Annual Notices - Open Enrollment Fall 2019

HIPAA 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.

We are providing this Notice from the I.A.F.F. Local 22 Philadelphia Fire Fighters Union Health Plan (referred to in this Notice as the "Plan") in order to inform you about the way that your health information may be used by the Plan. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protection.

The Plan is required by federal law to maintain the privacy of your protected health information ("PHI"). The Plan is also required by federal law to provide you with this description of the privacy policies and practices adopted by the Plan. The Plan must follow these policies and practices, but as permitted by law, the Plan reserves the right to amend or modify these privacy policies and practices.

Changes in our policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material changes within sixty (60) days of the date the change is adopted. The effective date of this notice is September 1, 2016.

Under HIPAA, how can the Plan use my protected health information ("PHI")? The Plan can use your PHI to facilitate your treatment, to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Plan use my protected health information ("PHI") with respect to payment for my treatment? The Plan may use your PHI for the broad range of actions needed to make sure that the Plan can make payment for the services you and your family receives. The Plan may use your PHI for making payment to providers for services or treatment you received, for making arrangements for payment through one of the networks of providers through which the Plan provides benefits to you, as well as for coordinating payment to providers though other health plans under the Plan's coordination of benefits rule. For example, the Plan provides participants with access to a network of providers outside this immediate geographic area. The Plan may provide your PHI to the network and directly to the provider in order to ensure that the provider receives the appropriate payment for the services that have been provided to you.

How does HIPAA permit the Plan to use my protected health information ("PHI") with respect to "health care operations?" The Plan may use your PHI for a broad range of actions required to assess the quality of the Plan's plan of benefits as well as for its administration and operations. These activities include, but are not limited to, ensuring that participants or their beneficiaries are eligible for benefits prior to making payment; taking corrective action to recoup overpayments and assessing health plan performance; reviewing the Plan's plan of benefits and determining whether a reduction in costs is possible; continuing case management and coordination of care; commissioning and reviewing actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the plan; resolving internal grievances; and undertaking medical review, legal, and auditing functions. For example, the Plan may use PHI to determine the most cost-effective manner of providing benefits to its participants and beneficiaries.

May the Plan use my protected health information ("PHI") for purposes besides payment and health care operations? Yes. HIPAA permits the Plan to use your PHI for a number of other purposes, including informing you of treatment alternatives or other health–related benefits that may be of interest to you.

Because my spouse takes care of the family paperwork, my spouse often calls to find out the status of my health claims and to get other information about me or my benefits. Can the Plan release information relating to payment of my claims to my spouse? Unless you tell the Plan otherwise, the Plan will provide claims payment information to your spouse without requiring an authorization from you. If you do NOT wish the Plan to provide your spouse with this information, you must tell the Plan in writing that you do NOT wish the Plan to release claims payment information to your spouse.

NOTE: If you wish the Plan to release other information to your spouse, please file an authorization form with the Plan office. You can obtain release forms by calling the Plan office.

May I call the Plan to get information about my children's health claims? The Plan will provide a minor child's parent, guardian (or person standing in loco parentis with respect to the child) with payment information about the child's claim. The Plan will carefully consider your written request for information other than claims payment information and will respond as permitted by these privacy policies and applicable state law. NOTE: If your child is not a minor, the Plan generally cannot provide you with the child's protected health information, even if the child is still covered under this Plan as your dependent.

Does HIPAA permit the Plan to disclose my protected health information ("PHI") to my employer or insurer? Under HIPAA, the Plan generally cannot disclose your PHI to your employer without your written authorization. It is important to note, however, that HIPAA does permit the Plan to disclose your PHI without your authorization to workers' compensation insurers, state administrators, or others involved in the workers' compensation systems to the extent the disclosure is required by state or other law.

May the Plan release my protected health information ("PHI") to the Plan's plan sponsor? HIPAA does permit the Plan to disclose information to the "plan sponsor" for administrative functions. Here, the "plan sponsor" is the Plan's Board of Trustees. The Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the plan.

May the Plan release my protected health information ("PHI") to law enforcement or other governmental entities? Your PHI may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law- enforcement investigations, and to comply with government-mandated reporting. Note, however, that the Plan may not disclose your PHI if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public benefits. In addition, the Plan may disclose your PHI in the course of a judicial or administrative proceeding if the Plan receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Plan will make reasonable efforts either to notify you or to obtain an order protecting your PHI.

