



**2023 MEDICARE RETIREE
BENEFIT BOOKLET
JANUARY 1, 2023 - DECEMBER 31, 2023**



UnitedHealthcare®



EXPRESS SCRIPTS®

Dade County Fire Fighters Insurance Trust

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 54 for more details.

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

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ADMINISTRATOR
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Claims Address:
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Dear Retiree,

As a Medicare participant you are afforded the opportunity to enroll in numerous types of supplemental plans to fill your medical and prescription needs in retirement. Our group only offers a Medicare Indemnity Plan which coordinates directly with traditional Medicare Part A & B.

The **Dade County Fire Fighters Insurance Trust** requires its retirees and covered dependents upon reaching Medicare eligibility to enroll and continue participation in Part A and B. Medicare is primary and **UnitedHealthCare (UHC)** is secondary for medical coverage. Your prescription coverage continues through **ExpressScripts** with annual deductible of \$25 per covered person prior to applying co-pays for medications. There is **NO** need to enroll in Part D for prescription coverage. Maintenance (daily medication) must be filled at Walgreens or via mail order directly through ExpressScripts for a 90 day supply.

Do I have to follow a network of providers to obtain services?

No, you just need to make sure providers and facilities you receive services accept Medicare assignment to obtain 100% coverage, after meeting 20% of annual Part B deductible (\$226 Part B deductible for 2023) and coordination of Medicare and UHC. You do not follow a network of providers through UHC for doctors, hospitals, facilities or laboratories.

When do I pay 20% co-insurance?

The 20% co-insurance will not apply unless you receive services from a provider or facility that does not accept Medicare assignment. After paying 20% of Part B deductible and coordination between Medicare & UHC your claim should be covered 100%.

Does Medicare coordinate dental coverage?

The UHC PPO and HMO/Solstice dental coverage we offer is optional and independent. You do not provide Medicare card for dental services.

Do I need to complete a UHC enrollment form if not making any changes 2023?

No, your current Medicare Indemnity medical, ExpressScripts prescription, optional dental and vision coverage will continue into the new year (January to December) unless you provide a request in writing in our office via USMail or email to end coverage.

I wish to add or remove a dependent to/from my coverage for 2023?

We need to receive a completed UHC enrollment/change form in booklet to add/remove dependent. To add spouse will need marriage certificate and birth certificate for dependent child under 26 years of age.

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

Important Notices

Eligible Members:

If you are an eligible retiree, then you are eligible to enroll in Dade County Fire Fighters Insurance Trust Benefits. Please be advised that participation in Medicare Part A and B is required by the Dade County Fire Fighters Insurance Trust by all members and covered dependents upon reaching age eligibility at 65 and/or approval of disability Medicare.

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.

When Coverage Begins:

There is no waiting period for eligible retirees and dependents to participate DCFF's benefits program. 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 Can You Enroll?

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

- 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.

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

Whether you are at home, traveling or you have a covered child going to school out-of-state, 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 care.



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.



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

As a DCFF retired member, 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, 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		UnitedHealthcare Medicare Indemnity Plan	
Deductible (per covered person)		\$226	
Coinsurance (Member Pays)		20%	
Maximum Out-Of-Pocket (includes coinsurance only) (Individual/Family)		\$1,000 / \$2,000	
Primary Physician Visits		20% of eligible expenses	
Specialist Physician Visits		20% of eligible expenses	
Preventive Care		100% Covered	
Hospitalization			
Inpatient		20% of eligible expenses	
Outpatient		20% of eligible expenses	
Emergency Care			
Emergency Room		20% of eligible expenses	
Urgent Care		20% of eligible expenses	
Diagnostic Lab & X-Ray			
Lab (Independent Lab / Outpatient Facility)		20% of eligible expenses	
X-Ray (Outpatient Facility)			
Complex Imaging			
CT/PET Scans, MRI		20% of eligible expenses	
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	
Name Brand Preferred		\$30 / \$67.50	
Non-preferred Name Brand		\$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: [Medicare Overview](#)

