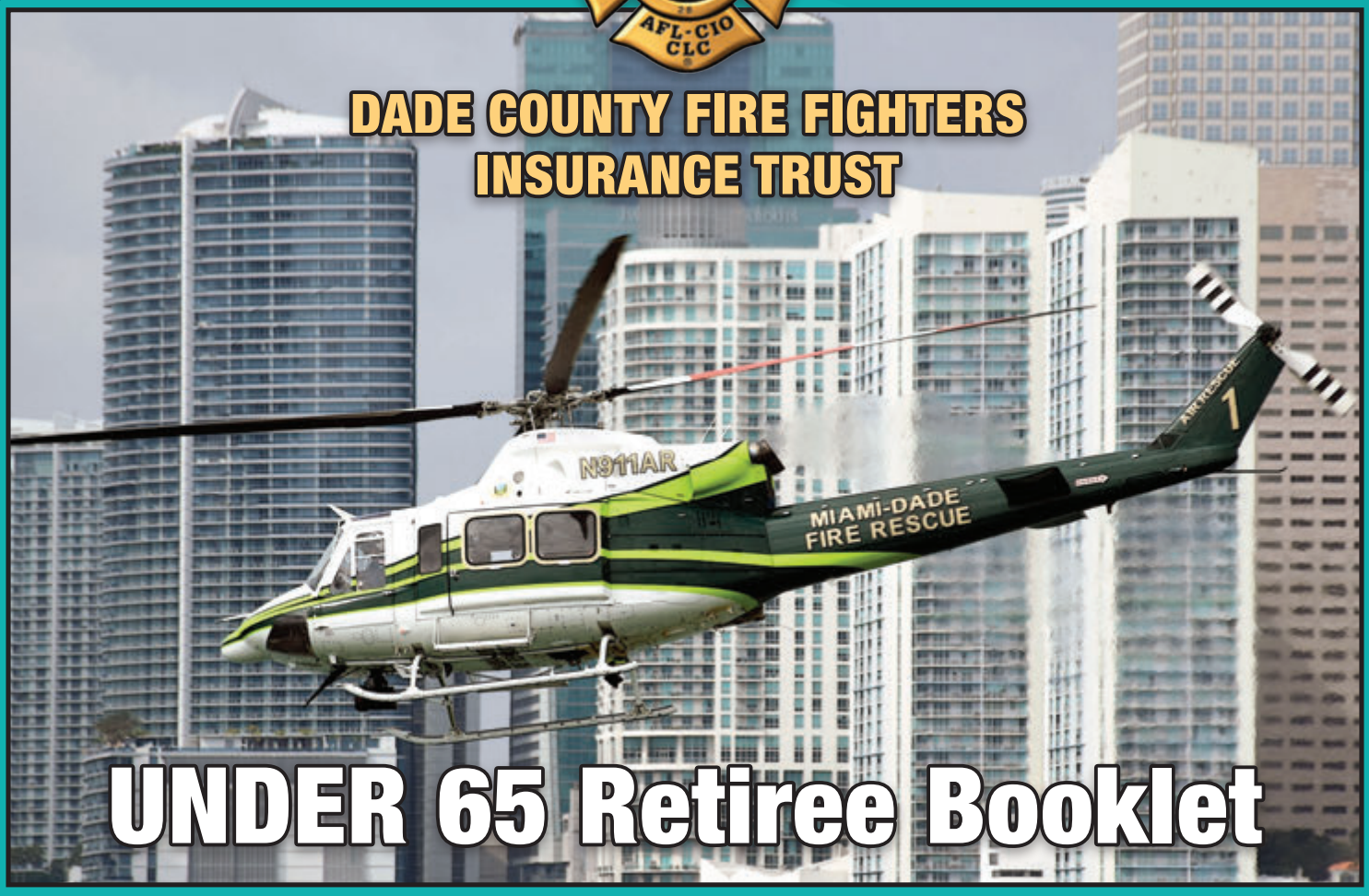
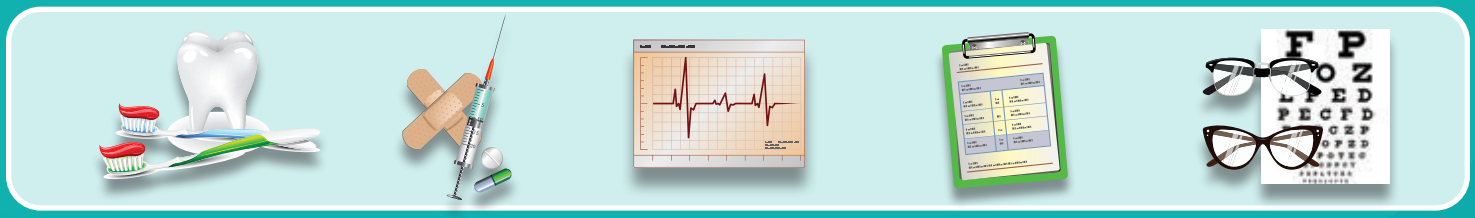
DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST



UNDER 65 Retiree Booklet



2022

OPEN ENROLLMENT

UnitedHealthcare®
A UnitedHealth Group Company
Medical, Dental & Vision Provider

EXPRESS SCRIPTS®
Pharmacy Provider

"Our Health Insurance Plan, We Can Control the Cost"

USE IT - DON'T ABUSE IT

Important Notice

If you or your spouse apply and are approved for **DISABILITY** Social Security prior to age 65, it is a requirement of the Trust that you elect and continue Medicare Part B based on Medicare disability eligibility. Medicare Part A (Hospital) is granted as part of disability Medicare. Failure to enroll in Part B when first eligible may result in significantly higher out of pocket expenses for your medical treatment as well as higher Part B premiums when you do enroll. The monthly premium for Part B may be deducted from your disability payments. The Part B premium may also be offset somewhat through a reduction in your Health Trust premium, as well as a reduction in your co-pays. If you have any questions regarding this notice please contact the Trust office. **This requirement is applicable to all retirees & dependents upon reaching Medicare eligibility of Part A & B at age 65.**

If you have a change in status (divorce, marriage, birth of a child, adoption, court order) it is your responsibility to notify and provide proper documentation to the Trust office within 30 days of the event to add or terminate a dependent. Coverage of an ex-spouse as a dependent under your Plan is considered fraud and you will be liable for all claims paid on their behalf by UnitedHealthCare.

Under the new HealthCare Reform Act your children may continue on your Group medical, prescription, dental & vision as an eligible dependent up to the age of 26. Coverage will be terminated on last day of the month he/she turns 26. In some cases, coverage may be extended from age 26 to 30 at additional monthly premium. Contact the Trust office for further details.

Please be advised that the Plan's Summary of Benefits & Coverage (**SBC**) as well as the Summary Plan Description (**SPD**) are available to you on-line at www.local1403.org or a copy can be provided upon request.

A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Disclosure Notices

Federal law requires these notices be included in employee benefit communications:

Grandfathered Plan Status - The Dade County Fire Fighters Insurance Trust Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Dade County Fire Fighters Insurance Trust Fund, 8000 NW 21 Street, Suite 222, Miami, Fl 33122 or by calling 786-437-2560.

DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST FUND

8000 NW 21st Street, Suite 222
Miami, Florida 33122-1605

Phone: (305) 593-6100

ADMINISTRATOR
UnitedHealthCare

Claims Address:
Post Office Box740800
Atlanta, GA 30374-0800

Dear Retiree Brothers and Sisters:

We are pleased to inform you there are no benefit, premium or carrier changes for 2022. **UnitedHealthcare (UHC**) is our sole provider for both medical Plans plus optional dental and vision with prescription coverage through **Express Scripts**.

You may review the 2022 benefits in the following pages of this booklet. There is no need to remit or complete paperwork if making **"No Changes"** to current coverage or dependents covered. Please make sure to mail your annual dental and vision premium unless enrolled in automatic premium deductions through your pension with the Florida Retirement System (FRS). **Open Enrollment additions, changes and terminations will be accepted up to January 15th, 2022.**

Our Plan under UHC's Choice Plus network for both the High and Low Option Plan provide you access to providers, facilities and hospitals throughout the United States. We highly recommend you register and explore the many options available on www.myuhc.com such as directory of network providers for medical plus optional dental and vision (if enrolled), hospitals, urgent cares, claims processed, request ID cards, deductibles, out of pocket and Plan coverages. Hard copies of UHC directories are no longer available through UHC or our office. **Keep in mind that address changes must be submitted to our office for processing.**

Our High Option Plan provides you the opportunity of in and out of network benefits. You may stay in network and only pay co-pays for office visits. If you wish to receive services from an out of provider, you may do so by satisfying the $500 annual deductible plus 20% co-insurance thereafter. There are certain benefits provided only through High Option under out of network such as massage therapy and acupuncture. The Low Option Plan is specifically an **IN-NETWORK** only plan. The Low Option Plan is not intended for you to meet the extremely high ($10,000) deductible nor the 50% co-insurance. If you are in the Low Option Plan you must be diligent in verifying in-network status of providers services are received from. Emergency room services regardless of in or out of network will be processed as in-network. Virtual visits are available in under both Plans, in-network only, at a $25 co-pay via www.myuhc.com. Make sure to carefully review the Plan summaries in the following pages for more details.

Prescription co-pays through our carrier**, Express Scripts**, remain the same in addition to the $25 prescription deductible per covered person that must be satisfied before co-pays apply. This means if your first prescription of the year has a $100 retail value and you normally pay $25, your first charge would be $50. If the cost of a medication is less than the tier co-pay, you will pay the lesser amount. The continuous soaring cost of prescriptions was one of the main reasons in requiring **ALL** maintenance/daily

medications be filled as a 90 day supply either in person at your nearest **Walgreens** or through USMAIL directly through Express Scripts. We encourage you to register and utilize www.express-scripts.com website to verify covered medications and applicable co-pays.

We ask that you to be mindful that covered dependent children will be automatically terminated from medical, prescription and optional dental and vision at the end of the month he/she turn 26 as per Federal law. A dependent that ceases to meet the Plan's eligibility may continue single coverage from age 26 up to age 30 for medical and prescription coverage only upon meeting criteria as per State of Florida law and payment of individual monthly premium equal to group's COBRA premium. For more details, call the Health Trust office. As per Federal mandate, all dependents terminated from Plan are offered continued benefits through COBRA.

We must emphasize the importance that **ALL** members and covered dependents enroll and maintain participation in Medicare Part A & B upon reaching eligibility due to age (65 years old) or if approved for Medicare coverage under disability Social Security. Failure to comply will result in much higher out of pocket costs. A copy of valid Medicare Part A & B card must be provided to our office in order to change eligibility with carrier and applicable monthly premium. If you have questions contact the Health Trust office.

UnitedHealthCare administers the two dental plans, PPO or HMO, for your consideration**.** UHC's affordable HMO/DMO **Florida in-network only** dental has a fee schedule without a need for referrals or assignment to a specific provider. The HMO/DMO dental is open-access which means you can receive services from any in-network provider without referrals. The UHC PPO dental is a National plan with in and out-of-network coverage. A yearly commitment and payment payable to **DCFF Insurance Trust** is required for either dental Plan.

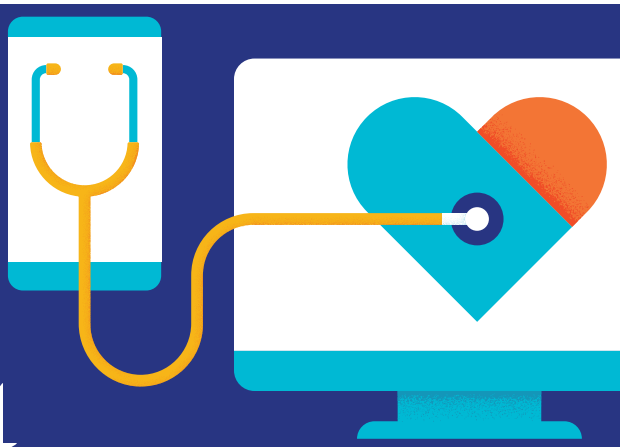
This booklet contains summaries of many of your benefits. It's easy to be confused about the terms and the best Plan for you to pick. If you are interested in making a change and have questions, we urge you to call or email our office to discuss your options. Open enrollment is the only time of the year when you are able to make changes in Plan type for medical, dental, and vision coverage. If you are adding dependents, we will need appropriate documentation such as marriage certificate, birth certificate, Social Security numbers or court orders to substantiate dependent eligibility.

