

Retiree Medical Plan of the Santa Monica Police Officers' Association Reimbursement Trust Coverage Period: 01/01/2024-12/31/2024
Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Retiree & Family | Plan Type: Reimbursement



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Plan Document by calling 1-562-463-5050. This summary describes the coverage provided by the Retiree Medical Plan of the Santa Monica Police Officers' Association Reimbursement Trust ("Plan"). This summary only describes the coverage offered under the Plan and does not reflect any coverage that may be offered in connection with the Plan.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services, but see the chart on page 2 for other costs for services this Plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	The Plan has no out-of-pocket limit	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart on page 2 describes the formula under which the Plan will reimburse you and your eligible dependents for medical premiums and medical expenses that qualify as "medical care" under the Internal Revenue Code section 213(d)
Does this plan use a <u>network</u> of <u>providers</u> ?	No	This Plan treats providers the same in determining payment for the same services.
Do I need a referral to see a <u>specialist</u> ?	No	You can see the specialist you choose without permission from this Plan.
<u>Are there services this plan doesn't cover?</u>	Yes	Some of the services this Plan doesn't cover are listed on page 2. See your Plan Document and Summary Plan Description for additional information about excluded services . You can receive a copy of these documents by calling 1-562-463-5050.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a provider is in a network.

Questions: Call 1-562-463-5050.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can request a copy of the Glossary by calling 1-562-463-5050.

Covered Services	Your Cost for Covered Services Under the Plan	Limitations & Exceptions
This Plan reimburses medical premiums and medical expenses based on the total of your Part A and Part B amounts that are calculated pursuant to section 3.2(a) of the Plan Document (provided you satisfy the eligibility requirements).	\$0 (subject to monthly and annual dollar limit requirements of this Plan)	See your Plan Document and Summary Plan Description for more details. You can receive a copy of these documents by calling 1-562-463-5050.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
<ul style="list-style-type: none"> Medical premiums or medical expenses that do not qualify as "medical care" under Internal Revenue Code section 213(d). 	<ul style="list-style-type: none"> Medical premiums and medical expenses that exceed the sum of your Part A and Part B reimbursement amounts.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State law may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan Office at 1-562-463-5050. You may also contact the U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Plan Office at Retiree Medical Plan of the Santa Monica Police Officers' Association Benefits Trust, care of Benefit Programs Administration, 1200 Wilshire Boulevard, Fifth Floor, Los Angeles, California 90017, telephone number (562) 463-5050.

Also, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or www.healthhelp.ca.gov. A list of state with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This Plan or policy does provide minimum essential coverage.**

Does this Coverage meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (562) 463-5050.