IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND

2021

BENEFITS INFORMATION GUIDE

Your benefits made simple.

Active Members

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 12 for more details.

BENEFIT OFFERINGS

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Medical	• Cigna NPOS
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BENEFITS ENROLLMENT & INFORMATION

Welcome to your 2021 Benefits Information Guide. At IAFF Local 587 Health Insurance Trust Fund, we understand the importance of a well-rounded benefits program and are dedicated to providing our members with unique benefits that meet the needs of you and your family. This Benefits Information Guide is a comprehensive tool to help you become familiar with the plans and programs that you and your family can enroll in for the plan year.

Important

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation. It is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the plan SPD prevails. See the Summary Plan Description for the full list of exclusions.

Open Enrollment

Open Enrollment is a period of time dedicated to selecting your benefits for the upcoming year. You can enroll or change your current elections and also add or remove dependents. Your selections will be effective from January 1, 2021 through December 31, 2021.

The Open Enrollment period for coverage in 2021 is through Friday, November 27th. This is a passive enrollment, which means you do not need to login to the system if you are not making any changes. Your current elections will rollover to next year.

Plan Changes

After this Open Enrollment period, you may not make changes to your coverage during the year unless you experience a qualified family status change. These are a few examples of qualified family status change events:

1) Special Enrollment Events (Add coverage for yourself and/or dependents).
   - Loss of other coverage
   - Acquire a new dependent through marriage, birth or adoption
   - Become eligible for Medicaid or CHIP

2) IRC Section 125 Status Change Events (Add, cancel or change coverage for yourself and/or dependents).
   - Loss or gain of other coverage
   - Divorce
   - Death of covered spouse or child
   - Change in employment status
   - Medicare entitlement

You should verify the allowed events with our Benefits Administrator. You must notify our Benefits Administrator within 30 days of an event (60 days in the case of Medicaid or CHIP eligibility).

Eligibility

Provided that contributions are received by the Trust on their behalf, the following persons will be eligible for benefits:

1) Miami Association of Firefighters IAFF Local 587/City of Miami bargaining unit employees on whose behalf the City is making a contribution, who are on and have been on the City's Fire Department payroll for at least ninety (90) days ("covered employees") and their dependents;

2) Covered employees who retire under the City of Miami Police and Fire Pension Fund after the date the Plan goes into effect and who were continuously a "covered person" for forty-eight (48) months before retiring or separating from employment and who were continuously a member of the Miami Association of Firefighters IAFF Local 587 during that 48 months ("covered retirees") and their dependents provided that the retiree is currently enrolled, or enrolls at time of retirement. For purposes of this provision, a "covered person" includes coverage under a family plan through another member. The incarceration of a retiree shall not disqualify the member for benefits, if otherwise eligible; provided however that benefits for the retiree member shall be suspended during the period of incarceration.

3) Non-bargaining unit employees who meet the following conditions:

- Must be on the City of Miami Fire Department Payroll for at least ninety days at the time of enrollment;
- Must be on the Miami Association of Firefighters IAFF Local 587 Payroll for at least ninety days at the time of enrollment;
- Must be a Local 587 member for two years (or length of time in Department if less than two years) prior to enrollment, and must maintain membership throughout the period of coverage; and
- Must make the election within thirty (30) days after appointment out of the bargaining unit.

4) Other employees on whose behalf the Trustees agree by rule to accept contributions.

Participants - Each participant becomes eligible for coverage on the later of:

i. the effective date of this Plan; or
ii. the day following the date the participant completes ninety (90) days of continuous employment with the City of Miami, or the Miami Association of Firefighters IAFF Local 587.

Dependents: Each dependent of a covered Participant becomes eligible for coverage on the latest of the following dates:

i. the effective date of this Plan; or
ii. placement for adoption; or
iii. marriage; or
iv. legal guardianship; or
v. court or administrative order; or
vi. the date the Participant is eligible for individual coverage; or
vii. the date the Participant first acquires a dependent, or
viii. the date the dependent loses alternative coverage through a qualifying event

Participants must notify the City and the Health Trust within 31 days of their acquiring a dependent or any other change affecting dependent status. The notice shall be in writing and shall further provide proof of such changes as may be required by the Board, (for example: divorce decrees, birth certificates, marriage licenses, etc. If the participant's coverage status is already under family coverage at the tie of acquiring an additional dependent, then the dependent(s) will become covered on the date that they meet the definition of an eligible dependent as described in the health trust. In such case, the Board of Trustees may waive the 31 day notice requirement.

