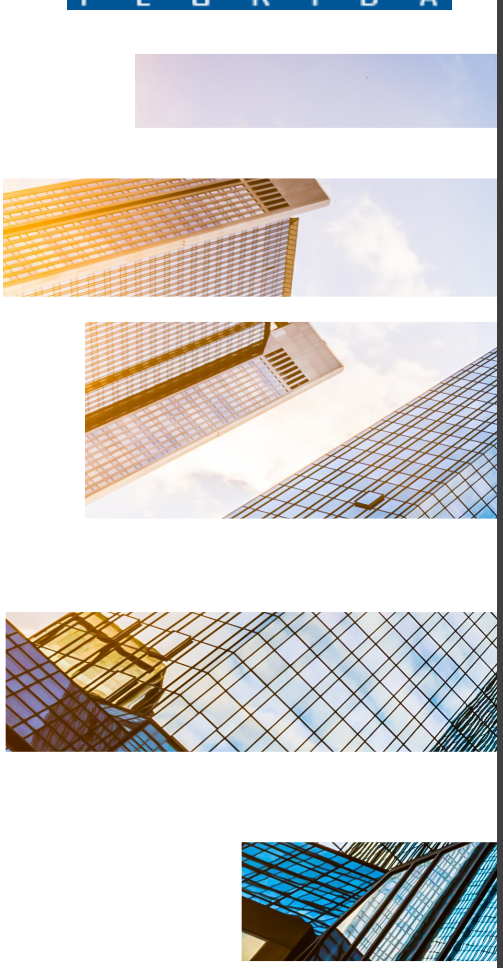
NORTH MIAMI
FLORIDA



2026 RETIREE BENEFITS GUIDE

YOUR BENEFITS.

YOUR CHOICES.

YOUR HEALTH.

January 1, 2026 -
December 31, 2026

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INTRODUCTION

Introduction

As a retiree of The City of North Miami when you retire you may be eligible to continue coverage under some of the benefits such as Medical, Dental, Vision and Basic Life on a voluntary basis. Please note that the rates reflected in this guide are the full monthly rates. Your rates may vary due to your retiree class. Please check the PlanSource system for your rate or reach out to the Personnel Department.

Eligibility & Enrollment

Your eligible dependents may also participate in the medical, dental, vision, if you are also enrolled.

An eligible dependent is:

- Your legally married spouse
- Domestic Partner
- Your child(ren) including:
  - A natural child
  - A stepchild
  - A legally adopted child or a child legally placed in your home for the purpose of adoption
  - A foster child or child for whom you or your spouse are the legal guardian
  - A child of your Domestic Partner
  - A child for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order.

Dependent children are covered until the end of the calendar year in which they turn 26. For medical plans, extended coverage to the end of the calendar year in which the dependent reaches age 30 may be available if the dependent meets all of the following requirements:

- Is not married
- Does not have dependent of their own
- Is a resident of the State of Florida or is a student
- Does not have coverage under any other group or individual policy
- Is not entitled to benefits under Title XVIII of the Social Security Act

Your Elections

As a retiree please remember that if you drop the City of North Miami coverage, you will not be permitted to come back onto the plan.

CONTACT INFORMATION

CITY OF NORTH MIAMI CONTACTS

Human Resources Department

Phone: 305.895.9866

hr@northmiamifl.gov

776 NE 125th St

1st Floor

North Miami, Fl 33161

CARRIER	PHONE #	WEBSITE
Cigna		
Customer Service		
Medical - Policy #00651879	**888.806.5094**	**www.Cigna.com**
Dental - Policy #0651879	**888.806.5094**	**www.Cigna.com**
Vision - Policy #0651879	**888.806.5094**	**www.Cigna.com**
MDLive		
Customer Service	**888.726.3171**	**www.mdliveforcigna.com**
Mutual of Omaha		
Customer Service		
Basic Life	**800.775.8805**	**www.mutualofomaha.com**
Corporate Synergies Group		
BenefitsVIP	**866.293.9736**	**Solutions@benefitsvip.com**

BenefitsVIP®
Help starts here.

HELP STARTS HERE

BenefitsVIP is a one-stop contact center staffed by seasoned professionals. This dedicated team of advocates is ready to help you and your family members resolve your benefits issues.
All contact with BenefitsVIP is completely confidential.

