

2026-2027 ACTIVE EMPLOYEE BENEFITS GUIDE

Open Enrollment:
August 20 to September 2

Benefits Overview

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City of Miami Beach is dedicated to offering a comprehensive benefits program as part of your overall compensation package. We hope this will aid in your financial planning now and in the future. We encourage you to familiarize yourself with your benefits to choose the best plans for you and your family.

Benefits Guide Overview

This benefits guide offers a comprehensive overview of our benefits and instructions on how to enroll in or access them. Receipt of this guide does not guarantee your eligibility for any benefits described within. The information in this guide supersedes all previous summaries. As this guide is only a summary, it does not cover every detail of the benefit programs. More detailed information can be found in the Summary Plan Description (SPD) and the applicable plan document, which often serves as the SPD. In case of a discrepancy between this guide and the plan document, the plan document will prevail. No rights will accrue to you or your dependents due to any statement, error, or omission in this guide. While reasonable efforts are made to inform employees of any changes to benefit plans, the City reserves the right to amend, replace, or terminate any benefit plans described in this booklet without prior notice to employees.

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

Monday—Friday, 8:30am—8:00pm (ET).

Welcome

MIAMIBEACH

Dear Team Miami Beach,



Our Human Resources (HR) team continues to work diligently to ensure your benefits offerings support your physical, mental, and financial well-being. This year is no different! I am pleased to share several updates and enhancements that reflect our ongoing investment in you.

First, I'm proud to announce that, for the 8th consecutive year, there will be **no increase** in employee health insurance premiums. **That is almost a decade of quality care sheltered from cost increases** caused by inflation and other economic factors beyond our control. Also, employees enrolled in any tier of coverage in the High-Deductible Health Plan (HDHP) will continue to receive a **$50 monthly credit**—essentially rendering this plan free to those in the employee-only tier of coverage. There is no greater showing of our appreciation to your contributions to this City than keeping health insurance—an indispensable benefit—affordable!

You can also anticipate **substantial savings in fees on deferred 457(b) accounts**. Starting in the new benefit plan year Nationwide Retirement will be our exclusive administrator for deferred retirement and defined contribution plans—457(b), OBRA, and 401(a). In exchange, Nationwide will reduce its fees. Stay tuned for additional enhancements—such as a five-year 3.5% fixed account offering, updated fund line-up, and reduced managed account fees—that will help grow your investments! As a result, starting October 1, 2026, new 457(b) accounts opened by any employee will be administered by Nationwide. Those with MissionSquare accounts opened on or before September 30, 2026 may remain in your plan and make investment updates as usual; however, no new entrants will be enrolled through MissionSquare with the exception of Police and Fire participants in their respective Retirement Health Savings PEHP plan.

The City continues to partner with Pierce Insurance to support you through the benefits enrollment process. Furthermore, I want to highlight a valuable concierge resource, **Benefits VIP**: a dedicated multilingual team of benefits specialists ready to resolve your insurance concerns. Through Benefits VIP, employees have year-round access to coverage and claims support. You'll find their contact information on the page margins of this guide. I trust that these support tools, in addition to our HR team, will help you make the right choice from among the several benefit offerings available to you and your family.

Proactive review of your benefits during Open Enrollment is strongly encouraged for all employees! If you need to make changes, Open Enrollment is the time to do so. Even if you have no changes to make, you must review your current selections, dependents, and beneficiaries to confirm enrollment and acknowledge your continued elections. Whether selecting new coverage or maintaining current plans, **everyone should take this important once-a-year opportunity to review their choices before September 2**. If you fail to take action, you risk being committed to a portfolio of benefits that may no longer serve your evolving needs. Please take time to inform yourself about the available offerings and elect, whether through an in-person or virtual appointment, a phone call, or through convenient 24/7 self-service online at pierceins.com/miamibeach. Visiting benefits counselors will also be stationed at locations across the City to assist.

Finally, **Open Enrollment is a valuable opportunity to clean-up your list of dependents**. Later this year, the City will partner with a team of auditors to ensure that all dependents enrolled in any City-sponsored Cigna medical plans are eligible to remain enrolled. Avoid coverage, deduction, and claims surprises: take action now to remain compliant and avoid potential future financial burdens. Dependent eligibility policies are described in detail within this guide.

As we begin the 2026–27 benefit plan year, I want to thank each of you for the work you do quietly, consistently, and with dedication every day for the City of Miami Beach. **Your commitment to public service is the driving force behind our success**, and I remain honored to lead such an outstanding team as City Manager. Your health, your peace of mind, and your future all matter to me, and I hope this year brings new opportunities for you to feel empowered and supported by your City. Let's make the most of our benefits and stay Miami Beach Strong together!

Respectfully,

Eric Carpenter
City Manager

Annual Enrollment

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Enrolling In Benefits for the 10/1/2026 Plan Year

Open Enrollment will be held from August 20th through September 2nd this year. Employees will be able to log in to the BenSelect platform through www.pierceins.com/miamibeach to complete their open enrollment selections. This enrollment platform can be accessed from employee workstations or home computers. For assistance with open enrollment selections, please contact our benefits partner, Pierce Insurance, at 800-421-3142, Monday - Friday, 8:00am - 5:00pm. Live chat and more information can be found at www.pierceins.com/miamibeach.

IMPORTANT REMINDERS

$50 Credit on All HDHP Enrollments

Employees who enroll in any tier of coverage in the High-Deductible Health Plan (HDHP) will receive a $50 monthly credit—essentially rendering the HDHP plan free to employees who enroll in the employee-only tier of coverage.

Year-Round Benefits Support

City of Miami Beach continues to partner with Pierce Insurance to provide employees with personal one-on-one appointments in English, Spanish or Creole. After Open Enrollment, employees can visit https://pierceins.com/miamibeach/ or call 800-421-3142 Monday-Friday, 8:00am—5:00pm to speak with a benefits counselor in English or Spanish.

Employees also have access to BenefitsVIP, an advocacy service available via email or phone. Employees or their dependents can contact a Benefits Advocate for questions regarding plan coverages, finding in-network providers, understanding bills, filing disability claims, etc. BenefitsVIP is available Monday - Friday, 8:30am - 8:00pm at 866.286.5354 or email answers@benefitsvip.com anytime!

Evidence of Insurability Forms

For disability, life and critical illness insurance policies, carriers will automatically approve coverages for newly eligible employees up to a specific amount, called the Guarantee Issue amount. Requests for coverages above that amount or requests for coverages after the initial eligibility period has passed will require **Evidence of Insurability** forms to be completed by the employee or spouse requesting coverage. Additional coverage will not be granted or charged to the employee unless the carrier approves the request. For more information, see page 24 of this benefit guide.

Electing Beneficiaries

Even if you are not making any changes to your benefits, it is recommended to confirm that your life insurance beneficiary information is up-to-date. As part of naming beneficiaries, you should identify them as clearly as possible and include their Social Security numbers. This will make it easier for the Life Insurance company to find them, and it will make it less likely that disputes will arise regarding the death benefit.

Cancer and Whole Life Carrier Name Change

Cancer and Whole Life coverages previously offered through Allstate are now being offered through The Standard, underwritten by American Heritage Life Insurance Company. This is not a new policy. Anyone who had previously enrolled with Allstate will still have coverage with The Standard / American Heritage Life Insurance Company.

Eligibility Policies

MIAMIBEACH

While proof of dependency will not be requested on-demand during your enrollment process, be aware that later this year, the City will partner with a team of auditors to ensure that all dependents enrolled in any City-sponsored Cigna medical plans are eligible to remain enrolled. Avoid coverage, deduction and claims surprises - TAKE ACTION NOW to remain compliant and avoid potential future financial burdens. Open Enrollment is a valuable opportunity to clean up your list of dependents.

The following dependents are eligible for the City's health or dental plans:

- Your lawful spouse or registered domestic partner. Domestic Partners must be registered with City of Miami Beach HR. Registrations from other municipalities will not be accepted. For additional information regarding domestic partner registrations, contact HR-Benefits@miamibeachfl.gov
- Your child until the end of the calendar year they turn 26
- Dependent non-disabled children after the calendar year they turn 26 until the end of the calendar year they turn 30 who meet the below criteria:
  - unmarried
  - does not have a dependent of their own
  - is either a Florida resident or a student
  - is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act.
- Your child who is 26 years or older, primarily supported by you, and incapable of self-sustaining employment due to a mental or physical disability. Proof of the child's condition and dependence may be required as a condition of coverage after the child ceases to qualify under the above criteria.
- A signed affidavit will be required to add over-age dependents. The cost to add these non-disabled dependents is 100% of the single employee-rate of coverage for health and dental plans and will be charged in addition to the employee portion of premium for employees and any other dependents.
- Examples of acceptable documents proving dependent eligibility include:
  - Marriage certificate
  - Birth certificate
  - Domestic Partner registration with the City of Miami Beach HR



Qualifying Life Events

Elections made during the open enrollment period cannot be changed during the plan year unless you or your dependent experience a Qualifying Life Event.

What is a Qualifying Life Event?