Medical Benefits - Continued



Benefits Description	UnitedHealthcare Medicare Indemnity Plan
Behavioral Health Services: Mental Health & Substance Abuse	<u>Inpatient</u> , <u>Outpatient</u> and <u>Residential Treatment</u> : 20% of eligible expenses
Home Health Care (Limited to 60 visits per calendar year)	\$0 copay
Maternity Services	20% of eligible expenses
Prosthetic Devices (Limited to \$10,000 per calendar year)	20% of eligible expenses
Reconstructive Procedures	20% of eligible expenses
Chiropractic Visits (Limited to 30 visits per calendar year)	20% of eligible expenses
Skilled Nursing / Inpatient Rehab Facility (Limited to 120 days per calendar year)	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	20% of eligible expenses
Transplant Services	20% of eligible expenses
Dental Services (Accident only)	20% of eligible expenses
Eye Examinations	20% of eligible expenses
Hospice Care (Limited to 360 days for total length of time under Plan)	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.

Your benefit at a glance



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

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

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

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

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

You could **save an average of 29%** with 3-month supplies compared to 1-month supplies from your local pharmacy². 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 shipping³
- 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

- 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 prescription⁴

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.

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.>

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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 PharmacySM or from any Walgreens or Duane ReadeTM 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](https://www.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 PharmacySM 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 PharmacySM or from a Walgreens pharmacy.³ Find out more at [express-scripts.com/KyleAndNick](https://www.express-scripts.com/KyleAndNick).

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

You can have the Express Scripts PharmacySM deliver it (with FREE standard shipping) by visiting [express-scripts.com/90day](https://www.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 PharmacySM to get my long-term drugs. Do I need to change anything?

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

¹ Duane ReadeTM 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](https://www.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

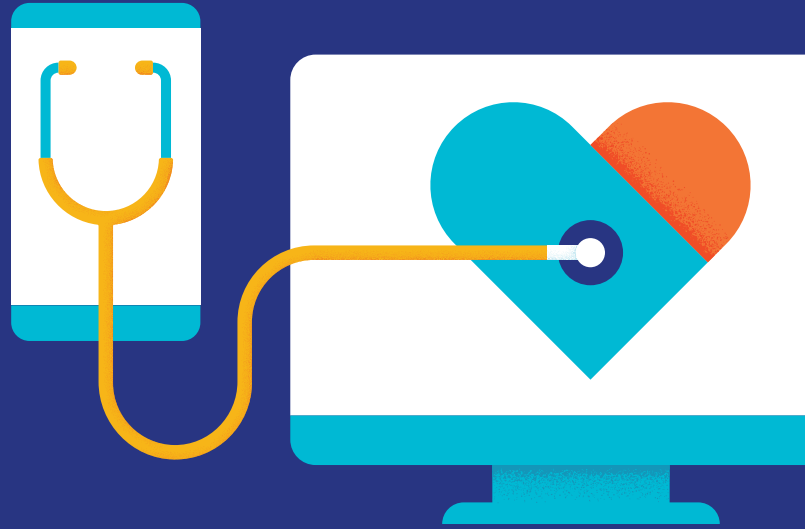
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RALLY®

Rally Health® provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the health survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

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

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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.

*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.

continued

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

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

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

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 locations¹ —including network doctors, other health care professionals and the locations listed on the back.



More important this year

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



Helping communities and health systems

They helped prevent nearly 91,000 flu-related hospitalizations in 2017–2018.³

Choose where to get your flu shot

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

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: carrsco.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

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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.

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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.



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



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



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

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.

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.



2023
Optional HMO Dental Annual Premium

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

FL Managed Care
Solstice S100B



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 detected¹ 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.

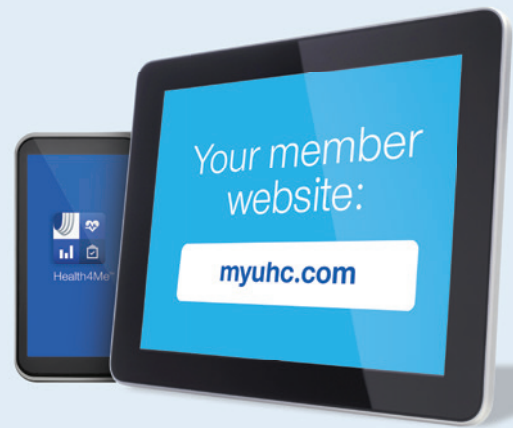
Hundreds of services and procedures will be covered with a fixed copay amount. This does not usually apply to preventive care services received in the network.

