MEMBERS BENEFITS GUIDE

PLAN YEAR: February 1, 2023 – January 31, 2024

Fraternal Order of Police Miami
Lodge 20 Insurance Trust Fund

The Fraternal Order of Police Miami Lodge #20 Insurance Trust Fund (Trust) is pleased to announce our Annual Open Enrollment for 2022 will begin on **November 15, 2022,** and will go through **January 13, 2023**. This is the time of year to make changes and you will be unable to do so after January 13th unless you have a qualifying family status change event (please refer to page 5 for more details). Benefits are effective **February 1, 2023, through January 31, 2024**. ***All enrollment or changes must be received by 5:00 pm on January 13, 2023, to become effective February 1, 2023.***

Meritain, an Aetna company, will continue to be our Third-Party Administrator for Medical coverage. Reliance Standard will continue to be the carrier for Life and AD&D coverage.

PLAN CHANGE REGARDING DEPENDENT COVERAGE: If your dependent is currently enrolled in the Plan and you remove them from the Plan after they reached Medicare Eligibility (usually age 65), they **cannot** be reenrolled in the Plan.

You will have applicable copays depending on the services rendered and the remainder of your balance for covered services will be paid by Meritain depending on the plan you are enrolled in (see page 9 for benefit details.)

- If you wish to change the plan you are currently enrolled in or if you have any other changes, such as adding or deleting a dependent, you **must** contact the Trust office at (305) 372-4605 within the Annual Open Enrollment period. If changes are not received by the Trust Office by **January 13, 2023, by 5:00 pm, they will not be accepted,** and any change will have to wait until the 2023 open enrollment period.

- If you **do not** need to make any changes (i.e., switch from one plan to another, add/delete dependents, etc.) **no action is required.**

- Please be advised that we will continue to offer Teladoc. This provides you access to medical consultation 24/7 through video conferencing or phone call. You can reach a doctor with the Teladoc mobile app, online at www.MyDrConsult.com, or at 1-800-362-2667.

If at any time you have questions or do not understand the Benefits, we encourage you to contact the Trust office (305-372-4605) or come by Room 324 in the Central Station and we will be happy to answer any questions.

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Insurance Coverage	Insurer or Vendor	Phone #	Website / Email Address
Medical	Meritain/Aetna	800-925-2272	www.meritain.com
Virtual Visit	Teladoc	800-362-2667	MyDrConsult.com
Basic Life and AD&D	Reliance Standard	800-435-7775	www.reliancestandard.com
Trust Office	Central Station Room 324	305-372-4605	fop20insurance@earthlink.net

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 35 for more details.

Eligibility

Eligible Members:

Full-time members working 30 hours or more per week are eligible to enroll in FOP Miami Insurance Trust Benefits.

Eligible Dependents:

Members: below is a list of eligible dependents. If your dependent no longer meets any of the criteria to be eligible, they are NOT permitted to remain on the plan. If you do not remove them within 60 days of becoming ineligible, YOU will be responsible for benefits incurred and possibly termination from the Plan.

Your Spouse: The person to whom you are legally married. If you cease to be married whether through divorce, annulment or otherwise, they are no longer eligible to be on the Plan.

Your Domestic Partner: Your Domestic Partner is unrelated individual of the same or opposite sex who meets the eligibility criteria in the Plan, has submitted all documentation required and has received approval from the Plan. Your Domestic Partner must maintain the criteria to continue to be enrolled in the Plan. Dependents of Domestic Partners are not eligible dependents.

Your Child: This may be your biological child, your legally adopted child, your child for whom you have legal guardianship, and a child with a qualified medical child support order. They may remain on the Plan until they turn 26 years of age.

Your Step-child: The child of your spouse only for as long as you remain married or until they turn 26 years of age.

Your Child placed with you in anticipation of adoption: Means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption.

Your Child over the age of 26 with a disability: Your Child who is unable to be self- supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be primarily dependent upon you for support.

Additional Information for Retirees and Medicare Eligible Members:

- **If you are eligible for Medicare, you must enroll in Medicare Part A & B. The health plan pays secondary, regardless of whether you have enrolled in Medicare Part A & B or not. If you are not enrolled, you will be responsible for the primary cost of the services. This includes all members who are eligible for Medicare whether due to age, disease, disability or any other reason.**

- **Medicare Cross-Over** – Please be advised that upon obtaining Medicare it is your responsibility to contact the Trust office and provide your Medicare number, so Meritain can set up the **Medicare Cross-Over**, which allows Meritain to see what Medicare has paid and to remit payment as your secondary insurer.

- **Medicare primary** members **do not** have to obtain pre-certification for services covered by Medicare.

- **Medicare allowable –** The Trust will not pay above the Medicare agreed rate.

Eligibility - continued

PLAN CHANGE REGARDING DEPENDENT COVERAGE:
If your dependent is currently enrolled in the Plan and you remove them from the Plan after they reached Medicare Eligibility (usually age 65), they **cannot** be reenrolled in the Plan.

When Coverage Begins:

Newly hired officers and dependents will be eligible to participate in FOP Miami Insurance Trust's benefits program on the first pay period following date of swearing in. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a qualifying family status event.

When Can You Enroll?

You can sign up for Benefits at any of the following times:

- Upon date of swearing in
- During annual open enrollment
- Within 60 days of a qualified family status change

If you do not enroll at one of the above times, you must wait for the next annual open enrollment period.

Qualified Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 60 days of the event date. Documentation will be required to verify your change of status. Failure to request a change of status within 60 days of the event may result in your having to wait until the next open enrollment period to make your change.

Information About Your Medical Plan Options

1. FOP INN Plan (HMO) (In-Network Benefits Only); Aetna Choice POS II Network

- Restricts members to a physician or facility that is "in the network".
- Selection of a primary care physician is not required, and no referrals are necessary to see a specialist.
- Benefits for out-of-network services are limited to *Life-Threatening Emergency Care only. If you go out-of-network and it is not a *life-threatening emergency, you will be responsible for the entire cost of the benefits. (*A life-threatening emergency will be determined based on the diagnosis, reports, and notes submitted by the hospital/doctors.)

2. FOP POS Plan (In & Out of Network Benefits): Aetna Choice POS II Network

- More FLEXIBLE for plan members. This Plan is designed for members that want the flexibility to see doctors that are in or out of the Aetna Choice POS II network and for those that live in areas with limited network.
- Selection of a primary care physician is not required, and no referrals are necessary to see a specialist.
- This plan is best for those members who want the option to see providers who are not in network, (at a higher cost to themselves), do not desire to have to switch doctors if their doctor leaves the network, and/or live in an area with few or no network providers.

You must verify if a provider is in the Choice POS II Network and can do so by visiting the Aetna/Meritain website at www.aetna.com or www.meritain.com.

3. Prescription Coverage

- Caremark will continue to be our prescription provider and their information appears on your Aetna/Meritain member identification card.
- ALL maintenance medications (i.e., birth control pills, thyroid medication, diabetic medication, etc.) must be ordered through CVS/Caremark and be delivered via mail to your home or picked up at your local CVS Pharmacy.
- Any member prescribed a specialty medication must enroll in Prudent Rx 1-800-578-4403 or otherwise the member will have to pay 100% of the cost of the medication.