Qualifying Life Events that allow changes during the plan year include (but are not limited to):

- Marriage, divorce, legal separation
- Birth or adoption of child
- Death of spouse, child or other qualified dependent
- Loss/gain of other group coverage
- Change of dependent status
- Change in employment status (employee, spouse or child)

The type of plan change you can make to your benefits due to a life event depends on the qualifying event that you experience. For example, if you get married, you can add your spouse to coverage under your plan(s) and/or cancel coverage under your plan(s) if enrolling in your spouse's coverage.

Once a Qualifying Life Event occurs, you have 30 days from the event to make changes. Documentation of the event will be required. Contact Pierce Insurance at 800-421-3142 to notify of a Qualifying Life Event and make changes to your plan. You will also need to send dated documentation to HR-Benefits@miamibeachfl.gov for verification and approval of the event. If you do not contact HR / Pierce Insurance or provide documentation of the event within 30 days, your changes may not be approved. Examples of acceptable verification documents include birth certificate, marriage certificate, death certificate, loss of coverage letter from a spouse's employer, etc. For more information on Qualifying Life Events, visit https://www.healthcare.gov/glossary/qualifying-life-event/.

NOTE: An employee taking a leave of absence, other than protected leave under Federal or State employment laws, may not be eligible to re-enter the benefits program until the next Plan Year.

Employees are responsible for paying benefit premiums in order to remain enrolled in their elected policies with the City of Miami Beach, including during periods of unpaid leave or absence when working reduced or zero hours. When payroll deduction is not possible due to these or any other circumstances, timely proactive payment of benefit premiums via check or electronic transfer may be necessary in order to ensure benefit policies remain in good standing. Employees who fall behind on benefit premium payments should contact HR immediately to make repayment arrangements. If benefits remain unpaid, these policies may be subject to cancellation.

Some policies may contain a pre-existing condition clause. Always read your policy for full details.



Medical

CIGNA OPEN ACCESS PLUS

BENEFIT	IN-NETWORK ONLY
Coinsurance	100% / 0%
Plan Year Deductible	**Individual**: $0 **Family**: $0
Medical Out-of-Pocket Maximum	**Individual**: $1,500 **Family**: $3,000
Rx Out-of-Pocket Maximum	**Individual**: $2,500 **Family**: $5,000
Preventive Care Adult & Child Preventive Care	Covered at 100%
Outpatient Care Primary Care Physician Office Visits Specialist Office Visits	$20 Copay $50 Copay
Outpatient Surgery	$200 Copay
Testing at Independent Facility Blood Work X-Ray Advanced Imaging (MRI, PET Scan, CAT Scan)	Covered at 100% Covered at 100% $200 Copay
Emergency Care Ambulance when medically necessary At hospital Emergency Room Urgent Care (Walk-in Clinic)	Covered at 100% $250 Copay $40 Copay
Inpatient Hospitalization	$250 Copay / Day
Mental Health Inpatient Outpatient	$250 Copay / Day $50 Copay
Prescription Drugs Retail Pharmacy (30-day Supply) Generic /Preferred / Non- Preferred Mail Order (90-day Supply) Generic /Preferred / Non- Preferred	 $15 / $50 / $75 Copay $30 / $100 / $150 Copay
Semi-Monthly Contributions	
Employee Only	$85.00
Employee + 1	$236.00
Family	$364.00

Find an In-Network Provider:

STEP 1: Go to www.Cigna.com

STEP 2: Click "Find a Doctor" at the top of the screen

STEP 3: Under "How are you Covered?" click "Employer or School"

STEP 4: Enter search criteria

STEP 5: If you are already registered then log in, otherwise click "Continue as guest"

STEP 6: Under "Select a Plan" choose "Open Access Plus, OA Plus, Choice Fund OA Plus" Or

Call Cigna's open enrollment hotline 24/7 with questions about your medical and dental plan elections. The hotline phone number is 800.564.7642

Remember, your covered dependents also have 100% coverage for preventive care! (This applies to all medical plans.)



Cigna no longer provides ID cards. They are available electronically through the Cigna portal: www.Cigna.com
Or, via the MyCigna app.

This guide is 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.

Medical

CIGNA OPEN ACCESS HDHP

BENEFIT	IN-NETWORK ONLY	OUT-OF-NETWORK
Coinsurance	90% / 10%	70% / 30%
Plan Year Deductible	**Individual**: $2,500 **Family**: $5,000	**Individual**: $5,000 **Family**: $10,000
Medical Out-of-Pocket Maximum	**Individual**: $4,000 **Family**: $8,000	**Individual**: $8,000 **Family**: $16,000
Preventive Care Adult & Child Preventive Care	Covered at 100%	Covered at 100%
Outpatient Care Primary Care Physician Office Visits Specialist Office Visits	 Deductible, then 10% Deductible, then 10%	 Deductible, then 30% Deductible, then 30%
Outpatient Surgery	Deductible, then 10%	Deductible, then 30%
Testing at Independent Facility Blood Work X-Ray Advanced Imaging (MRI, PET Scan)	 Deductible, then 10% Deductible, then 10% Deductible, then 10%	 Deductible, then 30% Deductible, then 30% Deductible, then 30%
Emergency Care Ambulance when medically necessary At hospital Emergency Room Urgent Care (Walk-in Clinic)	 Deductible, then 10% Deductible, then 10% Deductible, then 10%	 Deductible, then 30% Deductible, then 30% Deductible, then 30%
Inpatient Hospitalization	Deductible, then 10%	Deductible, then 30%
Mental Health Inpatient Outpatient	 Deductible, then 10% Deductible, then 10%	 Deductible, then 30% Deductible, then 30%
Prescription Drugs Retail Pharmacy (30-day Supply) Generic /Preferred / Non- Preferred Mail Order (90-day Supply) Generic /Preferred / Non- Preferred	 Deductible Deductible	 Deductible, then 30% Not Covered
Semi-Monthly Contributions		
Employee Only	$25.00	
Employee + 1	$75.00	
Family	$200.00	

Understanding your Deductible

Your deductible is the amount you pay out of pocket before the plan's coinsurance applies. Coinsurance is 10% for in-network services and 30% for out-of-network services.

For Individual (Employee Only) coverage:

- Deductible: $2,500 (in-network) or $5,000 (out-of-network)
- Out-of-pocket maximum: $4,000 (in-network) or $8,000 (out-of-network)

For Employee + 1/Family coverage:

- Family deductible: $5,000 (in-network) or $10,000 (out-of-network)
- Family out-of-pocket maximum: $8,000 (in-network) or $16,000 (out-of-network)
- The overall family deductible must be met before the plan begins to pay.

Cigna no longer provides ID cards. They are available electronically through the Cigna portal:
www.Cigna.com
Or, via the MyCigna app.

Employees who enroll in any tier of coverage in the High-Deductible Health Plan (HDHP) will receive a $50 monthly credit—essentially rendering the HDHP plan free to employees who enroll in the employee-only tier of coverage.

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Vision included with Medical

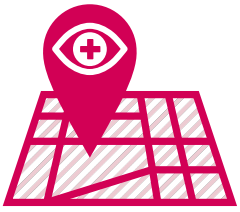
Vision Coverage

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. IF YOU ENROLL IN ONE OF THE CITY'S MEDICAL PLANS YOU WILL AUTOMATICALLY BE ENROLLED IN VISION COVERAGE .

EyeMed Select

Benefit	Plus Provider Network Member Cost	In-Network Member Cost	Out-of-Network Member Cost
Eye Exam	$0 Copay	$0 Copay	Reimbursed up to $28
Frequency Exam Lenses Frames	Once per plan year	Once per plan year	Once per plan year
Frames	$200 Allowance + 20% off balance	$150 Allowance + 20% off balance	Reimbursed up to $75
Lenses Single Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses	 $10 Copay $10 Copay $10 Copay $10 Copay	 $10 Copay $10 Copay $10 Copay $10 Copay	Reimbursed up to: $18 $32 $56 $56
Medically Necessary Contact Lenses	$0 Copay	$0 Copay	Reimbursed up to: $200
Elective Contact Lenses (in lieu of frames and lenses)	$150 Allowance	$150 Allowance	$120



The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 866.299.1358 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL

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Dental

Dental Coverage

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

Cigna's DHMO plan offers flexibility and savings with copays for all covered services. Employees enrolled in the DHMO must select a primary care dentist.

IN-NETWORK PROVIDERS:

Follow these steps to locate a participating dental provider:

STEP 1: Go to www.Cigna.com

STEP 2: Click on "Find a Doctor" on the top of the screen

STEP 3: Under "How are you Covered?" click "Employer or School"

STEP 4: Enter your ZIP code

STEP 5: Under "Doctor by Type" select the type of Dentist you need

STEP 6: Log in if you have an account or click "Continue as guest"

STEP 7: Under "Select a Plan" choose "DPPO/EPO-Total" if you are enrolled in the Cigna PPO and select "Cigna Dental Care Access" if you are enrolled in the DHMO plan

OR

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

	CIGNA DHMO	CIGNA DPPO	
Benefit	In-Network Only	In-Network	Out-of-Network
Annual Deductible	None	Individual: $50 Family: $150	
Benefit Maximums Annual	None	$2,500	
Diagnostic & Preventive Prophylaxis (Cleanings), Oral Exams, Tropical 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** Adult / Child Lifetime Maximum	Copay Schedule Adults & Children No maximum	Plan pays 50% Dependent children ot age 26 $1,500	
Implants**	Copay Schedule	Plan pays 50% after deductible	Plan pays 50%* after deductible
Semi-Monthly Contributions			
Employee Only	$4.34	$11.52	
Employee + 1	$7.60	$22.20	
Family	$11.94	$34.03	

*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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Health Savings Account (HSA)

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A Division of Webster Bank, N.A., Member FDIC

City of Miami Beach Employees who enroll in the Cigna HDHP Plan will also be enrolled in a Health Savings Account, or HSA, through HSA Bank. An HSA is a tax-favored savings account that is combined with an HDHP insurance plan. Funds in the savings account can be used to pay for the deductible, coinsurance and other qualified medical expenses. The account earns interest over time and all funds remain yours to keep, even if you leave employment with the City.

