2023 ACTIVE MEMBER BENEFIT BOOKLET

JANUARY 1, 2023 - DECEMBER 31, 2023

UnitedHealthcare EXPRESS SCRIPTS®

Dade County Fire Fighters Insurance Trust

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This summary is not a legal document and does not replace or supersede the "Evidence of Coverage", the policy, or the Summary Plan Description. Please refer to the Evidence of Coverage/insurance policy/Summary Plan Description /Benefit Summary for a complete description of the coverage, eligibility criteria, controlling terms, exclusions, limitations, and conditions of coverage.

DCFF Insurance Trust reserves the right to terminate, suspend, withdraw, reduce, or modify the benefits described in the Evidence of Coverage/policy/Summary Plan Description/Benefit Summary in whole or in part, at any time. No statement in this or any other document and no oral representation should be construed as a waiver of this right. This summary is the confidential property of **DCFF Insurance Trust.**

DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST FUND

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

Phone: 305-593-6100

ADMINISTRATOR
United HealthCare

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

Our annual Open Enrollment period for 2023 will run from Monday, October 24, 2022 through Friday, November 4, 2022. During this period, members may elect to make changes in plans, levels of coverage and update beneficiary and dependents covered. All changes made become effective on January 1, 2023 and are in effect from January to December.

Local 1403 bargaining unit members are eligible to participate in **Dade County Fire Fighters Insurance Trust** medical, dental and optional vision under our insurance, **UnitedHealthCare**, plus prescription coverage through **Express Scripts**.

Our group offers two medical options, High and Low Plan, both utilizing the UHC Choice Plus national network of providers in addition to either UHC PPO or HMO/Solstice dental. Be mindful that if you enroll in our medical plan, you cannot enroll in a dental plan through Miami-Dade County.

All Trust members are provided one-time annual salary normal death and two times annual salary accidental death & dismemberment life insuance benefit through Standard Life.

Trust members are afforded a unique benefit of subsidized retiree health insurance coverage at an affordable cost upon meeting FRS eligibiltiy as a retiree and Trust retiree subsidy eligibility of minimum ten (10) year vesting in health plan plus accruing of 4% per additional year for those hired after 2000.

What is the difference between UHC High and Low Option medical?
The High Option allows medical coverage at In-Network with applicable copay per visit, $300 In-Network deductible plus 10% co-insurance for hospital services & in-patient, $500 out of network deductible & 20% co-insurance applies to out of network provider services including 30 annual massage therapy and accupuncture visits. High Option has an employee only benefit of $800 per eye reimbursement for eye corrective surgery.

The Low Option is an In-Network co-pay only Plan. The very high $10,000 annual deductible and 50% co-insurance for out of network services makes it cost prohibitive for out of network use.

In-network copays for UHC High and Low Option

ER - $225 PCP - $25 Specialist - $35 $35 – Urgent Care

*"It is our Health Insurance Plan" – We **Can** Control the Cost*
USE IT – DON'T ABUSE IT

Are eye exams covered?
The UHC Low and High Option medical Plans both offer one eye exam a year as a benefit without coverage of hardware. Ailments or diseases of the eye are covered under medical.
If you are already wearing prescription glasses or contacts, we offer optional vision under UHC Spectera vision with a separate network of providers, annual eye exam and coverage of hardware.

How do I use Express Scripts prescription coverage?
Every year each covered member/employee and their dependents must meet $25 deductible prior to co-pays being applied.
All maintenance daily medications must be filled as a 90 day supply either at your local Walgreens or through mail order directly through Express Scripts.

Am not making any changes to coverage or dependents covered. Do I need to do anything?
Your 2022 coverages will automatically renew, if we do not receive completed paperwork with changes in our office by Friday, November 4, 2022. Your optional vision through UHC Spectera will also renew unless written notice of cancellation is received.

Are You Adding a New Dependent?
If you are adding a dependent for the 2023 plan year, you must provide supporting documentation that the dependent meets the eligibility requirement for coverage. Our Plan is unable to provide coverage of domestic partners.