5) A covered employee who participates as a dependent of another covered employee or retiree may revert to a primary covered employee status upon the occurrence of a qualifying event.

HOW TO ENROLL OR MAKE CHANGES - MMA MARKETLINK

Open Enrollment & Benefits Online Enrollment

Employees will need to make their benefit elections on MarketLink, our online enrollment system. Please follow the instructions below to login and make your elections. You may use a computer, smartphone or tablet device.

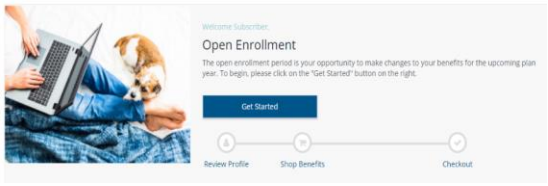
1. Go to www.plansource.com/login
2. Follow the instructions below for your Login ID and Password. You will be prompted to choose a new password.

    - Login ID/Username Your username is the first initial of your first name, up to the first six letters of your last name, and the last four digits of your SSN.
    - Password your initial password is your birthdate in the YYYYMMDD format.

      Example #1: Taylor Williams, SSN: XXX-XX-1234, Birthdate: January 4, 1982

      Login ID: jwillia1234, **Password:** 19820104

      Example #2: Rebecca Gray, SSN: XXX-XX-2345, Birthdate: August 14, 1962
      Login ID: rgray2345, **Password:** 19620814



3. On the homepage, click **"Get Started"** to begin.
4. First, you'll be asked to review and update your profile and ensure that all information listed about yourself and dependents is correct.
5. You can then begin shopping for benefits! Educational material about the specific plan type is available at the top of the page. Plan choices are displayed on "cards," which provide a brief summary of what is included in the plan. Click a card to get more details about a specific plan. To select a plan, indicate which family members are covered by clicking "edit family covered" and select the card for each family member you'd like to add to the plan. Click "Update Cart" to choose the plan.
6. To finalize and save your choices, click "Checkout." **You must complete the checkout process in order to be enrolled in benefits.**
7. You will then land on the Summary page that confirms you have completed the enrollment process. Note: You may download, email, or print the summary for your records.

Please note, this is a year-round portal, which allows you to visit frequently to confirm your benefits elections, update demographic information and/or make qualified life event changes. If you have questions, please contact your Benefits team at benefits@healthtrustmaff.org.

MEDICAL PLAN

IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND offers a medical plan through **Cigna.** **Cigna's** preferred lab facilities are **Lab Corp** & **Quest Diagnostics**. Below are highlights of the plan.

You can search for participating providers by visiting www.cigna.com and click "Find a Doctor, Dentist or Facility", selecting "For plans offered through your employer or school" and selecting "Cigna HealthCare Seamless Network – Florida."

PLAN HIGHLIGHTS	NPOS	
	In-Network	Out-of-Network[1]
Calendar Year Deductible (DED)		
Individual Family	$500 $1,000	$1,000 $2,000
Coinsurance	20%	40%
Calendar Year Out-of-Pocket Maximum *Includes DED, coins., and medical*		
Individual Family	$2,000 $4,000	$4,000 $8,000
Physician Visit		
Primary Care Physician (PCP)	$25	40% after DED
Specialist	$30	40% after DED
Telemedicine	$0	N/A
Preventative Care	Covered in Full	40% after DED
Lab Work and Diagnostic Imaging		
Independent Lab i.e., blood work	$0	40% after DED
Advanced Services Includes MRI, PET, CT	20% after DED	40% after DED
Hospital Services		
Inpatient Hospital	20% after DED	40% after DED
Outpatient Surgery	20% after DED	40% after DED
Emergency Medical Care		
Convenience Care Clinics	$25	40% after DED
Urgent Care	$25	$25
Emergency Room (waived if admitted)	$225	$225
Hearing Aids – **NEW Benefit**		
Hearing Aids – limited to once every 3 years	Covered at 100%; maximum allowance of $2,000	
Prescription Drugs (30-day supply)		
Tier 1	$10	50%
Tier 2	$40	50%
Tier 3	$60	50%
Tier 4	50%	50%
Out of Pocket Drug Maximum	$1,000 individual $2,000 Family	
Mail Order (90-day supply)		
Tier 1	$0	50%
Tier 2	$80	50%
Tier 3	$120	50%
Tier 4	50%	50%

(1) Out of network services are always subject to balance billing. Member will be responsible for payment of the difference between Cigna's allowable charges and the provider's actual fee.