An HSA saves you money:

- Contributions are tax-free.
- Interest and investment earnings grow tax-free.
- Withdrawals are not taxed if the funds are used for qualified medical expenses.

Examples of Qualified Expenses

- Chiropractor
- Contact lenses
- Dental treatment
- Eyeglasses
- Hearing aids
- Hospital services
- Laboratory fees
- Weight-loss programs
- Wheelchair

Examples of Non-Qualified Expenses

- Childcare
- Cosmetic surgery
- Electrolysis or hair removal
- Household help
- Teeth whitening
- Funeral expenses
- Health club dues
- Nutritional Supplements, without a letter of Medical Necessity

For a complete list of eligible expenses visit: 2025 Publication 502 (irs.gov)
Contact HSA Bank at 800.357.6246 for more details.

Contribution Rules

The IRS determines how much you can deposit into your HSA each year, and limits are set on a calendar/tax year basis. The 2026 IRS contribution schedule is below:

2026 Annual Contributions	
EMPLOYER CONTRIBUTION Distributed over 24 pay periods	EMPLOYEE ONLY: $500 EMPLOYEE + 1: $1,000 FAMILY: $1,500
EMPLOYEE ONLY COVERAGE	$3,900* (maximum contribution of $4,400)
EMPLOYEE + 1 COVERAGE	$7,750* (maximum contribution of $8,750)
FAMILY COVERAGE	$7,250* (maximum contribution of $8,750)

*Employee amounts shown are maximum contributions after Employer Contribution

Additional "Catch Up" Contributions

Those age 55+ and not enrolled in Medicare, can fund an additional $1,000/year. A Spouse age 55+ or older can make a separate $1,000 catch-up contribution to an account in their own name.

Open your Account!

- When you open a new HSA account, HSA Bank will send a welcome kit that includes instructions for accessing your account online.
- HSA Bank charges a $1.75 monthly service fee when an account has a balance of $3,000 or less.
- There is no minimum balance required for you to invest in the investment funds provided by HSA Bank. Once your account is set up, you can also roll over an existing HSA balance to HSA Bank.
- The City's contributions are deposited semi-monthly throughout the year.
- If an employee leaves the City, the funds are theirs to take with them.

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Pre-Tax Spending Accounts

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City of Miami Beach offers employees the option of making deposits into separate spending accounts for eligible healthcare (including Medical, Dental and Vision) expenses and dependent care (including child care) expenses.

An FSA allows employees to set aside pre-taxed dollars for healthcare and dependent care expenses. When planning how much to contribute to an FSA, keep in mind that all funds remaining in the account in excess of $680 at the end of the plan year will be forfeited.

Your FSA deductions cannot be changed or discontinued during the plan year unless you experience a qualifying event.



You must enroll or re-enroll every year to participate.

General Purpose Healthcare FSA:

NOT available if you are enrolled in the HDHP Medical Plan.

In addition to using this account to make copays, coinsurance payments or deductible payments this program lets employees pay for certain IRS approved medical care expenses. The 2026 annual maximum is $3,400 and a minimum $250 annual election is required.

Some examples of reimbursable expenses include:

- Hearing exams, hearing aids
- Vision expenses such as: contact lenses, eye examinations, and eyeglasses
- Orthodontia
- Chiropractic services
- Acupuncture
- Physical therapy
- Diabetic Supplies

FSA store®

www.FSAStore.com is the only one-stop-shop stocked exclusively with FSA-eligible products and services so there are no guessing games as to what is and isn't reimbursable which is what consumers face every time they walk into a drugstore.

Limited Purpose FSA:

A Limited Purpose FSA is similar to a general purpose health FSA except eligible expenses are limited to qualifying dental and vision expenses only. The 2026 annual maximum is $3,400 and a minimum $250 annual election is required.

Examples of reimbursable expenses include:

- Costs for dental and vision services
- Orthodontia
- Eye exams
- Contact lens materials
- LASIK eye surgery
- Cataract surgery
- Prescription eyeglasses
- Reading glasses and more

The Limited Purpose FSA can be used in conjunction with the HDHP Medical Plan.

Pre-Tax Spending Accounts

Dependent Care FSA

The Dependent Care FSA enables employees to use pre-tax dollars to pay for eligible dependent care expenses that are necessary for you (and your spouse) to work, actively look for work, or attend school full time. Dependent care FSA can be used for the caring of children under the age of 13 or dependent elders who live with you. The annual maximum contribution to the Dependent Care FSA is $7,500 ($3,750 if married and filing separately).

Examples of eligible expenses include:
- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

You should only contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan year. If you do not use the money within the plan year it will NOT be refunded to you or carried forward to a future plan year. **This is a use it or lose it benefit.**

Claim Submission & Reimbursement Options

If you participate in an FSA, you will automatically receive a debit Visa Card that can be used for FSA eligible expenses. You can also file your claims online at www.hsabank.com or submit your claims via mail, web portal, or mobile app. You can contact HSA Bank about your FSA account:

By Phone:
800.357.6246
You can also obtain account balances, view claims history, file claims, download forms and report a lost or stolen debit card at www.hsabank.com.

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Examples of Qualified Dependent Care FSA Expenses:

- Licensed nursery schools
- Qualified childcare centers
- Adult daycare facilities
- After school programs
- Summer camps for dependent children under age 13
- Preschool tuition

Examples of Non-Qualified Dependent Care FSA Expenses

- Dance lessons
- Educational, learning or study skills services
- Field trips
- Kindergarten tuition
- Language classes
- Private school tuition To see a list of all eligible expenses visit: https://www.irs.gov/publications/p502

Virtual Visits

MDLIVE® for Cigna Healthcare

Head-To-Toe Virtual Care From MDLIVE

It's not always easy to find time for the health care you need. The time and travel involved can lead to putting off care. That's why Cigna has partnered with MDLIVE. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of 10+ years of experience, and provide personalized care and prescriptions for hundreds of medical and behavioral health needs.

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost to identify conditions early.
- Routine care visits help you to build a relationship with a Primary Care Provider to help manage conditions.
- Prescriptions available through home delivery or local pharmacies, if appropriate.
- Receive orders for biometrics, blood work and screenings at local facilities.

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists.
- Schedule an appointment that works for you.
- Option to select the same provider for every session.
- Care for issues such as anxiety, stress, life changes, grief and depression.

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays.
- Care for hundreds of minor medical conditions.
- A convenient and affordable alternative to urgent care centers and the emergency room.
- Prescriptions available, if appropriate. Fast, customized care for skin, hair and nail conditions — no appointment required

Dermatology

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate.
- Care for common skin, hair and nail conditions: acne, eczema, psoriasis, rosacea, suspicious spots and more.
- Diagnosis and customized treatment plan, usually within 24 hours.

Three Steps to Connect:

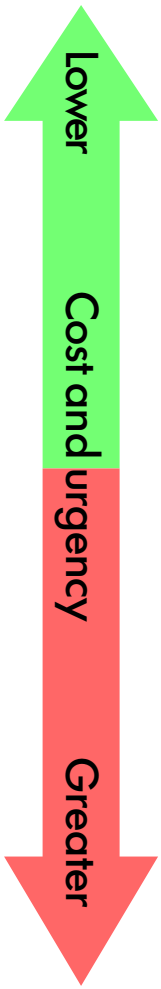
1. Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)
2. Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE.
3. Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care.

Know Before you Go!

Getting the Right Care

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

Where to Go	What it is	Type of Care	
Cigna Telehealth Connection	Connect with a board-certified doctor via video or phone when, where and how it works best for you.	• Colds and flu • Rashes • Sore throats	• Stomachaches • Fever • Allergies
Convenience Care Clinic	Treats minor medical concerns. Staffed by Nurse Practitioners and Physician Assistants. Located in retail stores and pharmacies. Often open nights and weekends.	• Colds and flu • Rashes or skin conditions • Sore throat, earaches	• Minor cuts or burns • Pregnancy testing • Vaccines • Sinus pain
Primary Care Physician	The best place to go for routine or preventive care, to keep track of medications, or for a referral to a specialist.	• General health issues • Routine Checkups	• Preventive care • Immunizations and screenings
Urgent Care	For conditions that aren't life threatening. Staffed by nurses and doctors; usually have extended hours.	• Sprains • Minor cuts • Burns	• Minor respiratory symptoms • Urinary tract infections
Emergency Room	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening call 911 or go to the nearest emergency room.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure / loss of consciousness	• Chest pain • Shortness of breath • Head injury/major trauma • Blurry or loss of vision • Overdose



myCigna App

Cigna is no longer distributing physical ID cards for plan participants. ID cards can be viewed, printed and sent to providers through the myCigna App.