Spouse = Marriage Certificate Children = Birth Certificate

ACTIVE EMPLOYEES			
	Choice Plus Low Option (Bi-Weekly)	Choice Plus High Option (Bi-Weekly)	UnitedHealthcare Dental Plan (DHMO or DPPO)
Employee Only	$34.95	$34.95	$0
Employee + Spouse	$209.95	$284.95	$10
Employee + Child	$194.95	$264.95	$5
Family	$259.95	$329.95	$15

ACTIVE EMPLOYEES	
	UnitedHealthcare / Spectera Vision Plan
Employee Only	$2.47
Employee + 1 Dependent	$4.93
Employee + 2 or more Dependents	$8.16

"It is our Health Insurance Plan" – We ***Can*** *Control the Cost*
USE IT – DON'T ABUSE IT

Important Notices

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include:

- Your legal spouse;
- Children up to age 26;
- A child over the age of 26 who is not able to support themselves due to mental disability, physical disability, mental illness, or development disability.

Under the HealthCare Reform Act your covered dependent son/daughter may continue on the Plan up to end of month they turn 26 years of age. Coverage will be terminated on last day of the month they turn 26. In some cases, medical and prescription coverage can be extended up to age 30 at an additional single premium. Contact the Trust office for further details.

When Coverage Begins:

Newly hired members and dependents will be eligible to participate in DCFF's benefits program at Date of Hire. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a qualifying family status events.

When Coverage Ends:

Medical, Dental, and Vision coverages will end on the last day of the month in which employment ends.

When Can You Enroll?

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

- Upon hire
- During annual open enrollment
- Within 30 days of a qualified family status change

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

Worker's Compensation

Your Health Plan excludes treatment for any injury or sickness that is eligible for benefits under Worker's Compensation. When seeking treatment for such injuries do not provide your United HealthCare insurance information to the facility. If it is determined that monies for such benefits were paid by the Plan, the Trust reserves the right to initiate recovery efforts against you for these fraudulent charges. You may be held liable for the cost of all treatment given. If your injury is denied by Workers Compensation, please contact Local 1403 Benefits Officer.

Qualified Family Status Change:

If you have a mid-plan year (January-December) change in status such as divorce, marriage, birth of a child, adoption, court order, ineligibility or loss of coverage of a spouse or dependent child it is your responsibility to notify and provide proper documentation to the Trust office within 45 days (60 days for birth) of the event to add or terminate a dependent. An ex-spouse ceases to be an eligible dependent on the Plan as of the last day of the month in which the final divorce decree is signed. Continuing to cover an ex- spouse under your medical, prescription, dental or vision is considered a FRAUDULENT ACT. You will be liable for all claims paid by insurance carrier on their behalf.

Educational Videos:

- **To learn about** Key Insurance Terms
- **To learn about** Balance Billing
- **To learn about** How to read an EOB
- **To learn about** How to Budget
- **To learn about** How to stretch your healthcare dollars

Medical Benefits

Welcome - We're Glad You're Here

While no one can predict the future, you can prepare for it. Your UnitedHealthcare benefits provide you with access to people, resources and tools to help you aren't feeling your best.

We have also created unique programs to help you improve your health and wellness. We believe knowledge is the heart of your healthcare, so we want to give you resources to help you:

- Be active with your health care
- Make healthy choices
- Find answers
- Save money
- Take charge of your health

Before You Enroll

Your doctor is likely already in our network. Whether you are at home, traveling or you have a covered child going to school out-of-state, a network doctor or hospital is likely close by. In addition, there are no referrals. You can see the specialist you want. Emergencies are covered anywhere in the world, and you usually don't have to worry about claim paperwork for network care.

The UnitedHealthcare Network:

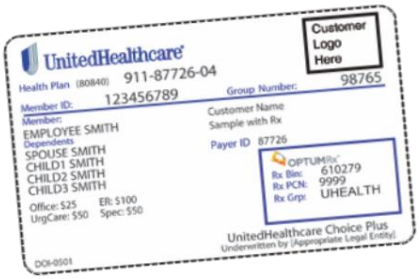
Find a network doctor or hospital.

Search by facility, location, gender, and languages spoken.

- **www.myUHC.com**
- Click on "Find Physician, Laboratory or Facility".
- Choose "Find a Physician."
- Select the "Choice Plus" network for the Low Plan or the Hight Plan to find a physician in your area.

Your ID Card - The Key to Accessing Care When You Need It

Your benefit plan is an important part of your daily life, even if you don't need services every day. It protects you and helps you better manage your health. Right now is the perfect time to find out all you can about your coverage before you need it, especially how it works and where to go for care.



Always carry your ID Card!

Your ID Card has information about you and your coverage. Put your ID Card in your wallet or your pocketbook so you won't forget it when you're at a doctor's office, drugstore and pharmacies. If you're at a hospital, show it to make sure you're not billed unnecessarily.