IMPORTANT: THE PLAN HAS PRE-CERTIFICATION REQUIREMENTS FOR CERTAIN PROCEDURES AND ADMISSIONS, INCLUDING EMERGENCY PROCEDURES AND ADMISSIONS. Either you or your representative must communicate with your providers to ensure that you receive precertification for any non-emergency admissions or non-emergency services prior to the services being performed AND emergency admissions must be pre-certified within 48 hours of admission or the next business day after being admitted. Failure for the facility/provider to receive authorization prior to services being performed may cause your claim to be paid with a 50% penalty or completely denied if the services are not deemed medically necessary.

YOUR RESPONSIBILITIES

- **YOU have sixty (60) days** from the time of a qualifying event (i.e., birth of a child, adoption, marriage, domestic partnership, divorce, termination of domestic partnership, death, reduction in work hours (becoming a part-time employee), change of spouse's employment, loss of employment, retirement, etc.) to add or remove dependents (spouse and/or children) to the plan. **After the sixty (60) days have lapsed, you will be required to wait until the next open enrollment.**
- **If your claim gets denied by Meritain you have *180 days* to appeal your denial.** Instructions on how to file an appeal are included in the explanation of benefits (EOB) provided by Meritain.
- You are responsible to read your explanation of benefits (EOB) and provide any information being requested to Meritain. Failure to provide the requested information will result in your claim not being processed.
- You are responsible to advise Meritain whether or not you have other insurance on a yearly basis. Failure to provide the requested information will result in any claims you may incur not being processed.
- You are responsible for providing your insurance card for Meritain to your providers. Failure to do so may result in a delay in claims and payments being processed.
- **You are responsible to create an account and log into the Meritain website at www.meritain.com.** Important information regarding your benefits is posted on this website. You have the right to an easy-to-understand summary about a health plan's benefits and coverage. A short, plain-language **Summary of Benefits and Coverage (SBC)** is available on the Meritain website and a hard copy can be sent to you upon request.

YOUR RESPONSIBILITIES

- If you get divorced or terminate your domestic partnership you **MUST** notify the Trust office **immediately**. Once a divorce or termination of domestic partnership becomes final your former spouse or domestic partner cannot remain on this plan, since they no longer meet the criteria of a qualified dependent. If you do not remove your spouse or domestic partner from the plan and they incur any medical and/or prescription expenses, **YOU will be required to reimburse the Trust and legal action may be taken against you**.

- You are responsible to notify the Trust if a dependent is no longer eligible due to divorce, over-age Dependent, a stepchild is no longer the Employee's Dependent, etc.). It is also your responsibility to notify the Trust if a dependent(s) turns age 26 or 65. If the Trust pays any bills in error due to lack of notification, it will be the responsibility of the Member to reimburse the Trust and failure to reimburse the Trust on a timely basis may result in termination from the Plan. **Any contributions paid for non-eligible dependents will not be reimbursed**.

- You are responsible for notifying the Trust if you have a change of address. The City of Miami does not provide the Trust with updated address information. **If we do not have your correct address, you will not receive important insurance information.**

- If you are an active officer and develop a condition or impairment which may have been caused by or is a result of having tuberculosis, heart disease or hypertension, **you must immediately file a report of injury**. This may be considered a work related injury under Florida Law and benefits may be covered by worker's compensation. The Plan does not cover work-related injuries. If you are denied coverage by your employer through worker's compensation, you may appeal directly to the Board of Trustees for a determination of coverage under the Plan. Please be advised that if you are covered through worker's compensation and you accept or have accepted a settlement, you are not entitled to coverage under the Plan for the work-related injury.

- Any current employee retiring on or after **February 1, 2018,** must have been enrolled in the health plan for at least **ten years** immediately prior to separation of service. Any current employee who retires from service **between February 1, 2023, and February 1, 2028,** will be eligible for benefits only if they were enrolled in the health plan during open enrollment for the 2018 plan year.

IMPORTANT: If you are a resident of North Carolina under state law you can only enroll in the POS Plan.

If at any time you have questions or do not understand the Benefits, we encourage you to contact the Trust office (305-372-4605) or come by Room 324 in the Central Station and we will be happy to answer any questions you may have.

All enrollments or changes must be dropped off by 5:00 pm/postmarked no later than January 13, 2023, to become effective February 1, 2023.

Medical Insurance

FOP Miami Insurance Trust offers medical benefits through Meritain Health, an Aetna Company. The chart below illustrates a brief description of these plans. Please refer to the Summary Plan Description (SPD) for complete plan details.

To locate providers within your network, visit www.aetna.com/docfind/custom/mymeritain.

- INN PLAN: **AETNA CHOICE POINT OF SERVICE II**
- POS PLAN: **AETNA CHOICE POINT OF SERVICE II**

Network

	FOP INN PLAN		FOP POS PLAN	
Benefits Description	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS** (Subject to Usual and Customary Charges)	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING PROVIDERS** (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited		Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited		Unlimited	
CALENDAR YEAR DEDUCTIBLE	$0	$1,000,000	$0	$0
NOTE: Benefits are paid at 100%, not subject to any Copays or Coinsurance for all Covered Persons enrolled in the post 65 retiree Plans.				
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes: Copays and Coinsurance – combined with Prescription Drug Card Program) Single/Family	$2,000 per person/ $17,400	Unlimited/ Unlimited	$2,000 per person/ $17,400	$7,500 per person/ $30,000
MEDICAL BENEFITS				
Acupuncture (Outpatient)	$25 Copay, then 100%	$25 Copay, then 100% (subject to Participating Provider Out-of-Pocket Maximum)	$25 Copay, then 100%	$25 Copay, then 100% (subject to Participating Provider Out-of-Pocket Maximum)
Calendar Year Maximum Benefit	$1,000		$1,000	
Allergy Serums and Injections	$5 Copay, then 100%	Not Covered	$5 Copay, then 100%	$5 Copay, then 70%
Allergy Testing and Treatment	$5 Copay, then 100%	Not Covered	$5 Copay, then 100%	$5 Copay, then 70%
Ambulance Services				
Ground	$30 Copay, then 100%	$30 Copay, then 100%	$30 Copay, then 100%	$30 Copay, then 100%
Air	$50 Copay, then 100%	$50 Copay, then 100%	$50 Copay, then 100%	$50 Copay, then 100%
Autism*	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit	$36,000		$36,000	
Lifetime Maximum Benefit	$200,000		$200,000	
*See Eligible Medical Expenses for additional information.				
Birthing Center	$50 Copay, then 100%	Not Covered	$50 Copay, then 100%	$50 Copay, then 70%
Cardiac Rehab (Outpatient)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Chiropractic Care/Spinal Manipulation	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit	$5,000		$5,000	
NOTE: Copay does not apply to the covered Retirees.				
Compression Garments	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Contraceptives				
Devices	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Injectable Contraceptives	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.				
Diabetic Supplies	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Diagnostic Testing, X-Ray and Lab Services (Outpatient)				
Independent Lab	$30 Copay, then 100%	Not Covered	$30 Copay, then 100%	$30 Copay, then 70%
Outpatient Lab Services (other than independent lab and those rendered in the office)	$50 Copay, then 100%	Not Covered	$50 Copay, then 100%	$50 Copay, then 70%
Diagnostic Tests and X-Ray	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Dialysis (Outpatient)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Performed in the Physician's Office	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Durable Medical Equipment (DME)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Emergency Services/Emergency Room Services	$200 Copay, then 100%	Paid at the Participating Provider level of benefits	$200 Copay, then 100%	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.				
Foot Orthotics	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Genetic Testing	$30 Copay, then 100%	Not Covered	$30 Copay, then 100%	$30 Copay, then 70%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.				
Hearing Aids	$25 Copay, then 100%	$25 Copay, then 100%	$25 Copay, then 100%	$25 Copay, then 100% (subject to Participating Provider Out-of-Pocket Maximum)
Maximum Benefit Per 24-Month Period combined with Implantable Hearing Devices Maximum Benefit	$1,500		$2,000	
Hearing Examination	$25 Copay, then 100%	$25 Copay, then 100%	$25 Copay, then 100%	$25 Copay, then 70%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.				

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Heart/Lung Test				
Lab Services (other than those rendered in the office)	$30 Copay, then 100%	Not Covered	$30 Copay, then 100%	$30 Copay, then 70%
All Other Tests	100%	Not Covered	100%	70%
NOTE: Applies to the Spouse and Dependent Children only. Includes any item or service not otherwise covered under the preventive services provision.				
Home Health Care	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit	60 visits		60 visits	
Hospice Care	100%	Not Covered	100%	70%
Hospice Bereavement Counseling (within 6 months of Covered Person's death)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit	12 visits		12 visits	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
Inpatient	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Room and Board Allowance*	Semi-Private Room Rate*	Not Covered	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	Not Covered	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100%	Not Covered	100%	70%
Outpatient	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
* A Private Room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or Private Rooms will be considered at the least expensive rate for a single or Private Room.				
Hyperbaric Oxygen Treatment				
Outpatient Facility	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Performed in the Physician's Office	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Implantable Hearing Devices	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Maximum Benefit Per 24-Month Period combined with Hearing Aids Maximum Benefit	$1,500		$2,000	
Infusion Therapy				
Home	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Outpatient	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit	60 visits		60 visits	
Maternity (non-facility charges)*				
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%	Not Covered	100%	$25 Copay, then 70%
Lactation Consultations	100%	100%, Deductible waived	100%	100%
Office Visits (if billed separately from global billing)	$30 Copay**, then 100%	Not Covered	$30 Copay**, then 100%	$30** Copay, then 70%
Diagnostic Testing, X-Ray (except sonograms) and Lab Services (Outpatient)	$30 Copay**, then 100%	Not Covered	$30 Copay**, then 100%	$30 Copay**, then 70%

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Sonograms				
First 3 Sonograms per Pregnancy	100%	Not Covered	100%	70%
All Other Sonograms				
Office	$25 Copay per visit, then 100%	Not Covered	$25 Copay per visit, then 100%	$25 Copay per visit, then 70%
All Other Outpatient	$100 Copay per visit, then 100%	Not Covered	$100 Copay per visit, then 100%	$100 Copay per visit, then 70%
All Other Prenatal, Delivery and Postnatal Care	100%	Not Covered	100%	70%
* See Preventive Services under Eligible Medical Expenses for limitations.				
** Copay applied to the Physician office visit component, Lab Work and miscellaneous services done in the office. All other services are paid subject to any Copay and Coinsurance.				
All other Lab Services, Diagnostic Tests and X-Rays will pay under the benefits in the Diagnostic Testing, X-Ray and Lab Services section.				
Medical and Surgical Supplies	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Mental Disorders				
Inpatient Professional Fees	$100 Copay, then 100% 100%	Not Covered Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Outpatient Office Visits/Telemedicine All Other Outpatient	 $15 Copay, then 100% 100%	 Not Covered Not Covered	 $15 Copay, then 100% 100%	 $15 Copay, then 70% 70%
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.				
Morbid Obesity	100%	Not Covered	100%	70%
Lifetime Maximum Benefit	$5,000		$5,000	
Orthotic Appliances, Devices and Casts	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Outpatient Therapies (respiratory/pulmonary, speech, occupational)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit (combined with PT Outpatient benefit)	60 visits		60 visits	
Pain Management	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Physical Therapy (PT) (Outpatient)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Home	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit (combined with Outpatient Therapies benefit)	60 visits		60 visits	
Physician's Services				
Inpatient Services	100%	Not Covered	100%	70%
Outpatient Services	100%	Not Covered	100%	70%

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Office Visits/Telemedicine: Primary Care Physician Specialist	 $15 Copay*, then 100% $30 Copay*, then 100%	 Not Covered Not Covered	 $15 Copay*, then 100% $30 Copay*, then 100%	 $15 Copay*, then 70% $30 Copay*, then 70%
Physician Office Surgery Primary Care Physician Specialist	 $15 copay*, then 100% $30 copay*, then 100%	 Not Covered	 $15 copay*, then 100% $30 copay*, then 100%	 $15 copay*, then 70% $30 copay*, then 70%
Teladoc	$5 Copay, then 100%	Not Covered	$5 Copay, then 100%	N/A
*Copay applied to the Physician office visit component, Lab Work and miscellaneous services done in the office. All other services are paid subject to any Copay and Coinsurance.				
Podiatry	Paid based on place of service	Not Covered	Paid based on place of service	Paid based on place of service
Pre-Admission Testing (Outpatient)	$30 Copay, then 100%	Not Covered	$30 Copay, then 100%	$30 Copay, then 70%
Preventive Services and Routine Care				
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%	Not Covered	100%	70%
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)				
Routine Care (age 19 and over): Primary Care Physician Specialist	 100% 100%	 Not Covered Not Covered	 100% 100%	 70% 70%
Well Child Care (up to age 19): Primary Care Physician Specialist	 100% 100%	 Not Covered Not Covered	 100% 100%	 70% 70%
Routine Bone Density Scan	100%	Not Covered	100%	70%
Routine Colonoscopy (age 45 and over)	100%	Not Covered	100%	70%
Maximum Benefit Per 10 Year Period	1 exam		1 exam	
Routine Diagnostic Testing, X-Ray and Lab Services (up to age 19) Primary Care Physician and Specialist	100%	Not Covered	100%	70%
Routine Diagnostic Testing, X-Ray and Lab Services (age 19 and over)	100%	Not Covered	100%	70%
Routine Hearing Examination	100%	Not Covered	100%	70%
Routine Immunizations (HPV Vaccine – age 9 and over; Meningitis Vaccine -up to age 25; Shingles Vaccine – age 50 and over)	100%	Not Covered	100%	70%

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Routine Mammogram and Breast Exams (age 35 to 40)	100%	Not Covered	100%	70%
Lifetime Maximum Benefit	1 baseline exam			
Routine Mammogram and Breast Exams (age 40 and over)	100%	Not Covered	100%	70%
Calendar Year Maximum Benefit	1 exam			
Routine Pap Smear and Pelvic Exams: Primary Care Physician Specialist	 100% 100%	 Not Covered Not Covered	 100% 100%	 70% 70%
Calendar Year Maximum Benefit	1 exam			
Routine Prostate Exams: Primary Care Physician Specialist (age 45 and over)	 100% 100%	 Not Covered Not Covered	 100% 100%	 70% 70%
Calendar Year Maximum Benefit	1 exam			
Routine PSA Test: Primary Care Physician Specialist (age 45 and over)	 100% 100%	 Not Covered Not Covered	 100% 100%	 70% 70%
Calendar Year Maximum Benefit	1 exam			
Routine Sigmoidoscopies and Proctosigmoidoscopy (age 45 and over): Primary Care Physician Specialist (age 45 and over)	 100% 100%	 Not Covered Not Covered	 100% 100%	 70% 70%
Maximum Benefit Per 10 Year Period	1 exam			
Private Duty Nursing (Outpatient)	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Calendar Year Maximum Benefit	30 visits			
Prosthetics	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
Refractive Surgery	100%	100%	100%	100%
Lifetime Maximum Benefit	$1,000 per eye		$1,500 per eye	
NOTE: If you are an active Employee or a Retiree who is actively employed as a policeman elsewhere a Surgery is covered under any medical circumstance. If you are a Dependent or the Retiree not employed as the policeman, the Surgery is covered only when Medically Necessary due to profound myopia, defined as 20/400 in both eyes.				
Routine Eye Examination (Covered Persons up to Age 19)	100%	100%	100%	100%
Calendar Year Maximum Benefit	1 exam			
NOTE: Includes any item or service not otherwise covered under the preventive services provision.				

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Routine Eye Examination (Covered Persons age 19 and over)	100%	100%	100%	100%
Calendar Year Maximum Benefit	1 exam up to $100 maximum			
NOTE: Includes any item or service not otherwise covered under the preventive services provision.				
Skilled Nursing Facility and Rehabilitation Facility	100%	Not Covered	100%	70%
Combined Calendar Year Maximum Benefit	60 days		60 days	
Combined Lifetime Year Maximum Benefit	365 days		365 days	
Sleep Studies				
Home &/or Sleep Centers	$25 Copay, then 100%	Not Covered	$25 Copay, then 100%	$25 Copay, then 70%
All Other Locations	$50 Copay, then 100%	Not Covered	$50 Copay, then 100%	$50 Copay, then 70%
Sterilization				
Primary Care Physician Specialist	$15 Copay, then 100% $30 Copay, then 100%	Not Covered Not Covered	$15 Copay, then 100% $30 Copay, then 100%	$15 Copay, then 70% $30 Copay, then 70%
Hospital	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
NOTE: Includes any item or service not otherwise covered under the preventive services provision.				
Substance Use Disorders				
Inpatient	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Outpatient: Office Visits/Telemedicine All Other Outpatient	 $15 Copay, then 100% 100%	 Not Covered Not Covered	 $15 Copay, then 100% 100%	 $15 Copay, then 70% 70%
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.				
Surgery (Facility, Miscellaneous and Professional fees) (Outpatient) (does not include Surgery in the Physician's office)	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Diagnostic Testing, X-Ray and Lab Services				
Diagnostic Testing and X-Ray Services	$100 Copay, then 100%	Not Covered	$100 Copay, then 100%	$100 Copay, then 70%
Lab Services	$30 Copay, then 100%	Not Covered	$30 Copay, then 100%	$30 Copay, then 70%
Temporomandibular Joint Dysfunction (TMJ)	$30 Copay, then 100%	Not Covered	$30 Copay, then 100%	$30 Copay, then 70%

Benefits Description	FOP INN PLAN		FOP POS PLAN	
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants	100% (Aetna IOE Program) * Not Covered (All Other Network Providers)	Not Covered	100% (Aetna IOE Program) * Not Covered (All Other Network Providers)	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100%.				
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.				
Urgent Care Facility – Free Standing	$30 Copay*, then 100%	Not Covered	$30 Copay*, then 100%	$30 Copay*, then 70%
Urgent Care Facility – Associated with Hospital	$75 Copay*, then 100%	Not Covered	$75 Copay*, then 100%	$75 Copay*, then 70%
*Copay applies per visit regardless of what services are rendered.				
Vision Hardware (Covered Persons up to age 19)				
Frames	100%	100% deductible waived	100%	100%
Calendar Year Maximum Benefit	$300		$300	
Lenses	100%	100% deductible waived	100%	100%
Vision Hardware (Covered Persons age 19 and over)	100%	100% deductible waived	100%	100%
Calendar Year Maximum Benefit	$300		$300	
Walk-in Health Clinics	$10 Copay, then 100%	Not Covered	$10 Copay, then 100%	$10 Copay, then 100%
All Other Eligible Medical Expenses	100%	Not Covered	100%	70%

Pursuant to Sec. 112.18, Fl. Stat, a condition or health impairment caused by tuberculosis, heart disease or hypertension which results in total or partial disability of any firefighter, law enforcement officer or correctional officer employed by any state, municipal, county, port authority, special tax district, or fire control district in the state of Florida may be covered under such Employer's Workers Compensation policy provided that such firefighter, law enforcement or correctional officer passed a physical examination upon entering into such employment which failed to reveal any evidence of such condition or impairment. A condition or health impairment which meets the presumption under Sec. 112.18 Fl. Stat may be covered for the Covered Person under this Plan.

Note: The Fraternal Order of Police Miami Lodge #20 follows the Florida Heart Act. As a result, all services relating to tuberculosis, heart disease or hypertension will not be covered for the Covered Person under this Plan.

Denial of services pursuant to Sec. 112.18 Fl. Stat may be appealed directly to the Board of Trustees.

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent your Physician from providing or performing the procedure, treatment or supply, however, the procedure, treatment or supply will not be considered covered benefits under this Plan.

BENEFIT DESCRIPTION	FOP INN PLAN	FOP POS PLAN
PHARMACY BENEFITS		
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.		
CALENDAR YEAR DEDUCTIBLE	$0	$0
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical)	$2,000 per person $17,400 family max	$2,000 per person $17,400 family max
Retail Pharmacy: 30-day supply		
Generic Drug	$10 Copay	$10 Copay
Formulary Drug	$25 Copay	$25 Copay
Non-Formulary Drug	$40 Copay	$40 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay	$0 Copay
Specialty Pharmacy Program: 30-day supply		
Generic Drug	$10 Copay	$10 Copay
Formulary Drug	$25 Copay	$25 Copay
Non-Formulary Drug	$40 Copay	$40 Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy after one refill at the retail pharmacy.		
CVS Maintenance Choice Mandatory: 90-day supply		
Generic Drug	$20 Copay	$20 Copay
Formulary Drug	$50 Copay	$50 Copay
Non-Formulary Drug	$80 Copay	$80 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay	$0 Copay
Mail Order Pharmacy: 90-day supply		
Generic Drug	$20 Copay	$20 Copay
Formulary Drug	$50 Copay	$50 Copay
Non-Formulary Drug	$80 Copay	$80 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay	$0 Copay

NOTE: If the above illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail.

MERITAIN® HEALTH

An Aetna Company

Meritain Health® Member Portal

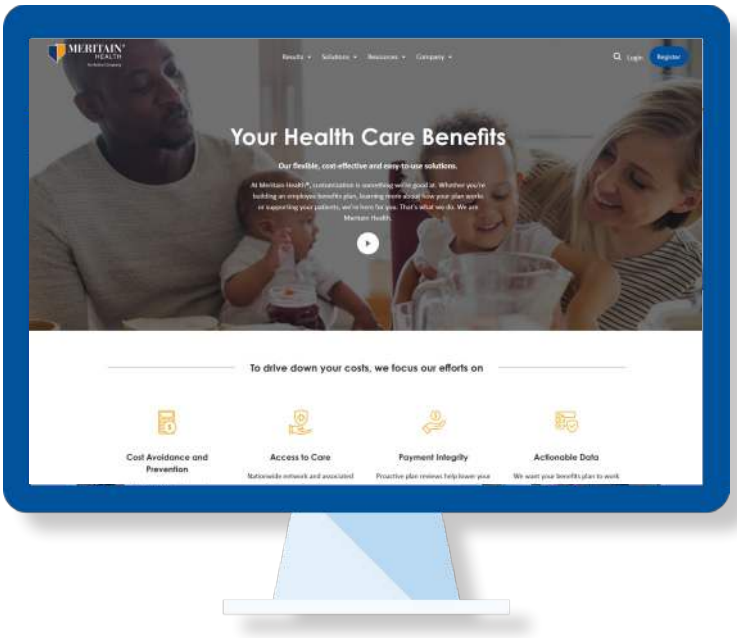
A fresh new connection to your benefits plan

Did you know you can find a variety of health care tools and resources at **www.meritain.com**?

Your member website gives you 24-hour access to a number of tools and resources that can help you manage your health benefits.

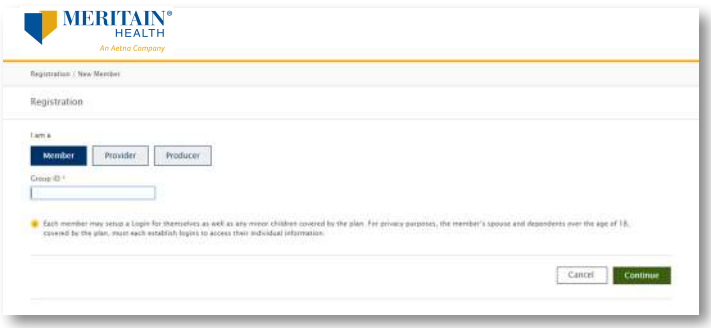
At meritain.com you can:

- Check your eligibility and benefits.
- Find the status of claims.
- View your Explanations of Benefits (EOBs).
- Review your benefit plan document.
- View deductibles and out-of-pocket limits.
- Access your ID card.



Access is as easy as 1–2–3

If you have an account, simply log in. If you're a new user, you'll need to register with these simple steps. When you're registering, you'll need your member ID and group ID from your ID card. (If you're new to the plan, you'll receive your ID card in the mail soon.)



Step 1

Go to **www.meritain.com** and click *Register*.

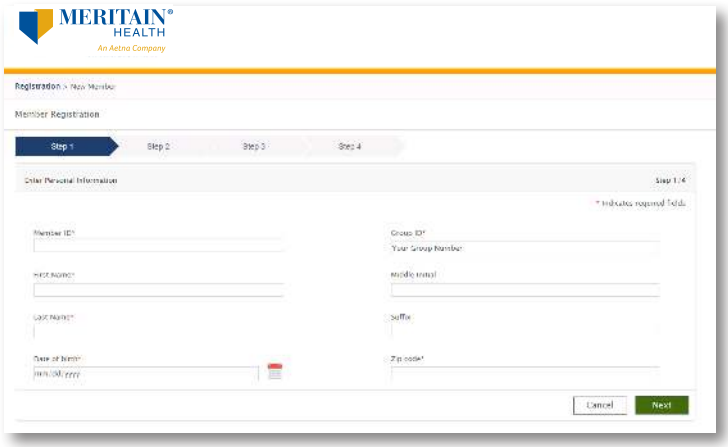
Step 2

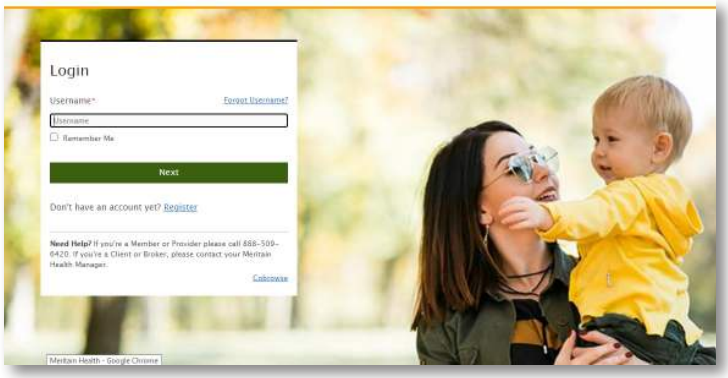
Select *Member* under *I am a* and enter your group ID. Then, click *Continue*.

Step 3

You'll need to enter the following information, then select *Submit*:

- Member ID (located on your member ID card)
- Group ID (located on your member ID card)
- First name (employee, spouse or adult dependent)
- Last name (employee, spouse or adult dependent)
- ZIP code
- Email (personal address)
- Date of birth (mm/dd/yyyy)





Then, you will create a username and password. After you confirm your email address—you're done!

You can now log in to your account with your new username and password.

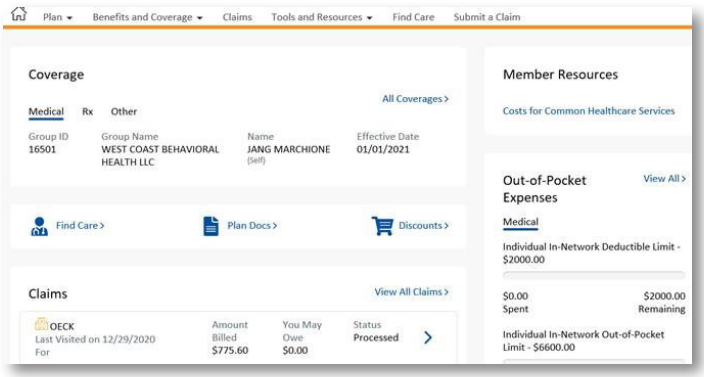
What you'll find at www.meritain.com

Simply click the name of each function in the top banner of the page to access the following options.

Click *Home* to return to the welcome page.

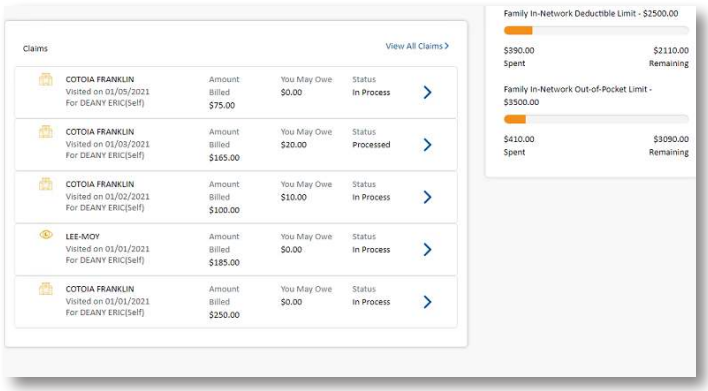
Health care plan overview

You can view deductibles and out-of-pocket maximums on the main page when you log in to your member account.



Claim information

Just click *Claims* to view your claim information. The *Apply* button lets you view all claims. Claims with statuses of *In Process, Processed* or *Awaiting Review* will be displayed. You can view and print the Explanation of Benefits (EOBs) by clicking for the claim details under the claim number.



Other features

Just click on the feature below to access your information.

- **Account Settings**

You can change your password or store your email address by going to the drop-down arrow located next to the person icon and *Welcome* in the upper right-hand corner of your page. From there, click *Account Settings* and update the information as needed.

- **Communication Preferences**

You now have flexibility in how you receive information. You can use one email address for portal changes, such as username recovery and password changes or security settings in your member portal. You can also use a second email address (if preferred) for receiving electronic communications on your plan activity.

You can click *Home* at any time to return to the welcome page.

Need help registering? Give us at the number on the back of your ID card.

Important information about the member portal

Spouses and dependents

Per the HIPAA Privacy Regulations, spouses and dependents over age 18 have partially protected health care information. To access their information, they'll need to register for their account using the previous steps. You can view financial information for all dependents, regardless of age.

Returning user login

When returning to the website after your account has been created, just enter your established username and password in the login box.

Incorrect login

You can click *Home* to return to the home page and try again if you receive an incorrect login message.

Website support

If you need help with the login process or forgot your username or password, we're here to help. You can contact customer service at the number on the back of your ID card.

If you need help navigating www.meritain.com or registering your account, simply call us at the number on the back of your ID card.

MERITAIN® HEALTH
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MERITAIN® HEALTH

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Your DocFind® Online Directory

Aetna Choice® Point of Service (POS) II

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the online DocFind directory from Aetna.* With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the DocFind directory anywhere you have internet access. Just:

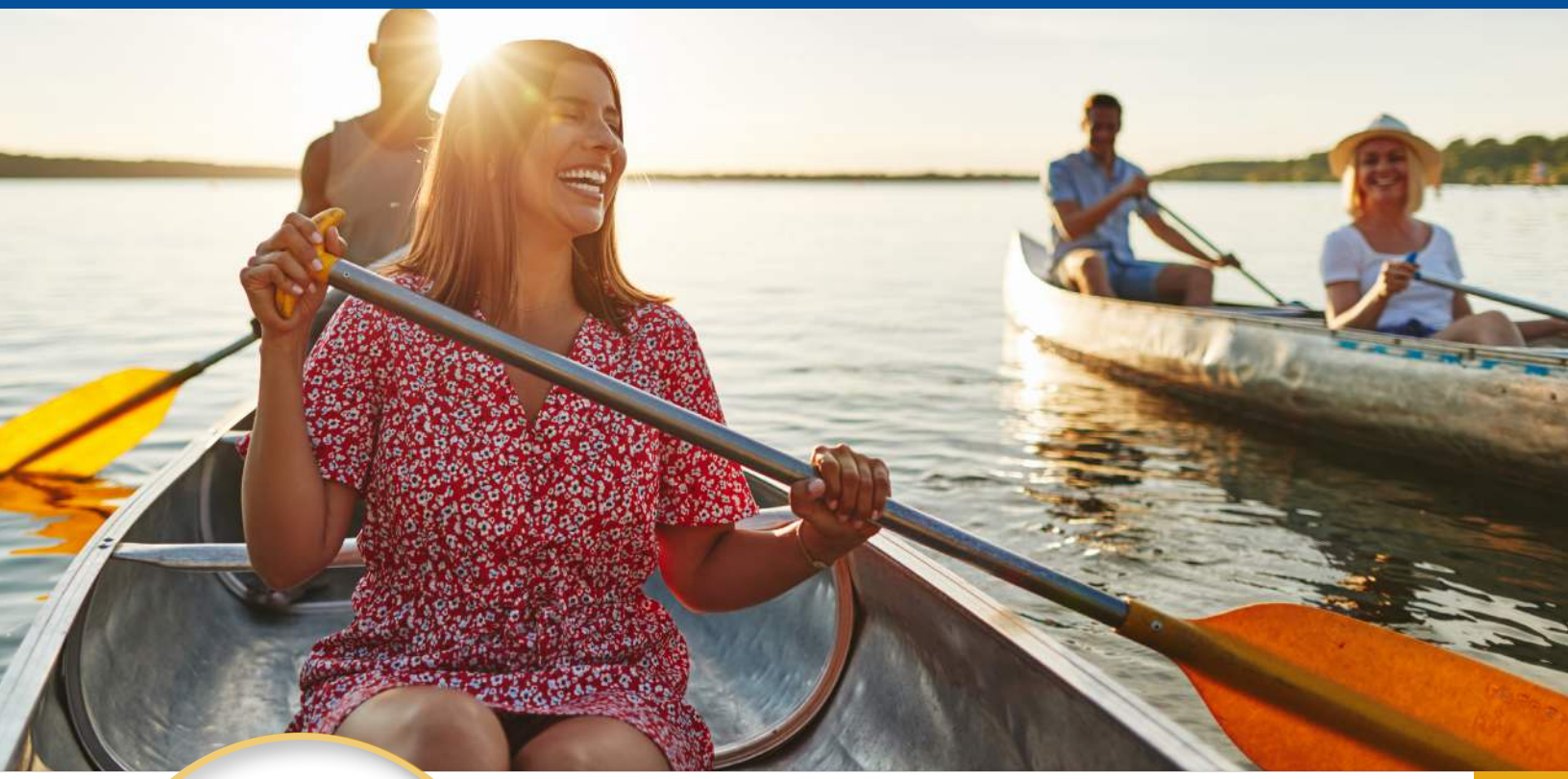
1. Visit **http://www.aetna.com/docfind/custom/mymeritain/**.
2. Key in the ZIP code, city, county or state of the desired geographical area in the *Enter location here* field. Click *Search*.
3. Key in *Aetna Choice® POS II (Open Access)* under *Select a Plan*. **Or** you can select *Aetna Choice® POS II (Open Access)* from the list of plans. Click *Continue.*
4. There are two options available to search for providers. The guided flow search uses some of our most commonly searched terms and easily organizes them for our users to find. To use the guided search flow, choose and click on one of the categories under *Find what you need by category*. **Or see step five.**
5. Use the search box, which includes type-ahead suggestions and will present provider, facility, specialty and condition search options based on what is entered. These suggested options will present an exact match or relevant providers. *What do you want to search for near* (will display your chosen location).
6. Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.
7. Narrow your search results by using the *Filter & Sort* option. Choices include Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations and Provider Type.

Why choose a primary care physician (PCP)?

Meritain Health® does not require you to choose a PCP, but we encourage you to choose one. Your PCP knows your health care needs, so they can help manage your health and coordinate your care. To find and choose a PCP, use the *Find Care & Pricing* tool on your member portal.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **1.800.343.3140** from 8:00 a.m.–9:00 p.m. ET, Monday through Friday.



ADVOCATES FOR
HEALTHIER LIVING

We are Meritain Health

As Advocates for Healthier Living, we provide easy-to-use health care benefits you can use to live well. We also take steps to help you save on the cost of your care. Contact us at the number on your ID card if you have any questions about your plan.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.*

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

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An Aetna Company

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MERITAIN® HEALTH

An Aetna Company

Reach a doctor 24/7

The Teladoc® solution

Teladoc is the on-demand health care solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions.

Benefits of Teladoc

- Saves time and money
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- Great health means peace of mind

With Teladoc, you can talk to a doctor 24/7/365 by phone, online video or mobile app. Use Teladoc for medical advice and care when:

- Your primary care doctor is not open.
- You are at home, traveling or do not want to take time off work to see a doctor.
- You need a prescription or refills*.

**Please note, there is no guarantee you will be prescribed medication.*

Highly qualified, experienced doctors

When you use Teladoc, your medical questions will be answered by a highly qualified doctor. Teladoc doctors are:

- Experienced—with an average of over 10–15 years in practice.
- Progressive—using the latest technology to provide excellent care.
- U.S. board-certified and state-licensed.
- Specially trained in telemedicine.

Our members love Teladoc

"We had a good experience with the doctor. She called and talked to me, and gave great service. I had no problem picking up my prescription. This is a really good service."

There's more than one way to reach a doctor

By phone.
Just call **1.800.835.2362**.

Online.
Simply request a video consultation online at **www.Teladoc.com**.

On the go.
You can download the Teladoc mobile app by visiting the App Store® or Google Play™.

Common conditions treated:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraine
- Eye/ear infection
- Rash/skin infections
- Sinus infections
- Stomachache/diarrhea
- Urinary tract infections
- Many other conditions

Contact a Teladoc physician at **1.800.TELADOC (1.800.835.2362)**, or by visiting **www.Teladoc.com**.

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TELADOC®

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MERITAIN® HEALTH

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Teladoc® Medical Experts

Expert advice when you need it most.

Our world-renowned medical experts can help you make confident medical decisions about a diagnosis, treatment option or the need for surgery.

Get an expert medical opinion

Are unsure about a diagnosis or need help deciding on a treatment option? We can help.

Find a doctor

Need help finding a doctor who specializes in your condition? We'll help find a doctor or specialist to help and support you.

Get critical case support

If you've been admitted into the hospital and want medical expert guidance, we can help you with critical care.

Medical records eSummary

We collect and organize your medical records and create a personal health summary in one secure file.

Ask the expert

If you have medical questions or concerns and want a leading expert's advice, we can help.

Consult a behavioral health navigator

If you you need guidance on a mental health condition or treatment that isn't improving, consult a behavioral health navigator.

Get treatment decision support

If you you need guidance and clarity on treatment options to make the best decision for your health, we can give treatment decision support.

Download on the App Store

Get it on Google play

Start finding relief today

Contact a Teladoc physician at **1.800.835.2362**, or by visiting **www.Teladoc.com**.
Download the app in the App Store® or Google Play Store™.

Follow us: @meritainhealth | Meritain Health

TELADOC®

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Which Do I Choose*?

*Important: **Call 911 Immediately** If You Are Experiencing a Life-Threatening Situation

Primary Care Physician

Your primary care physician, or regular doctor, is the best option for routine medical care and any non-urgent, unexpected health issues.

Below are SOME situations to consider when visiting a Primary Care Physician:**

- Annual checkups, physicals, health screenings
- Medication management including prescription refills and immunizations
- Non-urgent issues like pinkeye, migraines, sprained muscles, etc.

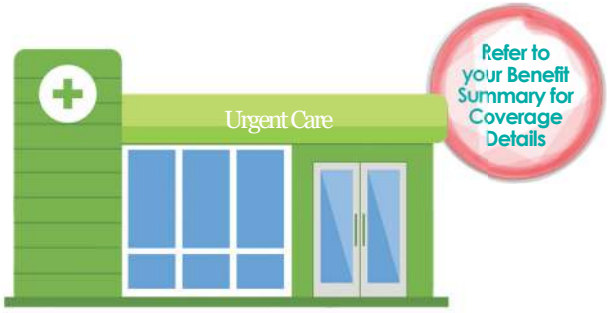
Online Telehealth

Remote | Web service: Cell | Laptop | Tablet | Desktop

Telehealth can be used to connect with a physician or medical services provider when remote care is an option.

Below are SOME situations to consider when using an Online Medical Service:**

- Outpatient Care
- Follow Up Visits
- Mental Health Support
- Rx Requests
- Diagnoses for Colds/Flu



Urgent Care

If you can't wait for an appointment with your regular doctor, an urgent care center may be your best option for unexpected health issues.

Below are SOME situations to consider when visiting Urgent Care:**

- Seasonal allergies
- Colds/Flus/Coughing
- Sinus or respiratory infections
- Stitches for minor cuts and animal bites
- Minor fractures/sprains (especially if needing x-ray)
- Urinary Tract Infections
- Vomiting/Diarrhea
- Skin irritations

Emergency Room

Go to the emergency room or call 911 when you are experiencing a potentially life-threatening condition.

Below are SOME situations to consider when visiting an ER:**

- Heavy, uncontrolled bleeding
- Coughing up or vomiting blood
- Signs of stroke, such as numbness, sudden loss of speech or vision
- Loss of consciousness or sudden dizziness
- Signs of a heart attack, like chest pain that lasts more than two minutes
- Major injuries such as broken bones or head trauma
- Severe allergic reactions

** This is **NOT** an exhaustive list. **Please use your own discretion** when deciding which facility to visit during a health-related event.

Scan on the QR codes below for videos with more information.

Telehealth

Places of Care

Health Plan Premiums

ACTIVE POLICE OFFICERS		
	FOP INN PLAN (BI-WEEKLY)	FOP POS PLAN (BI-WEEKLY)
Single	$48.10	$53.10
Employee + 1	$145.20	$164.20
Employee + 2	$182.80	$203.80
Employee +3	$220.40	$243.40
Employee +4	$259.00	$284.00
Employee +5	$296.60	$323.60
Employee +6	$334.20	$363.20
Employee +7	$372.80	$402.80

RETIREES		
	FOP INN PLAN (MONTHLY)	FOP POS PLAN (MONTHLY)
Single	$195.05	$200.05
Retiree + 1	$508.10	$532.10
Retiree + 2	$583.15	$608.15
Retiree +3	$658.20	$686.20
Retiree +4	$733.25	$763.25
Retiree +5	$808.30	$839.30
Retiree +6	$885.35	$915.35

RETIREES MEDICARE		
	FOP INN PLAN (MONTHLY)	FOP POS PLAN (MONTHLY)
Single	$149.50	$154.05
Dependent	$158.05	$177.05

Basic Life and AD&D Benefits

FOP Miami Insurance Trust will continue to provide its eligible employees Basic Life and AD&D insurance through Reliance Standard. This benefit guarantees that loved ones or other designated survivor(s), receive part of an employee's benefits after a death. The chart below gives a brief description of the Basic Life and AD&D plan attributes. Please refer to the carrier benefit summary for full benefit details.

Please be sure to complete or update the Beneficiary Information for your Basic Life and AD&D Benefits for the 2023 plan year.