Would the Plan release my protected health information ("PHI") if my health or safety or public health or safety would be jeopardized if it did not? If the Plan has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Plan will do so, after consideration of appropriate legal and ethical standards.

Must the Plan have an authorization to release my protected health information ("PHI")?

Yes. For example, the following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI; and
- Most uses and disclosures of psychotherapy notes (if the Plan maintains any psychotherapy notes).

Any other disclosure or use of your PHI for any other purpose not described in this notice requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Plan Office. If you change your mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Plan of your decision to revoke the authorization.

May the Plan use or disclose my genetic information for underwriting purposes? No. The Plan is prohibited from using or disclosing genetic information for underwriting purposes.

Do I have any rights to information under the federal privacy standards? Your rights to information under HIPAA include:

- the right to request restrictions on the use and disclosure of your PHI. The Plan will carefully consider, although is not required to honor, your request for restrictions;
- the right to restrict confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, for example, that you can make a written request that the Plan send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential). The Plan will attempt to honor reasonable requests;
- the right to opt out of receiving fundraising communications prepared by or for the Plan;
- the right to inspect and copy your PHI. The Plan may charge a reasonable fee for copying, assembling and postage;
- the right to an electronic copy of electronic medical records. The Plan will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format;
- the right to get notice of a breach of any of your unsecured PHI;
- the right to amend or submit corrections to your PHI. If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Plan may deny your request if, for example, you do not include the reason you wish to correct your records or if the records were not created by the Plan;
- the right to receive an accounting of how and to whom your PHI has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Plan and should state the period of time for which you are requesting an accounting;
- the right to file a complaint, that your privacy rights have been violated, with the Plan and the Secretary of U.S. Department of Health & Human Services. NOTE: you will not be penalized or otherwise retaliated against for filing a complaint;
- the right to receive a printed copy of this notice. You can find this notice on the Plan's website at www.local22healthplan.org. Please contact the Plan office for authorization forms for release of PHI.

Complaints? Comments? Requests? The Plan has designated the Plan Administrator as the Privacy Officer. If you wish to request information which you have a right to receive, want to file a Complaint with the Plan or if you have any comments or questions regarding this notice, please contact Kathleen Corcoran at kcorcoran@iaff22.org. Please note that the Plan can assess reasonable charges for copying and assembling documents you request as well as for postage.

The Women's Health and Cancer Rights Act of 1998

Under a federal law called the Women's Health and Cancer Rights Act of 1998, the Plan is required to provide you benefits for mastectomy related services and to provide you with notice of your eligibility for these services.

The Women's Health and Cancer Rights Act provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy, including lymph edema. The Plan's plan of benefits includes health benefits coverage through Keystone Health Plan East and the Independence Blue Cross Personal Choice plan. These plans include co-payments and deductibles that can apply to any services you receive from a physician or hospital, including services related to a mastectomy. Please review the summary plan description for the details on any applicable co-payments or deductibles. You can learn more about your benefits from the Plan office at 215-440-4421 or 215-440-4422.

Newborn's and Mother's Health Protection Act

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

FY 2020 Incentive

I. FY20 incentive payment for members and spouses (July 1, 2019 to June 30, 2020)

a. The FY20 incentive payment is available to all eligible health plan members and their spouses. The FY20 incentive payment provides $200 to a member and an additional $100 to a spouse for completing at least 2 of the following activities between July 1, 2019 and June 30, 2020

i. Complete a smoking cessation program
ii. Attend at least 4 visits with a registered dietician
iii. Complete at least 10 visits with a personal trainer or other certified fitness professional
iv. Complete at least a 5k run/walk
v. Complete at least a 25mile bike-a-thon
vi. Have a Heart Scan done through Temple University Hospital
vii. Have a cancer screening test – (Lung Cancer Screening done through Temple University Hospital and the Local 22 Health Plan sponsored screenings are all eligible programs.)
viii. Including but not limited to a colonoscopy, mammogram; etc.
ix. If you are diabetic, have your annual dilated eye exam
x. If you are diabetic, have your annual podiatric exam
xi. Download the IBX WIRE app on your mobile device.
xii. Participate and complete any of the eligible programs offered through the Philly Firefighter Motivated Fitness Program.
xiii. Participate and complete the Sleep Apnea Study offered by the Health Plan through Temple University Hospital.
xiv. Complete the IAFF on-line "Cancer Awareness" course – a 7 module on-line course offered on www.iaff.org under Health and Safety Programs – click on NEW Cancer Awareness and Prevention – you will earn a certificate of completion when all 7 modules are completed Forward the certificate of completion as documentation for this program.
xv. Health Plan sponsored Naturally Slim Program.