These Extras Are Part of Every Plan

When you enroll in a UnitedHealthcare health plan, you'll not only have the freedom to use any doctor or hospital in our nationwide network, including specialists, but you'll also be able to take advantage of many valuable programs and services to make your health care experience easier. And, they are available at no additional cost.

24-Hour Nurse Services lets you speak with a registered nurse by phone anytime. Nurses can even help schedule doctor appointments.

Health Coaches offer telephonic and online support to help lose weight, stress reduction, stop smoking, manage diabetes and more.

Healthy Pregnancy Program can help soon to-be-mothers through every stage of pregnancy and delivery.

Health And Wellness Programs can help you eat right, stop smoking and relax. You can participate online, in the comfort of your own home.

Medical Benefits

DCFF Insurance Trust offers medical benefits through UnitedHealthcare. Please refer to the carrier benefit summary for complete plan details. To locate providers within your network, visit **www.myuhc.com**. 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.

Benefits Description	Choice Plus Low Plan	Choice Plus High Plan	
	In-Network Only	In-Network	Out-of-Network
Deductible (Individual/Family)	None	$300 / $600	$500 / $1,000
Coinsurance (Member Pays)	None	10%	20%
Maximum Out-Of-Pocket (includes coinsurance only) (Individual/Family)	$1,500 / $3,000	$1,000 / $2,000	$2,000 / $3,000
Virtual Visits (must access through myuhc.com)	$25 Copay	$25 Copay	N/A
Primary Physician Visits	$25 Copay	$25 Copay	20% After Deductible
Specialist Physician Visits	$35 Copay	$35 Copay	20% After Deductible
Preventive Care	100% Covered	100% Covered	Not Covered
Hospitalization			
Inpatient	$150/day Copay ($600 max per admission)	10% After Deductible	20% After Deductible
Outpatient	$125 Copay		
Emergency Care			
Emergency Room	$225 Copay	$225	$225
Urgent Care	$35 Copay	$35 Copay	20% After Deductible
Diagnostic Lab & X-Ray			
Lab (Independent Lab / Outpatient Facility)	100% Covered	100% Covered	20% After Deductible
X-Ray (Outpatient Facility)		10% After Deductible	
Complex Imaging			
CT/PET Scans, MRI	$50 Copay (per service)	$50 Copay	20% After Deductible
Prescription Drugs Copay - Retail Pharmacy (30 Day Supply) / Mail Order Pharmacy (90 Day Supply)			
Annual Pharmacy Deductible of $25 must be met before copays apply			
Generics	$15 / $5	$15 / $5	Not Covered
Name Brand Preferred	$30 / $67.50	$30 / $67.50	
Non-preferred Name Brand	$55 / $130	$55 / $130	

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

Click to view: HMO Plans Overview

Click to view: PPO Plan Overview

Medical Benefits - Continued

Benefits Description	Choice Plus Low Plan	Choice Plus High Plan	
	In-Network Only	In-Network	Out-of-Network
Behavioral Health Services: Mental Health & Substance Abuse	Outpatient: $25 copay per visit Inpatient : $150 copay per day Residential Treatment: $150 copay per day ($600 maximum per admission)	Outpatient: $25 copay per visit Inpatient and Residential Treatment: 10% of eligible expenses	Outpatient, Inpatient and Residential Treatment: 20% of eligible expenses
Home Health Care (Limited to 60 visits per calendar year)	$0 copay	10% of eligible expenses	20% of eligible expenses
Maternity Services	$150 copay per day ($600 maximum per admission)	10% of eligible expenses	20% of eligible expenses
Orthotics (Limited to one pair per calendar year)	$100 copay	$100 copay	20% of eligible expenses
Prosthetic Devices (Limited to $10,000 per calendar year)	$0 copay	10% of eligible expenses	20% of eligible expenses
Reconstructive Procedures	N/A	10% of eligible expenses	20% of eligible expenses
Chiropractic Visits (Limited to 30 visits per calendar year)	$35 copay per visit	$35 copay per visit	20% of eligible expenses
Acupuncture / Massage Therapy (Limited to 30 visits per calendar year)	N/A	N/A	20% of eligible expenses
Skilled Nursing/Inpatient Rehab Facility (Limited to 120 days per calendar year)	$0 copay	10% of eligible expenses	20% of eligible expenses
Rehabilitation Services – Calendar Year Limits: Physical Therapy: 30 visits Occupational Therapy: 30 visits Speech Therapy: 30 visits Pulmonary Rehabilitation: 30 visits Cardiac Rehabilitation: 36 visits Pediatric/Child: Up to 60 visits	$35 copay per visit	$35 copay per visit	20% of eligible expenses
Transplant Services	$0 copay	10% of eligible expenses	20% of eligible expenses
Dental Services (Accident only)	$0 copay	10% of eligible expenses	
Eye Examinations	$35 copay per visit	$35 copay per visit	20% of eligible expenses
Hospice Care (Limited to 360 days for total length of time under Plan)	$0 copay	10% of eligible expenses	20% of eligible expenses