TIP

Use in-network providers. Participating providers (doctors, hospitals, and others in your plan's network) generally charge discounted rates for plan members. When you go to a non-participating provider you will likely pay a higher coinsurance percentage. And, you will likely have to pay the difference in price between the participating provider's discounted fee and the non-participating provider's "regular" fee.

MEDICAL – OUT OF AREA PLAN

IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND offers out of area employees a medical plan through **Cigna. Cigna's** preferred lab facilities are **Lab Corp** & **Quest Diagnostics**. Below are highlights of the plan.

You can search for participating providers by visiting www.cigna.com and click "Find a Doctor, Dentist or Facility", selecting "For plans offered through your employer or school" and selecting "Cigna HealthCare Seamless Network – Florida."

PLAN HIGHLIGHTS	Out of Area Plan
	Indemnity
Calendar Year Deductible (DED)	
Individual	$500
Family	$1,000
Coinsurance	20%
Calendar Year Out-of-Pocket Maximum *Includes DED, coins., and medical*	
Individual	$2,000
Family	$4,000
Physician Visit	
Primary Care Physician (PCP)	20% after DED
Specialist	20% after DED
Telemedicine	20% after DED
Preventative Care	Covered in Full
Lab Work and Diagnostic Imaging	
Independent Lab i.e., blood work	20% after DED
Advanced Services Includes MRI, PET, CT	20% after DED
Hospital Services	
Inpatient Hospital	20% after DED
Outpatient Surgery	20% after DED
Emergency Medical Care	
Convenience Care Clinics	20% after DED
Urgent Care	20% after DED
Emergency Room (waived if admitted)	20% after DED
Hearing Aids – **NEW Benefit**	
Hearing Aids – limited to once every 3 years	20% after DED
Prescription Drugs (30-day supply)	
Tier 1	$10
Tier 2	$40
Tier 3	$60
Tier 4	50%
Out of Pocket Drug Maximum	$1,000 individual $2,000 Family
Mail Order (90-day supply)	
Tier 1	$0
Tier 2	$80
Tier 3	$120
Tier 4	50%

DENTAL PLAN

IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND offers a Dental Preferred Provider Organization (DPPO) through **Cigna**. Below are highlights of the plan.

You can search for providers by visiting www.cigna.com and click "Find a Doctor, Dentist or Facility", selecting "For plans offered through your employer or school" and selecting "Total Cigna DPPO (Cigna DPPO Advantage/Cigna DPPO)", then entering your search criteria.

DPPO Plan: The DPPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind; you'll receive the highest level of benefit from the plan if you select an in-network contracted PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rates. A calendar year maximum benefit will apply to in and out-of-network services.

PLAN HIGHLIGHTS	DPPO	
	In-Network	Out-of-Network
Calendar Year Maximum Benefit	$1,500 per member	
Calendar Year Deductible (DED)		
Individual	$0	$0
Family	$0	$0
Preventive Services		
Oral Evaluations	100%	100%
Routine Cleanings	100%	100%
X-rays	100%	100%
Fluoride Application	100%	100%
Sealants: per tooth	100%	100%
Space Maintainers: non-orthodontic	100%	100%
Emergency Care to Relieve Pain	100%	100%
Basic Services		
Restorative: Fillings	100%	100%
Endodontics	100%	100%
Periodontics	100%	100%
Oral Surgery	100%	100%
Anesthesia	100%	100%
Bridges, Crowns and Inlays	100%	100%
Dentures	100%	100%
Denture Relines, Rebases and Adjustments	100%	100%
Major Services		
Inlays and Onlays	100%	100%
Prosthesis over Implant	100%	100%
Crowns	100%	100%
Bridges and Dentures	100%	100%
Orthodontics (Adult & Child)		
Comprehensive	100%; $2,500 Lifetime Maximum	

VISION PLAN

We offer a vision plan insured through Cigna. Benefits are available every 12 months for exams and lenses or contact lenses and for frames. Below are highlights of the plan.

You can search for providers by visiting www.cigna.vsp.com, clicking “Find a Cigna Vision Network Eye Care Professional”, and entering your search criteria.