Download the myCigna App for your Mobile Device.

Life can be busy and complicated. So, we created a simple-to-use tool that can help make your life easier (and healthier) while you're on the go. The MyCigna App helps you personalize, organize and access your important plan information on your phone or tablet. The app is available in Spanish too! Use the myCigna app to log in anytime, just about anywhere, to:

- Manage and track claims
- View, print or email ID card information
- Find in-network doctors and compare cost and quality information
- Review your coverage
- Track your account balances and deductibles
- Order your Cigna Home Delivery Pharmacy
- Compare prescription drug prices for Retail and Home Delivery pharmacies
- See cost estimates for medical procedures.
- Use the click-to-chat feature to connect with a live Cigna rep
- Compare quality of care information, including patient reviews from Cigna customers

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 myCigna.

Know Which Medications Your Plan Covers

It's important to know which medications your plan covers. Cigna makes it easy by providing up-to-date drug lists online.

Follow these simple steps to find out how your plan covers medications.

Step 1: Go to Cigna.com/druglist
Step 2: Select Standard 3 Tier drug list from the drop down menu
Step 3: Choose a search method: Type in your medication name and click Search, or look for your medication name in the in the alphabetical list.

Nationwide 457(b)

What makes the Nationwide 457(b) Plan a right choice for you?

For help as you set up your 457 (b) deferred compensation plan, visit your plan website or contact your Nationwide Retirement Specialist today!

For more information, contact:



Anthony Steel
305.972.5161
steela1@nationwide.com



Neil Cook
305.340.8772
cookn@nationwide.com

To schedule an appointment, scan this code:

Flexibility

- Easy enrollment over the phone, online or in-person
- Increase, decrease or stop deferrals, according to your needs
- No coordination of contributions with other qualified plan types
- Contribute up to the maximum to your 457(b) and a 403(b) or 401(k) account
- No-penalty withdrawals after separation from service, regardless of age
- Purchase pension plan service credit using 457(b) assets, if the pension plan allows
- Plan allows consolidation of outside retirement assets from qualified plans and IRAs

Interactivity

- Access your account. Anytime. Anywhere. Any device.
- My Interactive Retirement PlannerSM
- Support as you plan for retirement healthcare costs and Social Security benefits
- Web-based Learning Center to help you feel more confident about your retirement decision through the Plan
- Appointments with an Internal Retirement Specialist
  - Easily scheduled at retirementspecialists.myretirementappt.com

Investment Options

- Fixed account offering a competitive yield
- Broad spectrum of funds selected specifically for long-term investors
- Professional managed account solution for "do it for me" participants

People

- Personal Retirement Counselors who deliver financial needs analysis
- Local Specialists are available to present educational workshops on topics related to your needs
- Flexible Customer Service availability during the day, night and even on Saturday

Starting October 1, 2026, new 457(b) accounts opened by any employee will be administered by Nationwide. See the City Manager's welcome letter on page 3 for more information. Those with MissionSquare accounts opened on or before September 30, 2026 may remain in your plan and make investment updates as usual; however, no new entrants will be enrolled through MissionSquare with the exception of Police and Fire participants in their respective Retirement Health Savings PEHP plan.

MissionSquare 457(b)

MissionSquare RETIREMENT



Join the plan today.

Your employer offers retirement savings through the 457(b) Deferred Compensation Plan. The plan offers a range of investment options, including penalty-free withdrawals [1] that can help you achieve your savings goals and retire with confidence.

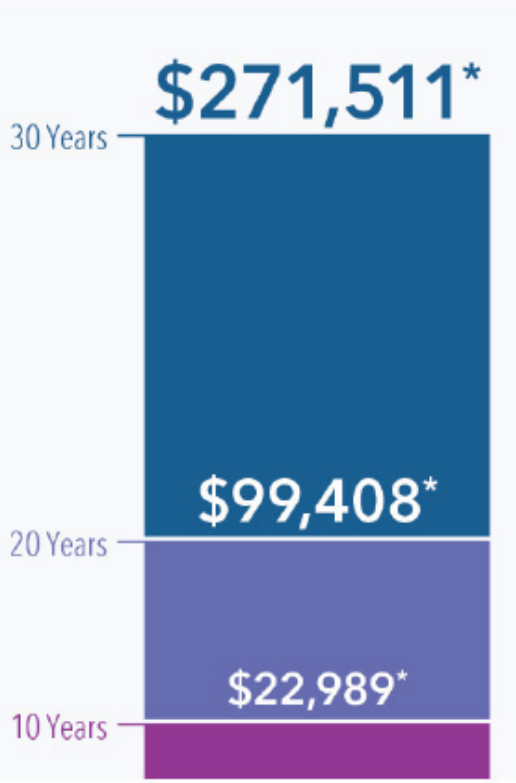
Control your contributions.

You can control how to invest and how much to contribute. By making small increases, you can save big over time. For example, if you contribute $25 each pay period and increase your contributions by $10 each year, your savings can multiply the longer you invest.*

We're here to help.

Your dedicated retirement services representative is ready to help with services, including investment guidance and specific retirement plan features and benefits.

[1]The penalty may apply to non-457(b) plan assets rolled into 457(b) plan and subsequently withdrawn prior to age 59 ½.



*Assumes $25 biweekly contribution first year and $10 additional biweekly contribution each year thereafter with an effective annual return of 6%, compounded biweekly. For illustrative purposes only. Your actual return may be higher or lower.

Questions? Contact your Mission Square Retirement Plans Specialist for more information.



Miguel Hidalgo
Retirement Plans Specialist
(202) 759-7075
mhidalgo@missionsquare.com

Scan the QR code to schedule a meeting

Starting October 1, 2026, new 457(b) accounts opened by any employee will be administered by Nationwide. See the City Manager's welcome letter on page 3 for more information. Those with MissionSquare accounts opened on or before September 30, 2026 may remain in your plan and make investment updates as usual; however, no new entrants will be enrolled through MissionSquare with the exception of Police and Fire participants in their respective Retirement Health Savings PEHP plan.

Cigna Employee Assistance Work/Life Support Program (EAP)

Here to help. And support. And problem-solve.

With our Assistance & Work/Life Support Program, you can get support for everyday issues and life challenges. The Assistance & Work/Life Support Program is here to connect you with real people who can help you find real solutions to life's challenges. These services are all confidential and available at no additional cost to you and anyone living in your household.

To access mindfulness exercises and discover stress management techniques, explore our Managing Stress Toolkit at Cigna.com/ManagingStress



Employee Assistance & Work/Life Support Program
24/7
Connect anytime Call 1.877.622.4327.
TTY/TDD users call 711. Connect through
myCigna.com Employer ID:
miamibeachfl
(for initial registration)

Emotional Health

Get 1-5 sessions per issue per year with a dedicated, licensed counselor at no cost to you.
Start by calling or using live chat to get a referral. Face to face or virtual sessions available for topics such as:

- Relationships and parenting
- Behavioral health and substance use
- Stress management

In addition to professional, face-to-face counseling, confidential phone consultations are available to you and anyone living in your household at no cost. Work with a licensed EAP clinician for 20–30 minutes per phone session. There are no limits to how often you can call for various concerns. Most issues are resolved or referrals for additional resources provided in two phone sessions.

Home Life Referrals

Referrals for community resources/services

- **Child care**: We'll help you find a place, program or person that's right for your family.
- **Senior care:** Learn about solutions related to caring for an aging loved one.
- **Pet care:** From veterinarians to dog walkers, we'll help you ensure your pets are well taken care of.

Financial and Legal Assistance

- **Financial services referral:** Free 30-minute financial consultations by phone per topic and 25% off tax preparation.†
- **Legal consulting**: Get a free 30-minute consultation with a network attorney and 25% off select fees.†
- **Identity theft:** Get a free 60-minute expert consultation by phone for prevention or if you are victimized.

†Customers are required to pay the entire discounted charge for any discounted legal and/or financial services. Legal consultations related to employment matters are excluded. Additional restrictions may apply.

cigna healthcare

Cigna Employee Assistance Work/Life Support Program (EAP)

Mental Health Care FAQ

If you don't have experience with mental health professionals, it can feel daunting to reach out. Where do I start? What kind of professional should I see? What happens at an appointment? What about a virtual visit? Getting answers to your questions can make it easier to take the first step.

Why make the call?

While mental health support is vital in a crisis, it's also a valuable tool that we can use when the challenges we face are not a crisis.

People seek professional support for many reasons. Some want help with thoughts, emotions, or repeated behavior patterns that are reducing their quality of life. It may be a specific concern that they need help with—grief, relationship problems, disordered eating, or substance abuse. Others may want to understand themselves better or grow. Or perhaps it's just a desire for someone who is trained in mental health to listen and help with general problem solving.

It can help to think of mental health care in the same way you think of physical health care. If something is causing pain or irritation or slowing you down, if there is something you'd like to correct or improve or just have questions about, a professional can help.

Call anytime for questions or support.

1.877.622.4327

myCigna.com

Employer ID: miamibeachfl

(for initial registration)

TTY/TDD users call 711

cigna healthcare

Who's who?