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

Click to view: HMO Plans Overview
Click to view: PPO Plan Overview

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 Acrredo

<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.

Get support to eat healthier, sleep better and move more

Rally® can offer small steps for a healthier lifestyle—and help you earn rewards along the way.

Take the Health Survey

Use your results to help set health goals.

Get personalized recommendations

Build healthier habits with well-being programs, activities and more.

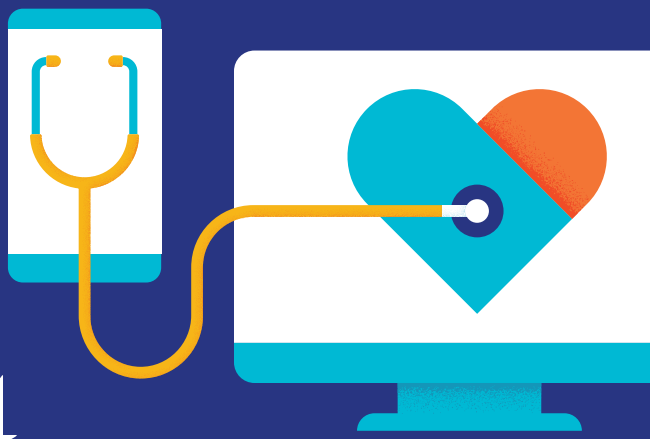
Earn rewards

Take healthy actions, achieve goals and earn Rally Coins.

Visit myuhc.com® > Health Resources > Rally

United Healthcare | RALLY®

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.

SCAN ME!

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.

Something on your mind? Message a dedicated therapist any time, anywhere

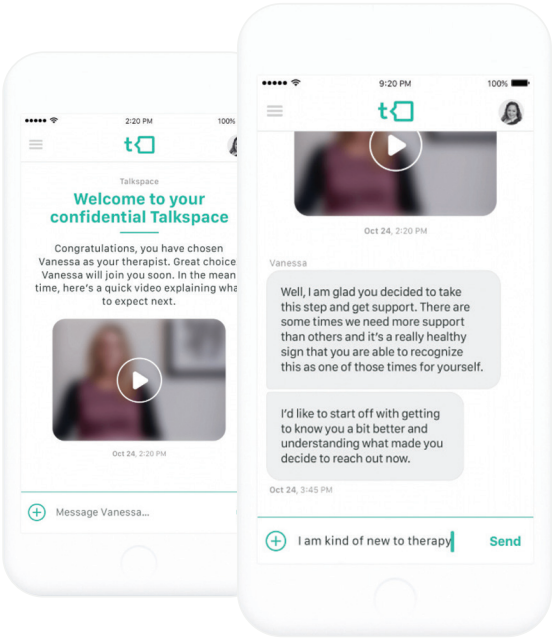
With Talkspace online therapy, you can regularly communicate with a therapist, safely and securely from your phone or desktop. Make progress. No office visit required.

talkspace

Here's how Talkspace can fit your life:

With Talkspace, you can message a licensed therapist, 24/7.

- Find a therapist with an online matching tool.
- Start therapy within hours of choosing your therapist.
- Message your therapist whenever — no appointments necessary.
- Get messages back throughout the day, five days a week.
- Choose real-time face-to-face video visits by appointment, when needed.
- You can also access Talkspace Psychiatry to schedule live video sessions with a psychiatrist trained in mental health care and prescription management for a tailored treatment plan.



Talkspace is convenient, safe and secure.

Simply register (first visit only) and choose a provider and message anywhere, anytime. **talkspace.com/connect**.

After you register, download the Talkspace app on your mobile phone. Talkspace is supported by Chrome, FireFox, Safari or Edge browsers on your desktop computer.