You may submit forms to make changes, additions or terminations via email to gloria.munoz@local1403.org, USMAIL or in person at our office.

Sincerely,

Dade County Fire Fighters Insurance Trust

Activate your myuhc.com account



Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- **Find, price and save on care—**you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

Activation is quick

1. Go to **myuhc.com > Register Now**
2. Fill out the required fields and create your username/password
3. Enter your contact information and security questions
4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates

Get started at myuhc.com

United Healthcare

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

[1] UnitedHealthcare Internal Claims Analysis, 2019.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

UnitedHealthcare®

Benefit Summary

Dade County Fire Fighters Insurance Trust

2022 Choice Plus (High Option)
Under 65 Retiree & Dependents

We know that when people are informed about their health and health care, they can make better health care decisions. We want to help you understand more about your health care and the resources that are available.

- **myuhc.com®** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **Customer Care telephone support** – Need more help? Call customer care using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for doctor or hospital.

Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete description of Benefits and the terms under which they are provided are contained in the Summary Plan Description (SPD).**

If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the SPD shall prevail.

Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.

Deductible must be met for all services where co-insurance applies.

Prior Notification is required for in-patient hospitalization and other services noted.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$300.00 per year	$500.00 per year
Family Deductible	$600.00 per year	$1,000.00 per year
>Member Co-payments do not accumulate towards the Annual Deductible		
>All individual Deductible amounts will count towards the family Deductible, but an individual will not have to pay more than the individual Deductible amount.		
Out-of-Pocket Maximum		
Individual Maximum	$1,000.00 per year	$2,000.00 per year
Family Maximum	$2,000.00 per year	$3,000.00 per year
>The Out-of-Pocket Maximum does not include the Annual Deductible.		
Ambulance Services – Emergency Only		
Ground Transportation	10% of Eligible Expenses	Same as Network Benefit
Air Transportation	10% of Eligible Expenses	Same as Network Benefit
Behavioral Health Services		
Mental Health & Substance Abuse Services - Outpatient	$25.00 co-pay per visit (individual) $25.00 co-pay per visit (group)	20% of Eligible Expenses
Behavioral Health Services		
Mental Health & Substance Abuse – Inpatient & Intermediate Treatment	10% of Eligible Expenses	20% of Eligible Expenses
Residential Treatment	10% of Eligible Expenses	20% of Eligible Expenses
> Must receive prior authorization through United Behavioral Health/Mental Health Designee for inpatient & Residential.		

MOST COMMONLY USED BENEFITS

2022 RETIREE & DEPENDENTS
Choice Plus (High Option)

Types of Coverage	Network Benefits	Non-Network Benefits
Dental Services – Accident Only		
	10% of Eligible Expenses	Same as Network Benefit
>Prior notification is required before follow-up treatment begins regardless if Network or Non-Network provider.		
Doctor's Office Visits		
Physician Office Visit	$25.00 per visit	20% of Eligible Expenses
Specialist Physician Office Visit	$35.00 per visit	20% of Eligible Expenses
Injections in Physician's Office	$25.00 per visit	20% per injection
Durable Medical Equipment		
	10% of Eligible Expenses	20% of Eligible Expenses
> Network & Non-Network Benefits for Durable Medical Equipment are limited to $10,000 per calendar year.		
> Prior notification is required when the cost is more than $1,000		
Emergency Room		
	$225.00 per visit >Co-pay waived if admitted.	$225.00 per visit >Notification required if admitted.
Eye Examinations		
	$35.00 co-pay per visit	20% of Eligible Expenses
>Refractive eye examinations are limited to one per calendar year.		
Home Health Care		
	10% of Eligible Expenses	20% of Eligible Expenses
> Network & Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.		
Hospice Care		
	10% of Eligible Expenses	20% of Eligible Expenses
> Network & Non-Network Benefits are limited to 360 days during entire period of time a Covered Person is covered under the Plan.		
Hospital – Inpatient Stay		
	10% of Eligible Expenses	20% of Eligible Expenses
>Prior Notification is required. Deductible & Co-Insurance apply to services rendered.		
Laboratory Services - Outpatient		
LabCorp & Quest Diagnostics (in-network provider)	$0.00 per visit	20% of Eligible Expenses
>Lab services billed in-network through hospital or Outpatient Facility will be subject to deductible & 10% co-insurance		
Maternity Services		
Hospital/Delivery	10% of Eligible Expenses	20% of Eligible Expenses
>$35 for initial visit to confirm pregnancy. No Copayment applies to Physician office visits for prenatal care after the first visit. >Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.		
Orthotics/Foot		
	$100.00 co-pay	20% of Eligible Expenses
> Limited to one (1) pair every calendar year		

MOST COMMONLY USED BENEFITS

2022 RETIREE & DEPENDENTS
Choice Plus (High Option)

Types of Coverage	Network Benefits	Non-Network Benefits
Outpatient Surgery, Diagnostic & Therapeutic Services		
Outpatient Surgery & Therapeutic Services (Colonoscopy – Deductible does not apply)	10% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic - **Radiology/Xray**	10% of Eligible Expenses	20% of Eligible Expenses
Mammograms – Preventative & Diagnostic	No co-payment	N/A
Mammograms – Preventative/Deductible does not apply	N/A	No co-Insurance
Mammograms – Diagnostic/Deductible does not apply	N/A	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services (CT & PET Scans, MRI & Nuclear Medicine)	$50.00 co-payment	20% of Eligible Expenses
Professional Fees for Surgical & Medical Services		
	10% of Eligible Expenses	20% of Eligible Expenses
Prosthetic Devices		
	10% of Eligible Expenses	20% of Eligible Expenses
>Network & Non-Network Benefits for prosthetic devices are limited to $10,000 per calendar year		
Reconstructive Procedures		
	10% of Eligible Expenses	20% of Eligible Expenses
Rehabilitation Services – Outpatient Therapy		
	$35.00 co-pay per visit	20% of Eligible Expenses
>Network & Non-Network Benefits are limited as follows: 30 visits of physical therapy; 30 visits of occupational therapy; 30 visits of speech therapy; 30 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.		
> Pediatric/Child- Up to 60 visits based on approved treatment plan.		
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
	10% of Eligible Expenses	20% of Eligible Expenses
> Network & Non-Network Benefits are limited to 120 days per calendar year.		
Spinal Treatment		
Chiropractic	$35.00 co-pay per visit	20% of Eligible Expenses
> Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network & Non-Network Benefits are limited to 30 visits per calendar year.		
Accupuncture/Massage Therapy	Out of Network Only	20% of Eligible Expenses 30 visits per calendar year
Transplantation Services		
	10% of Eligible Expenses	20% of Eligible Expenses
Urgent Care Services		
	$35.00 per visit	20% of Eligible Expenses
Virtual Visits		
	$25.00 per visit	Not Covered
>Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card		

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments

Hypnotism; rolfing; aromatherapy; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of foot subluxation.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD. This exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

UnitedHealthcare®

Benefit Summary

Dade County Fire Fighters Insurance Trust

2022 Choice Plus (Low Option)
Under 65 Retiree & Dependents

We know that when people are informed about their health and health care, they can make better health care decisions. We want to help you understand more about your health care and the resources that are available.

- **myuhc.com®** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **Customer Care telephone support** – Need more help? Call customer care using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for doctor or hospital.

Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete description of Benefits and the terms under which they are provided are contained in the Summary Plan Description (SPD).**

If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the SPD shall prevail.

Network health care services under this benefit plan are covered only when provided, arranged, or authorized by a Network Physician.

Prior Notification is required for in-patient hospitalization and other services noted.

*Your Choice Plus (low option) Plan offers limited out of network coverage. Other than Emergencies, **Out of Network Benefits** will result in a large deductible and 50% co-insurance of reasonable and customary charges. This plan is in-network only based on a lower dependent bi-weekly premium, large network or providers, and co-pays only for services.*

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits
Annual Deductible	
$10,000 deductible per person per calendar year for Out of Network benefits Out of Pocket Max does not include annual deductible or co-payments	
>Family Deductible not to exceed $20,000 per calendar year	
Out-of-Pocket Maximum	
Individual Maximum	$1,500.00 per year
Family Maximum	$3,000.00 per year
> Only Hospital Inpatient Co-Pays apply toward Out-of -Pocket maximum.	
Ambulance Services – Emergency Only	
Ground Transportation	$0.00 co-pay
Air Transportation	$0.00 co-pay

MOST COMMONLY USED NETWORK BENEFITS

2022 RETIREE & DEPENDENTS
Choice Plus (Low Option)

Types of Coverage	Network Benefits
Behavioral Health Services	
Mental Health & Substance Abuse Services - Outpatient	$25.00 co-pay per visit (individual) $25.00 co-pay per visit (group)
Mental Health & Substance Abuse – Inpatient & Intermediate Treatment	$150.00 co-pay per day
Residential Treatment	$150.00 co-pay per day
> Must receive prior authorization through United Behavioral Health/Mental Health Designee for inpatient & Residential. >Maximum $600.00 per admission	
Dental Services – Accident Only	
>Prior notification is required before follow-up treatment begins.	$0.00 co-pay
Doctor's Office Visits	
Physician Office Visit	$25.00 per visit
Specialist Physician Office Visit	$35.00 per visit
Injections in Physician's Office	$25.00 per visit
Durable Medical Equipment	
> Benefits for Durable Medical Equipment are limited to $10,000 per calendar year. > Prior notification is required when the cost is more than $1,000	$0.00 co-pay
Emergency Room	
>Co-pay waived if admitted.	$225.00 co-pay per visit
Eye Examinations	
>Refractive eye examinations are limited to one every calendar year.	$35.00 co-pay per visit
Home Health Care	
> Benefits are Limited to 60 visits for skilled care services per calendar year.	$0.00 co-pay
Hospice Care	
> Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Plan.	$0.00 co-pay
Hospital – Inpatient Stay	
>Prior Notification is required. >Maximum $600.00 per admission	$150.00 co-pay per day
Laboratory Services - Outpatient	
LabCorp & Quest Diagnostics (in-network provider)	$0.00 per visit

MOST COMMONLY USED NETWORK BENEFITS

2022 RETIREE & DEPENDENTS
Choice Plus (Low Option)

Types of Coverage	Network Benefits
Maternity Services	
Hospital/Delivery	$150.00 co-pay per day
>No Copayment applies to Physician office visits for prenatal care after the first visit.	
>Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	
>Maximum $600.00 per admission	
Orthotics	
	$100.00 co-pay
> Limited to one (1) pair every calendar year	
Outpatient Surgery, Diagnostic & Therapeutic Services	
Outpatient Surgery	$125.00 co-pay
Outpatient Diagnostic - **Radiology/Xray** (including Mammograms, colonoscopy & endoscopy)	$0.00 co-pay
Outpatient Diagnostic (CT & PET Scans, MRI & Nuclear Medicine)	$50.00 co-pay
Outpatient Therapeutic Services	$0.00 co-pay
Professional Fees for Surgical & Medical Services	
	Included in Hospital Co-pay
Prosthetic Devices	
	$0.00 co-pay
>Benefits for prosthetic devices are limited to $10,000 per calendar year	
Rehabilitation Services – Outpatient Therapy	
	$35.00 co-pay per visit
>Benefits are limited as follows: 30 visits of physical therapy; 30 visits of occupational therapy; 30 visits of speech therapy; 30 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	
> Pediatric/Child- Up to 60 visits based on approved treatment plan.	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	
	$0.00 co-pay
> Benefits are limited to 120 days per calendar year.	
Spinal Treatment	
Chiropractic	$35.00 co-pay per visit
> Benefits include diagnosis and related services and are limited to one visit and treatment per day.	
> Benefits are limited to 30 visits per calendar year.	
Transplant Services	
	$0.00 co-pay
Urgent Care Services	
	$35.00 co-pay per visit
Virtual Visits	
	$25.00 per visit
>Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card	

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments
Hypnotism; rolfing; aromatherapy; and other forms of alternative treatment.