866.293.9736
Monday—Friday
8:30am—8:00pm (ET)
Fax: 856.996.2775
solutions@benefitsvip.com

QUESTIONS ANSWERED HERE

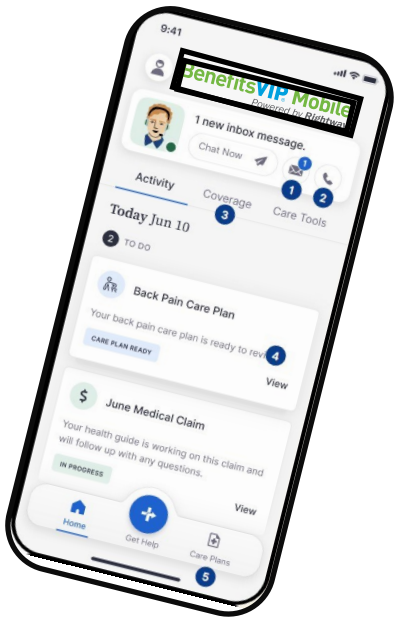
Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer questions, and quickly resolve claim and eligibility issues. Most inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP® Mobile
Powered by **Rightway**

BenefitsVIP Mobile Links You with Your Benefits Plans and Advocate Support

Powered by Rightway, BenefitsVIP Mobile gives you direct access to your dedicated BenefitsVIP advocacy team and the tools and resources to help you better utilize your benefits.
BenefitsVIP Mobile's features include:

- Contact BenefitsVIP: One-click connection with your dedicated BenefitsVIP team.
- Insurance Coverage: View a simple breakdown of your benefits, including out-of-pocket costs.
- Provider Search: Find a list of the best in-network providers & facilities.
- Appointment Scheduler: Book appointments with high-quality doctors.
- Review or Dispute a Bill: Get a medical bill explained or a claim issue resolved.
- Price Tools: Understand what a service or procedure will cost.
- Benefits Navigation: Connect with employer-sponsored benefits and access your benefits guide.



MEDICAL

HOW TO FIND A PROVIDER

Follow the steps below to locate a participating medical provider:

STEP 1: Go to **www.Cgna.com**

STEP 2: Click on "Find a doctor"

STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"

STEP 4: Enter search location "and click "Search"

STEP 5: If on the OA Elect Choice EPO 500 or OA Elect Choice EPO 2500 plan or the OA Elect Choice EPO 4000 plan: under "Cigna Open Access Plans" select "Elect Choice EPO (Open Access)".

If you are on Network Option 1500 plan, select "Health Network Option (Open Access)".

	BUY-UP PLAN	OPEN ACCESS ELECT CHOICE $500 EPO
BENEFIT		**IN-NETWORK ONLY**
Annual Deductible (Calendar Year)		**Individual:** $500 **Family:** $1,000
Out-of-Pocket Maximum		**Individual:** $5,000 **Family:** $10,000
Member Co-Insurance		20%
Preventive Care Adult Preventive Care, Adult Annual Physical Exam or Well-Child Care		No Charge
Outpatient Care Primary Care Physician office visits Specialist office visits Outpatient facility surgery Outpatient surgery physician / surgeon fees Telehealth / Virtual Visits		 $15 Copay—Tier 1/ $25 Copay—Tier 2 $35 Copay—Tier 1/ $45 Copay—Tier 2 Deductible, then 20% Deductible, then 20% **PCP:** $15 Copay | **Spec:** $35 Copay
Inpatient Hospitalization Facility		$750 Copay / Admission
Emergency Care Ambulance (when medically necessary) Hospital Emergency Room Urgent Care		 Deductible $350 Copay (waived if admitted) $50 Copay
Independent Outpatient Lab & X-Ray Blood Work & X-Rays Advanced Imaging (MRI, CT/PET Scans)		 No Charge $200 Copay
Mental Health Inpatient (Physician / Facility) Outpatient office visits		 $750 Copay / Admission $35 Copay
Prescription Drugs **Retail Pharmacy** (30 day supply) Tier 1 / Tier 2 / Tier 3 **Mail Order** (90 day supply) Tier 1 / Tier 2 / Tier 3 **Specialty Drugs** Preferred Specialty/Non-Preferred Specialty		 $0 / $50 / $90 $0 / $100 / $180 20% ($150 Maximum)
Monthly Contributions* Employee Only Employee + Spouse Employee + Children Employee + Family		 **$968.85** **$2,073.31** **$1,932.84** **$2,922.99**

*Retiree rates will vary based on your Retiree Class. Please see the PlanSource system or reach out to the Personnel Department. The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this conflicts in any way with the contract, the contract will prevail.

Cigna

MID PLAN	OPEN ACCESS ELECT CHOICE $2500 EPO
BENEFIT	**IN-NETWORK ONLY**
Annual Deductible (Calendar Year)	**Individual:** $2,500 **Family:** $5,000
Out-of-Pocket Maximum	**Individual:** $6,000 **Family:** $12,000
Member Co-Insurance	10%
Preventive Care	
Adult Preventive Care, Adult Annual Physical Exam or Well-Child Care	No Charge
Outpatient Care	
Primary Care Physician office visits	$20 Copay—Tier 1/ $30 Copay—Tier 2
Specialist office visits	$40 Copay—Tier 1 / $50 Copay—Tier 2
Outpatient facility surgery	Deductible, then 10%
Outpatient surgery physician / surgeon fees	Deductible, then 20%
Telehealth / Virtual Visits	**PCP:** $20 Copay | **Spec:** $40 Copay
Inpatient Hospitalization	
Facility	Deductible, then 10%
Physician / Surgeon	Deductible, then 20%
Emergency Care	
Ambulance (when medically necessary)	Deductible, then 10%
Hospital Emergency Room	$350 Copay (waived if admitted)
Urgent Care	$75 Copay
Independent Outpatient Lab & X-Ray	
Blood Work & X-Rays	No Charge
Advanced Imaging (MRI, CT/PET Scans)	$300 Copay
Mental Health	
Inpatient (Physician / Facility)	Deductible, then 10%
Outpatient office visits	$40 Copay
Prescription Drugs	
Retail Pharmacy (30 day supply)	
Tier 1 / Tier 2 / Tier 3	$0 / $50 / $90
Mail Order (90 day supply)	
Tier 1 / Tier 2 / Tier 3	$0 / $100 / $180
Specialty Drugs	
Preferred Specialty/Non-Preferred Specialty	20% ($150 Maximum)
Monthly Contributions*	
Employee Only	**$940.19**
Employee + Spouse	**$2,010.15**
Employee + Children	**$1,875.70**
Employee + Family	**$2,836.57**

*Retiree rates will vary based on your Retiree Class. Please see the PlanSource system or reach out to the Personnel Department. The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this conflicts in any way with the contract, the contract will prevail.

Download the myCigna App for your Mobile Device.

Download on the App Store

GET IT ON Google play

Don't Forget! myCigna App Users Log in with just One Touch!

When you download the myCigna App you can access your account with just a fingerprint on any compatible device.

Pharmacy Options

If you take prescription medication, you can save money by becoming an informed consumer and using the same buying techniques that you use when shopping for other goods and services.

Ways to save on your prescription drugs include:

- Generic medications
- Price comparison
- Drug substitution
- Discount prescription cards
- Over the counter drug substitutes
- Pharmaceutical company assistance programs

Local Pharmacies often offer free antibiotics and low priced medications.

Inquire at your local CVS, Publix, Target and Walmart pharmacies as to what discount programs are available.

GoodRx.com

Save up to 80% on most prescription drugs at virtually every U.S. pharmacy.

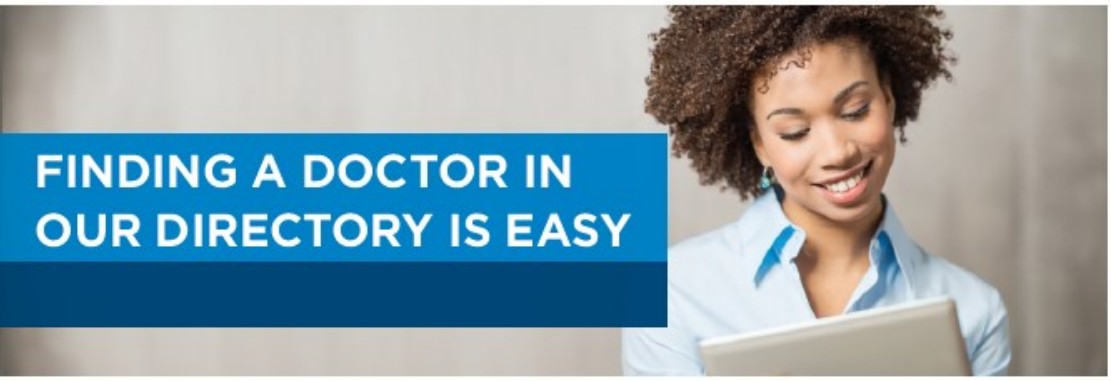
The GoodRx mobile app allows you to get prescription drug prices on-the-go with coupons built into the app. Show your smartphone to the pharmacist to save.

Visit **GoodRx.com** to learn the terms of their current program.

Cigna

	BASE PLAN	OPEN ACCESS ELECT CHOICE $4000 EPO
BENEFIT		**IN-NETWORK ONLY**
Annual Deductible (Calendar Year)		**Individual:** $4,000 **Family:** $8,000
Out-of-Pocket Maximum		**Individual:** $8,000 **Family:** $16,000
Member Co-Insurance		30%
Preventive Care		
Adult Preventive Care, Adult Annual Physical Exam or Well-Child Care		No Charge
Outpatient Care		
Primary Care Physician office visits		$20 Copay—Tier 1 / $30 Copay—Tier 2
Specialist office visits		$40 Copay—Tier 1 / $50 Copay—Tier 2
Outpatient facility surgery		Deductible, then 30%
Outpatient surgery physician / surgeon fees		Deductible, then 40%
Telehealth / Virtual Visits		**PCP:** $20 Copay | **Spec:** $40 Copay
Inpatient Hospitalization		
Facility		Deductible, then 30%
Physician / Surgeon		Deductible, then 40%
Emergency Care		
Ambulance (when medically necessary)		Deductible, then 30%
Hospital Emergency Room		$350 Copay (waived if admitted)
Urgent Care		$75 Copay
Independent Outpatient Lab & X-Ray		
Blood Work & X-Rays		No Charge
Advanced Imaging (MRI, CT/PET Scans)		Deductible, then 30%
Mental Health		
Inpatient (Physician / Facility)		Deductible, then 30%
Outpatient office visits		$40 Copay
Prescription Drugs		
Retail Pharmacy (30 day supply)		
Tier 1 / Tier 2 / Tier 3		$0 / $50 / $90
Mail Order (90 day supply)		
Tier 1 / Tier 2 / Tier 3		$0 / $100 / $180
Specialty Drugs		
Preferred Specialty/Non-Preferred Specialty		20% ($150 Maximum)
Monthly Contributions*		
Employee Only		**$852.49**
Employee + Spouse		**$1,822.68**
Employee + Children		**$1,700.77**
Employee + Family		**$2,572.03**

*Retiree rates will vary based on your Retiree Class. Please see the PlanSource system or reach out to the Personnel Department. The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this conflicts in any way with the contract, the contract will prevail.



Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

SEARCH YOUR PLAN'S NETWORK IN FOUR SIMPLE STEPS

Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current plan's network. To search other networks, use the **Cigna.com** directory.)

Step 2

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

Step 3

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Step 4

Optional: Select one of the plans offered by your employer during open enrollment.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

WELL-BEING SERVICES AT CVS MINUTECLINIC®

Cigna offers well-being service at CVS Pharmacy® and Target® locations:
Choose from these services:

- Smoking cessation
- Weight management
- Diabetes monitoring
- High cholesterol monitoring
- High blood pressure monitoring

You can work one-on-one with providers to help create personalized health plans and get the support you need for a healthier you.

Go to **MinuteClinic.com** to find the closest location and make appointments or view wait times.

WHERE TO GO FOR CARE

	Non-emergency Care from anywhere	Non-emergency In-person care	Non-emergency In-person care	Urgent In-person care	Emergency In-person care
	MDLive	**Primary Care Physician (PCP)**	**MinuteClinic®**	**Urgent Care Center**	**Emergency Room**
Care Options	MD live gives you 24/7 access to board-certified doctors by phone, video or mobile app. Talk to a doctor in minutes and get a diagnosis, treatment, and prescription (when needed), for non-emergency medica needs	Your PCP is the best option for in-person, non-emergency care. To find in-network PCPs near you, log in to your member website.	MinuteClinic offers convenient care 7 days a week from certified nurse practitioners and physician assistants at select CVS Pharmacy® and Target stores nationwide.	Urgent care centers provide quick care for serious, but not life-threatening, situations. Many urgent care centers offer imaging, X-ray and lab services.	The emergency room (ER) is for emergencies that can permanently impair or endanger your life. Using the ER for non-life-threatening issues can be very costly and probably means a very long wait time.
When to use	•Allergies •Flu •Bronchitis •Sinus infection •Food poisoning •Rash •Poison ivy/oak •Sunburn •Sore throat •Headache/migraine •Eye infection and more	•Physicals (wellness, screening) •Vaccinations & injections •Chronic condition management (heart disease, diabetes, arthritis, etc.) •Acute care (sinus infections and injuries) •Urgent care may be available by appointment	•Minor illnesses & injuries •Screenings & monitoring •Skin conditions •Vaccinations & injections •Wellness & physicals •Women's services •Travel health •Visit minuteclinic.com to confirm services available at your location	•Back/neck pain •Cuts that require stitches •Minor burns •Flu •Sprains •Fractures •Bronchitis •Headaches and more	•Chest pain •Severe abdominal pain Trouble breathing Uncontrollable bleeding Symptoms that may put your life at risk
Availability	24 hours a day 7 days a week 365 days a year	Weekdays during business hours *(May be open extended hours and/or Saturdays)*	7 days a week *(including evenings and weekends)*	Many open 7 days a week with extended hours	24 hours a day 7 days a week 365 days a year
How to access	By phone: **1-888-726-3171** By video: **mdliveforcigna.com** By mobile app: download the **Cigna Health** or **MDLIVE app** to get started	By appointment only	At select CVS Pharmacy and Target stores Schedule an appointment at **minuteclinic.com** or through the CVS Pharmacy app	Walk in	Walk in
Average wait time	On-demand within minutes *(Avg. wait 10 – 15 mins.; guaranteed within 1 hour or consult is FREE of charge)* Also by appointment	Average wait time of 22 minutes upon arrival	Make an appointment at minuteclinic.com	15 - 45 minutes typically	2 - 4 hours for non-emergency care typically
Average cost to you	**$** •Total cost is $45 or less. •Pay at the time of your consult. •No balance is ever billed to you.	**$$** •Pay your copay at appointment, if applicable. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.	**$** •No-cost or low-cost access to all covered services. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.	**$$$** •Pay your copay at time of visit, if applicable. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.	**$$$$** •Pay your copay at time of visit, if applicable. •Pay your estimated patient responsibility at time of visit, if applicable. •You may be billed for any balance.