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

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

[Dental Plan Overview](#)

UnitedHealthcare Dental HMO Plan

CODE	DESCRIPTION	MEMBER'S COPAY	CODE	DESCRIPTION	MEMBER'S COPAY
D0240	Intraoral - occlusal radiographic images	No Charge	D0367	*Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	175.00
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No Charge	D0368	*Cone beam CT capture and interpretation for TMJ series including two or more exposures	130.00
D0251	*Extra-oral posterior dental radiographic image	No Charge	D0369	*Maxillofacial MRI capture and interpretation	180.00
D0270	*Bitewing - single radiographic images	No Charge	D0370	*Maxillofacial ultrasound capture and interpretation	160.00
D0272	*Bitewings - two radiographic images	No Charge	D0371	*Sialoendoscopy capture and interpretation	160.00
D0273	*Bitewings - three radiographic images	No Charge	D0380	*Cone beam CT image capture with limited field of view - less than one whole jaw	140.00
D0274	*Bitewings - four radiographic images	No Charge	D0381	*Cone beam CT image capture with field of view of one full dental arch - mandible	130.00
D0277	*Vertical bitewings - 7 to 8 radiographic images	20.00	D0382	*Cone Beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	130.00
D0310	Sialography	150.00	D0383	*Cone beam CT image capture with field of view of both jaws, with or without cranium	175.00
D0320	Temporomandibular joint arthrogram, including injection	250.00	D0384	*Cone beam CT image capture for TMJ series including two or more exposures	130.00
D0321	Other temporomandibular joint radiographic images, by report	150.00	D0385	*Maxillofacial mri image capture	160.00
D0322	Tomographic survey	150.00	D0386	*Maxillofacial ultrasound image capture	160.00
D0330	*Panoramic radiographic images	No Charge	D0393	*Treatment simulation using procedures, by report	No Charge
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	75.00	D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin and cementum	No Charge
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	20.00	D0601	Caries risk assessment and documentation, with a finding of low risk	No Charge
D0364	*Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	140.00	D0602	Caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0394	*Digital subtraction of two or more images or image volumes of the same modality	No Charge	D0603	Caries risk assessment and documentation, with a finding of high risk	No Charge
D0395	*Fusion of two or more 3D image volumes of one or more modalities	No Charge	DENTAL PROPHYLAXIS		
TESTS AND EXAMINATIONS			D1110	*Prophylaxis - adult	No Charge
D0415	Collection of microorganisms for culture and sensitivity	No Charge	D1110	Additional prophylaxis - adult	15.00
D0425	Caries susceptibility tests	No Charge	D1120	*Prophylaxis - child	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			

UnitedHealthcare Dental HMO Plan

CODE	DESCRIPTION	MEMBER'S COPAY	CODE	DESCRIPTION	MEMBER'S COPAY
D0470	Diagnostic casts	No Charge	D1120	Additional prophylaxis - child	15.00
D0472	ORAL PATHOLOGY LABORATORY Accession of tissue, gross examination, preparation and transmission of written report	No Charge	D1206	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE) *Topical fluoride varnish	5.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Charge	D1208	*Topical application of fluoride - excluding varnish	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	D9910	*Application of desensitizing medicament	20.00
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	No Charge	D1310	OTHER PREVENTIVE SERVICES Nutritional counseling for control of dental disease	No Charge
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	No Charge	D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D0502	Other oral pathology	No Charge	D1330	Oral hygiene instructions	No Charge
D1520	*Space maintainer - removable - unilateral	No Charge	D1351	*Sealant - per tooth	No Charge
D1525	*Space maintainer - removable - bilateral	No Charge	D1352	*Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1550	Re-cementation or re-bond space maintainer	10.00	D1353	Sealant repair - per tooth	No Charge
D1555	Removal of fixed space maintainer	10.00	D1354	*Interim caries arresting medicament application	20.00
D1575	Distal shoe space maintainer - fixed - unilateral	No Charge	D1510	SPACE MAINTAINERS (PASSIVE APPLIANCES) *Space maintainer - fixed - unilateral	No Charge
D2140	AMALGAMS RESTORATIONS (INCLUDING POLISHING) Amalgam - one surface, primary or permanent	No Charge	D1515	*Space maintainer - fixed -	No Charge
D2150	Amalgam - two surfaces, primary or permanent	No Charge	D2510	INLAY/ONLAY RESTORATIONS Inlay - metallic - one surface	80.00
D2160	Amalgam - three surfaces, primary or permanent	No Charge	D2520	Inlay - metallic - two surfaces	90.00
D2161	Amalgam - four or more surfaces, primary or permanent	No Charge	D2530	Inlay - metallic - three or more surfaces	115.00
D2330	RESIN BASED COMPOSITE RESTORATIONS - DIRECT Resin-based composite - one surface, anterior	No Charge	D2542	Onlay - metallic - two surfaces	250.00
D2331	Resin-based composite - two surfaces, anterior	No Charge	D2543	Onlay - metallic - three surfaces	270.00
D2332	Resin-based composite - three surfaces, anterior	No Charge	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