B. Comfort or Convenience
Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental
Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs
Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services
Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care
Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of foot subluxation.

G. Medical Supplies and Appliances
Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse
Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition
Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance
Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers
Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD. This exclusion does not apply to mammography testing).

L. Reproduction
Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan
Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants
Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel
Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing
Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

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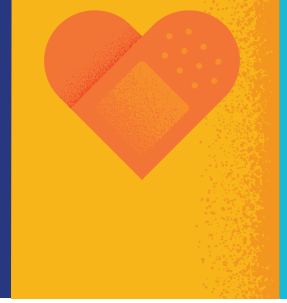
Get your flu shot — the best way to help prevent the flu

Each of us can help protect all of us.
Get a flu shot and show you care.



Take down the flu by getting your annual flu shot right away. Flu shots are:

Covered at $0 out-of-pocket

They're safely given at over 50,000 locations[1]—including network doctors, other health care professionals and the locations listed on the back.

More important this year

They're the best way to prevent the flu, according to the Centers for Disease Control and Prevention (CDC).[2]

Helping communities and health systems

They helped prevent nearly 91,000 flu-related hospitalizations in 2017–2018.[3]

Choose where to get your flu shot

Most plans cover flu shots at 100% at the following retail pharmacies and network convenience care clinics. If you're in California, however, certain convenience care clinics may not be covered at 100%. Check your plan details or call the number on your health plan ID card to be sure you're covered at the clinic you choose.

continued

United Healthcare

Retail pharmacies: Pharmacists associated with these retail pharmacies can administer flu shots. No appointments are necessary.

Albertsons® Companies including Albertsons Osco, Albertsons Sav-on, Acme Sav-on, Jewel-Osco, Safeway, Shaws Osco and Star Markets **Safeway®** including Carrs, Pavilions, Randalls, Tom Thumb and Vons **United Supermarkets®** including Albertsons Market, Amigos and Market Street	**ACME:** acmemarkets.com/pharmacy/pharmacy-services/immunizations **Albertsons:** albertsons.com/pharmacy/pharmacy-services/immunizations **Carrs:** carrsqc.com/pharmacy/pharmacy-services/immunizations **Haggen:** pharmacy.haggen.com/hgweb/#/home **Jewel Osco:** jewelosco.com/pharmacy/pharmacy-services/immunizations **Pavilions:** pavilions.com/pharmacy/pharmacy-services/immunizations **Randalls:** randalls.com/pharmacy/pharmacy-services/immunizations **Safeway:** safeway.com/pharmacy/pharmacy-services/immunizations **Shaws:** shaws.com/pharmacy/pharmacy-services/immunizations **Star Market:** starmarket.com/pharmacy/pharmacy-services/immunizations **Tom Thumb:** tomthumb.com/pharmacy/pharmacy-services/immunizations **Vons:** vons.com/pharmacy/pharmacy-services/immunizations **United:** unitedsupermarkets.com/page/pharmacy#immunizations
Costco Pharmacy	costco.com/pharmacy/adult-immunization-program
Harris Teeter®	harristeeter.com/pharmacy-services/#/app/cms
H-E-B®	heb.com/pharmacy/services/immunizations.jsp
Hy-Vee®	hy-vee.com/health/pharmacy/flu-shots
Kmart®	pharmacy.kmart.com/newrx-immunization
The Kroger Co. including Baker's, City Market, Copps, Dillons, Fred Meyer, Fry's, Gerbes, Jay C, King Soopers, Kwik Shop, Mariano's, Metro Market, Owen's, Payless, Pick 'n Save, QFC, Ralph's Grocery, Roundy's and Smith's Food & Drug Center	kroger.com/d/flu
Meijer®	meijer.com/services/pharmacy/pharmacy-services.html
Publix®	publix.com/pharmacy-wellness/pharmacy/pharmacy-services/vaccinations
Rite Aid®	riteaid.com/pharmacy/services/vaccine-central
Walgreens® including Duane Reade, Jim Meyers, Kerr Drug, May's Drug, Parkway Drug, Super D Drug, The Ryan Pharmacy and USA Drug	walgreens.com/flu
Walmart Inc. and Sam's Club®	walmart.com/cp/1228302

Network convenience care clinics: Convenience care clinics are typically located in retail stores and don't require appointments.

The Little Clinic®	thelittleclinic.com
MinuteClinic®	minuteclinic.com/services/vaccination
RediClinic®	rediclinic.com/riteaid
Walmart Care Clinic®	walmart.com/careclinic

Find a nearby location **uhc.com/flushot**

United Healthcare

[1] Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

[2] The Centers for Disease Control and Prevention, www.cdc.gov/flu/prevent/flushot.htm.

[3] The Centers for Disease Control and Prevention, cdc.gov, 2020.

Your benefit at a glance

EXPRESS SCRIPTS®

	3 Month	1 Month
Generics	$5.00	$15.00
Preferred brands	$67.50	$30.00
Nonpreferred brands (no generic)	$130.00	$55.00
Nonpreferred brands (generics available)	10% Co-pay (generic or brand)	Specialty Pharmacy by Acredo

<ANNUAL $25 PRESCRIPTION DEDUCTIBLE MUST BE MET PRIOR TO CO-PAYS TAKING EFFECT. DEDUCTIBLE APPLIES TO EACH COVERED MEMBER AND DEPENDENTS>

<Your benefit has a deductible. The deductible and out-of-pocket maximum are coordinated between home delivery and retail. The deductible is not included as part of the out-of-pocket maximum.>

You need to change how you're filling your prescriptions to avoid paying more. We can help.

Express Scripts manages the prescription plan for Dade County Fire Fighters Insurance Trust. Your plan requires that you and your covered dependents fill your long-term/daily medications as a 3-month supply instead of a 1-month supply. You have an option to fill at Walgreens or mail-order.

You could **save an average of 29%** with 3-month supplies compared to 1-month supplies from your local pharmacy[2]. A convenient 3-month supply makes it easier to stay on track with your medicine.

Choose your way to save with a 3-month supply

EXPRESS SCRIPTS®

- Delivered to your door with FREE standard shipping[3]
- Transfer prescriptions easily online, by phone or via Express Scripts® mobile app
- Auto-refills and refill reminders available
- Talk with a pharmacist by phone 24/7

OR

Walgreens

- More than 8,500 convenient locations, many open 24/7 (see back for additional information)
- Transfer your prescriptions easily in-store, by phone, online or via Walgreens mobile app
- Auto-refills and refill reminders available
- Get 300 Balance Rewards® points for filling a 3-month prescription[4]

To choose a 3-month supply and avoid paying more, log in or register at **express-scripts.com/90day**. Or if you'd like to have your prescriptions conveniently delivered to you, call 866-890-1419 and we'll contact your doctor to get your new prescription.

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1 You may be taking other medications that are not listed here. Please visit us online or call for a full list.

2 Savings based on claims from members who moved from a 1-month supply at a retail pharmacy to a 3-month supply with home delivery from the Express Scripts Pharmacy from Jan. to Dec. 2016. Members met their plan deductible. Does not include Medicare or federal government plans. Your savings may vary based on plan design.

3 Standard shipping costs are included as part of your prescription plan.

4 Points good on next purchase. Points on eligible prescriptions and other pharmacy transactions limited to 50,000 per calendar year and cannot be earned in AR, NJ, and NY or on prescriptions transferred to a Participating Store located in AL, MS, OR, TN, VA or PR. Only prescriptions picked up in store are eligible to earn points. Complete details at Walgreens.com/Balance.

Express Scripts manages your prescription benefit for <client name/your employer, plan sponsor or health plan.>

We're glad to help.

866-890-1419

<express-scripts.com/90day>

EXPRESS SCRIPTS®

Questions & Answers about your new Walgreens three-month supply network

1. What is a Walgreens three-month supply network?

It's a feature of your prescription plan managed by Express Scripts. With it, you have two ways to get up to a three-month supply of your long-term medications (those drugs you take regularly for ongoing conditions). You can conveniently fill those prescriptions either through home delivery from the Express Scripts Pharmacy℠ or from any Walgreens or Duane Reade™ pharmacy.[1]

2. How many Walgreens pharmacies are available to me?

There are more than 9,800 Walgreens pharmacies. To locate one, visit **express-scripts.com** and click "Prescriptions," then "Find a Pharmacy"; participating Walgreens pharmacies will be noted in your search results.

3. What happens if I keep filling my long-term medication like I'm doing now?

Per your plan, if you keep filling a one-month supply instead of a three-month supply, or if you're using a non-Walgreens pharmacy to fill your long-term medication, you'll pay either a higher cost or the full cost for your medication.

4. What does "full cost" mean?

"Full cost" is the actual cost of your medication. For example, the actual cost of the medication might be $75, but if you have a copayment or coinsurance, your payment might only be $20. "Full cost" means that your payment would be the entire $75.

5. What is the advantage of getting up to a three-month supply vs. a one-month supply?

By getting up to a three-month supply, you'll make fewer trips to the pharmacy, and you'll only need to make one payment every three months. Also, there's usually a savings for getting one three-month supply vs. three one-month supplies at retail.

Depending on your plan, after either the second or third time you purchase a one-month supply of a long-term drug at a non-Walgreens network pharmacy, you could pay a higher cost or the entire cost.[2] But you can avoid paying more by choosing a three-month option — either through home delivery from the Express Scripts Pharmacy℠ or from a Walgreens pharmacy. You will pay the same copayment for your three-month supply whether you fill through home delivery from the Express Scripts Pharmacy℠ or from a Walgreens pharmacy.[3] Find out more at **express-scripts.com/KyleAndNick**.

6. How do I get a three-month supply of my medication?

You can have the Express Scripts Pharmacy℠ deliver it (with FREE standard shipping) by visiting **express-scripts.com/90day**. You can also fill your prescription at a Walgreens pharmacy.

7. What is the difference between long-term and short-term drugs?

Long-term drugs, also called maintenance medications, are those you take on an ongoing basis, such as to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medications that you take for short periods of time. Under your plan, you can fill short-term prescriptions at any participating retail pharmacy in your network.

8. I already use home delivery from the Express Scripts Pharmacy℠ to get my long-term drugs. Do I need to change anything?

No. If you're using home delivery services from the Express Scripts Pharmacy℠ for your long-term drugs, you may already be saving money under your plan. Congratulations! You don't need to do a thing.

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[1] Duane Reade™ pharmacies are owned by Walgreens and are included in your plan's pharmacy network for long-term medications.

[2] The medications affected by this plan limit may change. To find out whether your medication's price is affected by these plan limits, visit express-scripts.com and select "Price a Medication" from the "Prescriptions" menu after you log in. After entering your medication, click "View coverage notes" on the results page. If you are a first-time visitor to our website, please take a moment to register and have your member ID number handy. If the cost of a medication at a retail pharmacy is lower than your plan's retail copayment or coinsurance, you will not pay more than the retail pharmacy's cash price, regardless of the number of times you purchase the prescription. In some cases, this price may be less than either your standard retail or mail copayment or coinsurance.

[3] Price may vary slightly for coinsurance plans.

Express Scripts manages your prescription plan.