A hurdle in getting started is understanding the differences between care providers. The primary differences are education/degree, focus, and ability to prescribe medication.

Mental Health Counselor or Therapist

- Master's degree
- Licensure/certification varies
- Trained to evaluate mental health and provide therapy based on specific training programs.

Clinical Social Worker

- Master's degree in social work
- Licensure varies by state
- Trained to evaluate mental health and provide therapy based on specific training programs.

Psychologist

- Doctoral degree
- State licensed
- Trained to evaluate mental health with testing and interviews. Can diagnose, provide therapy. Can't prescribe medication in most states

Psychiatrist

- Medical doctor who specializes in mental health
- State licensed, may also be board-certified
- Trained to diagnose mental health conditions, prescribe/manage medication, provide therapy

Certified Peer Specialist

- Specialists who have personal experience with a mental health condition or substance use
- Trained, certified and able to help with goal setting, mentoring, support and guidance.

Employee Wellness

Employee Gym

Located on the first floor of City Hall, the employee gym facility was made possible through the sponsorship of our Mayor, Steven Meiner and the support of our Commissioners.

The City Hall Gym is for the benefit of all employees and contains:

- Free weights
- Elliptical and treadmill
- Upper/lower body strength training circuit
- All-in-one functional trainer
- Shock-absorbing athletic flooring

All City employees will be able to use the facilities after completing the Fitness Room Waiver Form, available in the Quick Links section of the Intranet homepage or via QR code at the entrance of the gym and pictured on this page.

"The City's commitment to offering on-campus fitness classes truly highlights how much they value our well-being. I recently participated in one of the HIIT-style sessions and found it both welcoming and inclusive, regardless of fitness level. These classes offer not just a great workout, but also an opportunity to connect with colleagues from different departments who I might not cross paths with otherwise." — Destiny W.

In addition to the gym, fitness classes are offered Tuesday and Thursday in the City Hall G7 Parking Garage on the 6th Floor at 4:30pm, 5:30pm, and 6:30pm

"I love the employee gym at City Hall. It's the perfect way for me to squeeze in a workout before or after my shift, and it helps keep me energized throughout the week. It's even helped me stay on track with my new goal of hitting 10,000 steps every day. Definitely the best part of my day!" — Nat B.



Employee Wellness



Ready to get active, feel energized, or just live healthier than ever?

Join the City of Miami Beach's free wellbeing program today!

Get the Personify Health mobile app or go to join.personifyhealth.com

Download on the App Store | GET IT ON Google Play

Wellness is rewarding! In addition to the opportunity to redeem points for gift cards through app-tracked health activities, employees enrolled in the Cigna HDHP Medical plan can earn annual bonus contributions to their HSA accounts—potentially *doubling* their annual HSA seed money from the City by achieving 2 consecutive quarters (January-March and April-June) of Gold-level activity or higher. Those who qualify receive a lump-sum HSA bonus deposit in July—see chart below for current bonus amounts.

Point values and associated rewards subject to change.

Medical HDHP Tier of Coverage	Gold/Gold or Platinum/Gold	Platinum/ Platinum
Employee Only	$250	$500
Employee + 1	$500	$1,000
Employee + Family	$750	$1,500

personify™ HEALTH

Contributory Life/AD&D

Contributory Basic Life/AD&D

City of Miami Beach provides all full-time, benefit-eligible employees (excluding FOP bargaining unit) with Basic Life/AD&D coverage through Unum Life Insurance Company. Employees are automatically enrolled as soon as they are eligible and required to contribute 50% of the premium for this coverage.

Contributory Life/AD&D	
Life and AD&D Benefit Amount	1 x Annual Salary up to $250,000

Annual Earnings as determined by the plan may differ from your current earnings. Please check the plan documents for complete definitions.

Make Sure to Update Your Beneficiary Information NOW!

A beneficiary is the person or entity you name in a life insurance policy to receive the death benefit.

You can name:

- One person
- Two or more people
- A trust you've set up
- Your estate

If you don't name a beneficiary, the death benefit will be paid to your estate.

Two Levels of Beneficiaries:

Your Life Insurance policy should have both "primary" and "contingent" beneficiaries. The primary beneficiary receives the death benefit upon your passing, if they are found. Contingent beneficiaries receive the death benefit if the primary beneficiary is deceased or cannot be found. If no primary or contingent beneficiaries are living or cannot be found, the death benefit will be paid to your estate.

As part of naming beneficiaries, you should identify them as clearly as possible and include their Social Security numbers. This will make it easier for the Life Insurance company to find them, and it will make it less likely that disputes will arise regarding the death benefit.

How Basic Life/AD&D Insurance Can Help

Life and Accidental Death & Dismemberment insurance may provide additional financial support by:

- Assisting your family with the cost of your funeral or medical bills
- Covering household expenses
- Relieving debt you might leave behind
- Leaving an inheritance for your loved ones or even for an organization you are passionate about

Semi-Monthly Rates per $1,000	
Employee	$0.01775
Employer	$0.01775

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.

Evidence of Insurability (EOI)

When enrolling in certain coverages for the first time or increasing existing coverage amounts, you may be required to complete an Evidence of Insurability form. An Evidence of Insurability, or EOI, is a form that a carrier uses to confirm that an applicant is able to be insured for the amount of benefit being requested. An EOI must be completed proactively by you or your spouse - whoever is requesting the benefit amount. It includes a detailed health questionnaire and may include a paramedical examination. You or your spouse will not be eligible to receive the benefit amount requested until the form has been completed AND approved by the carrier. No payroll deductions will be taken for the higher amount until the carrier has approved the benefit. See the following page for situations in which an EOI may be required.

PIERCE INSURANCE

For additional help with enrollment or completing Evidence of Insurability forms, **Pierce Insurance** is available at https://pierceins.com/miamibeach/ or call

800-421-3142
Monday-Friday,
8:00am—5:00pm
English and Spanish support available

Completing and Submitting an EOI

When an EOI is required, **IT IS THE EMPLOYEE'S RESPONSIBILITY TO COMPLETE AND SUBMIT THE FORM TO THE CARRIER.**
The deadline to submit an EOI for changes made during this Open Enrollment is **September 30, 2026**. Employees will be notified during enrollment if their election requires an EOI for approval. EOI forms can be accessed online!

Unum Life or Disability:

Employees or their spouses can visit securehealth.unum.com/generichome or scan the QR code above and use Access Code: 4EI8HAC to complete and submit the EOI online.

Evidence of Insurability (EOI)

Voluntary Life Insurance

Initial Enrollment

Requesting an amount over the Guaranteed Issue amount. If you are newly eligible for voluntary life, and elect an amount over the Guarantee Issue amount for coverage for either yourself or your spouse, you or your spouse will be automatically enrolled in voluntary life up to the Guarantee Issue amount. The amount you requested over the Guarantee Issue amount will be pended until an EOI is received and approved by Unum.

Annual Open Enrollment

Enrolling for the first time after Initial Eligibility. If you are enrolling for the first time, but are past your initial new hire eligibility window, you will be required to complete an EOI for any coverage amount requested. You will not be approved for benefits or deducted for coverage until an EOI has been submitted and approved by Unum.

Employee Coverage Increase requests. Employees can request an increase in coverage during the annual Open Enrollment period, however any increase request will require an EOI. You will not be approved for the greater benefit amount or payroll deducted until an EOI has been submitted and approved by Unum.

Spouse Coverage Increase requests over Guarantee Issue Amount. If you request an increase for your spouse during annual Open Enrollment that increases your benefit to greater than the Guarantee Issue amount, your spouse will need to complete an EOI. This is true even if you are only requesting an increase of one increment. You will not be approved for the greater benefit amount or payroll deducted until an EOI has been submitted and approved by Unum.

Link – Unum EOI: securehealth.unum.com/generichome | Access Code: 4EI8HAC

Voluntary Disability Coverage

Annual Open Enrollment

Enrolling for the first time after Initial Eligibility. If you choose to enroll in either Voluntary Disability product with Unum during Annual Enrollment after previously waiving coverage, you will be required to complete an EOI. You will not be able to receive a benefit until your EOI has been reviewed and approved. Keep in mind that these policies may also have pre-existing condition exclusions as well. Always read the full plan document for more details.

Link – Unum EOI: securehealth.unum.com/generichome | Access Code: 4EI8HAC

Whole Life Insurance

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Initial Enrollment and Annual Open Enrollment

Requesting an amount over the Guaranteed Issue amount. If you are electing Whole Life coverage for the first time, and elect an amount over $150,000 (the GI amount) for either yourself or your spouse, you will need to complete additional health questions during the enrollment process. You will also be asked to provide your primary care provider's information and agree to allow American Heritage to speak with your provider to verify health conditions or status.

Voluntary Life / AD&D

Voluntary Life/AD&D

Employees may elect voluntary coverage for themselves and their dependents through Unum. Employee and Spouse Voluntary Life Insurance includes Accidental Death & Dismemberment coverage in the same amount as the Voluntary Life insurance. The combined total of Contributory & Voluntary Life policies may not exceed $500,000 .

Things to Remember:

- You must enroll in coverage in order to elect coverage for your dependents
- Payroll deductions may vary due to rounding
- You pay just one payroll deduction for child coverage, no matter how many children you are covering

Waiver of Premium

If you become disabled, you may be eligible to continue your voluntary life coverage at no cost to you.