A. Completion of any **two (2)** of the listed activities between 7/1/2019 and 06/30/2020.
B. Please do not hesitate to call Jerry Kots directly at 215-440-4426 or 267-549-6326 if you have additional questions. For FY20 we've tried to offer enough variety in our incentive activities that everyone can participate. **Don't miss out on this opportunity to earn$$ and get (or stay) healthy in the process!**
C. Send your documentation to Health Plan Incentive – **415 N 5th St – Philadelphia, PA – 19123 or e-mail the documentation to jkots@iaff22.org.**

DOCUMENTATION MUST BE RECEIVED BY JUNE 30, 2020

Presorted
First Class Mail
US Postage Paid
Philadelphia, PA
Permit No. 902

Firefighters & Paramedics
Local 22 Health Plan
415 N 5th Street
Philadelphia, PA 19123

FIREFIGHTERS & PARAMEDICS LOCAL 22 HEALTH PLAN

FALL 2019

As we head into the Holiday Season –

The staff of Local 22's Health Plan wish you and your family a Happy and Healthy Holiday.

We not only provide you and your family with best possible care when needed, we also offer many programs to improve and maintain your health while you are healthy.

Looking back over the past few months – we at the Health Plan would like to thank our members for their participation in the 6 weeks of Ultra-Sound Screenings. Over 1,000 members were tested. Early detection leads to higher rates of successful intervention.

And some quick reminders:

- November is Open Enrollment ("OE") month. Included in this packet is all your OE materials. You have until 12/02 to make any changes/additions.
- Our Philly Fire Motivated Fitness program offers one on one personal training as well as group fitness programs – free to our members and dependents. In August a pilot program – "Naturally Slim" – was introduced. The initial sessions were a success. A second session is planned for early 2020.
  For information on all our fitness programs go on our wellness/fitness website – www.pfmfitness.com
- Mental Health Consultants and Local 22's Peer support are always available to our members and their dependents. Many of us struggle with difficult times especially during the Holiday Season – help is a phone call away. All calls are strictly confidential.
- Another new benefit introduced in the Spring is Acupuncture. Both Personal Choice and Keystone plans are covering acupuncture treatments in network.
- All members are urged to participate in the FY 20 Incentive Program.

For additional details about the Acupuncture benefit, including the covered diagnoses, and for a full list of the activities that qualify for the FY20 incentive, visit the Health Plan website at www.local22healthplan.org.

www.local22healthplan.org

Summary of Medical Plan Benefits

Here is a summary of the benefits provided under the PPO and the HMO medical plans. For additional details on any benefit limit or exclusions please contact Independence Blue Cross or the Plan Office