UnitedHealthcare Dental HMO Plan

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

UnitedHealthcare Dental HMO Plan

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

Dental Benefits



UnitedHealthcare Dental HMO Plan

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

UnitedHealthcare Dental HMO Plan

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

UnitedHealthcare Dental HMO Plan

CODE	DESCRIPTION	MEMBER'S COPAY	CODE	DESCRIPTION	MEMBER'S COPAY
D5411	Adjust complete denture - mandibular	8.00	D5761	denture (laboratory) *Reline mandibular partial denture (laboratory)	35.00*
D5421	Adjust partial denture - maxillary	10.00	INTERIM PROSTHESIS		
D5422	Adjust partial denture - mandibular	10.00	D5810	*Interim Complete denture (maxillary)	220.00*
REPAIRS TO COMPLETE DENTURES			D5811	*Interim complete denture (mandibular)	220.00*
D5511	*Repair broken complete denture base, mandibular	15.00*	D5820	*Interim partial denture (maxillary)	220.00*
D5512	*Repair broken complete denture base, maxillary	15.00*	D5821	*Interim partial denture (mandibular)	220.00*
D5520	*Replace missing or broken teeth - complete denture (each tooth)	10.00*	OTHER REMOVABLE PROSTHESIS		
REPAIRS TO PARTIAL DENTURES			D5850	Tissue conditioning, maxillary	25.00
D5611	*Repair resin partial denture base, mandibular	15.00*	D5851	Tissue conditioning, mandibular	25.00
D5612	*Repair resin partial denture base, maxillary	15.00*	D5862	Precision attachment, by report	150.00
D5621	*Repair cast partial framework, mandibular	30.00*			
D5899	Unspecified removable prosthodontic procedure, by report	No Charge	D6068	alloy, high noble metal) *Abutment supported retainer for porcelain/ceramic FPD	695.00
NON-CLINICAL PROCEDURES			D6069	*Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	695.00
D5982	Surgical stent	100.00*	D6070	*Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	695.00
D5987	Commissure splint	100.00*	D6071	*Abutment supported retainer for porcelain fused to metal FPD (noble metal)	695.00
D5988	Surgical splint	100.00*	D6072	*Abutment supported retainer for cast metal FPD (high noble metal)	695.00
PRE-SURGICAL SERVICES			D6073	*Abutment supported retainer for cast metal FPD (predominantly base metal)	695.00
D6190	Radiographic/surgical implant index, by report	235.00	D6074	*Abutment supported retainer for cast metal FPD (noble metal)	695.00
SURGICAL SERVICES			D6075	*Implant supported retainer for ceramic FPD	695.00
D6010	*Surgical placement of implant body	950.00	D6076	*Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	695.00
D6012	*Surgical placement of interim body for transitional prosthesis	950.00	D6077	*Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	695.00
D6100	Implant removal, by report	700.00	D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of	36.00+
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			