Talkspace is your space. To use in your time. It's covered under your plan's behavioral health benefits.**

iOS • ANDROID • DESKTOP
MESSAGING • VOICE • VIDEO • PHOTO

***Data rates may apply.**

**Copayment may apply and will be charged weekly via credit card. You may use Talkspace as often as desired per week once copayment for that week has been paid.

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

If you are experiencing thoughts of suicide or if this is urgent and an emergency, call 911 or 1-800-SUICIDE (784-2433) or 1-800-273-TALK (8255).
UnitedHealthcare does not recommend or endorse any treatment, medication, suggested approach, specific or otherwise. The information provided herein is for educational purposes only. For advice about specific treatments or medications, please consult your physician and/or mental health care provider. Certain conditions and restrictions may apply. Also, certain treatments may not be covered in some benefit plans. Check your health plan regarding your coverage of services.

United Healthcare

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]

*** DCFF plan participants must make sure to inform provider to file claim through UHC medical NOT pharmacy.**

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.

Prescription Discounts

Take advantage of these Pharmacy discounts in addition to your medical plan. Please do not provide your insurance card when using these discounts. They are outside of your medical and Rx plan.

DCFF is always looking to protect its members' pockets when it can. Take a look at the various pharmacy discounts available to you simply for being a consumer. You do not need to be a member of the medical plan in order to participate in any of these programs. For more information, please visit the websites below and keep in mind that certain restrictions will apply.

You'll find medications for some of the most common ailments available in 90-day supplies for just $7.50. Check out what's on their list to see how you can save. Want your Medications delivered to your home? You can now get select prescriptions delivered for just $5. To review all the fine print please visit the Publix website directly.

https://www.publix.com/pharmacy

Mark Cuban's CostPlus aims to offer the public low cost generic drugs at a low price, no middleman (PBMs). Simple look up your medication, have your doctor send in the prescription and CostPlus will mail it to you.

To look up your medication, visit their website at www.costplusdrugs.com

$4 Prescriptions
Save big on 30-day generic medications for only $4 & spend just $10 on 90-day prescriptions. No insurance necessary.

Find your medication list at:
https://www.walmart.com/cp/4-prescriptions/1078664

Get a GoodRx Prescription Discount Card for free! Use the card for discounts of up to 80% on most prescription drugs at over 70,000 U.S. pharmacies. Get discounts for every member of your family, including pets! No expiration. No fees or obligations. No credit card required. GoodRx is not insurance. Savings based on pharmacy retail price.

GoodRx is 100% free. No registration required.

Visit their website at www.goodrx.com or download their app.

Which Do I Choose*?