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DADE COUNTY FIRE FIGHTERS INSURANCE TRUST

UnitedHealthcare

2022

RETIREE DENTAL OPTIONS PPO

SUMMARY OF BENEFITS

Annual Premium: $505 – Retiree Only $890 – Retiree+1 $1,300 - Family

	Non-Orthodontics		*Orthodontics*	
	In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual Annual Deductible	*$25*	*$50*	*$0*	*$0*
Family Annual Deductible	*$75*	*$150*	*$0*	*$0*
Maximum (combined for both In-Network and Out-of-Network services)	*$2,000 per person per calendar year*	*$2,000 per person per calendar year*	*$2,250 per person per lifetime*	*$2,250 per person per lifetime*

Annual deductible applies to preventive and diagnostic services	*No*
Annual deductible applies to orthodontic services	*No*
For new enrollees, a 12-month waiting period applies to major services & orthodontics	*No*
Orthodontic eligibility requirement	*Child/ Adult*

Covered Services	In-Network Plan Pays*	Out-of-Network Plan Pays**	Benefit Guidelines
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES			
Periodic Oral Examinations	100%	80%	Two per Calendar Year
Bitewing X-rays	100%	80%	One series of films per year.
Complete Series or Panorex X-rays	100%	80%	One time per 36 months.
Dental Prophylaxis (Cleanings)	100%	80%	Two per Calendar Year
Fluoride Treatments	100%	80%	For covered persons under the age of 16 years, 2 per Calendar Year
Sealants	100%	80%	For covered persons under the age of 16 years, once per first or second permanent molar every 5 years.
BASIC DENTAL SERVICES (Minor Restorative, Endodontics, Periodontics and Oral Surgery)			
Amalgam Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Composite Resin Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Space Maintainers	80%	80%	For covered persons under the age of 16 years, once per lifetime.
Root Canal Treatment	80%	80%	Once per site per lifetime.
Root Planing	80%	80%	Once every 24 months per quadrant.

Periodontal Surgery	80%	80%	Once every 36 months per site.
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
General Anesthesia	80%	80%	When clinically necessary.
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit.
MAJOR DENTAL SERVICES			
Crowns	50%	50%	Once every 5 years.
Fixed Bridges	50%	50%	Once every 5 years (alternate benefits for a partial denture may be applied).
Full Dentures	50%	50%	Once every 5 years; no allowance for overdentures or customized dentures.
Inlays and Onlays	50%	50%	Once every 5 years.
Partial Dentures	50%	50%	Once every 5 years; no allowance for precision or semi precision attachments.
Relining Dentures	50%	50%	Once every year after the 6 month period following initial insertion.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	50%	For repairs or adjustments done after 12 months following the initial insertion.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite including Phase I and Phase II	50%	50%	Preauthorization required.

*The in-network percentage of benefits is based on the discounted fee negotiated with the provider.

**The out-of-network percentage of benefits is based on the usual and customary rates prevailing in the geographic area in which the expenses are incurred.

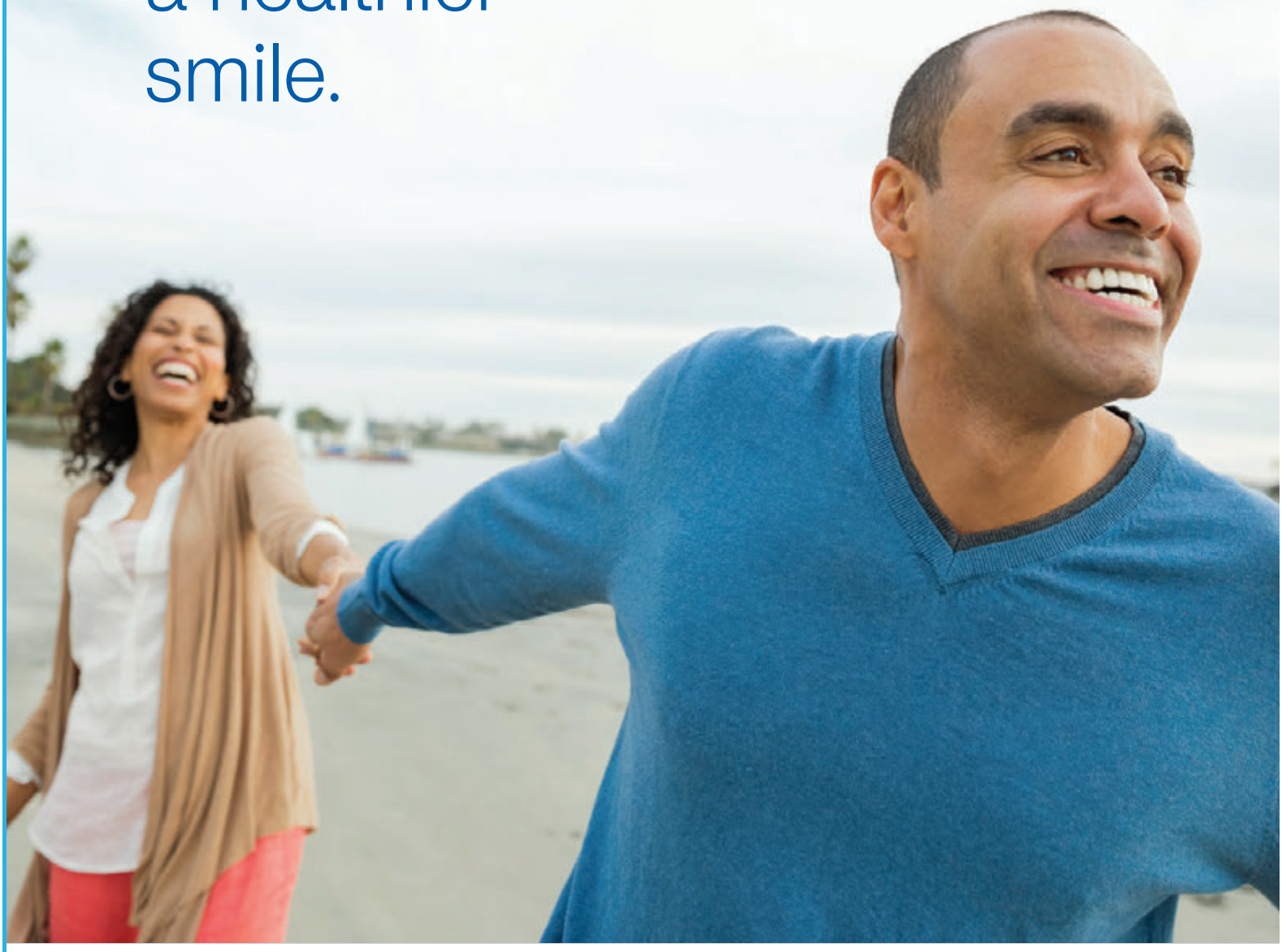
The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

You may contact United HealthCare PPO dental customer service at the number listed on your card for any questions regarding benefits, claims, in-network provider verification, or replacement identification cards. The in-network dental options PPO provider listing is availableon-line either at www.myuhcdental.com or by registering on www.myuhc.com.

UnitedHealthcare®

Dental Plans
Solstice Select Managed Care
Florida

Simpler benefits for a healthier smile.



2022
Optional HMO Dental Annual Premium

Retiree Only	$200.00
Retiree + 1 Dependent	$380.00
Retiree + Family	$525.00

FL Managed Care
Soltice S100B

Solstice

We're focused on helping you save money and keeping your teeth and gums healthier.

Giving you simplicity and lower costs.

This is a simpler, lower-cost plan that covers a range of dental services. You can see any dentist in our network you want. If you choose to see a dentist that is not in our network, you won't receive coverage so it's important to stay in the network.

See any network dentist and save.

Discounted specialist care with no referrals.

You can see any network specialist and get 25 percent off standard costs without a referral. See your dental plan documents for details.

Preventive care is covered 100% in our network.

Get coverage on hundreds of services.

No deductibles and annual maximums.

Helping you stay healthier.

Your plan may include the following wellness benefits. Please review your dental plan documents to view all the coverage details.

Oral cancer screenings.

Adults (age 18 and older) may get oral cancer screenings as part of your preventive care benefit.

There are over 49,000 new cases of oral cancer detected[1] and a little over 60% survive more than five years.[2]

Extra care during pregnancy.

You may get extra dental visits during pregnancy and the first three months after birth.[3]

Pregnant women are at higher risk of dental disease.[4]
During pregnancy, a woman is more likely to have gum disease. And gum disease is associated with pregnancy complications. Once a woman gives birth, she can pass oral bacteria on to her baby through kisses and sharing spoons. That's why it's so important to treat and detect oral diseases during pregnancy. And it's good to know that seeing a dentist when you're pregnant is safe.

How your teeth affect your health.

Gum disease is a painless disease that causes bacteria and toxins to enter your blood, which may also be connected to:[5]

- ✓ **Diabetes**
- ✓ **Heart disease**
- ✓ **Pregnancy complications**
- ✓ **Respiratory conditions**
- ✓ **Rheumatoid arthritis**

Search for local dentists.

Before you enroll, you can learn more about this plan and see if your dentist is in the network.

Visit **myuhc.com**

The network in Florida that you will want to search is called FL Managed Care – Solstice S100B.

Paying for dental care.

This plan is about being simpler. There are no deductibles and no annual maximums.

Please review your dental plan documents to view the plan's specific coverage and cost details.

1 Copayments.

Hundreds of services and procedures will be covered with a fixed copay amount. This does not usually apply to preventive care services received in the network.

2 No deductibles.

There is no minimum amount that you must pay before the plan begins to pay.

3 No annual maximums.

There is no limit to how much the plan will pay for covered services during the plan year.

Tap into your benefits on myuhc.com® and the UnitedHealthcare Health4Me® app.

SEARCH
for a network dentist or dental clinic.

ACCESS
and share your digital dental plan ID card.

ESTIMATE
dental costs.*

VIEW
claims and more.

*Not currently available on Health4Me.

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Dade County Fire Fighters Insurance Trust

D1073 - S100B

Dental Plan Schedule of Benefits

Members of the S100B Dental Plan are eligible to receive benefits immediately upon the Effective Date of coverage with:

- No Waiting Periods
- No Deductibles
- No Claim Forms to Submit

The Member copayments listed are offered by a participating in-network provider. The Member receives:

- Most diagnostic & preventive care at No Charge
- Cosmetic & orthodontia treatment covered

Members can locate a participating provider at

www.myuhc.com

Member Services Department: 800-955-4137

The patient/Member is ultimately responsible for verifications to the accuracy and appropriateness of all fees applicable to any dental benefit provided by a network provider. We urge all of our Members to verify all fees for proposed treatment via the "Schedule of Benefits" and/or with our Member Services Department prior to treatment.

The following Member copayments apply when a participating General Dentist performs services. An "*" denotes limitation on certain benefits (see "Exclusions/Limitations").