UnitedHealthcare Dental HMO Plan

CODE	DESCRIPTION	MEMBER'S COPAY	CODE	DESCRIPTION	MEMBER'S COPAY
D6064	*Abutment supported cast metal crown (noble metal)	695.00		the implant surfaces, without flap entry and closure	
D6065	*Implant supported porcelain/ceramic crown	695.00	D6085	Provisional implant crown	125.00
D6066	*Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	695.00	D6094	*Abutment supported crown - (titanium)	695.00
D6067	*Implant supported metal crown (titanium, titanium	695.00	D6096	Remove broken implant retaining screw	500.00
	supported removable denture for edentulous arch - mandibular		D6110	*Implant /abutment supported removable denture for edentulous arch - maxillary	1200.00
D6112	*Implant /abutment supported removable denture for partially edentulous arch - maxillary	940.00	D6205	*Pontic - indirect resin based	695.00
D6113	*Implant /abutment supported removable denture for partially edentulous arch - mandibular	940.00	D6210	*Pontic - cast high noble	195.00*
D6114	*Implant /abutment supported removable denture for edentulous arch - maxillary	3800.00	D6211	*Pontic - cast predominantly base metal	195.00*
D6115	*Implant /abutment supported fixed denture for edentulous arch - mandibular	3800.00	D6241	*Pontic - porcelain fused to predominantly base metal	195.00*
D6116	*Implant /abutment supported fixed denture for partially edentulous arch - maxillary	2200.00	D6242	*Pontic - porcelain fused to noble metal	195.00*
D6117	*Implant /abutment supported fixed denture for partially edentulous arch - mandibular	2200.00	D6245	*Pontic - porcelain/ceramic	
D6118	*Implant /abutment supported interim fixed denture for edentulous arch - mandibular	1760.00	D6250	*Pontic - resin with high noble metal	195.00*
D6119	*Implant /abutment supported interim fixed denture for edentulous arch - maxillary	1760.00	D6251	*Pontic - resin with predominantly base metal	195.00*
	OTHER IMPLANT SERVICES		D6252	*Pontic - resin with noble metal	195.00*
D6080	Implant maintenance procedures, including removal	180.00	D6253	*Provisional Pontic - further treatment or completion of diagnosis necessary prior to final impression	No Charge
D6090	Repair implant supported prosthesis, by report	400.00		FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS	
D6092	Recement implant/abutment crown	45.00	D6545	Retainer - cast metal for resin bonded fixed prosthesis	180.00
D6093	Recement implant/abutment supported fixed partial denture	65.00	D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	225.00*
D6095	Repair implant abutment, by report	220.00	D6600	Retainer inlay - porcelain/ceramic, two surfaces	195.00*
	FIXED PARTIAL DENTURE PONTICS		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	CODE	DESCRIPTION	MEMBER'S COPAY
D6609	porcelain/ceramic, two surfaces Retainer onlay - porcelain/ceramic, three or more surfaces	195.00*	D6790	porcelain/ceramic *Retainer crown - full cast high noble metal	195.00*
D6610	Retainer onlay - cast high noble metal, two surfaces	195.00*	D6791	*Retainer crown - full cast predominantly base metal	195.00*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	195.00*	D6792	*Retainer crown - full cast noble metal	195.00*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	195.00*	D6793	*Provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	125.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	195.00*	D6794	*Retainer crown - titanium	195.00*
D6614	Retainer onlay - cast noble metal, two surfaces	195.00*	OTHER FIXED PARTIAL DENTURE SERVICES		
D6615	Retainer onlay - cast noble metal, three or more surfaces	195.00*	D6930	Re-cement or re-bond fixed partial denture	10.00
D6624	Retainer inlay - titanium	195.00*	D6940	Stress breaker	125.00
D6634	Retainer onlay - titanium	195.00*	D6950	Precision attachment	125.00
FIXED PARTIAL DENTURE RETAINERS - CROWNS			D6980	Fixed partial denture repair necessitated by restorative material failure	80.00
D6710	*Retainer crown - indirect resin based composite	195.00*	EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)		
D6720	*Retainer crown - resin with high noble metal	195.00*	D7111	Extraction, coronal remnants - deciduous tooth	45.00
D6721	*Retainer crown - resin with predominantly base metal	195.00*	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10.00
D6722	*Retainer crown - resin with noble metal	195.00*	D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	25.00
D6740	*Retainer crown - porcelain/ceramic	195.00*	OTHER SURGICAL PROCEDURES		
D6750	*Retainer crown - porcelain fused to high noble metal	195.00*	D7220	Removal of impacted tooth - soft tissue	40.00
D6751	*Retainer crown - porcelain fused to predominantly base metal	195.00*	D7230	Removal of impacted tooth - partially bony	55.00
D6752	*Retainer crown - porcelain fused to noble metal	195.00*	D7240	Removal of impacted tooth - completely bony	63.00
D6780	*Retainer crown - 3/4 cast high noble metal	195.00*	D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	100.00
D6781	*Retainer crown - 3/4 cast predominantly base metal	195.00*	D7250	Removal of residual tooth roots (cutting procedure) spaces, per quadrant	25.00
D6782	*Retainer crown - 3/4 cast noble metal	195.00*	VESTIBULOPLASTY		
D6783	*Retainer crown - 3/4	195.00*	D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	370.00
D7251	Cronectomy - intentional partial tooth removal	270.00	D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and	990.00
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			

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CODE	DESCRIPTION	MEMBER'S COPAY	CODE	DESCRIPTION	MEMBER'S COPAY
D7280	Exposure of an unerupted tooth	125.00		hyperplastic tissue)	
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	125.00		SURGICAL EXCISION OF SOFT TISSUE LESIONS	
D7283	Placement of device to facilitate eruption of impacted tooth	80.00	D7410	Excision of benign lesion up to 1.25 cm	25.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	115.00	D7411	Excision of benign lesion greater than 1.25 cm	50.00
D7286	Incisional biopsy of oral tissue-soft	60.00	D7412	Excision of benign lesion, complicated	55.00
D7287	Exfoliative cytological sample collection	50.00		SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7288	Brush biopsy - transepithelial sample collection	25.00	D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	65.00
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	30.00		EXCISION OF BONE TISSUE	
	ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE		D7471	Removal of lateral exostosis (maxilla or mandible)	95.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	20.00	D7472	Removal of torus palatinus	95.00
			D7473	Removal of torus mandibularis	95.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	20.00	D7485	Reduction of osseous tuberosity	95.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50.00		SURGICAL INCISION	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth	50.00	D7510	Incision and drainage of abscess - intraoral soft tissue	20.00
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00	D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	20.00
	REPAIR OF TRAUMATIC WOUNDS		D7520	Incision and drainage of abscess - extraoral soft tissue dentition	20.00
D7910	Suture of recent small wounds up to 5 cm	35.00		COMPREHENSIVE ORTHODONTIC TREATMENT	
	OTHER REPAIR PROCEDURES		D8070	Comprehensive orthodontic treatment of the transitional dentition	1800.00
D7921	Collection and application of autologous blood concentrate product	125.00	D8080	Comprehensive orthodontic treatment of the adolescent dentition	1850.00
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogeneuous or nonautogeneuous, by report	350.00	D8090	Comprehensive orthodontic treatment of the adult dentition	1950.00
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	800.00		MINOR TREATMENT TO CONTROL HARMFUL HABITS	
D7952	Sinus augmentation via a vertical approach	350.00	D8210	Removable appliance therapy	103.00
D7953	Bone replacement graft for ridge preservation - per site	100.00	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	CODE	DESCRIPTION	MEMBER'S COPAY
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	50.00		construction and placement of retainer(s)	
D7963	Frenuloplasty	50.00	D8681	Removable orthodontic retainer adjustment	No Charge
D7970	Excision of hyperplastic tissue - per arch	140.00	D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	No Charge
D7971	Excision of Pericoronal Gingiva	102.00	D8999	Unspecified orthodontic procedure, by report	250.00
D7972	Surgical reduction of fibrous tuberosity	125.00			
	LIMITED ORTHODONTIC TREATMENT			UNCLASSIFIED TREATMENT	
D8010	Limited orthodontic treatment of the primary dentition	1000.00	D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Charge
D8020	Limited orthodontic treatment of the transitional dentition	1000.00	D9120	Fixed partial denture sectioning	No Charge
D8030	Limited orthodontic treatment of the adolescent dentition	1000.00	D9210	ANESTHESIA Local anesthesia not in conjunction with operative or surgical procedures	No Charge
D8040	Limited orthodontic treatment of the adult	1350.00	D9211	Regional block anesthesia	No Charge
	anesthesia		D9212	Trigeminal division block	No Charge
D9215	Local anesthesia	No Charge		removable partial denture, maxillary	
D9222	Deep sedation/general anesthesia - first 15 minutes	50.00	D9935	Cleaning and inspection of removable partial denture, mandibular	No Charge
D9223	Deep sedation/general anesthesia - each 15 minute increment	50.00	D9940	*Occlusal guard, by report	250.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	65.00	D9942	Repair and/or relining of Occlusal guard	40.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	20.00	D9943	Occlusal guard adjustment	25.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	65.00	D9950	Occlusion analysis - mounted case	75.00
D9248	Non-intravenous conscious sedation	15.00	D9951	Occlusal adjustment - limited	25.00
	DRUGS		D9952	Occlusal adjustment - complete	75.00
D9610	Therapeutic parenteral drug, single administration	15.00	D9973	External bleaching - per tooth	30.00
D9630	Drugs or medicaments dispensed in the office for home use	15.00	D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	240.00
	MISCELLANEOUS SERVICES		D9991	Dental case management - addressing appointment compliance barriers	No Charge
D9910	*Application of desensitizing medicament	20.00	D9992	Dental case management - care coordination	No Charge
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	No Charge	D9993	Dental case management - motivational interviewing	No Charge
D9932	Cleaning and inspection of removable complete denture,	No Charge	D9994	Dental case management - patient education to improve oral health literacy	No Charge

