MIAMIBEACH

2022-2023 Benefits Guide
Retired Employees

Welcome

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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.

Annual Benefits Enrollment

Know Your Benefits

During this annual open enrollment period, take time to review the benefits which are available to you for the upcoming plan year.
In addition to this benefit summary, you may call Cigna's open enrollment hotline for any questions relating to your medical and dental plan elections. The hotline is available 24 hours a day, 7 days a week. The phone number for the hotline is **800.564.7642.**

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 no later than **Friday August 26, 2022** 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 and any proof of dependency documents:
1) **By mail** to: City of Miami Beach
Attn: HR / Benefits Open Enrollment
1700 Convention Center Drive
Miami Beach, FL 33139

2) **In-person:** Deliver to a staff member at the front desk of the Human Resources Department on the third floor of City Hall (address under number 1 above).

3) **E-Mail:** send all documents to **openenrollment@miamibeachfl.gov**

4) **Fax:** send all documents to **305.673.7529**

If You Are Not Making Any Changes, there is no further action required.

Eligibility

Retirees and eligible dependents or members of their family may participate in the City-sponsored insurance benefit program. Proof that your covered dependents qualify for coverage is required by the City and could include your legal spouse, domestic partner, children or stepchildren. The City requires that you prove dependent eligibility by producing documentation at the time of enrollment—this documentation can include 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.

Eligible dependents for the City's health and dental plans are (1) your lawful spouse, (2) your registered domestic partner, (3) any child of yours 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 full-time or parttime student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act.
- Who is 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.

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Coordination with Medicare

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

If you do not enroll in Medicare Part B when eligible, Cigna will still pay your claim as if you were enrolled in Part B and treat your coverage through the City's plan 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 are enrolled in Medicare Parts A and B upon attaining age 65. 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**.

You may also contact Alexandra Alvarado, the City's Onsite Cigna Representative at **305.673.7000**, **extension 26909**, for additional information.

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Medical Plan Options

Administered by Cigna

www.mycigna.com 800.244.6224	Cigna Open Access	Cigna Open Access HDHP		Cigna Open Access PPO (No NEW enrollees as of 10/1/2019)	
BENEFIT	**In-Network Only**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Coinsurance	100% / 0%	90% / 10%	70% / 30%	80% / 20%	60% / 40%
Plan Year Deductible: Individual Family	$0 $0	$2,500 $5,000	$5,000 $10,000	$500 $1500	$750 $1,750
Out-of-Pocket Maximum: Individual	$1,500 Medical $2,500 Rx	$4,000	$8,000	$2,000 Medical $2,500 Rx	$2,000 Medical $2,500 Rx
Out-of-Pocket Maximum: Family	$3,000 Medical $5,000 Rx	$8,000	$16,000	$6,000 Medical $5,000 Rx	$6,000 Medical $5,000 Rx
Preventive Care Adult & Child Preventive Care	No Charge	No Charge	Deductible, then 30%	No Charge	Deductible, then 40%
Outpatient Care Primary Care Physician Office Visits Specialist Office Visits	$20 Copay $50 Copay	Deductible, then 10% Deductible, then 10%	Deductible, then 30% Deductible, then 30%	$20 Copay $50 Copay	Deductible, then 40% Deductible, then 40%
Outpatient Surgery	$200 Copay	Deductible, then 10%	Deductible, then 30%	$100 per Visit Copay + DED, then 20%	$500 per Visit Copay + DED, then 40%
Lab & X-Ray at Independent Facility Blood Work X-Ray Advanced Imaging	No Charge No Charge $200 Copay	Deductible, then 10% Deductible, then 10% Deductible, then 10%	Deductible, then 30% Deductible, then 30% Deductible, then 30%	No Charge No Charge Deductible, then 20%	Deductible, then 40% Deductible, then 40% Deductible, then 40%
Emergency Care Ambulance when 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 10% Deductible, then 10% Deductible, then 30%	Deductible, then 20% $200 Copay, then 20% $40 Copay	Deductible, then 20% $200 Copay then 20% Deductible, then 40%
Inpatient Hospitalization	$250 Copay/Day	Deductible, then 10%	Deductible, then 30%	$100 per Admission Copay + DED, then 20%	$500 per Admission Copay + DED, then 40%
Mental Health Inpatient	$250 Copay/Day	Deductible, then 10%	Deductible, then 30%	$100 per Admission Copay + DED, then 20%	$500 per Admission Copay + DED, then 40%
Mental Health Outpatient	$50 Copay	Deductible, then 10%	Deductible, then 30%	$50 Copay	Deductible, then 40%
Prescription Drugs **Retail Pharmacy** (30 day supply) Generic/Preferred Brand/Non-Preferred Brand **Mail Order** (90 day supply) Generic/Preferred Brand/Non-Preferred	 $15/$50/$75 Copay $30/$100/$150 Copay	 Deductible, then 10% Deductible, then 10%	 Deductible, then 30% Not Covered	 $15/$50/$75 Copay $45/$150/$225 Copay	 30% Coinsurance Not Covered