CODE	DESCRIPTION	MEMBER'S COPAY
	CLINICAL ORAL EVALUATIONS	
D0120	*Periodic oral evaluation - established patient	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0145	*Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	*Comprehensive oral evaluation - new or established patient	No Charge
D0160	*Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Charge
D9986	Missed appointment	25.00
	DIAGNOSTIC IMAGING	
D0210	*Intraoral - complete series (including bitewings)	No Charge
D0220	Intraoral - periapical first radiographic images	4.00
D0230	Intraoral - periapical each additional radiographic images	2.00
D0171	Re-evaluation - post-operative office visit	No Charge
D0180	*Comprehensive periodontal evaluation - new or established patient	No Charge
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	25.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Charge
D9440	Office visit - after regularly scheduled hours	25.00
D9450	Case presentation, detailed and extensive treatment planning	No Charge
D0365	*Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	130.00
D0366	*Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	130.00

CODE	DESCRIPTION	MEMBER'S COPAY
D0240	Intraoral - occlusal radiographic images	No Charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No Charge
D0251	*Extra-oral posterior dental radiographic image	No Charge
D0270	*Bitewing - single radiographic images	No Charge
D0272	*Bitewings - two radiographic images	No Charge
D0273	*Bitewings - three radiographic images	No Charge
D0274	*Bitewings - four radiographic images	No Charge
D0277	*Vertical bitewings - 7 to 8 radiographic images	20.00
D0310	Sialography	150.00
D0320	Temporomandibular joint arthrogram, including injection	250.00
D0321	Other temporomandibular joint radiographic images, by report	150.00
D0322	Tomographic survey	150.00
D0330	*Panoramic radiographic images	No Charge
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	75.00
D0350	2D oral/facial photographic image obtainedintra-orallyor extra-orally	20.00
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw 3d image volume	140.00
D0394	*Digital subtraction of two or more images or image volumes of the same modality	No Charge
D0395	*Fusion of two or more 3D image volumes of one or more modalities	No Charge
	TESTS AND EXAMINATIONS	
D0415	Collection of microorganisms for culture and sensitivity	No Charge
D0425	Caries susceptibility tests	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	65.00
D0460	Pulp vitality tests	No Charge
D0367	*Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	175.00
D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	130.00
D0369	*Maxillofacial MRI capture and interpretation	180.00
D0370	*Maxillofacial ultrasound capture and interpretation	160.00
D0371	*Sialoendoscopy capture and interpretation	160.00
D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	140.00
D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	130.00
D0382	*Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	130.00
D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	175.00
D0384	*Cone beam CT image capture for TMJ series including two or more exposures	130.00
D0385	*Maxillofacial mri image capture	160.00
D0386	*Maxillofacial ultrasound image capture	160.00
D0393	*Treatment simulation using procedures, by report	No Charge
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	No Charge
D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
	DENTAL PROPHYLAXIS	
D1110	*Prophylaxis - adult	No Charge
D1110	Additional prophylaxis - adult	15.00
D1120	*Prophylaxis - child	No Charge

CODE	DESCRIPTION	MEMBER'S COPAY
D0470	Diagnostic casts	No Charge
	ORAL PATHOLOGY LABORATORY	
D0472	Accession of tissue, gross examination, preparationand transmission of written report	No Charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Charge
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparationand transmission of written report	No Charge
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparationand transmission of written report	No Charge
D0502	Other oral pathology bilateral	No Charge
D1520	*Space maintainer - removable - unilateral	No Charge
D1525	*Space maintainer - removable - bilateral	No Charge
D1550	Re-cementation or re-bond space maintainer	10.00
D1555	Removal of fixed space maintainer	10.00
D1575	Distal shoe space maintainer – fixed – unilateral	No Charge
	AMALGAMS RESTORATIONS (INCLUDING POLISHING)	
D2140	Amalgam - one surface, primary or permanent	No Charge
D2150	Amalgam - two surfaces, primary or permanent	No Charge
D2160	Amalgam - three surfaces, primary or permanent	No Charge
D2161	Amalgam - four or more surfaces, primary or permanent	No Charge
	RESIN BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-based composite - one surface, anterior	No Charge
D2331	Resin-based composite - two surfaces, anterior	No Charge
D2332	Resin-based composite - three surfaces, anterior	No Charge

CODE	DESCRIPTION	MEMBER'S COPAY
D1120	Additional prophylaxis - child	15.00
	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)	
D1206	*Topical fluoride varnish	5.00
D1208	*Topical application of fluoride - excluding varnis	No Charge
D9910	*Application of desensitizing medicament	20.00
	OTHER PREVENTIVE SERVICES	
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	*Sealant - per tooth	No Charge
D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1353	Sealant repair - per tooth	No Charge
D1354	*Interim caries arresting medicament application	20.00
	SPACE MAINTAINERS (PASSIVE APPLIANCES)	
D1510	*Space maintainer - fixed - unilateral	No Charge
D1515	*Space maintainer - fixed -	No Charge
	INLAY/ONLAY RESTORATIONS	
D2510	Inlay - metallic - one surface	80.00
D2520	Inlay - metallic - two surfaces	90.00
D2530	Inlay - metallic - three or more surfaces	115.00
D2542	Onlay - metallic-two surfaces	250.00
D2543	Onlay - metallic-three surfaces	270.00
D2544	Onlay - metallic-four or more surfaces	290.00
D2610	Inlay - porcelain/ceramic - one surface	225.00*
D2620	Inlay - porcelain/ceramic - two surfaces	250.00*
D2630	Inlay - porcelain/ceramic - three or more surfaces	275.00*
D2642	Onlay - porcelain/ceramic - two surfaces	310.00*
D2643	Onlay - porcelain/ceramic - three surfaces	340.00*
D2644	Onlay - porcelain/ceramic - four or more surfaces	350.00*
D2650	Inlay - resin-based composite - one surface	180.00
D2651	Inlay - resin-based composite - two surfaces	200.00
D2652	Inlay - resin-based composite - three or more surfaces	250.00
D2662	Onlay - resin-based composite - two surfaces	225.00

CODE	DESCRIPTION	MEMBER'S COPAY
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Charge
D2390	Resin-based composite crown, anterior	No Charge
D2391	Resin-based composite - one surface, posterior	No Charge
D2392	Resin-based composite - two surfaces, posterior	No Charge
D2393	Resin-based composite - three surfaces, posterior	No Charge
D2394	Resin-based composite - four or more surfaces, posterior	No Charge
	GOLD FOIL RESOTRATIONS	
D2410	Gold foil - one surface	65.00
D2420	Gold foil - two surfaces	90.00
D2430	Gold foil - three surfaces	120.00
D2750	*Crown - porcelain fused to high noble metal	195.00*
D2751	*Crown - porcelain fused to predominantly base metal	195.00*
D2752	*Crown - porcelain fused to noble metal	195.00*
D2780	*Crown - 3/4 cast high noble metal	195.00*
D2781	*Crown - 3/4 cast predominantly base metal	195.00*
D2782	*Crown - 3/4 cast noble metal	195.00*
D2783	*Crown - 3/4 porcelain/ceramic	195.00*
D2790	*Crown - full cast high noble metal	195.00*
D2791	*Crown - full cast predominantly base metal	195.00*
D2792	*Crown - full cast noble metal	195.00*
D2794	*Crown - titanium	195.00*
D2799	*Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
	OTHER RESTORATIVE SERVICES	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	10.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	10.00
D2920	Re-cement or re-bond crown	10.00
D2921	Reattachment of tooth fragment, incisal edge or cusp	10.00
D2929	*Prefabricated porcelain/ceramic crown - primary tooth	34.00*
D2930	Prefabricated stainless steel crown - primary tooth	35.00
D2931	Prefabricated stainless steel crown - permanent tooth	40.00
D2663	Onlay - resin-based composite - three surfaces	245.00
D2664	Onlay - resin-based composite - four or more surfaces	275.00
	CROWNS - SINGLE RESTORATIONS ONLY	
D2710	*Crown - resin-based composite (indirect)	195.00
D2712	*Crown - ¾ resin-based composite (indirect)	195.00
D2720	*Crown- resin with high noble metal	195.00*
D2721	*Crown - resin with predominantly base metal	195.00*
D2722	*Crown - resin with noble metal	195.00*
D2740	*Crown - porcelain/ceramic substrate per unit applies dentition	195.00*
D2949	Restorative foundation for an indirect restoration	20.00
D2950	Core buildup, including any pins when required	35.00
D2951	Pin retention - per tooth, in addition to restoration	10.00
D2952	Post and core in addition to crown, indirectly fabricated	80.00
D2953	Each additional indirectly fabricated post - same tooth	95.00
D2954	Prefabricated post and core in addition to crown	75.00
D2955	Post removal	20.00
D2957	Each additional prefabricated post - same tooth	30.00
D2960	Labial veneer (resin laminate) - chairside	200.00
D2961	Labial veneer (resin laminate) - laboratory	225.00*
D2962	Labial veneer (porcelain laminate) - laboratory	350.00*
D2971	Additional procedures to construct new crown under existing partial denture framework	45.00
D2975	Coping	95.00
D2980	Crown repair necessitated by restorative material failure	95.00
D2981	Inlay repair necessitated by restorative material failure	95.00
D2982	Onlay repair necessitated by restorative material failure	95.00
D2983	Veneer repair necessitated by restorative material failure	95.00
D2990	Resin infiltration of incipient smooth surface lesions	29.00
	PULP CAPPING	
D3110	Pulp cap - direct (excluding final restoration)	10.00
D3120	Pulp cap - indirect (excluding final restoration)	10.00

CODE	DESCRIPTION	MEMBER'S COPAY
D2932	Prefabricated resin crown	90.00
D2933	Prefabricated stainless steel crown with resin window	135.00
D2940	Protective restoration	5.00
D2941	Interim therapeutic restoration - primary (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	5.00
D3221	Pulpal debridement, primary and permanent teeth	95.00
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	75.00
	ENDODONTIC THERAPY ON PRIMARY TEETH	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	40.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	40.00
	ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES & FOLLOW-UP CARE)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	100.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	175.00
D3330	Endodontic therapy, molar (excluding final restoration)	210.00
D3331	Treatment of root canal obstruction; non-surgical access	85.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75.00
D3333	Internal root repair of perforation defects	125.00
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	250.00
D3347	Retreatment of previous root canal therapy - bicuspid	285.00
D3348	Retreatment of previous root canal therapy - molar	350.00
	OTHER ENDODONTIC PROCEDURES	
D3910	Surgical procedure for isolation of tooth with rubber dam	95.00
	PULPOTOMY	
D3220	Therapeutic pulpotomy	20.00
	APEXIFICATION/RECALCIFICATION PROCEDURES	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	90.00
D3352	Apexification/recalcification - interim medication replacement	90.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	90.00
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy - anterior	96.00
D3421	Apicoectomy - bicuspid (first root)	300.00
D3425	Apicoectomy - molar (first root)	150.00
D3426	Apicoectomy (each additional root)	75.00
D3427	Periradicular surgery without apicoectomy	96.00
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	32.00
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	25.00
D3430	Retrograde filling - per root	55.00
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	150.00
D3432	Guided tissue regeneration in conjunction with per site, in conjunction with periradicular surgery	150.00
D3450	Root amputation - per root	85.00
D3460	Endodontic endosseous implant	535.00
D3470	Intentional reimplantation (including necessary splinting)	175.00
	tooth bounded spaces per quadrant	
D4263	Bone replacement graft – retained natural tooth – first	450.00

CODE	DESCRIPTION	MEMBER'S COPAY
D3920	Hemisection (including any root removal), not including root canal therapy	80.00
D3950	Canal preparation and fitting of preformed dowel or post	75.00
	SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	175.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	66.00
D4212	Gingivectormy or gingivoplasty to allow access for restorative procedure, per tooth	40.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	163.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	150.00
D4245	Apically positioned flap	150.00
D4249	Clinical crown lengthening - hard tissue	175.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	375.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or edentulous tooth position in graft	325.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	75.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	250.00
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	325.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration	325.00
D4266	Guided tissue regeneration - resorbable barrier, per site	325.00
D4267	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	325.00
D4268	Surgical revision procedure, per tooth	No Charge
D4270	Pedicle soft tissue graft procedure	235.00
D4273	Autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	280.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	100.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	502.00
D4276	Combined connective tissue and double pedicle graft, per tooth	65.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or	215.00
	OTHER PERIODONTAL SERVICES	
D4910	*Periodontal maintenance	40.00
D4910	Additional Periodontal maintenance procedures	100.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	20.00
D4921	Gingival irrigation - per quadrant	15.00
D4999	Unspecified periodontal procedure, by report	No Charge
	COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5110	*Complete denture - maxillary	210.00*
D5120	*Complete denture -	210.00*