PLAN HIGHLIGHTS	VISION	
	In-Network	Out-of-Network
Exam *1 every 12 months*	$0 Copay	$45 Allowance
Lenses *1 every 12 months*		
Single	$0 Copay	Up to $40 Allowance
Bifocal	$0 Copay	Up to $65 Allowance
Trifocal	$0 Copay	Up to $75 Allowance
Progressives	$0 Copay	Up to $75 Allowance
Lenticular	$0 Copay	Up to $100 Allowance
Frames *1 every 12 months*	$200 Allowance	Up to $133 Allowance
Contact Lenses[1] *1 every 12 months*		
Medically Necessary	Covered in Full	Up to $210 Allowance
Elective	$200 Allowance	Up to $160 Allowance
Lens Enhancements		
Polycarbonate lenses for children under age 19	$0 Copay	Not Covered
Oversize Lenses	$0 Copay	Not Covered
Rose Tint #1 and #2	$0 Copay	Not Covered

(1) In lieu of eyeglass benefits

CONTRIBUTIONS – MEDICAL + DENTAL + VISION

ACTIVES	BI-WEEKLY CONTRIBUTIONS
Member Only	$51.00
Member + Spouse*	$106.00
Member + Child(ren)*	$92.00
Member + Family*	$137.00

**Important Note – If you are covering (1) a domestic partner (2) a domestic partner's child(ren) and/or (3) your child(ren) between the ages of 26 and 30, there will be imputed income reflected on your paycheck based on the actual cost of coverage.*

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND 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. IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND has determined that the prescription drug coverage offered by the Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also 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 while enrolled in IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage as an active employee, please note that your IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare

prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage as a former employee.

You may also choose to drop your IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage. If you do decide to join a Medicare drug plan and drop your current IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage, be aware that you and your dependents may not be able to get this coverage back.

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 IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND 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 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND changes. You also may request a copy of this notice at any time.

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 drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 23, 2020
Name of Entity/Sender: IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND
Contact–Position/Office: Nydia Kaye/Benefits Manager
Address: 2980 NW South River Drive Miami, FL 33125
Phone Number: 305-425-1938

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in the group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact:

Benefits Office
305-425-1938
benefits@healthtrustmaff.org

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IAFF Local 587 Health Insurance Trust Fund, Inc. ("IAFF Local 587 Health Insurance Trust Fund ") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of IAFF Local 587 Health Insurance Trust Fund , the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by IAFF Local 587 Health Insurance Trust Fund, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the IAFF Local 587 Health Insurance Trust Fund HIPAA Privacy Officer or

IAFF Local 587 Health Insurance Trust Fund , Inc.
Attention: HIPAA Privacy Officer
Benefits Office
305-425-1938

benefits@healthtrustmaff.org

Effective Date

This Notice as revised is effective December 13, 2020.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet at. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing

with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEW HEALTH INSURANCE MARKETPLACE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
OMB No. 1210-0149
(expires 6-01-2023)

Part A: General Information

Now that key parts of the health care law have taken effect, there is a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in the fall of 2020 for coverage starting January 1, 2021.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resource department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit Healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name IAFF Local 587 Health Insurance Trust Fund	**4. Employer Identification Number (EIN)** 82-7012034	
5. Employer address 2980 NW South River Drive	**6. Employer phone number** 305-425-1938	
7. City Miami	**8. State** Florida	**9. Zip code** 33125
10. Who can we contact about employee health coverage at this job? Nydia Kaye		
11. Phone number (if different from above)	**12. Email address** benefits@healthtrustmaff.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees.

  ☑ Some employees. Eligible employees are:
  - Employees working 30 or more hours per week.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:
  - Spouse or domestic partner and children to age 30, if they qualify

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE 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, 2020. Contact your State for more information on eligibility –

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

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[2] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity/Sender: IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND
Contact–Position/Office: Nydia Kaye/Benefits Manager
Address: 2980 NW South River Drive Miami, FL 33125
Phone Number: 305-425-1938

[2] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

ADA WELLNESS PROGRAM NOTICE

NOTICE REGARDING WELLNESS PROGRAM

The carrier wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test for specific conditions. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive of participating in the program. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and our company may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information include a registered nurse, doctor or health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

DIRECTORY & RESOURCES

Need additional information? Have a question about one of your benefits? Keep this brochure handy for a quick reference for all your benefit needs. Below is contact information for each of our providers.

CONTACT INFORMATION

Trust Office		
Benefits Manager	305-425-1938	benefits@healthtrustmaff.org
Medical, Dental, Vision		
Cigna	1-800-244-6224	www.cigna.com

IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND