IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND

2027 Insurance Benefits Options - Retired Members

Health Insurance – Aetna Medical, Dental, Vision
Health Reimbursement Account (HRA)
Gym & Wellness Program – FitOn
Advanced Eye Care Reimbursement

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This document contains a summary in English of information about the IAFF Local 587 Health Insurance Trust Fund upcoming open enrollment benefits. If you have difficulty understanding any part of this document, contact your Plan Administrator at 305-425-1938 during regular business hours or by email at benefits@healthtrustmaff.org.

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 17 for more details.

IAFF Local 587
Health Insurance Trust

MIAMI ASSOCIATION OF FIRE FIGHTERS
I.A.F.F. Local 587 · Organized October, 1938
International Association of Firefighters, AFL-CIO, CLC

Chair: Alexander Cardenas
Co-Chair: Sigfredo Delgado
Trustees: Raul Cernuda
Christopher Diaz
Akeem Donaldson
Tom Gabriel
Robert Jorge
Louis Marshall
Nikko Osborne
Alt: Troy Sutton

Dear Retiree Member,

IAFF Local 587 Health Insurance Trust Fund (Trust) Open Enrollment for 2027, will run from November 2 through November 13, 2026.

As in previous years, enrollment will be **passive**, meaning your current benefit elections will automatically carry over into 2027, unless you make changes. ***If changes are needed, you must complete them through the PlanSource portal or return the enrollment form included in your package before Open Enrollment closes.***

As Chairman of the Trust, I am pleased to *announce that member contributions will remain unchanged for 2027, with no reduction in benefits.*

This marks **eight consecutive years** in which your Union Health Trust has either reduced or maintained contribution rates while continuing to enhance benefits. For our retired members, this reflects the value of having a union-managed Trust dedicated to protecting your healthcare coverage and keeping it affordable.

While your benefits remain the same, **the Trust will transition from Cigna to Aetna/Meritain effective January 1, 2027.**

Cigna has been a valued partner throughout the Trust's establishment and growth over the past seven years. However, as our Trust and benefits have evolved, so have our members' needs and expectations.

Following an extensive competitive review and the recommendations of our professional consultants, the Trust selected **Aetna/Meritain** as a partner better equipped to support our expanding benefits and provide the responsive service our members deserve.

Our priority is to ensure a seamless transition for members and their families. With Aetna's extensive provider network, **more than 97% of the providers currently used by our members are expected to remain in-network.** Additional information, which may not be included in this package, including website access, customer service contacts, and provider verification instructions, will be provided shortly.

The Trust remains committed to providing comprehensive, affordable healthcare coverage that supports the health and well-being of our retired members and their families. With enhanced benefits, improved service, and stable contribution rates for 2027, I am confident we are continuing to fulfill that commitment.

Fraternally,

Alexander Cardenas, Chairman/President
IAFF Health Insurance Trust/ IAFF Local 587
305-633-3442

BENEFITS ENROLLMENT INFORMATION

When do I Enroll?

Open Enrollment is a period of time dedicated to selecting your benefits for the upcoming year. You can enroll or change your current elections and also add or remove dependents. Your selections will be effective from **January 1, 2027** through **December 31, 2027**.

The Open Enrollment period for coverage in 2027 is from ***Monday, November 2, 2026, through Friday, November 13, 2026.*** This is a passive enrollment, which means you do not need to login to the system if you are not making any changes. Your current elections will rollover to next year.

November	January
Open Enrollment November 2, 2026 – November 13, 2026	Plans Effective January 1, 2027 - December 31, 2027

How do I Enroll?

IAFF Local 587 Health Insurance Trust Fund provides Retirees with two options to enroll. The Trust encourages the use of our user-friendly and secure online tool, PlanSource. Alternatively, changes can be made using an Enrollment Form. Please refer to page 6 for instructions on how to enroll.

Who Can Enroll?

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

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

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

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

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

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

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

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

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

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

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

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

Benefit Termination Rules

Should your employment terminate, or your work status change, making you ineligible for benefits, your benefits will terminate at the end of the month.

As a retiree, should you elect to terminate your coverage from the plan, you will not be able to return to the plan.

Dependent children are generally eligible only up until age 26 but might be eligible up until the end of the year that they turn age 30, if they meet specific requirements.

Making Plan Changes

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

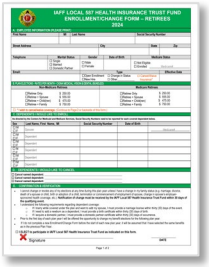
1) Special Enrollment Events (Add coverage for yourself and/or dependents).
   - Involuntary loss of other coverage
   - Acquire a new dependent through marriage, birth or adoption
   - Become eligible for Medicaid or CHIP

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

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

Enroll or Make Changes

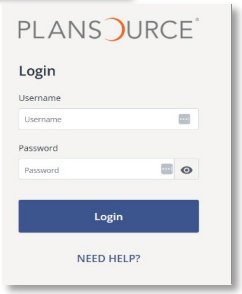
If you do not need to make changes to your insurance, you do not need to follow these steps.



For security and ease, Retirees who need to make changes to their benefit elections are encouraged to do so on PlanSource, our online enrollment system. Please follow the instructions below to login and make your elections or alternatively fill out the enclosed Enrollment Form and return to the Trust.

Go to https:// benefits.plansource.com

Follow the instructions below for your Login ID and Password. You will be prompted to choose a new password.



Login ID/Username Your username is the first initial of your first name, up to the first six letters of your last name, and the last four digits of your SSN.

Password your initial password is your birthdate in the YYYYMMDD format. You will be prompted to reset your password.

Example #1: Taylor Williams, SSN: XXX-XX-1234, Birthdate: January 4, 1982
Login ID: twillia1234, **Password:** 19820104

Note: During Open Enrollment, the system resets passwords to the above default (YYYYMMDD).

HAVING TROUBLE LOGGING IN? Click the "NEED HELP?" link to obtain your username and/or reset your password.

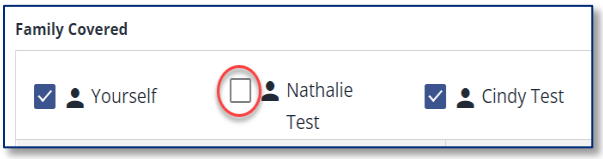
On the homepage, click "Get Started" to begin.

You will need to review and update your personal information, if necessary, to ensure that all information listed is correct. If you have a spouse or domestic partner on the plan, we encourage you to add their email here.

Next, you will need to review your dependent information. If you wish to add coverage for dependent(s) in any benefits, you would need to add them here.

Next, you can shop for benefits!

When choosing benefits for the first time, you will click on the ***Shop Plans*** button



When updating existing coverage, you will click on the ***View or Change*** button

To ensure that your dependents are covered, please make sure that you have checked the checkbox next to their name.

Click ***Update Cart*** to add coverage to your cart. You may also see a ***Take Survey*** button. When you complete all elections, click to ***Review & Checkout***.

If selections are correct, click ***Checkout*** button.

You must complete the checkout process in order to be enrolled in benefits.

You will land on the Summary page that confirms you have completed the enrollment process.
Note: You may download, email, or print the summary for your records.

If you have any questions, please contact your Benefits Team at benefits@healthtrustmaff.org or 305-425-1938

Insurance Glossary

Here is a list of relevant insurance-related terms to help you navigate the information provided in this guide .

Healthcare Provider: A healthcare provider is a person or company that provides a healthcare service to you, such as a dentist, primary care physician, chiropractor, clinical social worker, etc.

In-Network: Doctors, clinics, hospitals, and other providers are considered in network when they have made an agreement to care for the health plan's members. Health plans cover a greater share of the cost for using in-network healthcare providers than for providers who are out of network.

Out-of-Network: A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out of network, but covered employees will pay more out of pocket to use out-of-network providers than for in-network providers. Employees are also responsible for any difference between what the provider charges and the insurance company pays.

Preventive Care Services: Covered services intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Your policy specifies what qualifies as preventive coverage at a 100% level.

Copay: A copay is a fixed-dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time healthcare services are received.

Coinsurance: The portion of an eligible medical bill a plan member must pay. Coinsurance amounts are usually a percentage of the total eligible medical bill, such as 20%. Coinsurance applies after the member meets a required deductible or copay amount. Coinsurance is part of certain healthcare plans.

Deductible: A fixed-dollar amount that a plan member must pay for eligible services before the insurer begins applying insurance benefits. Deductibles are part of certain healthcare plans and based on a plan member's specific benefit period.

Out-of-Pocket Maximum: The highest dollar amount you will need to pay during your benefit period for covered medical services from network providers. See your plan benefit for a list of services included.

Health Plans

Medical Plan - AETNA

IAFF Local 587 Health Insurance Trust Fund offers a medical plan through **Aetna. Aetna's** preferred lab facilities are **Lab Corp** & **Quest Diagnostics**. Below are highlights of the plan. You can search for participating providers by visiting www.aetna.com and click "Find a Doctor", selecting "Plan through employer", entering your zip code and select "Medical", then select **"Aetna Choice® POS II (Open Access)"** as your network.

COVERAGE	Aetna Choice POS II Plan	
	In-Network	**Out-of-Network[1]**
Calendar Year Deductible		
Individual	$500	$1,000
Family	$1,000	$2,000
Member Coinsurance	20%	40%
Calendar Year Out-of-Pocket Maximum *Includes Deductible, coinsurance., and medical*		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Physician Visit		
Preventive Care	$0 copay	40% after DED
Primary Care Physician (PCP)	$25 copay	40% after DED
Specialist	$30 copay	40% after DED
Telemedicine	$0 copay	N/A
Lab Work & Diagnostic Imaging		
Independent Lab i.e., blood work, x-ray	$0 copay	40% after DED
Advanced Services Includes MRI, PET, CT	20% after DED	40% after DED
Hospital Services		
Inpatient Hospital	20% after DED	40% after DED
Outpatient Surgery	20% after DED	40% after DED
Emergency Medical Care		
Convenience Care Clinics	$25 copay	40% after DED
Urgent Care	$25 copay	$25 copay
Emergency Room (waived if admitted)	$225 copay	$225 copay
Infertility		
Lab, radiology, counseling, surgical treatment, includes artificial insemination (excludes in-vitro fertilization, GIFT, ZIFT, etc.)	Coverage varies	Not covered
Hearing Aids		
Hearing Aids – limited to once every 3 years	Covered at 100%, maximum allowance of $2,000	
Prescription RX (30-day supply)		
Tier 1	$10 copay	50% coinsurance
Tier 2	$40 copay	50% coinsurance
Tier 3	$60 copay	50% coinsurance
Tier 4	50% coinsurance	50% coinsurance
Out-of-pocket drug maximum	$1,000 individual / $2,000 family	
Mail Order (90-day supply)		
Tier 1	$0 copay	50% coinsurance
Tier 2	$80 copay	50% coinsurance
Tier 3	$120 copay	50% coinsurance
Tier 4	50% coinsurance	50% coinsurance

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

Dental Plan - AETNA

IAFF Local 587 Health Insurance Trust Fund offers a Dental Preferred Provider Organization (DPPO) through **Aetna**. Below are highlights of the plan.

You can search for providers by visiting www.aetna.com and click "Find a Doctor", selecting "Plan through employer", entering your zip code and select "Dental", then select **"Dental PPO/PDN with PPO II."** as your network.

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

Plan Highlights	DPPO	
	In-Network	**Out-of-Network[1]**
Calendar Year Maximum Benefit – Enhanced Benefit	$2,000 per member	
Calendar Year Deductible (DED)		
Individual Family	$0 $0	$0 $0
Preventive Services		
Oral evaluations	100%	100%
Routine cleanings	100%	100%
X-rays	100%	100%
Fluoride application	100%	100%
Sealants: per tooth	100%	100%
Space maintainers: non-orthodontic	100%	100%
Emergency care to relieve pain	100%	100%
Basic Services		
Restorative: fillings	100%	100%
Endodontics	100%	100%
Periodontics	100%	100%
Oral Surgery	100%	100%
Anesthesia	100%	100%
Bridges, crowns, and inlays	100%	100%
Dentures	100%	100%
Denture relines, rebases and adjustments	100%	100%
Major Services		
Inlays and onlays	100%	100%
Prosthesis over implant	100%	100%
Crowns	100%	100%
Bridges and dentures	100%	100%
Orthodontics (Adult & Child)		
Comprehensive	100%; $2,500 Lifetime Maximum	

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

Vision Plan - AETNA

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

You can search for providers by visiting www.aetna.com and click "Find a Doctor", selecting "Plan through employer", entering your zip code and select "Vision", then select **"Aetna Vision Preferred."** as your network.

Plan Highlights	Vision	
	In-Network	**Out-of-Network[2]**
Exam (One every 12 months)	$0 copay	$45 allowance
Lenses (One every 12 months)		
Single	$0 copay	Up to $40 allowance
Bifocal	$0 copay	Up to $65 allowance
Trifocal	$0 copay	Up to $75 allowance
Progressives	$0 copay	Up to $75 allowance
Lenticular	$0 copay	Up to $100 allowance
Frames (One every 12 months)	$200 allowance	Up to $133 allowance
Contact Lenses[1] (One every 12 months)		
Medically necessary	Covered in full	Up to $210 allowance
Elective	$200 allowance	Up to $160 allowance
Lens enhancements		
Polycarbonate lenses for children under age 19	$0 copay	Not covered
Oversize lenses	$0 copay	Not covered
Rose tint #1 and #2	$0 copay	Not covered

(1) In lieu of eyeglass benefits

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

Advanced Eye Care Reimbursement (formerly Lasik only)*

Members and their dependents covered by the Plan are eligible for up to a $5,000 maximum lifetime benefit for any FDA approved procedures to improve your eyesight. The Advanced Eye Care Reimbursement benefit is administered by Diversified. For more information or to request reimbursement visit www.div125.com. Login instructions are available on page 14 of this booklet.

The Advanced Eye Care Reimbursement benefit does not cover procedures included with cataract

CONTRIBUTIONS
MEDICAL + DENTAL + VISION

Non-Medicare Retirees	Monthly Contributions
Member Only	$250.00
Member + Spouse	$555.00
Member + Child(ren)	$475.00
Member + Family	$750.00

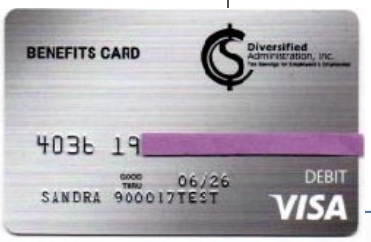
Medicare Retirees	Monthly Contributions
Member Only	$250.00
Member + Spouse	$555.00
Member + Child(ren)	$475.00
Member + Family	$750.00

Voluntary & Additional Benefits

Health Reimbursement Account (HRA)

Health Reimbursement Account (HRA) – The HRA will be administered by Diversified. It can be used to pay for or reimburse for any IRS Code Section 213(d) Eligible Medical Expense. Please see the booklet enclosed with this package.

Coverage Level	Reimbursement Amount
Member Only	$1,000.00
Member + Spouse	$2,000.00
Member + Child(ren)	$2,000.00
Member + Family	$3,000.00



SECTION 105 HRA PLAN INFORMATION

PLAN YEAR FROM 01/01/2027 To 12/31/2027

We will be processing **weekly** this year.

If your claim is in our office by 4:00 pm on Tuesday, we will be able to process it on Wednesday.

You will receive the money shortly after the processing date.

**Any claim received after the cut-off date will be processed on the following date.

Participants can now submit claims directly on our www.Div125.com website, or on our Mobile Phone app without the need for a separate claim form.

ALL USERS MUST LOG IN TO THE WEX ACCOUNT THE FIRST TIME USING THE FOLLOWING INSTRUCTIONS:

- Go to www.Div125.com
- Click on the blue CDH Login button in the upper right-hand corner
- Click in the **Existing Users** box, entering the Username and Password following the instructions on the next lines.
- Your first time username is your first initial, your last name, and the last 4 of your SSN - jsample9999
- If you have another login from a different group's benefits, one of those logins will have a 1 after it - jsample99991
- Click the next button, and a password field will appear below where you entered your username
- Your first time password is your 5-digit zip, your first initial (lowercase), and the last 4 of your SSN - 33333j9999
- After setting up 3 security questions, you can customize your username and password. Answers are CASE sensitive.

Administrative Services provided by
Diversified Administration
6600 Taft Street, Suite 304
Hollywood, Fl. 33024
Phone (954) 983-9970 Option 3
Fax (954) 983-9695
www.Div125.com
E-mail claims to Claims@Div125.com

Scan for the **iPhone** Diversified App

Scan for the **Android** Diversified App

3

WHICH EXPENSES ARE ABLE TO BE REIMBURSED WITH YOUR HRA PLAN?

THE FOLLOWING EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT WITH AN FSA PLAN

- Acupuncture Services
- Alcoholism & Drug Abuse Treatment
- Birth Control Pills & Devices
- Blood Pressure Cuffs
- Blood Sugar Test Kits for Diabetics
- Braces & Orthodontia
- Chiropractic Adjustments
- Compression Products (30-40 mmHg or above)
- Contact Lenses & Glasses
- Crutches & Medical Equipment
- Deductibles, Coinsurance, and Copays
- Dental Procedures and Dentures
- Doctor Office Visits
- Eyeglasses, including Exam Fee
- Flu Shots & Vaccines
- Handicapped Persons' Special Schools
- Hearing Devices and Batteries
- Incontinence Products
- Insulin & Other Diabetic Supplies
- Laboratory & Diagnostic Fees
- Lasik Eye Surgery
- Hospitalization and Clinical Care
- Menstruation Products
- Obstetrics & Gynecology
- Orthopedic Shoes
- Over the Counter Medications
- Oxygen and Oxygen Equipment
- Physical & Speech Therapy
- Prescription Medication
- Psychiatrists & Psychologists
- Smoking Cessation Programs
- Surgical Procedures
- Thermometers
- Vasectomy Operations
- Walkers, Wheelchairs & Canes
- X-Rays & Medical Imaging

THE FOLLOWING EXPENSES WILL NEED A LETTER OF MEDICAL NECESSITY / RX

- Alopecia Treatment
- Certain "Dual Use" Rx (Botox)
- Cervical Pillows
- Dermatologist (not matching a copay)
- Learning Disability Treatment
- Massage Therapy Sessions
- Orthopedic Shoes
- Probiotics & Most Supplements
- Service Animals
- Weight Loss Programs and Rx

THE FOLLOWING EXPENSES ARE NOT REIMBURSABLE UNDER AN FSA PLAN

- Baby Wipes & Diapers
- Body Lotions & Creams
- Cosmetic Surgery / Prescriptions
- Deodorants & Moisturizers
- Electrolysis Procedures
- Hair Transplants & Rogaine
- Marijuana (Medical or Otherwise)
- Teeth Bleaching & Toothpaste
- Soap, Face Wash & Body Wash
- Q-tips, Dental Floss, & Toiletries

Gym Membership & Wellness

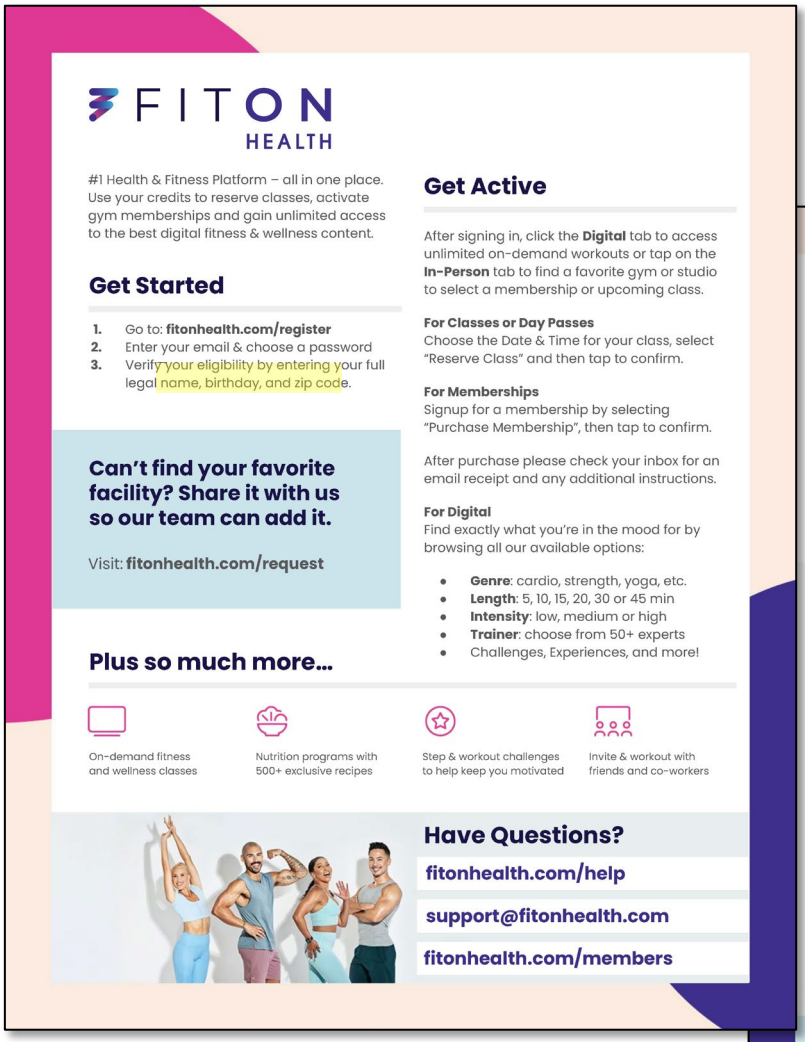
FitOn

Our vision is to improve our culture of health by increasing communication about our well-being and health benefit offerings and engage our members and their spouses in healthy activities available.

FITON HEALTH

This program gives each plan participating member and their spouse 15 credits per month. These points provide access to, many at no cost to you, participating gyms and/or local fitness studios.

If you have not already started to use this great benefit, and want to start, follow the instructions below.
Note: you must use this link to enroll: www.fitonhealth.com/register



FITON HEALTH

#1 Health & Fitness Platform – all in one place. Use your credits to reserve classes, activate gym memberships and gain unlimited access to the best digital fitness & wellness content.

Get Started

1. Go to: **fitonhealth.com/register**
2. Enter your email & choose a password
3. Verify your eligibility by entering your full legal name, birthday, and zip code.

Can't find your favorite facility? Share it with us so our team can add it.

Visit: **fitonhealth.com/request**

Get Active

After signing in, click the **Digital** tab to access unlimited on-demand workouts or tap on the **In-Person** tab to find a favorite gym or studio to select a membership or upcoming class.

For Classes or Day Passes
Choose the Date & Time for your class, select "Reserve Class" and then tap to confirm.

For Memberships
Signup for a membership by selecting "Purchase Membership", then tap to confirm.

After purchase please check your inbox for an email receipt and any additional instructions.

For Digital
Find exactly what you're in the mood for by browsing all our available options:

- **Genre**: cardio, strength, yoga, etc.
- **Length**: 5, 10, 15, 20, 30 or 45 min
- **Intensity**: low, medium or high
- **Trainer**: choose from 50+ experts
- Challenges, Experiences, and more!

Plus so much more...

On-demand fitness and wellness classes

Nutrition programs with 500+ exclusive recipes

Step & workout challenges to help keep you motivated

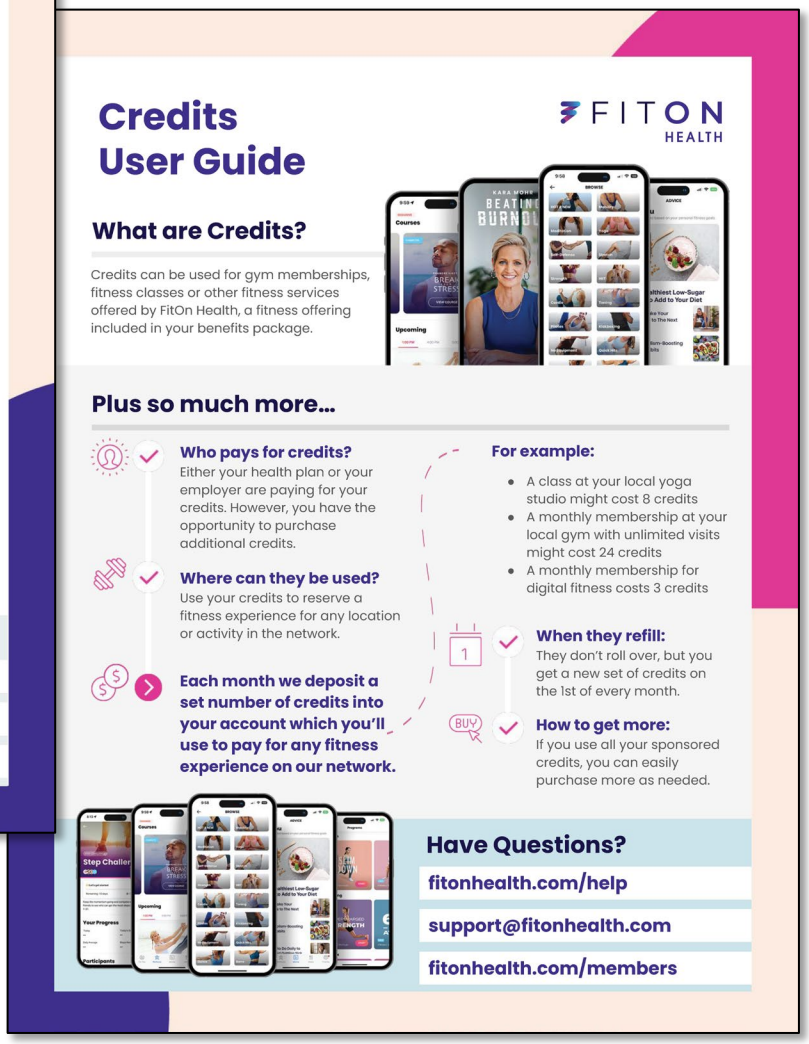
Invite & workout with friends and co-workers

Have Questions?

fitonhealth.com/help

support@fitonhealth.com

fitonhealth.com/members



Credits User Guide

FITON HEALTH

What are Credits?

Credits can be used for gym memberships, fitness classes or other fitness services offered by FitOn Health, a fitness offering included in your benefits package.

Plus so much more...

Who pays for credits?
Either your health plan or your employer are paying for your credits. However, you have the opportunity to purchase additional credits.

Where can they be used?
Use your credits to reserve a fitness experience for any location or activity in the network.

Each month we deposit a set number of credits into your account which you'll use to pay for any fitness experience on our network.

For example:

- A class at your local yoga studio might cost 8 credits
- A monthly membership at your local gym with unlimited visits might cost 24 credits
- A monthly membership for digital fitness costs 3 credits

When they refill:
They don't roll over, but you get a new set of credits on the 1st of every month.

How to get more:
If you use all your sponsored credits, you can easily purchase more as needed.

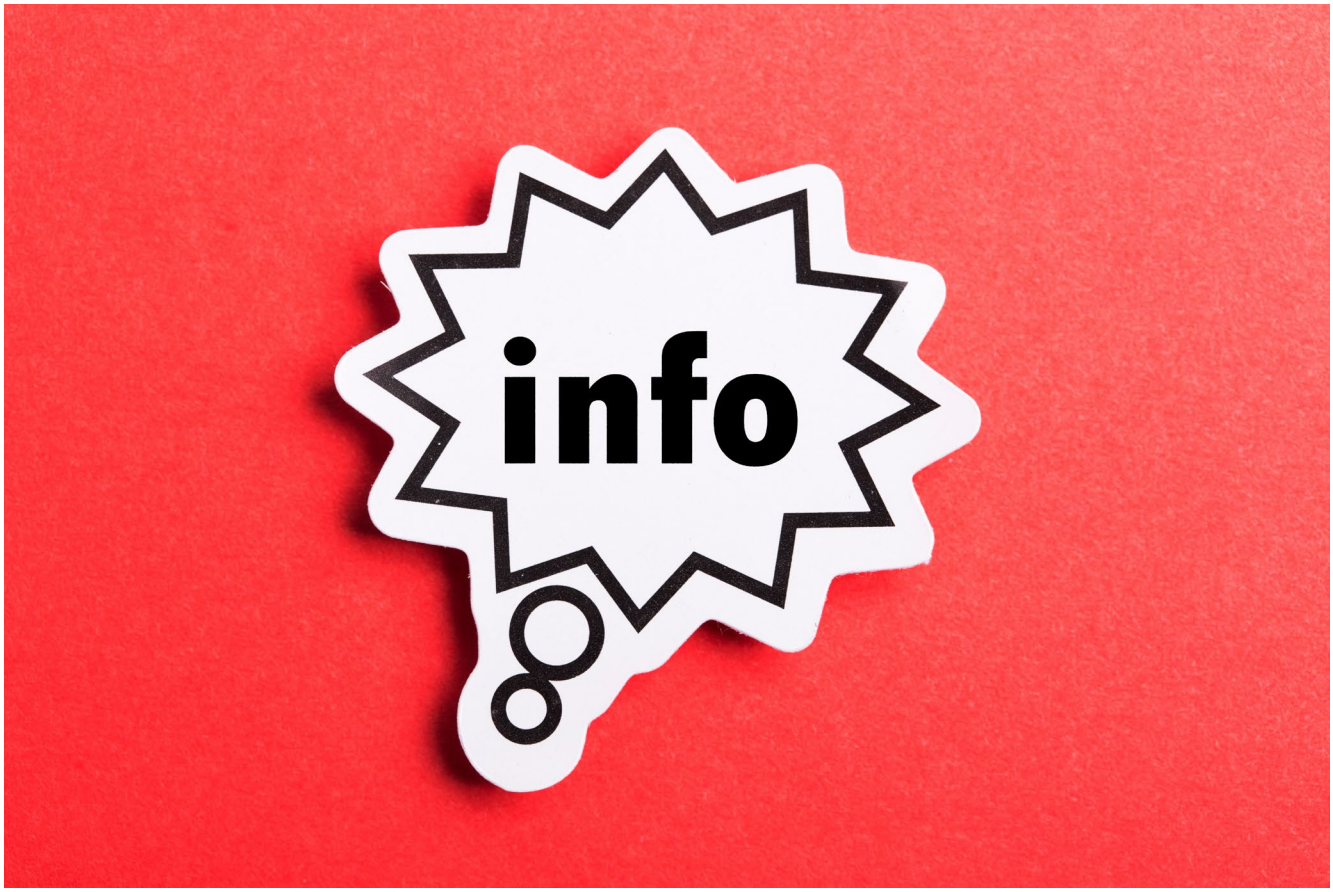
Have Questions?

fitonhealth.com/help

support@fitonhealth.com

fitonhealth.com/members

Annual Notices



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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage as an active employee, please note that your IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND coverage as a former employee.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	October 20, 2026
Name of Entity/Sender:	IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND
Contact--Position/Office:	Nydia Soto/Benefits Manager
Address:	2980 NW South River Drive Miami, FL 33125
Phone Number:	1-305-425-1938

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND's group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or obtain more information, contact:

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

Women's Health Cancer Rights Act (WHCRA) Notice

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 305-425-1938.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 310-321-2322 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

HIPAA Notice of Privacy Practices

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

IAFF Local 587 Health Insurance Trust Fund("IAFF Local 587 Health Insurance Trust Fund") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of IAFF Local 587 Health Insurance Trust Fund, the Plan, and your legal rights regarding your protected health information, including certain substance use disorder (SUD) records covered by 42 CFR part 2 (Part 2), held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

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

(1) your past, present or future physical or mental health or condition;

(2) the provision of health care to you; or

(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully insured group health plans offered by Miami Beach Fire Local 1510 Insurance Trust Fund, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

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

IAFF Local 587 Health Insurance Trust Fund
Attention: HIPAA Privacy Officer
Benefits Office
305-425-1938
benefits@healthtrustmaff.org

Effective Date

This Notice, as revised, is effective January 1, 2027.

Our Responsibilities

We are required by law to:

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

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

How We May Use and Disclose Your Protected Health Information

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

For Treatment

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

For Payment

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

For Health Care Operations

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

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information, including SUD treatment records, to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

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

To Avert a Serious Threat to Health or Safety

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

To Plan Sponsors

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

Special Situations

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

Organ and Tissue Donation

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

Military and Veterans

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

Workers' Compensation

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

Public Health Risks

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

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

Health Oversight Activities

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

Lawsuits and Disputes

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

SUD treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Law Enforcement

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

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

Coroners, Medical Examiners and Funeral Directors

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

National Security and Intelligence Activities

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

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement

official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or

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

Required Disclosures

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

Government Audits

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

Disclosures to You

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

Notification of a Breach.

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

Other Disclosures

Personal Representatives

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

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;

(2) treating such person as your personal representative could endanger you; or

(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

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

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of SUD Part 2 treatment records, psychotherapy notes, and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

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

Right to Inspect and Copy

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

Right to Amend

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

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

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

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

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

Right to a Paper Copy of This Notice

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

For more information, please see Your Rights Under HIPAA**.**

Complaints

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

Part A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period[1] for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your plan administrator.

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.

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 This Special Enrollment Period is no longer available.

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

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

- As your employer, we offer a health plan to:
  ☐ All employees. Eligible employees are:
  _____
  ☑ Some employees. Eligible employees are:
  - Employees working 30 or more hours per week
- With respect to dependents:
  ☑ We do offer coverage. Eligible dependents are:
  - Spouse or domestic partner and children up to age 26 or 30, if they qualify

  ☐ We do not offer coverage.

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

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

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov/ HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid	MONTANA - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov/ Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay *or* aren't required to pay for COBRA continuation coverage.

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to

elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

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[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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

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

Plan contact information

Name of Entity/Sender:	IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND
Contact--Position/Office:	Nydia Soto/Benefits Manager
Address:	2980 NW South River Drive Miami, FL 33125
Phone Number:	1-305-425-1938

EEOC Wellness Program Notice

Notice Regarding Wellness Program
IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.
However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Nydia Soto at 305-425-1938.

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

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND may use aggregate information it collects to design a program based on identified health risks in the workplace, IAFF LOCAL 587 HEALTH INSURANCE TRUST FUND's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Nydia Soto at 305-425-1938

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. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant

surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

When balance billing isn't allowed, you also have 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 any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

DIRECTORY & RESOURCES

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

CONTACT INFORMATION

Trust Office	305-425-1938	
	benefits@healthtrustmaff.org	www.healthtrustmaff.org
Wellness Center	1-786-558-2825	
	benefits@healthrustmaff.org	
Medical, Dental, Vision		
Aetna	1-800-925-2272 Service hours : 7:00 AM - 6:30 PM CST	www.aetna.com
Health Reimbursement Account	954-983-9970	
Diversified Administration, Inc.	claims@div125.com	www.div125.com
Ignite Wellness		
FitOn	support@fitonhealth.com	https://www.fitonhealth.com/
Advanced Eye Care – Trust	954-983-9970	
Diversified Administration	claims@div125.com	www.div125.com

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

This document contains a summary in English of information about your upcoming benefits enrollment. If you have difficulty understanding any part of this document, contact:

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

IMPORTANT

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation.

It is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

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