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

Primary Care Physician

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

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

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

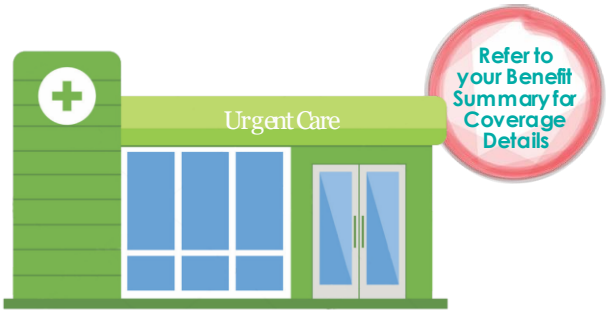
Online Telehealth

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

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

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

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



Urgent Care

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

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

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

Emergency Room

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

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

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

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

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

Telehealth

Places of Care

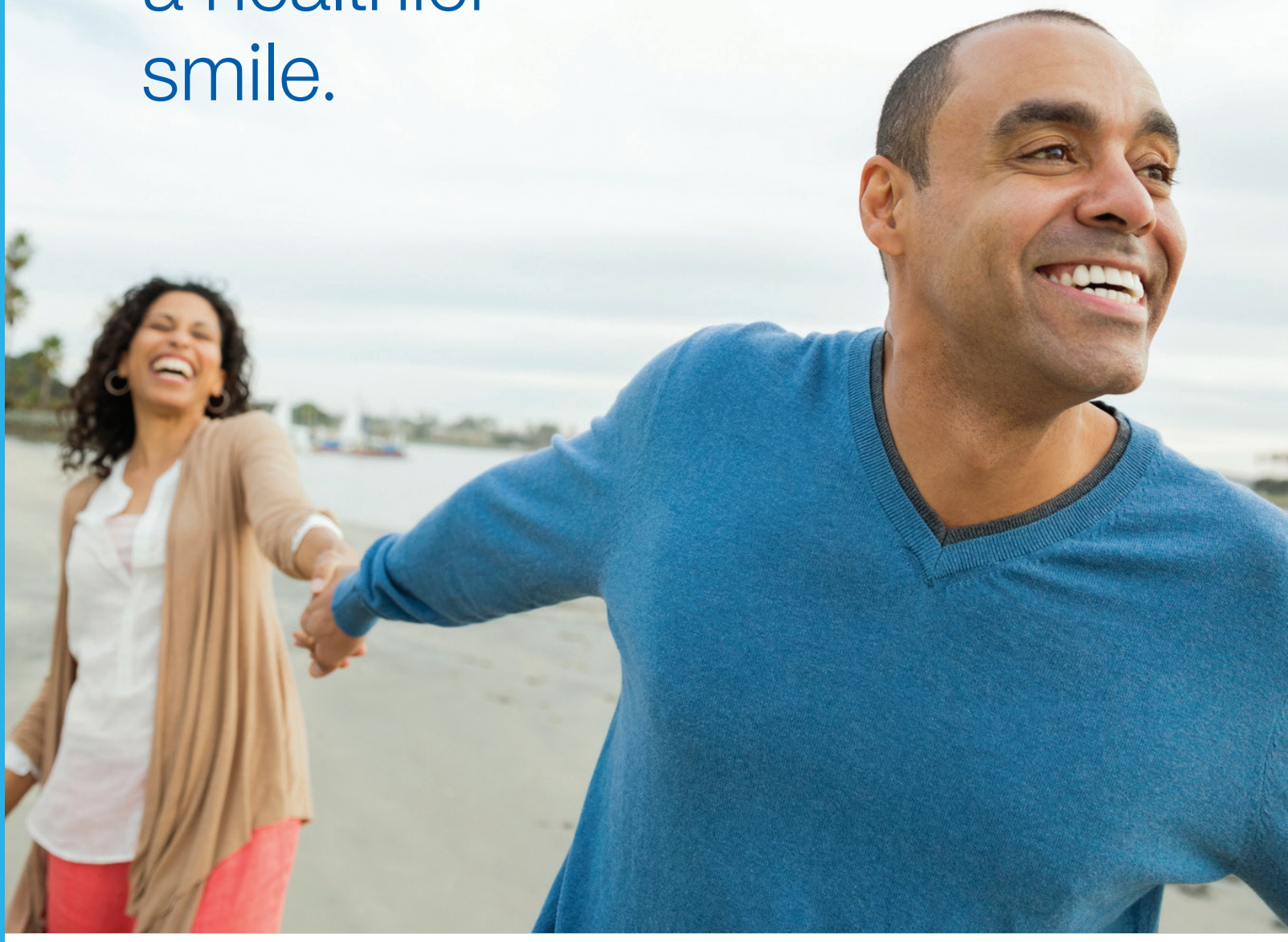
Dental Benefits

DCFF Insurance Trust offers a PPO (DPPO) plan through **UnitedHealthcare.** The DPPO provides In-Network and Out-of-Network benefits. The chart on this page illustrates a brief description of the dental plan's attributes. Please refer to the carrier benefit summary for full benefit details. To find a dental provider, please visit **www.myuhc.com.**

UnitedHealthcare Dental PPO Plan		
Benefits Description	In-Network	Out-of-Network
Calendar Year Maximum (Individual)	$2,000	$2,000
Calendar Year Deductible		
Individual / Family	$25 / $75	$50 / $150
Preventive Services		
Oral Exam	100% Covered by plan; Deductible does not apply	Member pays 20%; Deductible does not apply
Cleanings		
Routine X-Ray		
Fluoride Application		
Sealants		
Basic Services		
Fillings	Member pays 20% After Deductible	Member pays 20% After Deductible
Oral Surgery / Simple Extractions		
Root Canal / Endodontics		
Minor & Major Periodontics		
Space Maintainers		
Surgical Extraction Incl Impacted Wisdom Teeth		
General Anesthesia		
Palliative Treatment (Relief of Pain)		
Major Services		
Crowns / Inlays / Onlays	Member pays 50% After Deductible	Member pays 50% After Deductible
Stainless Steel / Resin Crowns		
Full and Partial Dentures		
Relining Dentures		
Bridges		
Repairs to Full Dentures, Partial Dentures, Bridges		
Orthodontics (Deductible does not apply)		
Services	Member pays 50%	Member pays 50%
Adult / Child	Yes / Yes	
Lifetime Maximum (per covered person)	$2,250	$2,250

Click on link to view a short video on how the Dental Insurance works.
Dental Plan Overview

Simpler benefits for a healthier smile.



