2023–2024 Retiree Benefits Guide

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 by **Friday August 31,2023** 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

If you are satisfied with your current benefit elections and you would like to make NO changes, no further action is needed.

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) you dependent child 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.
- 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.

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 Thomas Olloqui, the City's Onsite Cigna Representative at **305.673.7000**, **extension 26909**, for additional information.

Medical Plan Options

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 Family	$1,500 Medical $2,500 Rx $3,000 Medical $5,000 Rx	$4,000 $8,000	$8,000 $16,000	$2,000 Medical $2,500 Rx $6,000 Medical $5,000 Rx	$2,000 Medical $2,500 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 Outpatient	$250 Copay/Day $50 Copay	Deductible, then 10% Deductible, then 10%	Deductible, then 30% Deductible, then 30%	$100 per Admission Copay + DED, then 20% $50 Copay	$500 per Admission Copay + DED, then 40% 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.
- Together with the HSA, there are significant tax advantages, as any amounts you put in your HSA and any interest that accumulates are tax-free.
- The City also contributes to your HSA if you elect the HDHP with 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.

A new Medicare plan option will be available for January 1, 2024!

We are pleased to share a new group Medicare Advantage PPO plan option will be offered to Medicare-eligible City of Miami Beach retirees and dependents beginning January 1, 2024.

This new 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 new plan option will be **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.

City of Miami Beach Medicare Advantage Open Enrollment will start on November 1.
Watch your mail for more coverage details, coming next month.

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.®

Cigna®

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.

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.

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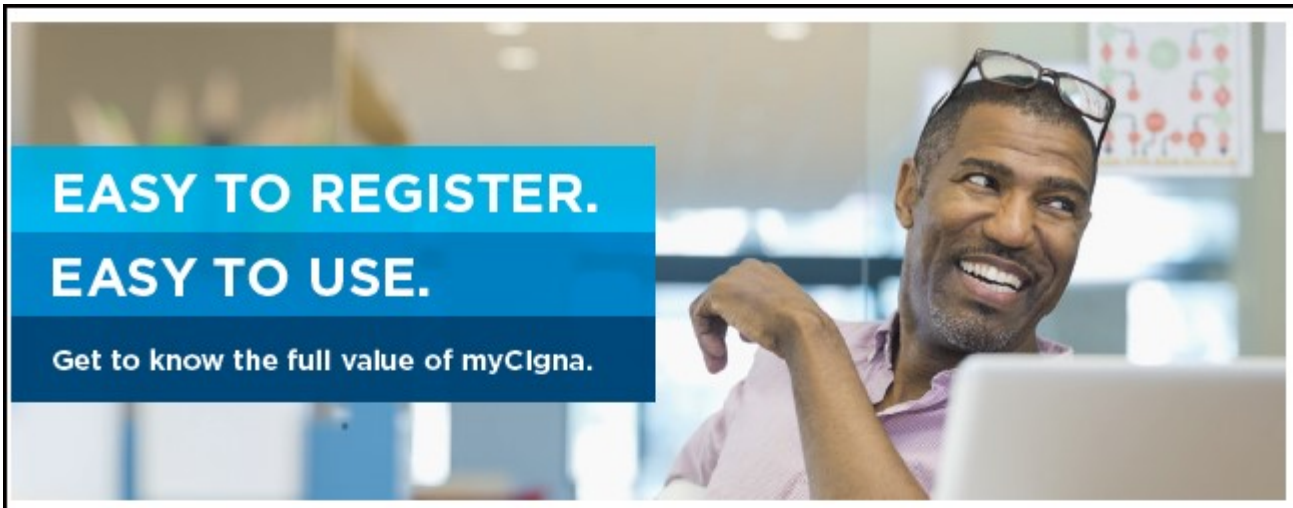
Para obtener ayuda en español llame al número en su tarjeta de Cigna.

official plan documents, the plan documents, policies and insurance certificates will prevail.



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**

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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.®

Cigna.

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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.

	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.

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

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 2023-2024 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	$44.39
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

Important Notice from City of Miami Beach
About
Your Prescription Drug Coverage and Medicare

If you and/or your covered dependents are not Medicare eligible, this document is for information purposes only.

However, if any of your covered benefit eligible dependents are Medicare eligible, please read this information carefully so that you and your dependents can make an informed decision regarding their prescription drugs.

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with City of Miami Beach and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Miami Beach has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Under your coverage with City of Miami Beach, you are currently offered a prescription drug program that covers the following:

HMO Benefit Plan	**Retail – 30-day supply**	**Mail Order - Up to a 90-day supply (Certain Maintenance Drugs)**
Generic Prescriptions Preferred Brand Prescriptions Non-Preferred Brand Prescription	$15 co-pay $50 co-pay $75 co-pay	$30 co-pay $100 co-pay $150 co-pay
PPO Benefit Plan	**Retail – 30-day supply**	**Mail Order - Up to a 90-day supply (Certain Maintenance Drugs)**
Generic Prescriptions Preferred Brand Prescriptions Non-Preferred Brand Prescription	$15 co-pay $50 co-pay $75 co-pay	$45 co-pay $150 co-pay $225 co-pay

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HDHP Benefit Plan	Retail – 30 day supply	Mail Order - Up to a 90 day supply (Certain Maintenance Drugs)
Generic Prescriptions	Deductible then 10%	Deductible then 10%
Preferred Brand Prescriptions	Deductible then 10%	Deductible then 10%
Non-Preferred Brand Prescription	Deductible then 10%	Deductible then 10%

Medicare Part D Plan

By contrast, the Medicare Part D Benefit is structured to provide coverage for prescription drug coverage as follows:

- Annual Deductible of $545.
- Initial Coverage Limit of $5,030 inclusive of the Annual Deductible. Cost to Medicare enrollees vary based on plan.
- Donut Hole maximum of $3,515 begins once Initial Coverage limit is reached and ends when there is a total spend of $8,000. Part D enrollees will receive a 75% Donut Hole discount on the total cost of their brand-name drugs purchased while in the Donut Hole. Medicare Part D beneficiaries who reach the Donut Hole will also pay a maximum of 25% co-pay on generic drugs purchased while in the Coverage Gap.
- True Out of Pocket Maximum of $8,000.

When can you join a Medicare Drug Plan?
Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of Miami Beach group health plan coverage will not be affected. You and your dependents can enroll in a Part D plan as a supplement to, or in lieu of, the group health plan coverage. However, if your existing prescription drug coverage is under a Medicare Advantage Plan, you cannot have an existing prescription drug coverage and Part D coverage.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the City of Miami Beach medical benefit plan during an open enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of Miami Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & you" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program for personalized help.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TYY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Name of Entity/Sender:	The City of Miami Beach
Contact--Position/Office:	Human Resources
Address:	1700 Convention Center Drive Miami Beach, FL 33139
Phone Number:	305-673-7000

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Cigna changes. You also may request a copy.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

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 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.

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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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 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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