CODE	DESCRIPTION	MEMBER'S COPAY
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	392.00
	NON SURGICAL PERIODONTAL SERVICE	
D4320	Provisional splinting - intracoronal	100.00
D4321	Provisional splinting - extracoronal	100.00
D4341	*Periodontal scaling and root planing - four or more teeth per quadrant	36.00†
D4342	*Periodontal scaling and root planing - one to three teeth per quadrant	29.00†
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	35.00
D4355	*Full mouth debridement to enable comprehensive evaluation and diagnosis	35.00†
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	45.00†
	(including any conventional clasps, rests and teeth)	
D5223	*Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	240.00*
D5224	*Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	240.00*
D5225	*Maxillary partial denture - flexible base (including any clasps, rests and teeth)	220.00*
D5226	*Mandibular partial denture - flexible base (including any clasps, rests and teeth)	220.00*
D5281	*Removable unilateral partial denture - one piece cast metal (including clasps and teeth	235.00*
	ADJUSTMENTS TO DENTURES	
D5410	Adjust complete denture - maxillary	8.00
	mandibular	
D5130	*Immediate denture – maxillary	210.00*
D5140	*Immediate denture – mandibular	210.00*
	PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5211	*Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	210.00*
D5212	*Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	210.00*
D5213	*Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	220.00*
D5214	*Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	220.00*
D5221	*Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	230.00*
D5222	*Immediate mandibular partial denture – resin base	230.00*
D5622	*Repair cast partial framework, maxillary	30.00*
D5630	*Repair or replace broken clasp – per tooth	15.00*
D5640	*Replace broken teeth - per tooth	10.00*
D5650	*Add tooth to existing partial denture	30.00*
D5711	*Rebase complete mandibular denture	75.00*
D5720	*Rebase maxillary partial denture	75.00*
D5721	*Rebase mandibular partial denture	75.00*
D5730	*Reline complete maxillary denture (chairside)	45.00*
D5731	*Reline complete mandibular denture (chairside)	45.00*
D5740	*Reline maxillary partial denture (chairside)	45.00*
D5741	*Reline mandibular partial denture (chairside)	45.00*
D5750	*Reline complete maxillary denture (laboratory)	35.00*
D5751	*Reline complete mandibular denture (laboratory)	35.00*
D5760	*Reline maxillary partial	35.00*

CODE	DESCRIPTION	MEMBER'S COPAY
D5411	Adjust complete denture - mandibular	8.00
D5421	Adjust partial denture - maxillary	10.00
D5422	Adjust partial denture - mandibular	10.00
	REPAIRS TO COMPLETE DENTURES	
D5511	*Repair broken complete denture base, mandibular	15.00*
D5512	*Repair broken complete denture base, maxillary	15.00*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	10.00*
	REPAIRS TO PARTIAL DENTURES	
D5611	*Repair resin partial denture base, mandibular	15.00*
D5612	*Repair resin partial denture base, maxillary	15.00*
D5621	*Repair cast partial framework, mandibular	30.00*
D5899	Unspecified removable prosthodontic procedure, by report	No Charge
	NON-CLINICAL PROCEDURES	
D5982	Surgical stent	100.00*
D5987	Commissure splint	100.00*
D5988	Surgical splint	100.00*
	PRE-SURGICAL SERVICES	
D6190	Radiographic/surgical implant index, by report	235.00
	SURGICAL SERVICES	
D6010	*Surgical placement of implant body	950.00
D6012	*Surgical placement of interim body for transitional prosthesis	950.00
D6100	Implant removal, by report	700.00
	IMPLANT SUPPORTED PROSTHETICS	
D6056	*Prefabricated Abutment	385.00
D6057	*Custom Abutment	495.00
D6058	*Abutment supported porcelain/ceramic crown	695.00
D6059	*Abutment supported porcelain fused to metal crown (high noble metal)	695.00
D6060	*Abutment supported porcelain fused to metal crown (predominantly base metal)	695.00
D6061	*Abutment supported porcelain fused to metal crown (noble metal)	695.00
D6062	*Abutment supported cast metal crown (high noble metal)	695.00
D6063	*Abutment supported cast metal crown (predominantly base metal)	695.00

CODE	DESCRIPTION	MEMBER'S COPAY
	denture (laboratory)	
D5761	*Reline mandibular partial denture (laboratory)	35.00*
	INTERIM PROSTHESIS	
D5810	*Interim Complete denture (maxillary)	220.00*
D5811	*Interim complete denture (mandibular)	220.00*
D5820	*Interim partial denture (maxillary)	220.00*
D5821	*Interim partial denture (mandibular)	220.00*
	OTHER REMOVABLE PROSTHESIS	
D5850	Tissue conditioning, maxillary	25.00
D5851	Tissue conditioning, mandibular	25.00
D5862	Precision attachment, by report	150.00
	alloy, high noble metal)	
D6068	*Abutment supported retainer for porcelain/ceramic FPD	695.00
D6069	*Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	695.00
D6070	*Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	695.00
D6071	*Abutment supported retainer for porcelain fused to metal FPD (noble metal)	695.00
D6072	*Abutment supported retainer for cast metal FPD (high noble metal)	695.00
D6073	*Abutment supported retainer for cast metal FPD (predominantly base metal)	695.00
D6074	*Abutment supported retainer for cast metal FPD (noble metal)	695.00
D6075	*Implant supported retainer for ceramic FPD	695.00
D6076	*Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	695.00
D6077	*Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	695.00
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of	36.00†

CODE	DESCRIPTION	MEMBER'S COPAY
D6064	*Abutment supported cast metal crown (noble metal)	695.00
D6065	*Implant supported porcelain/ceramic crown	695.00
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	695.00
D6067	*Implant supported metal crown (titanium, titanium	695.00
	supported removable denture for edentulous arch – mandibular	
D6112	*Implant /abutment supported removable denture for partially edentulous arch– maxillary	940.00
D6113	*Implant /abutment supported removable denture for partially edentulous arch– mandibular	940.00
D6114	*Implant /abutment supported fixed denture for edentulous arch– maxillary	3800.00
D6115	*Implant /abutment supported fixed denture for edentulous arch– mandibular	3800.00
D6116	*Implant /abutment supported fixed denture for partially edentulous arch– maxillary	2200.00
D6117	*Implant /abutment supported fixed denture for partially edentulous arch– mandibular	2200.00
D6118	*Implant/abutment supported interim fixed denture for edentulous arch– mandibular	1760.00
D6119	*Implant/abutment supported interim fixed denture for edentulous arch– maxillary	1760.00
	OTHER IMPLANT SERVICES	
D6080	Implant maintenance procedures, including removal	180.00
D6090	Repair implant suported prosthesis, by report	400.00
D6092	Recement implant/abutment crown	45.00
D6093	Recement implant/abutment supported fixed partial denture	65.00
D6095	Repair implant abutment, by report	220.00
	FIXED PARTIAL DENTURE PONTICS	

CODE	DESCRIPTION	MEMBER'S COPAY
	the implant surfaces, without flap entry and closure	
D6085	Provisional implant crown	125.00
D6094	*Abutment supported crown - (titanium)	695.00
D6096	Remove broken implant retaining screw	500.00
D6110	*Implant /abutment supported removable denture for edentulous arch – maxillary	1200.00
D6205	*Pontic - indirect resin based	695.00
D6210	*Pontic - cast high noble	195.00*
D6211	*Pontic - cast predominantly base metal	195.00*
D6241	*Pontic - porcelain fused to predominantly base metal	195.00*
D6242	*Pontic - porcelain fused to noble metal	195.00*
D6245	*Pontic - porcelain/ceramic	
D6250	*Pontic - resin with high noble metal	195.00*
D6251	*Pontic - resin with predominantly base metal	195.00*
D6252	*Pontic - resin with noble metal	195.00*
D6253	*Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No Charge
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS	
D6545	Retainer - cast metal for resin bonded fixed prosthesis	180.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	195.00*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	195.00*
D6602	Retainer inlay - cast high noble metal, two surfaces	195.00*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	195.00*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	195.00*
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	195.00*
D6606	Retainer inlay - cast noble metal, two surfaces	195.00*
D6607	Retainer inlay - cast noble metal, three or more surfaces	195.00*
D6608	Retainer onlay -	195.00*

CODE	DESCRIPTION	MEMBER'S COPAY
	porcelain/ceramic, two surfaces	
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	195.00*
D6610	Retainer onlay - cast high noble metal, two surfaces	195.00*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	195.00*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	195.00*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	195.00*
D6614	Retainer onlay - cast noble metal, two surfaces	195.00*
D6615	Retainer onlay - cast noble metal, three or more surfaces	195.00*
D6624	Retainer inlay - titanium	195.00*
D6634	Retainer onlay - titanium	195.00*
	FIXED PARTIAL DENTURE RETAINERS - CROWNS	
D6710	*Retainer crown - indirect resin based composite	195.00*
D6720	*Retainer crown - resin with high noble metal	195.00*
D6721	*Retainer crown - resin with predominantly base metal	195.00*
D6722	*Retainer crown - resin with noble metal	195.00*
D6740	*Retainer crown - porcelain/ceramic	195.00*
D6750	*Retainer crown - porcelain fused to high noble metal	195.00*
D6751	*Retainer crown - porcelain fused to predominantly base metal	195.00*
D6752	*Retainer crown - porcelain fused to noble metal	195.00*
D6780	*Retainer crown - 3/4 cast high noble metal	195.00*
D6781	*Retainer crown - 3/4 cast predominantly base metal	195.00*
D6782	*Retainer crown - 3/4 cast noble metal	195.00*
D6783	*Retainer crown - 3/4	195.00*
D7251	Cronectomy - intentional partial tooth removal	270.00
D7260	Oroantral fistula closure	160.00
D7261	Primary closure of a sinus perforation	275.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	100.00
	porcelain/ceramic	
D6790	*Retainer crown - full cast high noble metal	195.00*
D6791	*Retainer crown - full cast predominantly base metal	195.00*
D6792	*Retainer crown - full cast noble metal	195.00*
D6793	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
D6794	*Retainer crown - titanium	195.00*
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Re-cement or re-bond fixed partial denture	10.00
D6940	Stress breaker	125.00
D6950	Precision attachment	125.00
D6980	Fixed partial denture repair necessitated by restorative material failure	80.00
	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)	
D7111	Extraction, coronal remnants - deciduous tooth	45.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10.00
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	25.00
	OTHER SURGICAL PROCEDURES	
D7220	Removal of impacted tooth - soft tissue	40.00
D7230	Removal of impacted tooth - partially bony	55.00
D7240	Removal of impacted tooth - completely bony	63.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	100.00
D7250	Removal of residual tooth roots (cutting procedure) spaces, per quadrant	25.00
	VESTIBULOPLASTY	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	370.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and	990.00

CODE	DESCRIPTION	MEMBER'S COPAY
D7280	Exposure of an unerupted tooth	125.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00
D7283	Placement of device to facilitate eruption of impacted tooth	80.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	115.00
D7286	Incisional biopsy of oral tissue-soft	60.00
D7287	Exfoliative cytological sample collection	50.00
D7288	Brush biopsy - transepithelial sample collection	25.00
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	30.00
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE	
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	20.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	20.00
D7320	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant	50.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth	50.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
	REPAIR OF TRAUMATIC WOUNDS	
D7910	Suture of recent small wounds up to 5 cm	35.00
	OTHER REPAIR PROCEDURES	
D7921	Collection and application of autologous blood concentrate product	125.00
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogeneous or nonautogeneous, by report	350.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	800.00
D7952	Sinus augmentation via a vertical approach	350.00
D7953	Bone replacement graft for ridge preservation – per site	100.00

