	\$1,620.00	N/A
Retiree + Sp + Child	\$1,025.00	\$656.00	\$1,892.00	N/A
MEDICARE				
Single	\$269.00	\$206.00	\$587.00	\$115.75
With Spouse O/U*	\$604.00	\$462.00	\$1,320.00	N/A
With Spouse O/O**	\$537.00	\$410.00	\$1,173.00	\$231.49
With Child	\$604.00	\$462.00	\$1,320.00	\$231.49
With Spouse/Child O/U*	\$757.00	\$578.00	\$1,654.00	N/A
With Spouse/Child O/O**	\$690.00	\$527.00	\$1,507.00	\$347.24
O/U* = Medicare Enrollee and Pre-Medicare Enrollee				
O/O** = Two Medicare Enrollees				

Dental—Cigna Monthly Rates

Coverage Tier	Cigna DHMO (P4XV0)	Cigna PPO
Single	\$8.68	\$23.03
Retiree + 1	\$15.20	\$44.39
Family	\$23.88	\$68.06

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Contact Information

BENEFIT	PLAN	CONTACT	WEBSITE / EMAIL
Medical	Cigna	800.244.6224	www.mycigna.com
Dental PPO & DHMO	Cigna	800.244.6224	www.mycigna.com
Vision Plan	EyeMed Vision	866.299.1358	www.eyemedvisioncare.com
Human Resources	City of Miami Beach	305.673.7524	www.miamibeachfl.gov
Pension Office	MBERP	305.673.7437	PENS_Dept@miamibeachfl.gov
RetireeFirst	Medicare Services	1-855-460-6970	www.retireefirst.com
BenefitsVIP	Member Services	866.293.9736	answers@benefitsvip.com

Disclosures

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is

qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose

dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the

information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

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Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance

coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid
Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

Disclosures

CHP+ Customer Service: 1-800-359-1991/
State Relay 711
Health Insurance Buy-In Program (HIBI):
<https://www.mycyhibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
<https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website:
<http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium
Webpage:
<https://www.maine.gov/dhhs/ofa/applications-forms>
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840
TTY: 711
Email:
masspreassistance@accenture.com

MINNESOTA – Medicaid
Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid
Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084
Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: <http://dhcnp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid
Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rte Share Line)

SOUTH CAROLINA – Medicaid
Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022 Website: <https://dhr.wv.gov/bms/>

WEST VIRGINIA – Medicaid and CHIP
<http://mywvhipp.com/>
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

This guide is intended for information purposes only. The plan documents, insurance certificates and policies will serve as the governing document for eligibility, benefits and premiums for the plans offered. In case of conflict between information in this guidebook and the official plan documents, the plan documents, policies and insurance certificates will prevail.

MIAMI BEACH