UnitedHealthcare 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) relines 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.



Underwritten by Solstice Benefits, Inc.
Administered by Dental Benefit Providers, Inc.





Welcome to your vision plan.

Get the most out of your benefits.

2023 Optional Vision Annual Premium	
Retiree Only	\$ 65.00
Retiree + 1 Dependent	\$ 128.00
Retiree + 2 or more Dependents	\$ 212.00

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](#).

UnitedHealthcare Vision Plan		
Benefits Description	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.

 Member Name: John Smith Member ID: Same ID as Medical + Dental Member Web: www.myuhcvision.com Customer Service: (800)638-3120 Vision Identification Card <i>Powered by Spectera Eyecare Networks</i>	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.
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UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX.

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 Annual Premiums

RETIREEES		
	UnitedHealthcare DHMO	UnitedHealthcare DPPO
Retiree Only	\$200	\$505
Retiree + 1 Dependent	\$380	\$890
Family	\$525	\$1,300

RETIREEES	
	UnitedHealthcare / Spectera Vision Plan
Retiree Only	\$65
Retiree + 1 Dependent	\$128
Retiree + 2 or more Dependents	\$212

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



1

EMPLOYEE INFORMATION

LAST NAME

FIRST NAME

MI

SEX

DATE OF BIRTH

SOCIAL SECURITY NUMBER

MARITAL STATUS

HOME ADDRESS

CITY

STATE

ZIP CODE

HOME PHONE NUMBER

CELLULAR PHONE NUMBER

EMAIL ADDRESS

RETIREMENT DATE

RETIREE PLAN

2

TYPE OF COVERAGE

Medical

☐ High Option
☐ Low Option
☐ Medicare Indemnity

Dental (Optional)
☐ DPPO
☐ DMO

3

WHO SHOULD BE COVERED

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

4

TYPE OF CHANGE

☐ Add Spouse/Child (complete Sec 5)
☐ Terminate Spouse/Child (complete Sec 5)
☐ Address (enter above)
☐ Name Change (complete Sec 5)
☐ Terminate All Coverage - Reason

☐ Reinstatement - Reason
☐ Surviving Spouse Former Employee SSN
☐ COBRA Continuee Former Employee SSN
☐ Open Enrollment

5

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

(A) Add
(T) Term
(C) Chg

Last Name

First Name

MI

Social Security #

Date of Birth (Month/Day/Year)

Sex

Handicapped

Spouse

Child-1*

Child-2*

Child-3*

Child-4*

Child-5*

6

OTHER INSURANCE

On the day your coverage begins, will any family members, including those not listed above, be covered by any other health benefit plan, health or dental insurance, Medicare or Medicaid?
Is another person legally responsible for coverage for your children?
If you answered yes to either of the questions above, please complete the following:

Person's Name with Other Health Plan

Sex

Other Company's Name and Phone Number

Other Company's Policy Number and Effective Date

Medicare Number

Part A Effective Date

Part B Effective Date

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AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this plan (Us), I authorize any health care professional or entity to give The UnitedHealthcare Insurance Company and its affiliates (and the employee) or any of their designees (UnitedHealthcare), any and all records and information pertaining to medical history or services rendered to Us for any administrative purpose, including but not limited to, but not limited to, the use of a Social Security Number for purpose of identification, I understand and agree that any omissions or inaccuracies made on this form will be the responsibility of the individual who provided the information. I understand that this authorization is effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.
If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.
NOTICE OF ENROLLMENT RIGHTS
I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.
Health insurance or medical services benefits provided or administered by The UnitedHealthcare Insurance Company, Hartford, CT.