UnitedHealthcare®

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.

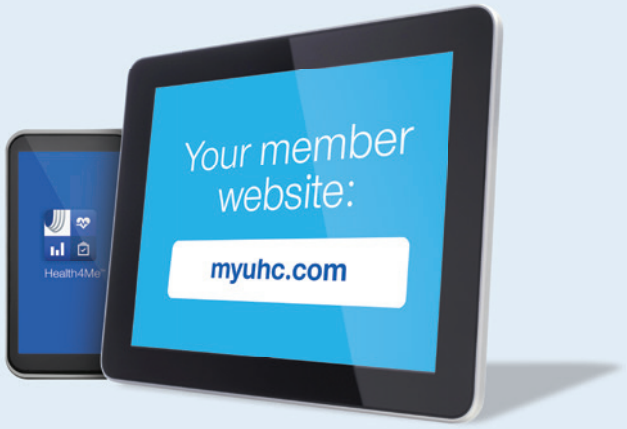
Hundreds of services and procedures will be covered with a fixed copay amount. This does not usually apply to preventive care services received in the network.

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.

Dental Benefits

DCFF Insurance Trust offers a managed dental plan (DHMO) through **UnitedHealthcare.** The DHMO provides in-network only benefits. The chart on the following pages illustrates services provided and associated copays. Please refer to the carrier schedule of benefits for full benefit details. To find a dental provider, please visit **www.myuhc.com.**

In Florida, the network that you will want to search is called FL Managed Care – Solstice S100B.

UnitedHealthcare
Dental HMO Plan
Benefits Description

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

Click on link to view a short video on how the Dental Insurance works.
Dental Plan Overview

Dental Benefits

UnitedHealthcare

UnitedHealthcare
Dental HMO Plan

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 obtained intra-orally or 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

CODE	DESCRIPTION	MEMBER'S COPAY
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

Dental Benefits

UnitedHealthcare

UnitedHealthcare
Dental HMO Plan

CODE	DESCRIPTION	MEMBER'S COPAY
D0470	Diagnostic casts	No Charge
	ORAL PATHOLOGY LABORATORY	
D0472	Accession of tissue, gross examination, preparation and 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, preparation and transmission of written report	No Charge
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and 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 (PASSME 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

Dental Benefits

UnitedHealthcare

UnitedHealthcare
Dental HMO Plan

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

CODE	DESCRIPTION	MEMBER'S COPAY
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

Dental Benefits

UnitedHealthcare

UnitedHealthcare
Dental HMO Plan

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

Dental Benefits

UnitedHealthcare

UnitedHealthcare
Dental HMO Plan

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	Gingivectomy 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

CODE	DESCRIPTION	MEMBER'S COPAY
	site in quadrant	
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*

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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†
D5223	(including any conventional clasps, rests and teeth) *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
D5411	Adjust complete denture - mandibular	8.00
D5421	Adjust partial denture - maxillary	8.00
D5422	Adjust partial denture - mandibular	8.00
	REPAIRS TO COMPLETE DENTURES	
D5510	Repair broken complete denture base	30.00*
D5520	Replace missing or broken teeth - complete denture (each tooth)	30.00*
	REPAIRS TO PARTIAL DENTURES	
D5611	*Repair resin partial denture base, maxillary	30.00*
D5612	*Repair resin partial denture base, mandibular	30.00*
D5621	*Repair cast partial framework, mandibular	30.00*

CODE	DESCRIPTION	MEMBER'S COPAY
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*

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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†

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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*

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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

CODE	DESCRIPTION	MEMBER'S COPAY
	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)	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

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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

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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

Solstice

Underwritten by Solstice Benefits, Inc.

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Dental Benefits

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Dental HMO Plan

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.

UnitedHealthcare
Dental HMO Plan

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.

2023
Optional Vision Bi-weekly Premium

Employee Only	$ 2.47
Emplyee + 1 Dependent	$ 4.93
Employee + 2 or more Dependents	$ 8.16

UnitedHealthcare

spectera®

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.