Benefit Description**	Reliance Standard Basic Life and AD&D
Eligibility	**All Active Full-Time Employees**
Benefit Amount	$50,000
Benefit Maximum	$50,000
Benefits Will Reduce	No Benefit Reductions
AD&D	Equal to Benefit Amount
Premium Cost	*Employer Paid Benefit*

Benefit Description**	Reliance Standard Basic Life and AD&D
Eligibility*	**Retirees**
Benefit Amount	$1,000 Increments
Benefit Maximum	$15,000
Benefits Will Reduce	10% per year starting at age 61; final reduction at age 65
AD&D	Equal to Benefit Amount
Premium Cost	*Employee Paid Benefit*

* All coverage subject to Evidence of Insurability.
**This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the above illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Bereavement Support Services
Comfort and Guidance for Challenging Times

Bereavement Support Services provide confidential and professional support services to all covered employees and family members to cope with the loss of a loved one—at no extra cost.

Along with your coverage from Reliance Standard Life Insurance Company, you are offered access to unlimited and confidential telephonic grief counseling, legal and financial consultation through ACI Specialty Benefits just when you need it most.

Grief Counseling

- ***Unlimited*** Telephonic Assessment and Referral

Legal and Financial Services

- ***Unlimited*** Phone Consultation for Any Financial Issue
- ***Unlimited*** Phone Consultation for Any Legal Issue
- Online Legal and Financial Resource Center Including Document Preparation

Program Access

- All Covered Employees and Family Members Eligible, Regardless of Location or Relationship
- 24/7, 365 Days-a-year Dedicated Toll-Free Line, Always Live Answer

Questions or to Access Services

Contact ACI Specialty Benefits toll-free at

855-RSL-HELP

(855-775-4357)

rsli@acieap.com

Bereavement Benefit services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

Powered by ACI SPECIALTY BENEFITS

RS-1948 (06/2017)

Required Annual Employee Disclosure Notices
Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires the FOP Insurance Trust to notify you, as a participant or beneficiary of the FOP Miami Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

All stages of 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 compilations of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.

Keep this notice for your records and call the FOP Miami Lodge #20 Insurance Trust Office at 305-372-4605 or 800-525-7015 for more information.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less then 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
Require a mother to give birth in a hospital; or
Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description.

Keep this notice for your records and call the FOP Miami Lodge #20 Insurance Trust Office at 305-372-4605 or 800-525-7015 for more information.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

There are certain events which will allow you to enroll in this plan other than during Open Enrollment, commonly referred to as a Special Enrollment Period.

If you are declining enrollment 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 towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 60 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.

Please contact the Fraternal Order of Police Miami Lodge # 20 Insurance Trust Fund (Trust Office) if you have any questions regarding the submittal of a Special Enrollment Request, (305) 372-4605 or toll-free (800) 525-7015. If you qualify for a Special Enrollment, you must contact the Trust Office where you will be directed to complete an enrollment form or other appropriate documentation and provide the supporting documentation for your Special Enrollment Event.

Additional FAQs regarding HIPAA and Special Enrollment Rights can be found at:

http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. The group health plan may extend dependent coverage beyond the ACA requirements, to age 30 depending on the State so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary, leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

To obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

Although this is not an Erisa plan, as a participant in the Plan you are entitled to certain rights and protections. All participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents subject to Florida Public Records Law.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

PATIENT PROTECTION MODEL DISCLOSURE

You do not need prior authorization from **Meritain Health** or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit the **Meritain Health** website at **www.meritain.com.**

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Lissette Priegues-Granado
400 N.W. 2nd Ave
Room 324
Miami, FL 33128
305-372-4605
fop20insurance@earthlink.net

MAILING ADDRESS
P.O. Box 011127
Miami, FL 33101

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services: If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

• You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network).

Your health plan will pay out-of-network providers and facilities directly.

• Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an In-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed or for more information about your rights under federal law, you may contact: www.cms.gov/nosurprises/consumer.

Important Notice from the Fraternal Order of Police Miami Lodge 20 Insurance Trust Fund (Trust) 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 the Fraternal Order of Police Miami Lodge 20 Insurance Trust Fund (Trust) 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 Trust has determined that the prescription drug coverage offered by the Trust 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 through 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 do decide to enroll in a Medicare drug plan, your current coverage with the Trust will be affected. The Trust cannot coordinate with any other Medicare Plan.

If you do decide to join a Medicare drug plan you cannot drop your current coverage with the Trust unless you also drop your medical coverage.

Please contact your Plan Administrator for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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 Trust 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 Your Current Prescription Drug Coverage…
Contact the person listed below for any further explanation of the prescription drug coverage plan provisions/options under the Trust, please consult the relevant plan document provisions.

For More Information About This Notice…
Contact the person listed below**.** NOTE: You will receive this notice each year. You will also get it before the next period you can enroll in a Medicare prescription drug coverage, and if this coverage through the Trust 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:	September 2022
Name of Entity/Sender:	Fraternal Order of Police Miami Lodge 20 Insurance Trust Fund
Contact--Position/Office:	Lissette Priegues-Granado (Benefits Manager)
Address:	P.O. Box 011127
Phone Number:	305-372-4605

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.

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- 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/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Notice Effective Date: February 1, 2023

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Lissette Priegues-Granado
400 N.W. 2nd Ave
Room 324
Miami, FL 33128
305-372-4605
fop20insurance@earthlink.net

MAILING ADDRESS
P.O. Box 011127
Miami, FL 33101

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-457-4584
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid and CHIP (Hawki)**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health- insurance-buy-program HIBI Customer Service: 1-855-692-6442	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – 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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
VIRGINIA – Medicaid and CHIP	**CALIFORNIA - Medicaid**
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 October 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. 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.

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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 (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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.

1. Employer Name **Fraternal Order of Police Miami Lodge 20 Insurance Trust Fund**	**2. Employer Identification Number (EIN)** **59-6798275**
3. Employer Address 400 N.W. 2nd Ave, Room 324	**4. Employer Phone Number** **305-372-4605**
5. City Miami	**6. State** Florida
7. Zip Code 33128	**8. Who can we contact about employee health coverage at this job?** Lissette Priegues-Granado
9. Phone Number (if different from above)	**10. Email address** fop20insurance@earthlink.net

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    All Full Time Employees averaging a minimum of 30 hours per week and Retirees.

  - [ ] Some employees. Eligible employees are :

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal Spouse, and Dependent Children up to Age 26

  - [ ] We do not offer coverage .

[x] 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 premiu m 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums .

• 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 (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

400 N.W. 2nd Ave
Room 324
Miami, FL 33128
305-372-4605

MAILING ADDRESS:
P.O. Box 011127
Miami, FL 33101

The information in this Benefits Summary is presented for illustrative purposes only. This summary is not a legal document and does not replace or supersede the Plan Documents. Please refer to the Plan Documents for a complete description of the coverage, eligibility criteria, controlling terms, exclusions, limitations, and conditions of coverage. FOP Miami Insurance Trust reserves the right to terminate, suspend, withdraw, reduce, or modify the benefits in whole or in part, at any time. No statement in this or any other document and no oral representation should be construed as a waiver of this right. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this Benefits Summary and the actual plan documents, the actual plan documents will prevail. Pursuant to the Health Insurance Portability and Accountability Act of 1996, all information required to be confidential is maintained as such by the FOP Miami Insurance Trust. If you have any questions about this summary, contact the Trust Office.

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