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High Deductible Health Plan (HDHP)

A HDHP provides comprehensive health care coverage like a traditional health plan where members are responsible for paying for their medical expenses before the deductible is satisfied. HDHPs are also referred to as consumer driven health care plans because employees are able to use incentives and 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.

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What are some of the advantages to an HDHP plan?

- Lower monthly premiums,
- Insured against serious medical conditions,
- Maintain more control and flexibility for how your dollars are spent.
- Eligibility for a Health Savings Account (HSA) which builds savings with investment options.
- You have 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.

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.

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HEALTHIER STARTS HERE

How Cigna makes a difference

Cigna makes it easy to be healthier.

Cigna offers so much more than your employer's medical coverage. From helping you answer health questions 24 hours a day to a virtual team of health and wellness coaches, we're here for you.

24/7/365 service

Whenever you need us, just call the toll-free number printed on the back of your Cigna ID card 24 hours a day, seven days a week, 365 days a year.

- Get answers to health, claims and plan questions.
- Order an ID card, update information and check claim status.
- Find a health advocate for help with improving specific health issues.
- Speak with a Spanish speaking service representative or someone who can translate one of 200 languages.

Health Information Line

Have a health question? You can talk with a clinician 24 hours a day, seven days a week.

- Get help deciding where and when you should get treatment for your immediate care needs.
- Call if you need general health information or have a specific health concern.
- You can also listen to hundreds of podcasts to help you stay informed about your health.

Select a topic and listen via live-stream on your computer via **myCigna.com**.

Network of quality doctors

You can save money when you use a doctor, hospital or facility that's part of your plan's Cigna network. It's easy to find quality, cost-effective care right where you need it. You can find a doctor right on Cigna.com or on the myCigna® website or app once enrolled.

Preventive care covered 100% in-network

Getting and staying healthy is important. That's why certain preventive care services are totally covered when you use an in-network doctor. These services may include:[1]

- Screenings for blood pressure, cholesterol and diabetes.
- Testing for colon cancer.
- Mammograms and Pap tests.

For a complete list of covered preventive care services, see your plan materials or, for more information, go to **Cigna.com/takecontrol**.

Answers by Cigna for Amazon Alexa

Need help with health plan or insurance terms? Just ask Alexa on all Amazon Echo devices. Enable the Answers by Cigna skill and take health care into your own hands – without so much as lifting a finger.[2]

JUST ASK amazon alexa

myCigna

Where you will find everything you need to stay on top of your plan, and your health.

- Find in-network doctors and medical services.
- View ID card information.
- Manage and review your coverage.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, or their affiliates.

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- Manage and track claims.
- Take your health assessment.
- Compare cost and quality information for doctors and hospitals.
- Access a variety of health and wellness tools and resources.

You can also access myCigna on the go by downloading the myCigna App.[3]

Telehealth for 24/7 care

Cigna Telehealth Connection helps you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. You can connect with a board-certified provider via video chat or phone, when, where and how it works best for you.[4]

- **Choose when:** 24/7/365. Day or night, weekdays, weekends and holidays.
- **Choose where:** Home, work or on the go.
- **Choose how:** Phone or video chat.

See your enrollment materials for details.

Know before you go

Here's an at-a-glance view of your options when you need medical care.[5] In an emergency, always dial 911 or visit the nearest emergency room.

	Cost	Wait time	Severity
Cigna Telehealth Connection	$		
Convenience care clinic	$		
Primary care provider	$$		
Urgent care center	$$$		
Emergency room	$$$$		

Cigna Healthy Rewards®[6]

Get discounts on the health products and programs you use every day for weight management, nutrition, vision, hearing care and more.

Just use your ID card when you pay and let the savings begin.

Cigna Veteran Support Line

This free hotline is available 24/7/365 to all veterans, their families and caregivers. No need to be a Cigna customer. Cigna stands ready to connect you with:

- Pain management resources.
- Substance use counseling.
- Financial support.
- Food, clothing, housing.
- Legal assistance.
- Parenting and child care.
- Aging services.
- Weekly Mindfulness for Vets sessions by phone and more.

Call **855.244.6211**.

Pain management resources

Visit **Cigna.com/helpwithpain** or text 25792 to receive tips for healthy pain management[7]

1. Plans may vary and not all preventive services are covered. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). See your plan materials for a complete list of covered preventive care services.
2. The Answers by Cigna skill is for informational and educational purposes only. You are encouraged to consult a licensed insurance agent and review your plan documents for the details of your specific health plan or insurance policy.
3. The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply.
4. Telehealth services are provided by independent third-party providers. These services are provided exclusively by such third-party providers, and not by Cigna. Providers are solely responsible for any treatment provided. Not all providers have video chat capabilities and video chat is not available in all areas. Telehealth services may not be available to all plan types or in all areas. A primary care provider referral is not required for this service.
5. This chart is for illustrative purposes only and is not medical advice. Actual costs and wait times may vary. Always consult your doctor for appropriate examinations, treatment, testing and care recommendations, including prior to choosing a provider for care. In an emergency, dial 911 or visit the nearest emergency room.
6. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. **A discount program is NOT insurance and you must pay the entire discounted charge.**
7. Message and data rates may apply. To view our Privacy policy, please visit Cigna.com/Privacy. This service is for educational purposes only. Medical advice is not provided.

Health care providers that participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients; they are not agents of Cigna. Product availability may vary by location and plan type and is subject to change.

All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan materials.

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KNOW BEFORE YOU GO

Lower — Cost and time — Greater

	Virtual care	Convenience care clinic	Health care provider's office	Urgent care center	Emergency room
	For minor medical conditions. Connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit **myCigna.com**, or call MDLIVE at **888.726.3171** to talk with a doctor 24/7.*	For minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care or to keep track of medications. Many PCPs offer virtual care. Contact your PCP to schedule an in-person or virtual care visit. Find a PCP on **myCigna.com**.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life threatening, call 911 or go to the nearest ER. "Freestanding" ER locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed at a much higher cost than at other health care facilities.
Conditions treated**	› Colds and flu › Rashes › Sore throats › Headaches › Stomachaches › Fever › Allergies › Acne › Urinary tract infections (UTIs) and more	› Colds and flu › Rashes or skin conditions › Sore throats, earaches, sinus pain › Minor cuts or burns › Pregnancy testing › Vaccines	› General health issues › Preventive care › Routine check-ups › Vaccines and screenings	› Fever and flu symptoms › Minor cuts, sprains, burns, rashes › Headaches › Lower back pain › Joint pain › Minor respiratory symptoms › UTIs	› Sudden numbness, weakness › Uncontrolled bleeding › Seizure or loss of consciousness › Shortness of breath › Chest pain › Head injury/major trauma › Blurry or loss of vision › Severe cuts or burns › Overdose
Your cost and time	› Costs the same or less than a visit with your primary care provider (PCP) › Appointments typically in an hour or less › No need to leave home or work	› Same or lower than provider's office › No appointment needed	› May charge copay/ coinsurance and/ or deductible › Usually need appointment › Short wait times	› Costs lower than emergency room (ER) › No appointment needed › Wait times vary	› Highest cost › No appointment needed › Wait times may be long

Cigna Health Information Line

A telephone service staffed by clinicians who help you understand and make informed decisions about health issues you are experiencing, at no extra cost. These clinicians can help you choose the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a PCP's appointment or finding the nearest in-network urgent care center. Just call the number on your Cigna ID card, go to **myCigna.com** or use the **myCigna® App**.*** Open 24/7.

Together, all the way.®

Offered by Cigna Health and Life Insurance Company or its affiliates.

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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.

Download on the App Store | GET IT ON Google Play

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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.

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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

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.

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.

Together, all the way.®

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

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HEALTHY CHOICES DESERVE HEALTHY DISCOUNTS

Start saving today with Cigna Healthy Rewards®*

Just use your Cigna ID wallet card when you pay and let the savings begin.

Get discounts on the health products and programs you use every day for:

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices**
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts**

Real brands. Real discounts. Real easy.

Log into **myCigna.com** and navigate to Healthy Rewards Discount Program or call **800.870.3470**.