	Personal Choice PPO Medical Plan		Keystone Health Plan East HMO Medical Plan
Plan Feature	**In-Network**	**Out-of-Network1** [1]	**In-Network**
Annual Deductible	$0 per individual $0 per family	$250 per individual $500 per family	$0 per individual $0 per family
Out-of-Pocket Maximum	$1,000 per individual $2,000 per family	$1,000 per individual $2,000 per family	$1,000 per individual
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Physician Services			
Primary care office visit	$15 copayment	80% after deductible	$15 copayment
Specialist office visit	$25 copayment	80% after deductible	$25 copayment
Preventive Care (for adults and children)	100%	80% after deductible	100%
Pediatric Immunizations	100%[2]	80%, no deductible	100%[2]
Routine Gynecological Exam and Pap test (1 per calendar year for women of any age)	100%	80%, no deductible	100% (no referral required)
Mammogram	100%	80%, no deductible	100% (no referral required)
Inpatient and Outpatient Services			
Maternity			
First OB Visit	$15 copayment	80% after deductible	$0 copayment
Hospital	100%	80% after deductible	100%
Inpatient Hospital Services			
Facility	100%	80% after deductible	100%
Physician/Surgeon	100%	80% after deductible	100%
Inpatient Hospital Days	Unlimited	70	Unlimited
Outpatient Surgery			
Facility	100%	80% after deductible	100%
Physician/Surgeon	100%	80% after deductible	100%
Skilled Nursing Facility	100%	80% after deductible	100% up to 180 days per calendar year
Emergency Room	$25 copayment (waived if admitted)	$25 copayment, no deductible, copay waived if admitted	$25 copayment (waived if admitted)
Urgent Care Center	$17 copayment	80% after deductible	$17 copayment
Ambulance			
Emergency	100% when medically necessary	100%, no deductible	100% when medically necessary
Non-emergency	100% when medically necessary	80% after deductible	100% when medically necessary
Outpatient Laboratory	100%	80% after deductible	100%
Outpatient Radiology	100%	80% after deductible	100%
Therapy Services			
Physical, Speech, Occupational	$10 copayment	80% after deductible	100%. Up to 60 consecutive days per condition covered, subject to significant improvement
Pulmonary Rehabilitation	$10 copayment	80% after deductible	100%
Respiratory therapy	$10 copayment	80% after deductible	100%
Restorative services, including chiropractic care	$25 copayment	80% after deductible	100%. Up to 60 consecutive days per condition covered, subject to significant improvement
Other Services			
Home Health Care	100%	80% after deductible	100%
Durable Medical Equipment	100%	80% after deductible	100%
Mental Health Care			
Inpatient	100%	80% after deductible	100%
Outpatient	$25 copayment	80% after deductible	$25 copayment
Substance Abuse Treatment			
Inpatient	100%	80% after deductible	100%
Outpatient	$25 copayment	80% after deductible	$25 copayment

[1] Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Independence Blue Cross, and the actual charge of the provider.
[2] Office visit subject to co-payment

November is Open Enrollment Month

There are three (3) actions you can take during Open Enrollment (OE) and the changes you make will be effective January 1, 2020:

1 Medical Plan
There are 2 medical plans offered: Personal Choice PPO and Keystone HMO, both through Independence Blue Cross. During OE you can change from one medical plan to the other

2 Dental Plan
There are 2 dental plans offered: a PPO and a DMO, both through Aetna. During OE you can change from one dental plan to the other

3 Eligible Dependent(s)
You can add your spouse or dependent child(ren) to the Health Plan

There is 1 prescription drug plan and 1 vision plan, so there are no elections you need to make there.

Included in this packet are comparisons of the 2 medical plans and the 2 dental plans, to help you make an informed decision for you and your family. Additionally, detailed information about all your benefits can be found on the Plan's website at www.local22healthplan.org. If you want to make any changes, you need to come into the Health Plan no later than **Monday, December 2nd** (note that the office is closed 11/28 and 11/29 for the Thanksgiving holiday).

If you do not wish to change your medical or dental plan, and if you have no changes to your eligible dependents, there is no action required on your part.

And, as always, please don't hesitate to call the Health Plan office if you have any questions or if you'd like to discuss your benefit options.

IAFF Local 22 Health Plan Comparison of PPO and DMO Dental Plans

	PPO		DMO
	In-network	**Out of network***	**In-network coverage only**
Annual Deductible			
Individual	None	None	None
Family	None	None	None
Preventive Services	100%	100%	100%
Basic Services	100%	100%	100%
Major Services	100%	100%	100%
Dental Implants	100%	100%	Not Covered
Annual Benefit Maximum**	$5,500		None
Office Visit Copay	N/A	N/A	N/A
Orthodontic Services	100%	100%	100%
Orthodontic Deductible	None	None	None
Orthodontic Lifetime Maximum**	$4,000	$4,000	None

*Out of Network services reimbursed at % of allowed charge. Out of network providers may bill you for the difference between amount charged and amount paid by Aetna.
**Annual and Lifetime Maximums are total of in-network and out-of-network treatment combined

www.local22healthplan.org

Important Notice from the Local 22 Philadelphia Fire Fighters Health Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Local 22 Philadelphia Fire Fighters Health Plan ("Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. The Plan has determined that the prescription drug coverage offered by the Plan through Benecard 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, your current Plan coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the Plan is creditable (i.e. as good as Medicare coverage), you can keep your existing drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Plan 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 the Plan 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 at 215-440-4418. 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 the Plan changes. You may also 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: 10/15/2019
Name of Sender: Local 22 Philadelphia Fire Fighters Health Plan
Contact: Kathleen M. Corcoran, Administrator
Address: 415 N. 5th Street
Philadelphia, PA 19123
Phone Number: 215-440-4418