X Signature

Date

8

TO BE COMPLETED BY EMPLOYER

DATE OF HIRE

HEALTH/CHANGE EFF. DATE

POLICY NUMBER

GRP/SUBGRP/ENFT GRP

PLAN VARIATIONS/SUB

REPORTING CODE/BRANCH

Enrollment Application and Change Form

Instructions

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

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

SECTION 1 Complete all information.

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

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

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

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

A = To add a dependent to your benefit plan.

T = To terminate yourself or a dependent's coverage.

C = To change information about yourself or a dependent.

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

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

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

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



SOCIAL SECURITY NUMBER	Retiree / Widow			<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Address Change <input type="checkbox"/> Change Date of Change / / <input type="checkbox"/> Number Change	
LAST NAME	FIRST NAME	MI	DATE OF BIRTH		
ADDRESS	CITY	STATE	ZIP		
TELEPHONE NUMBER					
Cell ()		Home ()		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married	
PLAN COVERAGE <input checked="" type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree Plus 1 Dependent <input type="checkbox"/> Retiree Plus 2 or More Dependents					
Annual Premium	\$ 65.00	\$ 128.00	\$ 212.00		

Last Name	First Name	MI	Relationship**	Date of Birth	Social Security Number
			<input type="checkbox"/> Wife <input type="checkbox"/> Husband		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter		

COMPANY NAME: Dade County Firefighters Insurance Trust			ENROLLEE EFFECTIVE DATE: (Mo/Day/Yr) ____/____/____	
ENROLLMENT: <input type="checkbox"/> Retirement <input type="checkbox"/> Other	DATE OF RETIREMENT: (Mo/Day/Yr) ____/____/____	POLICY NUMBER:	PLAN CARIATION/REPORTING CODE:	PLAN CODE:

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

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Dade County Fire Fighters Insurance Trust

Retired Member Policy #645783

PLEASE PRINT ALL INFORMATION CLEARLY

Retirement Date: ____/____/____

Retiree Name: _____

Sex: **Male** or **Female** (Circle)

Date of Birth: ____/____/____

Social Security # ____ - ____ - ____

Home Phone: (____) ____ - ____

Cell Phone # (____) ____ - ____

E-Mail Address: _____

Address _____ City _____ State: _____ Zip Code: _____

☐ Single

☐ Married

☐ Divorced

☐ Widowed

I hereby designate the following as my beneficiary (ies)

Primary Beneficiary (ies)

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

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

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

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

\$25,000 Normal Death Benefit up to age 65

\$16,500 Normal Death Benefit after age 65

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



Retiree Signature _____ **Date** _____

State of Florida

SS:

County of Dade

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

Notary Public, State of _____

☐ Personally Known

☐ Produced Identification

☐ Identification Produced _____

Underwritten by STANDARD LIFE INSURANCE COMPANY, Portland, OR

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 balance 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:
 - o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - o Cover emergency services by out-of-network providers.
 - o 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.
 - o 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

Important Notice from Dade County Fire Fighters Insurance Trust, About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year during Medicare open enrollment period (October to December).

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Dade County Fire Fighters Insurance Trust coverage will not be affected.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

You should also know that if you drop or lose your current coverage with Dade County Fire Fighters Insurance Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dade County Fire Fighters Insurance Trust changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	January 1, 2023
Name of Entity/Sender:	Dade County Fire Fighters Insurance Trust
Contact--Position/Office:	Dale Sutton / Personnel Manager
Address:	8000 NW 21st Street, Suite 222, Miami, FL 33122
Phone Number:	(305) 593-6100

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo. 1210-0149
(expires 6-30-2023)

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](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

☒ 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:

☒ We do offer coverage. Eligible dependents are:

Legal Spouse and Dependent Children up to Age 26

☐ We do not offer coverage .

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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)



8000 NW 21st Street
Suite 222
Miami, FL 33122-1605
305-593-6100

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.