Portability/Conversion

If you leave employment with the City, you may contact Unum directly, to inquire about continuing your policy. You must contact Unum within 30 days of your employment termination.

Exclusions

Unum may not pay benefits caused directly or indirectly by excluded losses as identified in the contract.

Dependent Coverage Increases

Employees can increase existing dependent coverage by $10,000 each Open Enrollment up to $30,000 without requiring Evidence of Insurability.

Coverage Guidelines			
	Minimum	Guarantee Issue (GI)	Maximum
Employee	$10,000	5 times annual salary, up to $300,000	5 times annual salary, up to $500,000
Spouse	$20,000	100% of Employee's Benefit up to $30,000	100% of Employee's Benefit, up to $50,000
Child	$10,000	$10,000 (14 Days to 6 Months $1,000)	100% of Employee's Benefit, up to $10,000

MONTHLY RATES PER $1,000 OF COVERAGE	
AGE	COST
Under 25	$0.084
25-29	$0.079
30-34	$0.092
35-39	$0.119
40-44	$0.173
45-49	$0.268
50-54	$0.434
55-59	$0.691
60-64	$0.915
65-69	$1.427
70+	$2.477

Voluntary Life Example:

A 52 year old will pay $0.434 per $1,000 of coverage. If they elect $50,000 in voluntary coverage, the premium calculation would be:

$50,000 ÷ $1000 = 50 ($1000s of Coverage)

50 X $0.434 = $21.70 (Monthly Cost)

$21.70 ÷ 2 = $10.85 Payroll Deduction

Evidence of Insurability Form

An evidence of insurability (EOI) form is required to apply for the plan during annual enrollment or if coverage was previously waived during the initial eligibility period.

Note: Benefit coverage and payroll deductions will not take effect until EOI is approved by Unum.

Dependent Supplemental Life					
Spouse Life	$20,000	$30,000	$40,000	$50,000	If you elect coverage for your spouse, it will include $10,000 of coverage for each child.
Child Life	$10,000	$10,000	$10,000	$10,000	
Semi-Monthly Premium	$1.00	$1.50	$2.00	$2.50	

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Voluntary Short-Term Disability

City of Miami Beach provides eligible employees the opportunity to enroll in Voluntary Short-Term Disability (STD). Coverage is available through Unum, and offered to eligible full-time employees. Please refer to your Unum summary for additional details, including limitations and exclusions. This coverage is designed to replace a portion of your income should you become unable to work due to a non-work related injury or sickness.

Voluntary Short-Term Disability Schedule of Benefits	
Benefits Begin	15th day Accident/Sickness
Benefit Duration	26 weeks
Percentage of Income Replaced	60%
Maximum Weekly Benefit	$1,500

MONTHLY STD RATES PER $10 OF COVERAGE	
AGE	COST
Under 25	$0.369
25-29	$0.398
30-34	$0.369
35-39	$0.346
40-44	$0.383
45-49	$0.427
50-54	$0.457
55-59	$0.678
60-64	$0.870
65 +	$0.988

Pre-Existing Condition Exclusion

The plan has a 12-month pre-existing condition exclusion for any illness or injury for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs in the 3 months prior to coverage.

Evidence of Insurability Form

An evidence of insurability (EOI) form is required to apply for the plan during annual enrollment if coverage was previously waived during the initial eligibility period.

Note: Benefit coverage and payroll deductions will not take effect until EOI is approved by Unum.

Short-Term Disability Premium Example:

For a 53 year old employee earning $1,538.46 per week, the calculation would be:

$1,538.46 x 0.60 (60% benefit) = $923.07 (weekly benefit)

$923.07 ÷ $10 = 92.307 ($10s of coverage)

92.307 x $0.457 = $42.18 (Monthly Rate)

$42.18 ÷ 2= $21.09 Semi-Monthly Contribution

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Voluntary Long-Term Disability

Pre-Existing Condition Exclusion

The pre-existing condition under this plan is a 12/24 which means any condition that you receive medical attention for in the 12 months prior to your effective date of coverage that results in a disability during the first 24 months of coverage would not be covered.

MONTHLY LTD RATES PER $100 OF COVERAGE	
AGE	COST
Under 25	$0.080
25-29	$0.110
30-34	$0.176
35-39	$0.270
40-44	$0.373
45-49	$0.555
50-54	$0.768
55-59	$0.979
60-64	$0.986
65-69	$1.286
70 +	$1.542

Long-Term Disability Premium Example:

For a 29 year old earning $4,000 per month, the calculation would be:
$4,000 ÷ $100 = 40 ($100s of Coverage)
40 x $0.110 = $4.40 (Monthly Rate)
$4.40÷ 2 = $2.20 Semi-Monthly Contribution

In addition to Voluntary Short-Term Disability the City of Miami Beach provides eligible employees the opportunity to enroll in Voluntary Long-Term Disability (LTD).

Coverage is available through Unum, and offered to eligible full-time employees. Please refer to your Unum summary for additional details, including limitations and exclusions. This coverage is designed to replace a portion of your income should you become unable to work due to a non-work related injury or sickness.

Voluntary Long-Term Disability Schedule of Benefits	
Benefits Begin	181st day
Benefit Duration	See Chart Below
Percentage of Income Replaced	60%
Maximum Monthly Benefit	$10,000

Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Evidence of Insurability Form

An evidence of insurability (EOI) form is required to apply for the plan during annual enrollment or if coverage was previously waived during the initial eligibility period.

Note: Benefit coverage and payroll deductions will not take effect until EOI is approved by Unum.

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.

Hospital Indemnity

The plan that can help with expenses and protect your savings.

Help protect yourself from the high costs of hospital care with Aflac. Hospital Indemnity Protection helps cover unexpected expenses and medical bills that can come from even a short stay. All benefits are paid directly to the insured and can be used towards any expense from out-of-pocket medical costs to transportation, meals, childcare and more.

HIGH PLAN: GP-55297.PLAN-346434B LOW PLAN: GP-55297.PLAN-346435B (Low Coverage)

HOSPITAL INDEMNITY BENEFIT	BENEFIT AMOUNT	
	HIGH	LOW
Hospital Admission per confinement (once per covered sickness oraccident per calendar year for each insured)	$1,000	$500
Hospital Confinement per day (maximum of 31 days per confinement for each covered sickness or accident for each insured)	$100	$50
Hospital Intensive Care Benefit per day (maximum of 10 days per confinement for each covered sickness or accident for each insured	$100	$50
Successor Insured Benefit If spouse coverage is in force at the time of the employee's death, the surviving spouse may elect to continue coverage, including any dependent child coverage in force at the time.		

Key Differences:

- The High Plan offers higher benefit payouts for Hospital Admission, Confinement, and Intensive Care
- The Low Plan offers lower premiums but reduced benefit amounts.
- Both plans include 24-hour coverage, family eligibility and portability.

Semi-Monthly Hospital Indemnity Payroll Deductions		
	High	Low
Employee Only	$6.24	$3.13
Employee + Spouse	$12.28	$6.15
Employee + Child(ren)	$9.61	$4.82
Employee + Family	$15.65	$7.84

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Accident Insurance

Aflac

Accidents can happen when you least expect them—having accident insurance helps cover unexpected medical and non-medical costs so you can focus on recovery.

PLAN FEATURES:

- 24-Hour Coverage (which means an injury arising from any employment and an injury or sickness covered by worker's compensation will not be excluded under this policy) .
- Available for all family members of participating employees.
- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guarantee-issued (which means you qualify for coverage without having to answer health questions).
- Convenience of payroll-deducted premiums.
- There are no waiting periods.
- Benefits are paid regardless of any other medical insurance.

KEY BENEFITS	High Coverage	Low Coverage
Initial Treatment—Emergency Room	$200	$250
Initial Treatment—Doctor's Office Facility	$200	$150
Hospital Admission	$900	$850
Hospital Confinement (per day)	$250	$250
Intensive Care (per day)	$300	$250
Concussion	$400	$ -
Lacerations over 15 cm	$600	$500
Coma	$7,500	$ -
Fractures	Up to $6,000	Up to $5,000
Dislocations	Up to $6,500	Up to $4,000
Dismemberment	Up to $17,500	Up to $15,000

WELLNESS RIDER		
Wellness Benefit (Max number of payments per calendar year, per insured: 1)	$60	$50

	Low Plan Only		
ACCIDENTAL DEATH RIDER	Employee	Spouse	Children
Accidental Death	$50,000	$25,000	$25,000
Accidental Common–Carrier Death	$100,000	$50,000	$20,000

Semi-Monthly Accident Payroll Deductions	High	Low
Employee Only	$6.25	$3.76
Employee + Spouse	$10.14	$6.35
Employee + Child(ren)	$11.21	$7.55
Employee + Family	$15.10	$10.13

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Critical Illness

Aflac

The Aflac Group Critical Illness Plan provides cash benefits when an insured person is diagnosed with a covered critical illness and these benefits are paid directly to you (unless otherwise assigned). The plan provides a lump-sum benefit to help with out of pocket medical expenses and the living expenses that can accompany a covered critical illness.