For Cigna customers who don't have access to **myCigna.com** and want an Active&Fit Direct™ gym membership:

- Call **800.870.3470**; and
- Press 3 to be transferred to a customer service agent.

* Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your your plan benefi ts. **A discount program is NOT insurance, and you must pay the entire discounted charge.** All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.

** Fitness Membership and Devices along with Yoga Products and Virtual Workouts can only be accessed by login into **myCigna.com** and navigating to Healthy Rewards Discount Program.

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CUSTOMER SUCCESS STORY

Joan breaks a 30-year bad habit with Cigna's Tobacco Cessation Program

Meet Joan

- 51 years old
- Smoked for 30 years

Her risk factors

- High blood sugar
- Overweight
- High cholesterol and triglycerides
- High blood pressure

It's never too late to get healthy

Joan smoked about a pack of cigarettes a day for 30 years. She never tried to quit before. And at age 51, she found herself facing several serious health problems. She had a high risk of heart attack, stroke and diabetes. She knew she needed to make a change.

Joan felt very alone, but she wasn't. Cigna's Tobacco Cessation Program was there for her. For every step of her journey.

Help was just a call away

Joan contacted Cigna's Tobacco Cessation Program and talked with a wellness coach. On the first call, Joan's coach told her about different ways to quit smoking.

- Joan chose a method known as nicotine fading.
- She eventually moved to nicotine replacement therapy gum.
- She got down to 1–2 cigarettes a day.
- Joan worked with her coach about how to quit completely.
- She struggled with not smoking at work.

Overcoming barriers

Not smoking at work was hard for Joan. Her coworker wasn't supportive of her healthy changes. And when she stopped taking smoke breaks, she stopped taking breaks altogether. This increased her stress levels. Together, Joan and her coach worked to:

- Manage stress triggers
- Take regular breaks during her workday

To learn more, call 888-123-1234

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company or its affiliates.

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Dental

Dental Coverage

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

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 DHMO	CIGNA PPO	
BENEFIT	**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% (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			
Single Vision Lenses	$10 Copay	$10 Copay	Up to $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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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

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

*Frame allowance may vary by plan.

PDF-2005-M-278

Monthly Premiums

No Increase in Retiree Premium for the 2022-2023 Plan Year			
Medical—Cigna Monthly Rates			
	OAP In-Network Only	**OAP**	**OAP**
Coverage Tier	**Standard**	**HDHP**	**PPO**
PRE-MEDICARE			
Single	$354.00	$228.00	$772.00
Retiree + 1	$742.00	$476.00	$1,620.00
Family	$1,025.00	$656.00	$1,892.00
MEDICARE			
Single	$269.00	$206.00	$587.00
With Spouse O/U*	$604.00	$462.00	$1,320.00
With Spouse O/O**	$537.00	$410.00	$1,173.00
With Child	$604.00	$462.00	$1,320.00
With Spouse/Child O/U*	$757.00	$578.00	$1,654.00
With Spouse/Child O/O**	$690.00	$527.00	$1,507.00
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	$44.40
Family	$23.88	$68.06

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

If you have questions regarding any of the benefits, please contact your dedicated BenefitsVIP team at 866.286.5354 or email answers@benefitsvip.com.

Monday—Friday, 8:30am—8:00pm (EST).

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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 <u>are no more restrictive that 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.</u>

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.

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE

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Disclosures

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.
I
f 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 January 31, 2022. 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:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA: Medicaid
Website:
Health Insurance Premium Payment (HIPP) Program 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
CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service:
1-855-692-6442

FLORIDA: Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA: Medicaid
A 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

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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

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

MASSACHUSETTS: Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

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

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://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE: Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
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: http://www.nd.gov/dhs/

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Disclosures

services/medicalserv/medicaid/
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
http://www.oregonhealthcare.gov/
index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA: Medicaid
Website:
https://www.dhs.pa.gov/Services/
Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND: Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347,
or 401-462-0311 (Direct Rite 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: http://gethipptexas.com/
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:
http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA: Medicaid and CHIP
Website: https://www.coverva.org/
en/famis-select https://
www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone:1-800-432-5924

WASHINGTON: Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA: Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
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 January 31, 2022, 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 1/31/2023)

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MIAMIBEACH

Human Resources Department
1700 Convention Center Drive,
Miami Beach, FL 33139
Tel: 305.673.7524 | Fax: 305.673.7023
openenrollment@miamibeachfl.gov

This guide was prepared by our broker partner:

FOUNDATION
RISK PARTNERS

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