CODE	DESCRIPTION	MEMBER'S COPAY
	hyperplastic tissue)	
	SURGICAL EXCISION OF SOFT TISSUE LESIOINS	
D7410	Excision of benign lesion up to 1.25 cm	25.00
D7411	Excision of benign lesion greater than 1.25 cm	50.00
D7412	Excision of benign lesion, complicated	55.00
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	65.00
	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	95.00
D7472	Removal of torus palatinus	95.00
D7473	Removal of torus mandibularis	95.00
D7485	Reduction of osseous tuberosity	95.00
	SURGICAL INCISION	
D7510	Incision and drainage of abscess - intraoral soft tissue	20.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
D7520	Incision and drainage of abscess - extraoral soft tissue	20.00
	dentition	
	COMPREHENSIVE ORTHODONTIC TREATMENT	
D8070	Comprehensive orthodontic treatment of the transitional dentition	1800.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1850.00
D8090	Comprehensive orthodontic treatment of the adult dentition	1950.00
	MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D8210	Removable appliance therapy	103.00
D8220	Fixed appliance therapy	103.00
	OTHER ORTHODONTIC SERVICES	
D8660	Pre-orthodontic treatment examination to monitor growth and development	35.00
D8670	Periodic orthodontic treatment visit	No Charge
D8680	Orthodontic retention (removal of appliances,	300.00

CODE	DESCRIPTION	MEMBER'S COPAY
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	50.00
D7963	Frenuloplasty	50.00
D7970	Excision of hyperplastic tissue - per arch	140.00
D7971	Excision of Pericoronal Gingiva	102.00
D7972	Surgical reduction of fibrous tuberosity	125.00
	LIMITED ORTHODONTIC TREATMENT	
D8010	Limited orthodontic treatment of the primary dentition	1000.00
D8020	Limited orthodontic treatment of the transitional dentition	1000.00
D8030	Limited orthodontic treatment of the adolescent dentition	1000.00
D8040	Limited orthodontic treatment of the adult anesthesia	1350.00
D9215	Local anesthesia	No Charge
D9222	Deep sedation/general anesthesia – first 15 minutes	50.00
D9223	Deep sedation/general anesthesia – each 15 minute increment	50.00
D9239	Intravenous moderate (conscious) sedation/ analgesia- first 15 minutes	65.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	65.00
D9248	Non-intravenous conscious sedation	15.00
	DRUGS	
D9610	Therapeutic parenteral drug, single administration	15.00
D9630	Drugs or medicaments dispensed in the office for home use	15.00
	MISCELLANEOUS SERVICES	
D9910	*Application of desensitizing medicament	20.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No Charge
D9932	Cleaning and inspection of removable complete denture,	No Charge

CODE	DESCRIPTION	MEMBER'S COPAY
	construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	No Charge
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	No Charge
D8999	Unspecified orthodontic procedure, by report	250.00
	UNCLASSIFIED TREATMENT	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Charge
D9120	Fixed partial denture sectioning	No Charge
	ANESTHESIA	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	No Charge
D9211	Regional block anesthesia	No Charge
D9212	Trigeminal division block	No Charge
	removable partial denture, maxillary	
D9935	Cleaning and inspection of removable partial denture, mandibular	No Charge
D9940	*Occlusal guard, by report	250.00
D9942	Repair and/or reline of Occlusal guard	40.00
D9943	Occlusal guard adjustment	25.00
D9950	Occlusion analysis - mounted case	75.00
D9951	Occlusal adjustment - limited	25.00
D9952	Occlusal adjustment - complete	75.00
D9973	External bleaching - per tooth	30.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	240.00
D9991	Dental case management – addressing appointment compliance barriers	No Charge
D9992	Dental case management – care coordination	No Charge
D9993	Dental case management – motivational interviewing	No Charge
D9994	Dental case management – patient education to improve oral health literacy	No Charge

SPECIALTY SERVICES

1. This Member Schedule of Benefits applies when listed dental services are performed by a participating General Dentist, unless otherwise authorized by Solstice.
2. Procedures not listed on the Schedule of Benefits that are performed by a participating General Dentist will be charged at the participating General Dentist's usual and customary fee less 25%.
3. The Network General Dentist you select may not perform all procedures listed. The Co-payments shown apply to Network General Dentists.
4. Should the services of a Network Specialty Dentist (NSD) (Oral Surgeon, Endodontist, Periodontist, or Pediatric Dentist) be necessary, you may receive this care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or (2) You may obtain prior written authorization from Solstice and receive specialty treatment by an approved a NSD at the listed Co-payments. Please refer to the Specialty Care Referral Policy in your Member handbook.
5. Should the services of an Orthodontist be necessary, you may receive care in either of two ways: (1) You may go directly to a NSD with no referral and receive a 25% reduction off the provider's Usual and Customary Fee; or (2) You may contact Member Services to locate your nearest participating Orthodontist who will perform covered services at the listed member Co-payment.
6. Members seeking implant treatment should refer to their participating implantologist, a select Network of Participating Providers. Not all providers perform the implant procedures at the Co-payment listed on the Schedule of Benefits. Please refer to the provider listing at www.myuhc.com under "Locate A Provider."

EXCLUSIONS

1. Services performed by a dentist or dental specialist, not contracted with Solstice without prior approval.
2. Any dental services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the Member's dental health or experimental in nature, as determined by the participating Solstice dentist.
3. Orthographic surgery or procedures and appliances for the treatment of myofunctional, myoskeletal or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
4. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions, or medications.
5. Treatment of malignancies, cysts, or neoplasms, without proof of medical necessity and prior Solstice approval.
6. Dental procedures initiated prior to the Member's eligibility under this benefit plan or started after the Member's termination from the plan.
7. Any dental procedure or treatment unable to be performed in the dental office due to the general health or physical limitations of the Member, including but not limited to, physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

LIMITATIONS

1. Any oral evaluation (excluding problem) is limited to One (1) time per consecutive six (6) months; Comprehensive exams can only be covered one (1) time per 36 months, if and only if patient is considered to be new or an established patient. All subsequent oral evaluations will be at a 25% reduction off the dentist's usual and customary fee without a frequency limitation
2. All bitewing X-rays are limited to one set in any twelve (12) consecutive month period.
3. The dental prophylaxis or periodontal maintenance procedure is limited to one (1) time in any consecutive six (6) month period. Any additional procedures will follow D1110 and D4910 Member copayments as listed in the Schedule of Benefits.
4. Fluoride treatment is limited to one (1) in any twelve (12) consecutive month period.
5. Sealants (D1351 or D1352) are limited to one (1) time per tooth in any three (3) consecutive year period. This is only allowed for unrestored permanent molar teeth for children under the age of 16.
6. Space maintainers and all adjustments are limited to children under the age of 16.
7. Harmful habit appliances are limited to one (1) time per person under the age of 16.
8. General anesthesia or IV sedation is available when listed on the Schedule of Benefits, medically necessary, and previously approved by Solstice.
9. New dentures include one (1) reline within the first six (6) months
10. Replacement of crowns, implants, and fixed bridges or dentures is limited to one (1) time every consecutive five (5) years.

11. When crown, implant and/or bridgework exceed six (6) consecutive units, there will be an additional charge of $30.00 per unit.
12. "Copayments marked by '*' do not include the cost of material and laboratory fees. Additional cost to patient is as follows:
    - High noble metal (precious) up to $145.00
    - Titanium metal up to $120 (covered with proof of allergy to other metals)
    - Noble metal (semi-precious) up to $120.00
    - Predominantly base metal (non-precious) up to $55.00
    - Crown laboratory fees up to $155.00
    - Laboratory fees on dentures up to $225.00
    - Porcelain laboratory fees for D2610-D2644, D2929, D2961, D2962, D6600, D6601, D6608, and D6609 up to $65.00
    - Denture repair laboratory fees up to $50.00
    - All ceramic and/or porcelain crown material fees up to $155.00"
13. Copayments marked by "†" are not eligible at a specialist.
14. Either D0210, D0251, or D0330 are reimbursable one (1) time every five (5) consecutive years.
15. Copies of X-rays can be obtained for $2 per periapical image up to a maximum of $30. Panoramic X-ray can be obtained for a $15 fee.
16. D0274, D0277 or D0210 are payable only when other inclusive image has not been taken (paid) within the last six (6) months.
17. All denture adjustment fees are for dentures which were not fabricated at the present office; All denture adjustment for new dentures made within 12 months are at no fee to the member.
18. Emergency treatment is available for palliative treatment for the abatement of pain up to $100.00 per occurrence.
19. Surgical removal of wisdom tooth covered when pathology (disease) exists. Surgical removal of wisdom teeth/3rd molar when pathology does not exist will be covered at 25% off of the general dentists or specialists usual and customary fees. Orthodontic related surgeries (except D7280) needed to relieve crowding or to facilitate eruption are available at a 25% reduction off of the doctor's usual and customary fees.
20. Member may choose Invisalign in place of traditional Orthodontic treatment, and would pay the sum of the listed member Ortho co-pay plus the difference in cost for the enhanced treatment.
21. Occlusal Guard(s) is limited to one (1) time in any consecutive thirty-six (36) months for the purposes of habitual grinding/Bruxism.
22. D0364-D0395 is limited to one (1) time per sixty (60) months, covered only in a dental setting and not in a radiographic imaging center.

Welcome
to your vision plan.

Get the most out of your benefits.

2022
Optional Vision Annual Premium

Retiree Only	$ 65.00
Retiree + 1 Dependent	$ 128.00
Retiree + 2 or more Dependents	$ 212.00

UnitedHealthcare®

Thank you for choosing a vision plan from UnitedHealthcare. We're here to help make your health care experience easier.

This guide will help you understand:

- What your vision plan covers.
- How to use your plan.
- Ways to save money.

Need help?

Visit myuhcvision.com.

Log in to your member website for 24/7 access to personal details about your vision plan.

Have a UnitedHealthcare health plan?

Access both your vision and health plan benefits on **myuhc.com®**. You can also search providers and access your Vision ID Card on your mobile device with the **UnitedHealthcare Health4Me® app**.

Call toll-free.
1-800-638-3120, TTY 711.

If you don't have computer access, need language assistance or can't find answers, call us Monday through Friday, 7 a.m. to 10 p.m. CT or Saturday 8 a.m. to 5:30 p.m. CT.

Find out what your vision plan covers.

Eye exam.

Your plan includes a fully covered exam. A copay may apply.

Your plan uses Spectera Eyecare Networks, a national network of eye doctors, which includes optometrists and ophthalmologists. They are located at both private practice and retail settings. Network eye doctors can help save you money.

Frame allowance.[1]

When you use a network provider, you have an allowance you can use to help buy any frame your eye doctor offers.

Contact lens benefit.[1]

You get contact lenses, a fitting and up to two follow-up visits. Choose from popular brands, including some that are fully covered.

Lens options.[1]

Popular lens options are available to you at price-protected amounts. Plus, standard scratch coating and polycarbonate lenses for dependent children are available at no cost.

Additional pairs of glasses.

Certain providers will offer a 20% discount on additional pairs of eyeglasses, including prescription sunglasses.

Log in to **myuhcvision.com** to see your vision plan documents and complete coverage details.

Take steps to protect your eyes.

1 Find an eye doctor in your network.[2]

Choose from local and national network providers in Spectera Eyecare Networks. Here are just some of the well-known retail locations in your network:

Log in to **myuhcvision.com** to search by provider name, specialty or location.

America's Best Contacts & Eyeglasses

Costco Optical

Eyeglass World

For Eyes by GrandVision

Visionworks

Warby Parker

No network eye doctor in your area?

If there aren't any network providers within 30 miles of where you live or work, you may be able to see an out-of-network provider with network benefits. Log in to **myuhcvision.com** to learn more.

2 Schedule your annual eye exam.

Regular visits to an eye doctor can help keep your eyes healthy and improve your overall health.

If you get headaches, eyestrain or blurry vision, it may be time for new glasses. In some cases, medications can cause these issues, but symptoms may be a sign of a more serious problem. An eye exam can help find any underlying causes.

Get a complete eye exam.

A dilated exam lets your doctor look inside your eye and check your eye health. The exam can also show early signs of illness, even before other parts of your body are affected.