VIRTUAL VISITS

MDLIVE

MDlive® Virtual Visits

With Virtual Visits, it's easy to video chat with a doctor 24/7—whenever, wherever.

MD live gives you 24/7 access to board-certified doctors by phone, video or mobile app.

Talk to a doctor in minutes and get a diagnosis, treatment and prescription (if needed), for non-emergency medical needs.

Quality care when and where you need it.

Use a Virtual Visit for everyday medical conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- And more

How to access

By phone: **888.726.3171**

By video: **www.mdliveforcigna.com**

By mobile app: download the **Cigna Health** or **MD live app** to get started

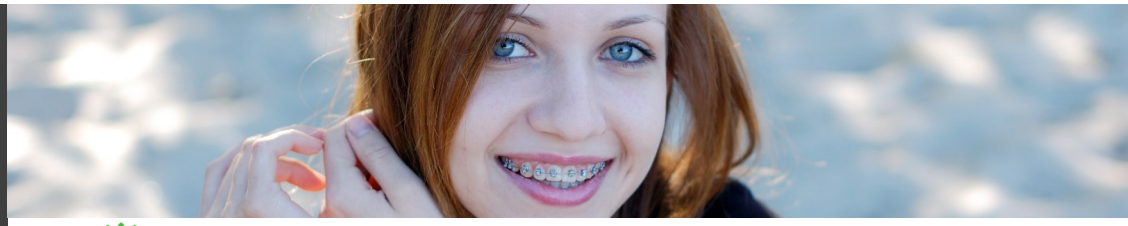
cigna healthcare

MDLIVE

VIRTUAL VISITS MAY SAVE YOU TIME AND MONEY.

On-demand within minutes *(Avg. wait 10 – 15 mins.; guaranteed within 1 hour or consult is FREE of charge).*
Also by appointment.

DENTAL



Cigna

FINDING A PPO DENTAL PROVIDER

Follow the steps below to locate a participating dental provider:

STEP 1: Go to **www.Cigna.com**
STEP 2: Click on "Find a doctor"
STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"
STEP 4: Enter search location "and click "Search"
STEP 5: Under Select a Plan, scroll down to "Dental PPO/ PDN with PPO II network" select "Dental PPO/PDN with PPO II
STEP 6: Select "Dental Care" then select type of dentist

FINDING A DHMO DENTAL PROVIDER

Follow the steps below to locate a participating dental provider:

STEP 1: Go to **www.Cigna.com**
STEP 2: Click on "Find a doctor"
STEP 3: If you are already a member log in; if not, under Guests select "Plan from an employer"
STEP 4: Enter search location "and click "Search"
STEP 5: Under Select a Plan scroll down to "DMO®/DNO/ Managed Dental" select "DMO® /DNO"
STEP 6: Select "Dental Care" then select "Dentists (Primary Care)

DENTAL PLANS	PPO PLAN		DHMO PLAN
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Calendar Year Deductible	**Individual:** 25 **Family:** $75	**Individual:** $50 **Family:** $150	**Individual:** $0 **Family:** $0
Benefit Maximum Per Calendar Year	$2,500		N/A *Primary Dentist Election Required*
Diagnostic & Preventive Services Cleanings; Oral Exams; Topical Fluoride & Sealants (up to age 16); X-rays; Bitewing; & Space Maintainers	100%	100%	Some Procedures Covered @ 100% (See Fee Schedule)
Basic Services Fillings; Extractions; Oral Surgery; Endodontics; Periodontics; Periodontal Surgery; Anesthesia	90%	80%	Copays Apply (See Fee Schedule)
Major Services Bridge and Dentures; Crowns, Inlays, Onlays, Repairs of Dentures,	60%	50%	Copays Apply (See Fee Schedule)
Orthodontic Services Adults & Children	50% $2,500 Lifetime Max	50% $2,500 Lifetime Max	Copays Apply No Lifetime Max
Monthly Contributions Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	 **$47.37** **$94.75** **$106.61** **$153.98**		 **$12.69** **$23.21** **$33.00** **$47.93**

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this conflicts in any way with the contract, the contract will prevail.