KEY FEATURES:

- Lump sum benefit for critical illnesses
- No pre-existing condition exclusion or waiting period
- Guaranteed issue up to $35,000 for employees
- Coverage of children for 50% of employee's face amount
- Waiver of premium after 90 days of disability
- Portable at the same rate (Take it with you when you leave employment or retire.)

EMPLOYEE OR SPOUSE / NON-TOBACCO PREMIUMS PER $1,000 (24 PAY PERIODS)

Ages	PER $1,000
18-29	$0.194
30-39	$0.232
40-49	$0.292
50-59	$0.442
60-69	$0.806
70 +	$1.028

EMPLOYEE OR SPOUSE / TOBACCO PREMIUMS PER $1,000 (24 PAY PERIODS)

Ages	PER $1,000
18-29	$0.226
30-39	$0.324
40-49	$0.444
50-59	$0.698
60-69	$1.326
70 +	$1.622

Covered Critical Illness Benefits	Percentage of Face Amount
Heart Attack	100%
Stroke (Ischemic or Hemorrhagic)	100%
Kidney Failure (End-Stage Renal Failure	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	100%
Major Organ Transplant	100%
Coma	100%
Paralysis	100%
Loss of Sight, Hearing or Speech	100%
Benign Brain Tumor	100%
Type 1 Diabetes	100%
Coronary Artery Bypass	100%

Health Screening Benefit	
Health Screening Benefit (1 per calendar year)	Employee/Spouse $150 Child: 100% of the health screening amount

AVAILABLE CRITICAL ILLNESS COVERAGE AMOUNTS:

- Employee Face Amount: $5,000 to $50,000 in $5,000 increments
- Spouse Face Amount: $2,500 to $25,000 in $2,500 increments
- Child Coverage at no additional cost
- Rates are based on ATTAINED AGE and will increase as you age.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

Protecting insureds for over 60 years

Cancer Insurance

After a cancer diagnosis, your life can become a whirlwind of doctor appointments and difficult decisions. Your finances don't need to be added to your list of worries. Cancer Insurance can help you rest a little easier.

Here's How It Works

- Select the coverage that's right for you and your family
- If diagnosed with cancer or a specified disease, you file a claim
- You may receive a lump-sum benefit via check or direct deposit that you can use however you wish*

Protecting Your Finances

You've worked hard for your savings - don't let a cancer diagnosis wipe them out.

- Protect your checking and savings
- Don't dip into your 401(k)

Meeting Your Needs

- Coverage can include your dependents
- Includes coverage for cancer and 29 specified diseases
- Waiver of premium after 90 days when disabled due to cancer (employee only)
- Coverage may be converted; refer to your certificate for details

Benefit Amounts

Hospital Confinement and Related Benefits	Plan 1	Plan 2
Continuous Hospital Confinement (daily)	$200	$300
Extended Benefits[1] (daily)	$200	$300
Government or Charity Hospital (daily)	$200	$300
Private Duty Nursing Services[1] (daily)	$200	$300
Extended Care Facility[1] (daily)	$200	$300
At Home Nursing[1] (daily)	$200	$300
Hospice Care Center[1] (daily) or	$200	$300
Hospice Care Team[1] (per visit)	$200	$300
Radiation/Chemotherapy	**Plan 1**	**Plan 2**
Radiation/Chemotherapy[1] (every 12 months)	$5,000	$10,000
Blood, Plasma, and Platelets[1] (every 12 months)	$5,000	$10,000
Bone Marrow or Stem Cell Transplant (once/year)		
1. Autologous	1. $500	1. $500
2. Non-autologous (cancer or specified disease treatment)	2. $1,250	2. $1,250
3. Non-autologous (Leukemia)	3. $2,500	3. $2,500
Ambulatory Surgical Center[1] (daily)	$250	$250
Second Surgical Opinion[1]	$200	$200
Transportation and Lodging Benefits	**Plan 1**	**Plan 2**
Ambulance[1] (per confinement)	$100	$100
Non-Local Transportation (coach fare or amount shown per mile[4])	$0.40/mi	$0.40/mi
Outpatient Lodging[3] (daily; limit $2,000/12 mo. period)	$50	$50
Family Member Lodging[3] (daily per trip; max. 60 days) and Transportation (coach fare or amount shown per mile[4])	$50 $0.40/mi	$50 $0.40/mi
Miscellaneous Benefits	**Plan 1**	**Plan 2**
Inpatient Drugs and Medicine[1] (daily)	$25	$25
Physician's Attendance[1] (daily)	$50	$50
Physical or Speech Therapy[1] (daily)	$50	$50
New or Experimental Treatment[1] (every 12 months)	$5,000	$5,000
Prosthesis[1] (per amputation)	$2,000	$2,000
Comfort/Anti-Nausea Benefit[1]	$200	$200
Waiver of Premium (employee only)	Yes	Yes

[1]Pays actual charges up to amount listed [2]Pays actual charges up to amount listed in certificate Schedule . [4]Maximum of 700 miles.

Plan 1 Premiums

Mode	EE	F
Semi-Monthly	$6.85	$11.52

Plan 2 Premiums

Mode	EE	F
Semi-Monthly	$11.13	$18.75

EE = Employee; F = Family

Issue Ages: 18 and over if Actively at Work

Additional Benefits	Plan 1	Plan 2
Cancer Initial Diagnosis (one-time benefit)	$2,000	$3,000
Cancer Screening	$50	$100

Allstate BENEFITS

HAS TRANSITIONED TO

AMERICAN HERITAGE LIFE INSURANCE COMPANY

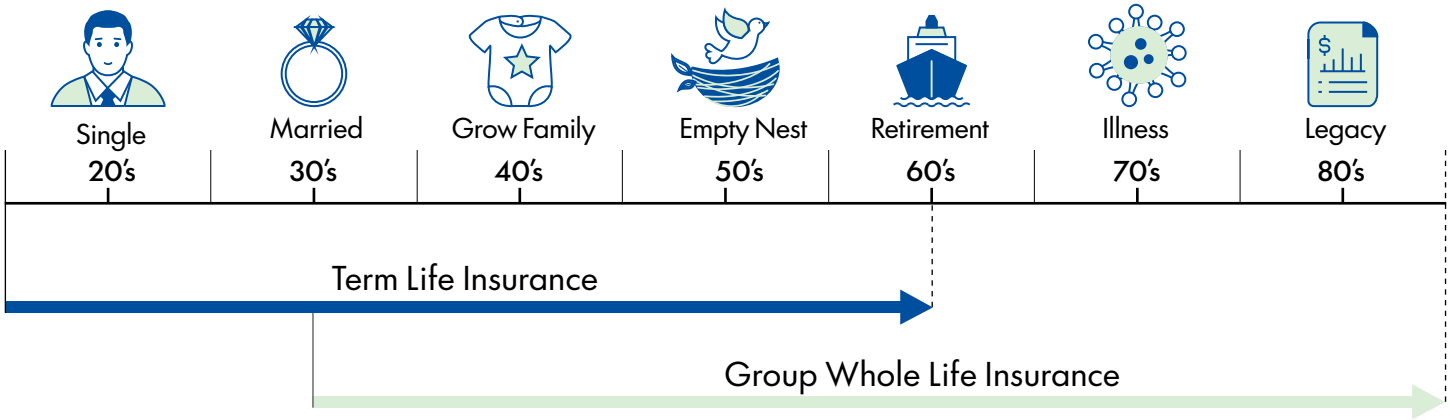
Group Whole Life Insurance

AMERICAN HERITAGE LIFE INSURANCE COMPANY

There are moments in life that cause us to think about how our loved ones would make ends meet, if we died unexpectedly and their financial support was reduced.

Coverage for all stages of life

As people move through the stages of life, certain factors dictate the type of life insurance they need. During working years, an employer may provide Term Life insurance, but the wraparound coverage of our Group Whole Life product can help give peace of mind because the money you spent builds cash value that you can use later in life or add to the term benefit payout. The graph below illustrates the need for term and permanent Group Whole Life Insurance throughout the various stages of life.



Benefits

Group Whole Life Insurance Provides Either:

Death Benefit - pays a lump-sum cash benefit when the insured dies before age 121

Maturity Benefit - pays a lump-sum cash benefit if the insured is still living at age 121

Additional Rider Benefits

Accelerated Death Benefit for Terminal Illness or Condition - a lump-sum advance of 75% of the death benefit (not to exceed $100,000), when certified terminally ill. Premiums are waived after the payment of the benefit .

Children's Term - level term insurance for each covered dependent child under age 26. Not available if dependent child is covered under a separate certificate. Subject to state limits on dependent life coverage .

Accelerated Death Benefit for Long Term Care with Restoration of Benefits and Extension of Benefits - a monthly advance of 6% of the death benefit for up to 34 months while receiving qualified long-term care services after a 90-day elimination period when certified chronically ill by a licensed health care practitioner. The restoration benefit restores the death benefit and cash value to the pre-acceleration amounts, and the extension benefit extends the death benefit for a period equal to the original benefit term. Premiums are waived for the months when the benefit is payable .

Employees requesting coverage higher than $150,000 will be required to complete additional health questions during Open Enrollment. No benefit greater than $150,000 will be provided until these have been reviewed and approved by the carrier.

AMERICAN HERITAGE LIFE INSURANCE COMPANY Formerly Allstate BENEFITS

The riders have exclusions and limitations, may vary in availability by issue or termination age, and may not be available to all covered dependents or in all states. Additional premiums may be required for riders added to coverage.