At your appointment, be sure to:

- State that you have vision insurance with UnitedHealthcare.
- Give your name and date of birth, or
- Show your vision ID card so the provider can verify your benefits.

Use your ID card.

You don't need your ID card to use your benefits, but it can help your eye doctor know how to bill for services. Access your ID card from your computer or mobile device at **myuhcvision.com**.

3 Discover more ways to save by using myuhcvision.com.

Laser vision correction.

Save money at more than 550 Laser Vision Network of America locations.[3]

Contact lenses.

Order contact lenses at **uhccontacts.com** online for 10% off.

You can also save on hearing aids!

Buy high-quality digital hearing aids, starting at $699 each, through hi HealthInnovations®.

[1] Plans may vary. Check your coverage at myuhcvision.com to verify benefits.
[2] Not all providers participate in all plans. Check with your provider before using your benefits. Warby Parker added to the network effective January 2018.
[3] Network location count as of October 1, 2017.

How to Use Your Vision Care Benefits

Step 1. Review Your Plan Benefits
Review your plan benefits for details on your plan design and any applicable copays. You can find this in the **Benefits** section of myuhcvision.com.

Step 2. Find a Provider
You may easily locate providers near you by selecting the **Providers** option from the top menu on our Web site.

Step 3. Schedule Your Appointment
Once you chose a provider, call to schedule your appointment. Tell them you are a UnitedHealthcare vision plan member, give the primary insured's last name, patient's name and date of birth. If asked for member ID #, please provide that as well, it is located on your ID card below. To help the provider process your service through insurance you can take this ID card to your appointment.

Step 4. Get Your Eye Exam
Your eye doctor will give you a complete eye exam. This exam includes a case history and an exam for eye illness and vision impairment. If you need glasses or contact lenses, your provider will determine your specific prescription. If an illness or eye disorder is found you may be referred to your health plan for medical eye coverage.

Step 5. Choose Your Eyewear
If prescription eyewear is necessary, your provider will help you with your selection and order your prescription. Prescription eyewear includes eyeglasses and/or contacts depending on your plan coverage. If you have any questions or concerns about your glasses or contacts let your provider know. They are there to help you both during and after your appointment.

Out-of-Network Benefits*
You get the greatest cost savings with an in-network provider. If you'd prefer to see a provider outside of our network, most plans cover part of your exam and eyewear. You will be required to pay for your purchases at the time of service and request reimbursement from UnitedHealthcare. You can also check the out-of-network reimbursement link located on the Benefits page myuhcvision.com for more information.

Questions?
Your satisfaction is very important to us — we encourage you to contact us with any questions you may have and to share your feedback by calling our toll-free number: 1-800-638-3120.

UnitedHealthcare®

Member Name: **John Smith**
Member ID: **Same ID as Medical + Dental**
Member Web: www.myuhcvision.com
Customer Service: (800)638-3120

Vision Identification Card

Powered by Spectera Eyecare Networks

fold here

Vision Care Benefits
Exam Copay: $10.00
Material Copay: $15.00

Submit Out-of-Network Claims to:
UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Note to Providers:
For more information about this UnitedHealthcare Vision plan, please visit us online at www.Spectera.com or call 1-800-638-3120.

OnlineID-rev.2/2014

**Out-of-network benefits are not available on all plans. Please check your benefit summary for plan specifics before going to an out-of-network provider.*

Dade County Fire Fighters Insurance Trust

UnitedHealthcare®

Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.
In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for diabetics only	Twice every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Materials	$ 15.00
Retinal Screening for Diabetics	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider). The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2] (Selection contact lenses refers to our formulary contact list. Contact lenses not listed on the formulary are referred to as non-selection. A copy of the list can be found at myuhcvision.com).	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider.
Non-selection contact lenses An allowance is applied toward the purchase of contact lenses outside the selection. Materials copay (if applicable) is waived.	$125.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $125.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at Lasik*Plus*® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $125.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

☐ NEW COVERAGE
☐ REQUEST FOR CHANGE

Enrollment Application and Change Form

PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY.

UnitedHealthcare®

1 EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS
			☐ Male ☐ Female			☐Single ☐Married ☐Widow

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER
				( )

EMPLOYER NAME		RETIREMENT DATE:	EMAIL ADDRESS:	CELLULAR PHONE NUMBER
DADE COUNTY FIRE FIGHTERS INSURANCE TRUST	**RETIREE PLAN**			( )

2 TYPE OF COVERAGE

Medical
- ☐ **High Option**
- ☐ **Low Option**
- ☐ **Medicare Imdennity**

Dental (Optional)
- ☐ **DPPO**
- ☐ **DMO**

3 WHO SHOULD BE COVERED

- ☐ Retiree **or** Widow Only (Single)
- ☐ Retiree **or** Widow Plus 1 Dependent
- ☐ Retiree **or** Widow Plus 2 Dependent
- ☐ Retiree **or** Widow Plus 3 Dependent
- ☐ Retiree **or** Widow Plus 4 Dependent

4 TYPE OF CHANGE

- ☐ Add Spouse/Child (complete Sec 5)
- ☐ Terminate Spouse/Child (complete Sec 5)
- ☐ Address (enter above)
- ☐ Name Change (complete Sec 5)
- ☐ Terminate All Coverage - Reason _____
- ☐ Reinstatement - Reason _____
- ☐ Surviving Spouse Former Employee SSN _____
- ☐ COBRA Continuee Former Employee SSN _____
- ☐ Open Enrollment

5 * Dependent children covered up to end of month he/she turns 26

(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Social Security #	Date of Birth (Month/Day/Year)	Sex	Handicapped
	Spouse					☐ M ☐ F	☐ Y ☐ N
	Child-1*					☐ M ☐ F	☐ Y ☐ N
	Child-2*					☐ M ☐ F	☐ Y ☐ N
	Child-3*					☐ M ☐ F	☐ Y ☐ N
	Child-4*					☐ M ☐ F	☐ Y ☐ N
	Child-5*					☐ M ☐ F	☐ Y ☐ N

6 OTHER INSURANCE

On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, Medicare or Medicaid? ☐ Y ☐ N

Is another person legally responsible for coverage for your children? ☐ Y ☐ N

If you answered yes to either of the questions above, please complete the following:

Person's Name with Other Health Plan		Social Security Number
Date of Birth	Sex	Other Company's Name and Phone Number
Other Company's Policy Number and Effective Date		
Medicare Number	Part A Effective Date	Part B Effective Date

7 AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give The United HealthCare Insurance Company and its affiliates (and the employer) or any of their designees ("United HealthCare"), any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependent's coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.

NOTICE OF ENROLLMENT RIGHTS

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Health insurance or medical services benefits provided or administered by The United HealthCare Insurance Company, Hartford, CT.

X Signature _____ ***Date*** _____

8 TO BE COMPLETED BY EMPLOYER

DATE OF HIRE	HEALTH/CHANGE EFF. DATE	POLICY NUMBER	GRP/SUBGRP/BNFT GRP	PLAN VARIATION/SUB	REPORTING CODE/BRANCH	

Enrollment Application and Change Form

Instructions

Use this form and follow the instructions for each section below. Please make sure that all applicable fields are completely and accurately filled out.

Check appropriate box to indicate if you are enrolling for the first time or making a change.

SECTION 1 Complete all information.

SECTION 2 Check the coverage plan you would like Medicare High Option or Low Option, Dental (optional) DPPO or DMO.

SECTION 3 Select who should be covered on the plans.(Copy of marriage and birth certificates must be provided for covered dependents)

SECTION 4 Complete this section if you are making a change. Select the box which indicates the type of change you are making.

SECTION 5 Fill in the appropriate action code for completing this form:

A = To add a dependent to your benefit plan.
T = To terminate yourself or a dependent's coverage.
C = To change information about yourself or a dependent.

Print your full name and the names of your covered dependents, if any. If any member listed has another health plan, check the box marked COB (Coordination of Benefits) and complete Section 7. Provide Social Security Number, date of birth, and sex for each dependent and check the appropriate boxes indicating if a dependent is handipcapped or a full-time student. (If you have more than 5 dependents, please attach an additional enrollment form.)

SECTION 6 This section must be completed for all new enrollments or coverage changes.

SECTION 7 You sign and date this form in order for it to be processed.

SECTION 8 This section is to be completed by the Plan benefit representative.

UnitedHealthcare®

Vision Enrollment Form

Dade County Firefighters Insurance Trust

SOCIAL SECURITY NUMBER	Retiree / Widow	❑ Enroll ❑ Cancel ❑ Change ❑ Address Change ❑ Number Change Date of Change / /
LAST NAME	FIRST NAME / MI	DATE OF BIRTH
ADDRESS	CITY / STATE	ZIP
TELEPHONE NIMBER Cell ( ) Home ( )		❑ Male ❑ Female ❑ Single ❑ Married

PLAN COVERAGE	❑ Retiree Only	❑ Retiree Plus 1 Dependent	❑ Retiree Plus 2 or More Dependents
Annual Premium	$ 65.00	$ 128.00	$ 212.00

INFORMATION FOR DEPENDENT COVERAGE

Last Name	First Name	MI	Relationship**	Date of Birth	Social Security Number
			❑ Wife ❑ Husband		
			❑ Son ❑ Daughter		
			❑ Son ❑ Daughter		
			❑ Son ❑ Daughter		
			❑ Son ❑ Daughter		

EMPLOYER INFORMATION - TO BE FILLED OUT BY EMPLOYER

COMPANY NAME: Dade County Firefighters Insurance Trust			ENROLLEE EFFECTIVE DATE: (Mo/Day/Yr _____/_____/ _____	
ENROLLMENT: ❑ Retirement ❑ Other	DATE OF RETIREMENT: (Mo/Day/Yr) _____/_____/ _____	POLICY NUMBER:	PLAN CARIATION/REPORTING CODE:	PLAN CODE:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I wish to enroll in the plan indicated above as offered by Dade County Firefighters Insurance Trust. I understand that this is a minimum one (1) year commitment. I hereby authorize deduction of the applicable bi-weekly amount from my salary for coverage of optional benefits for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me herein is true and complete to the best of my knowledge.

SIGNATURE:_____ DATE: _____

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Dade County Fire Fighters Insurance Trust

Retired Member Policy #645783

PLEASE PRINT ALL INFORMATION CLEARLY **Retirement Date**: ____/_____/_____

Retiree Name:_____ **Sex**: **Male** or **Female** (Circle)

Date of Birth: ____/_____/_____ **Social Security #** _____ - _____ - _____

Home Phone: (____) _____ - _____ **Cell Phone #** (____) _____ - _____

E-Mail Address: _____

Address _____ **City** _____ **State:** _____ **Zip Code:**_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

I hereby designate the following as my beneficiary (ies)

Primary Beneficiary (ies)

Name and Address	Percent %	Relation	Date of Birth	Social Security#

Contingent Beneficiary (ies) *Will only apply if Primary is deceased

Name and Address	Percent %	Relation	Date of Birth	Social Security#

As a retired member under the **Fire Fighters Insurance Trust** you are entitled to a Life Insurance benefit equal to:

$25,000 Normal Death Benefit up to age 65

$16,500 Normal Death Benefit after age 65

Proper notarization and signature must be obtained to validate beneficiary designations.

Retiree Signature _____ **Date** _____

State of Florida

SS:

County of Dade

Before me on this _____ day of _____, 20_____ personally appeared the above individual and swore the information contained herein to be true and of his/her free will.

_____ Notary Public, State of _____

☐ Personally Known ☐ Produced Identification ☐ Identification Produced _____

Underwritten by STANDARD LIFE INSURANCE COMPANY, Portland, OR*

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DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST

8000 NW 21 STREET
MIAMI, FLORIDA 33122-1605
Phone: 305-593-6100

2022 Under 65 Retiree Booklet

Information contained herein does not constitute an insurance certificate or policy.