Vision Benefits

DCFF Insurance Trust will continue to offer a comprehensive vision benefit through **UnitedHealthcare**. The chart below gives a brief description of the vision plan attributes. Please refer to the carrier benefit summary for full benefit details. To find a vision provider, please visit **www.myuhc.com.**

Your vision network is the Spectera Vision Network.

Benefits Description	UnitedHealthcare Vision Plan In-Network	Out-of-Network
Copays		
Eye Exam	$10 Copay	N/A
Materials Copay	$15 Copay	N/A
Exams - Once Every 12 Months		
Eye Exam	Covered 100% after copay	Up to $40 Reimbursement
Frames - Once Every 12 Months		
Frame	Up to $130 Allowance plus 30% off balance	Up to $45 Allowance
Lenses - Once Every 12 Months		
Single	Covered 100% after copay	Up to $40 Allowance
Bifocal		Up to $60 Allowance
Trifocal		Up to $80 Allowance
Lenticular		
Contact Lenses - Once Every 12 Months		
Medically Necessary	Fully covered minus exam/materials Copays	Up to $210 Allowance
Conventional	Up to $125 Allowance	Up to $125 Allowance
Laser Vision Correction		
Laser Vision Discount	Discounts available through QualSight LASIK	N/A

Click on link to view a short video on how the Vision Plan works.
Vision Insurance

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:
Member ID:
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.*

Benefits Payroll Deductions

ACTIVE EMPLOYEES			
	Choice Plus Low Option (Bi-Weekly)	Choice Plus High Option (Bi-Weekly)	UnitedHealthcare Dental Plan (DHMO or DPPO)
Employee Only	$34.95	$34.95	$0
Employee + Spouse	$209.95	$284.95	$10
Employee + Child	$194.95	$264.95	$5
Family	$259.95	$329.95	$15

ACTIVE EMPLOYEES	
	UnitedHealthcare / Spectera Vision Plan
Employee Only	$2.47
Employee + 1 Dependent	$4.93
Employee + 2 or more Dependents	$8.16

Insurance Contacts & Customer Care

Insurance Coverage	Insurer or Vendor	Phone #	Website / Email Address
Medical	UnitedHealthcare	888-607-5214	www.myuhc.com
Rx	Express Scripts	855-747-5794	Express-scripts.com/Rx
Dental HMO	UnitedHealthcare / Solstice	800-955-4137	www.myuhc.com
Dental PPO	UnitedHealthcare	800-816-3596	www.myuhc.com
Vision	UnitedHealthcare / Spectera Vision	800-638-3120	www.myuhcvision.com
TeleHealth	UnitedHealthcare	855-615-8335	Myuhc.com/virtualvisits
Employee Medical Accounts	Anchor Benefit Consulting	800-845-7629	www.anchorbenefit.com

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

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Refer to your plan for the applicable deductibles and coinsurance.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

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

MICHELLE'S LAW DISCLOSURE

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

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

NOTICE OF GRANDFATHERED 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.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Dade County Fire Fighters Insurance Trust
8000 NW 21st Street
Suite 222
Miami, FL 33122-1605
305-593-6100
Dale.Sutton@local1403.org

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been balance billed or have any questions regarding balance billing, please contact:

Dade County Fire Fighters Insurance Trust
8000 NW 21st Street
Suite 222
Miami, FL 33122-1605
305-593-6100
Dale.Sutton@local1403.org

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

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Pay for your health services

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

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

Administer your plan

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

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

Run our organization

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

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

How else can we use or share your health information?

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

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

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

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

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

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

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

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

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

Changes to the Terms of this Notice

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

Notice Effective Date: January 1, 2023

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Dade County Fire Fighters Insurance Trust
8000 NW 21st Street
Suite 222
Miami, FL 33122-1605
305-593-6100
Dale.Sutton@local1403.org

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
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PART A: General Information

When key parts of the Health Care Law took effect in 2014, it created a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins annually in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name **Dade County Fire Fighters Insurance Trust**	**2. Employer Identification Number (EIN)** **59-2185490**
3. Employer Address 8000 NW 21st Street, Suite 222	**4. Employer Phone Number** **305-593-6100**
5. City Miami	**6. State** Florida
7. Zip Code 33122-1605	**8. Who can we contact about employee health coverage at this job?** Dale Sutton
9. Phone Number (if different from above)	**10. Email address** Dale.sutton@local1403.org

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

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

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

  - [ ] Some employees. Eligible employees are:

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

    Legal Spouse and Dependent Children up to Age 26

  - [ ] We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notes

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