Identity Theft and Legal Coverage

norton LifeLock Benefit Solutions

Take Back Control of Your Identity

Your personal data is everywhere—from doctor's offices to mobile apps. Norton LifeLock Benefit Plans prevent fraud, block scams, monitor activity, and strengthen your financial wellbeing.

Protect Your Well-Being from Every Angle

- Fraud Detection Monitor identity and finances to detect fraud early
- Threat Prevention Block scams and cyber threats to protect your data and devices
- Financial Insights Gain financial insights into your credit, spending and subscriptions

Financial and Digital Wellness

- Identity Restoration Get peace of mind with expert help if your identity is compromised
- Enhanced Privacy Remove your personal details from data broker sites and enjoy a safer, more private internet experience
- Scam Detection Built-in AI assistant helps you navigate suspicious websites and SMS messages, and offers advice if you think you're being scammed

Find Out More

Benefit Plans are 60% less than the retail equivalent.
pierceins.com/miamibeach

BENEFIT ESSENTIAL		BENEFIT PREMIER		BENEFIT PREMIER PLUS	
Semi-Monthly rate (24 pay periods)		Semi-Monthly rate (24 pay periods)		Semi-Monthly rate (24 pay periods)	
Employee Only (18+)	Employee + Family	Employee Only (18+)	Employee + Family	Employee Only (18+)	Employee + Family
$2.50	$4.99	$4.00	$7.49	$5.24	$8.74

LegalEASE

With the LegaEASE Plan, you're covered when you run into life's challenges with paid in full benefits for personal legal matters. LegalEASE has the largest and most highly qualified Attorney Provider Network, with attorneys in all 50 states focusing in over 60 areas of law. We've got you covered no matter the situation or location.

What's Included?

- FAMILY LAW
- ESTATE PLANNING & WILLS
- AUTO & TRAFFIC
- HOME & RESIDENTIAL
- FINANCIAL & CONSUMER
- GENERAL COVERAGE

Plan Details:

$8.72 per semi-monthly paycheck deduction.

Who's Covered:

Employee, Spouse or Domestic Partner, Dependent Children up to age 26.

Offered only during Open Enrollment, don't miss the opportunity to sign up for LegalEASE Plan for paid in full coverage in 2026. Visit pierceins.com/miamibeach or give us a call at (800) 421-3142 to learn more.

Rainwalk Pet Insurance

We've partnered with Rainwalk to offer pet insurance at a discount as an employee benefit

Benefits

- $100 routine vaccination coverage included
- No lifetime limits on chronic conditions
- Choose any veterinarian or service provider
- Flexible annual limits up to $20K
- Multiple reimbursement options (70/80/90%)
- Broad deductible range ($100-$750)
- No age limit once enrolled
- Venmo or direct deposit reimbursement
- Free unlimited 24/7 virtual vet visits
- Claims history not a factor in policy premiums
- Optional breeding-related expenses add-on
- Congenital and hereditary conditions included
- Prescription diet and supplements included
- Behavioral conditions included
- No orthopedic waiting period
- 10% employee discount

See Sample Policy for more benefits and details

FAQ

https://rainwalkpetinsurance.com/faq/

About

https://rainwalkpetinsurance.com/about/

Sample Policy

Additional Perks

- PETS First Choice: 20% off Pets First Choice Pharmacy
- BOXIECAT: 15% off Boxie Cat Litter
- The Pets Table: 60% off high-quality food from The Pets Table
- Exclusive discounts on Brio Treats
- zigzag — Your journey to pup happiness.: 1 month of free dog training by Zigzag

Contact us

Help@rainwalk.io
844-520-0041



Pet health insurance is administered by Rainwalk Technology, Inc. NPN# 19561832 (CA agency #6005294) located at 1225 Laurel Street, Suite 421, Columbia, SC 29201 and underwritten by Incline Casualty Company, Inc. or Physicians Mutual Insurance Company, Inc NAIC# 80578 with offices at 2600 Dodge Street Omaha, NE 68131. Coverage is subject to policy terms, conditions, limitations, exclusions, underwriting review, and approval, and may not be available for all risks or in all states. Rates and discounts vary, are determined by many factors, and are subject to change.

Carrier Contacts

BENEFIT	PLAN	CONTACT	WEBSITE / EMAIL	SALARY GROUP(S)
Medical, Rx	Cigna	800.244.6224	www.mycigna.com	General & Unclassified
Medical, Vision	FOP Health Trust	954.663.3796	mbfophtadminstrator@miamibeachfop.org	FOP
Medical, Dental, Vision	IAFF Health Trust	954.683.3866	www.ffitf.com	IAFF
HSA / FSA	HSA Bank	800.357.6246	www.hsabank.com	All
Dental PPO & DHMO	Cigna	800.244.6224	www.mycigna.com	General, Unclassified & FOP
Vision	EyeMed Vision	866.299.1358	www.eyemed.com	General & Unclassified
Contributory, Supplemental & Dependent Life	Unum	800.421.0344	www.unum.com	ALL
Short-Term & Long-Term Disability	Unum	877.217.5495	www.unum.com	ALL
Enrollment Assistance	Pierce Insurance	800.421.3142	https://pierceins.com/miamibeach/	ALL
Cancer & Whole Life Insurance	The Standard/ American Heritage	800.521.3535	standard.com/ahl/mybenefits	ALL
Accident, Critical Illness, & Hospital Indemnity	Aflac	800.433.3036	https://aflacgroupinsurance.com/customer_service/	ALL
Group Assistance Work/Life Support Program	Cigna Behavioral	877.622.4327	www.mycigna.com Employer ID: miamibeachfl	ALL
Discount Pet Insurance	Rainwalk	844.520.0041	help@rainwalk.io	ALL
Legal Plan Coverage	LegalEase	800.421.3142	www.legaleaseplan.com/miamibeachfl	ALL
ID Theft	Norton LifeLock	800.543.3562	https://support.norton.com	ALL

RETIREMENT SOLUTIONS	PLAN	CONTACT	WEBSITE/EMAIL	SALARY GROUP(S)
Nationwide Retirement Solutions				
457 Deferred Compensation Plan (plan code 0036817)	Retirement Plans	877.677.3678	www.nrsforu.com cookn@nationwide.com	ALL
401(a) Retirement Plan (plan code 013-02677)		800.772.2182		
OBRA (plan code 0036817002)		877.677.3678		
MissionSquare (Formerly ICMA)				
457 Deferred Compensation Plan (plan code 303294	Retirement Plans	Miguel Hidalgo 866.630.3041	mhidalgo@missionsquare.com	ALL
401(a) Retirement Plan (plan code 109219)		800.669.7400	www.missionsq.org	
Roth 401 (plan code 705588)				
Pension Offices				
General & Unclassified Pension	Retirement Plan	305.673.7437	www.mberp.com	General & Unclassified
Fire & Police Pension	Retirement Plan	305.673.7039	www.miamibeachfl.gov/city-hall/fire-police-pension/	FOP & IAFF

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.

SPECIAL ENROLLMENT RIGHTS CHIPRA – CHILDREN'S HEALTH INSURANCE PLAN

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible. You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

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.

NO SURPRISES ACT

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible. What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill

Disclosures

you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing."

This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles).

You can't be balance billed for these emergency services.

This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network.

In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.

These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have these protections:

· You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

· Generally, your health plan must:

· Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

· Cover emergency services by out-of-network providers.

· Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

· Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-692-7447 (1-855-MyARHIPP)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website:
https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/ 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
GA HIPP Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2
ILLINOIS – Medicaid
Medicaid Application Website:
https://abe.illinois.gov
HIPP Hotline: 217-524-8268
HIPP Email:
hfs.boc.hipp@illinois.gov
INDIANA – Medicaid
Website:
https://www.in.gov/medicaid/
Additional Information:
http://www.in.gov/fssa/dfr/
Family and Social Services Administration:
Phone: 1-800-403-0864
Member Services:
Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website:
https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid

Disclosures

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kynect.ky.gov
KCHIP Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Customer Service:
1-888-342-6207
Email: healthy@la.gov
LaHIPP Website:
https://www.ldh.la.gov/lahipp
Phone: 1-877-697-6703
Email: La.HIPP@la.gov
Fax: 1-888-716-9787
Mailing Address: 100 Crescent Centre Parkway, Suite 1000

Tucker, GA 30084
MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711
MASSACHUSETTS – Medicaid and CHIP
Website:
https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email:
masspremassistance@accenture.com
MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672
MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005
MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid Website:
http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178
NEVADA – Medicaid
Website: http://dhcfp.nv.gov
Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll-Free: 1-800-852-3345 ext. 15218
Email:
DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance:
609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid Website:
https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website:
https://medicaid.ncdhhs.gov/
Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website:
https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website:
http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
HIPP Website:
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347
Direct RIte Share Line:
401-462-0311
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:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone:
1-800-440-0493
UTAH – Medicaid and CHIP
UPP Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program:
https://medicaid.utah.gov/buyout-program/
CHIP Website:
https://chip.utah.gov/
VERMONT – Medicaid
Website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
FAMIS Select:
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
HIPP Programs:
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924
To see if any other states have added a premium assistance program since January 31, 2026, 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
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