VISION

PPO VISION PLAN

BENEFIT	IN-NETWORK (ALLOWANCE)	OUT-OF-NETWORK (REIMBURSEMENT)
Eye Exam	$10 Copay	Up to $45
Frequency (within a consecutive 12-month period)		
Exam	12 months	12 months
Lenses	12 months	12 months
Frames	12 months	12 months
Contact Lenses (in lieu of eyeglasses)	12 months	12 months
Frames	$130 Allowance + 20% off Balance	Up to $71
Lenses		
Single Vision Lenses	$0 Copay	Up to $32
Bifocal Vision Lenses	$0 Copay	Up to $55
Trifocal Vision Lenses	$0 Copay	Up to $65
Lenticular Vision Lenses	$0 Copay	Up to $80
Standard Progressive Lenses	$65 Copay	Not Covered
Contact Lenses (in lieu of glasses)		
Medically Necessary	$0 Copay	Up to $210
Elective Contact Lenses	$110 Allowance	Up to $98
Monthly Contributions		
Employee Only	**$5.00**	
Employee + Spouse	**$9.49**	
Employee + Child(ren)	**$10.00**	
Employee + Family	**$14.70**	

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this conflicts in any way with the contract, the contract will prevail.

FINDING A VISION PROVIDER

Follow the steps below to locate an in-network Vision provider:

STEP 1: Go to **www.Cigna.com**
STEP 2: Click on “Find a doctor”
STEP 3: If you are already a member log in; if not, under Guests select “Plan from an employer”
STEP 4: Scroll all the way to the bottom of the page and under vision click on “ Cigna Vision Directory (Serviced by EyeMed)
STEP 5: Enter search location “and click “Search

BASIC LIFE

Mutual of Omaha

HOW BASIC LIFE INSURANCE CAN HELP

Life 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 an organization you are passionate about

Retiree Voluntary Basic Life

As a retire of The City of North Miami you may continue your basic life insurance through Mutual of Omaha. You will be responsible to the cost of this coverage which will be reflected in the PlanSource system. Please remember once you drop this coverage you will not be eligible for this coverage in the future.

- **Age Reduction**: Basic Life benefits are reduced to 65% at age 65, to 50% at age 70, to 35% at age 75.

Be Sure to Update your Beneficiary Information

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
- The trustee of a trust you've set up
- Your estate

Note: 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. Contingent beneficiaries receive the death benefit if the primary beneficiary cannot be located. If no primary or contingent beneficiaries are located, 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 confirm their identity and decrease the likelihood of potential disputes.

Be A Wise Health Care Consumer

Knowing your four health numbers is key to a healthier you.
At your annual check-up, ask your doctor for your four health numbers (Blood Pressure, Cholesterol, Blood Sugar and BMI-Body Mass Index).

Blood pressure:
A telltale sign for possible heart disease, stroke and kidney disease. Understanding your blood pressure numbers is key to controlling high blood pressure. The American Heart Association recommends a normal Blood Pressure range of Systolic mm Hg (upper number) Less then 120 and Diastolic mm HG (lower number) Less than 80 (120/80).

Cholesterol
HDL is good. LDL is bad. Keeping both in check is essential. The American Heart Association (AHA) recommends that all adults age 20 or older have their cholesterol and other traditional risk factors checked every four to six years, and work with their healthcare providers to determine their risk for cardiovascular disease and stroke.

Blood Sugar
A leading determinant for the onset of diabetes. What is a normal blood sugar level? And how can you achieve normal blood sugar? For someone without diabetes, a fasting blood sugar on awakening should be under 100 mg/dl. Before-meal normal sugars are 70–99 mg/dl. "Postprandial" sugars taken two hours after meals should be less than 140 mg/dl.

Body Mass Index (BMI)
The measure of body fat based on height and weight that applies to adult men and women. In general, BMI is an inexpensive and easy-to-perform method of screening for weight category, for example underweight, normal or healthy weight, overweight, and obesity. There are many calculators online to assist you with obtaining your BMI.

https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

Do you know your financial health numbers?

Knowing them is just as important as knowing your overall health numbers. Your financial health comes down to a series of ratios. Here's where you should start:

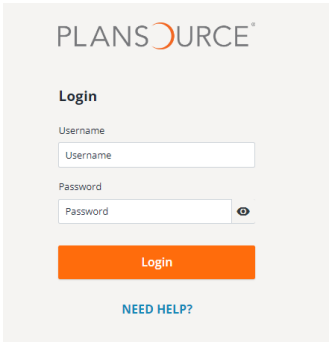
1. **Credit Score:** Your FICO credit score—a ratio determined independently by three credit bureaus and based primarily on your track record of paying bills on time – is about far more than just being approved for loans.

2. **Emergency Fund:** The number you need to know: How many months could you survive on your savings? The key is to achieve an overall balance in your finances, with about half your income going toward fixed expenses like rent and utilities, 20% for financial goals like savings, and 30% for day-to-day expenses like groceries and gas, advises Vera Gibbons, personal finance consultant - mint.com

3. **Net Worth:** People tend to think of this number as their "wealth," says LearnVest's von Tobel, but it's not really about how much you have at any given point. Rather, people should use net worth as a starting point to see how they are doing down the road.

PLANSOURCE ONLINE ENROLLMENT INSTRUCTIONS

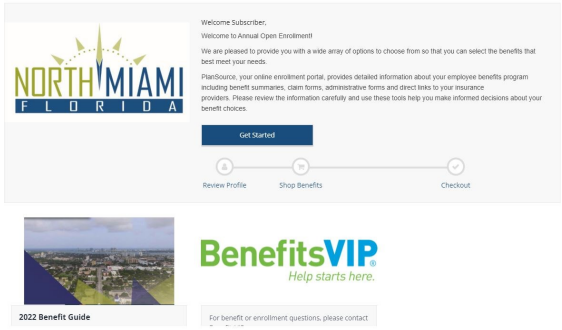
STEP 1:



- Login to PlanSource at **https://benefits.plansource.com** using the credentials below:
- **USERNAME:** First initial of your First Name + up to the first six characters of your Last Name + Last four (4) digits of your SSN. **Example:** John Employee, whose SSN is 000-00-1234, would have a username of JEMPLOY1234; and John Plan, whose SSN is 000-00-9876 would have a username of Jplan9876.
- **PASSWORD:** Please use your existing password to login. If you have forgotten, click on the "NEED HELP?" link to reset. You will be prompted to enter your Username and the email address that we have on file in PlanSource.

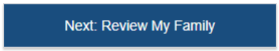
STEP 2:

Click **"Get Started"** to begin the enrollment process.



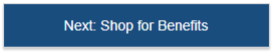
STEP 3:

You will be asked to review your personal information then scroll down and click on **"Next: Review My Family"**

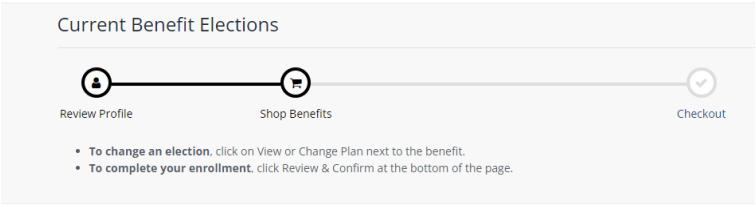


STEP 4:

You can now review your family information. You can now add a family member, edit a family member or remove a family member. When done click on **"Next: Shop for Benefits"**



PLANSOURCE



Step 5:

This page will show you your current elections and give you the opportunity to add, change or remove plans,

If this page reflects the benefits you would like for the 2026 plan year you will click **"Review and Checkout"**

Step 6:
If you would like to change a plan election click **"View or Change Plan"** benefit plan you would like to change.

You will then choose the plan you wish to enroll in or click on the decline coverage box. Then click on **"Update Cart"**

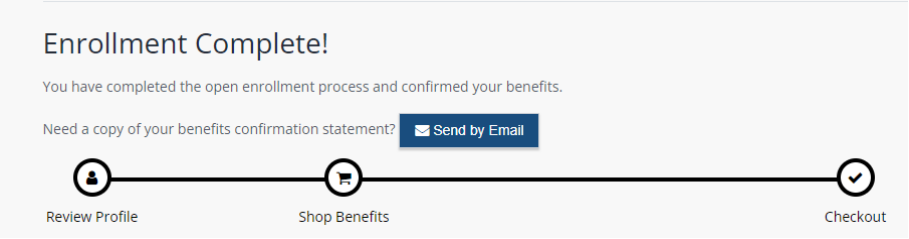
Step 6:

Please continue to follow the prompts as you move through your elections, they will vary based on the choices you make. When you have completed making your choices you will then click on **"Review and Checkout"**

Step 7:

Click on **"Checkout"**

Your enrollment is now complete you can have a copy of your enrollment emailed to yourself by clicking **"Send by Email"**



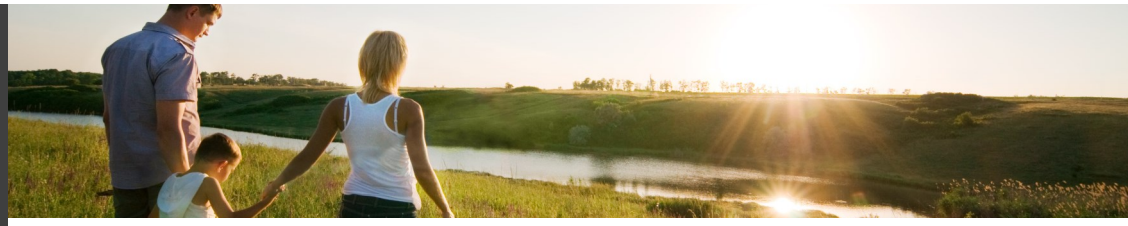
Don't miss this final step, your enrollment is not complete until you reach this page.

Questions?

If you have questions about Open Enrollment; enrolling online; or need assistance logging in, contact your dedicated BenefitsVIP Team, Monday – Friday, 8:30 am – 8:00 pm (ET), or your HR team.

By phone: 866-293-9736
By email: solutions@benefitsvip.com

MEDICARE PART D



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

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

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

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

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

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

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

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

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of North Miami group health plan coverage will not be affected. You and your dependents can enroll in a Part D plan as a supplement to, or in lieu of, the group health plan coverage. However, if your existing prescription drug coverage is under a Medigap policy, you cannot have an existing prescription drug coverage and Part D coverage. If you enroll in Part D coverage, you should inform your Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts.

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

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

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

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

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

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

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

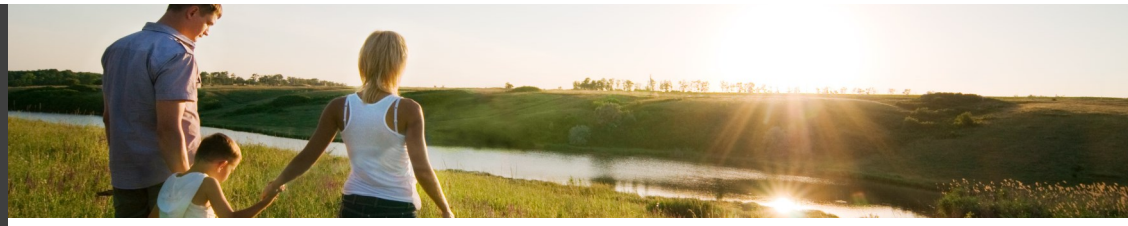
For more information about this notice or your current prescription drug coverage contact:

Name of Entity/Sender:	City of North Miami
Contact--Position/Office:	Human Resources Department
Address:	776 NE 125 Street 1st Floor
Phone Number:	North Miami, FL 33161

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

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

COBRA



The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called 'continuation coverage') at group rates in certain instances where coverage under the plan would otherwise end. An employee, spouse of an employee or a dependent child of an employee covered by the Entity's group health plan has the right to choose this continuation coverage if coverage is lost for any of the following reasons provided below.

Employee	• Reduction in hours of employment (that disqualifies group insurance participation eligibility) or • Termination of employment (for reasons other than gross misconduct).
Spouse of Employee	• The death of your spouse or • A termination of your spouse's employment (for reasons other than gross misconduct) or • A reduction in your spouse's hours of employment or • Divorce or legal separation from your spouse or • Your spouse becomes entitled to Medicare.
Dependent Child of Employee	• The death of a parent or • A termination of the parent's employment (for reasons other than gross misconduct) or A reduction in the parent's hours of employment with the Entity or • Parent's divorce or legal separation or • A parent becomes entitled to Medicare or • The dependent child ceases to be a "dependent child" under the Entity's group health-plan.

COBRA is administered by a 3rd party administrator, WEX COBRA. You will receive a COBRA packet in mail directly from WEX COBRA and all forms and payments will be submitted directly to WEX should you elect COBRA.

WEX COBRA
PO Box 2079
Omaha, NE 68103-2079

Customer Service: 866.451.3399

DISCLOSURES

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

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

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

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

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

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:
1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

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

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:
The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

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 employ-

DISCLOSURES

er, 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, 2024. Contact your State for more information on eligibility –

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

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

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

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://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

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/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:
Iowa Medicaid | Health & Human ServicesMedicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

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

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

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

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/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
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email:
DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 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 and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
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: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

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

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

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

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

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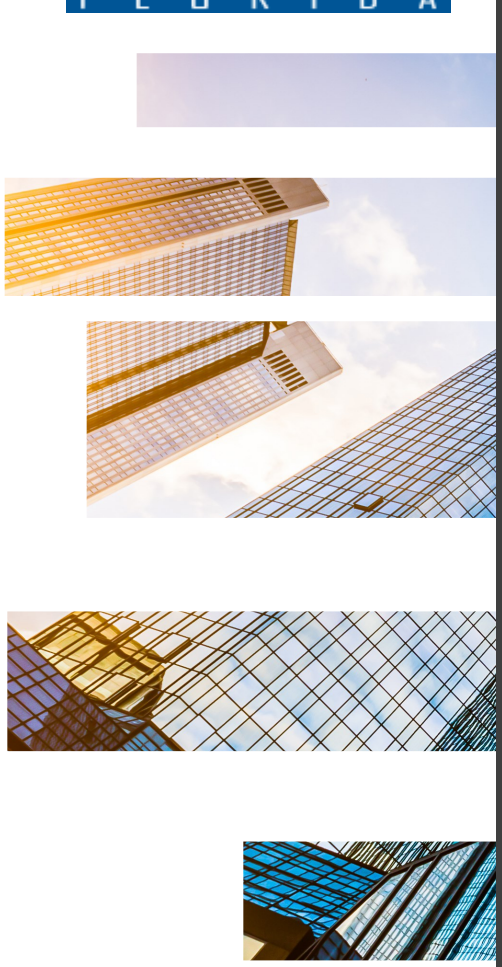

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