DADE COUNTY FIRE FIGHTERS INSURANCE TRUST

2025 RETIREES UNDER 65 BENEFIT BOOKLET

January 1, 2025 - December 31, 2025

UnitedHealthcare®

EXPRESS SCRIPTS®

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

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

DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST FUND

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

Phone: 305-593-6100

ADMINISTRATOR
UnitedHealthCare

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

All eligible retired Trust Plan members and their dependents under the age of sixty-five (65) have the option to enroll in either High or Low Plan for medical utilizing the UnitedHealthCare (UHC) Choice Plus national network of providers. You may choose to participant in either optional UHC PPO or HMO/Solstice dental or UHC vision at an additional premium.

All retired Trust members under the age of 65 are provided a life insurance benefit of $25,000 normal death througth Standard Life. You may update your beneficiary designation at any time by requesting a form from our office or printing the form on Local 1403's website under Health Trust and remitting to our office.

Every year during the month of December retired members are able to make changes to medical and dental plan type, add or remove dependents from coverage, enroll or end optional vision. Your elections are in effect for the entire year of 2025. All changes are effective January 1, 2025. Forms only need to be completed and sent into our office if you are making a change.

What is the difference between UHC High and Low Option medical?
The High Option allows medical coverage at In-Network with applicable copay per visit, $300 In-Network deductible plus 10% co-insurance for hospital services & in-patient, $500 out of network deductible & 20% co-insurance applies to out of network provider services including 30 annual massage therapy and accupuncture visits.
The Low Option is an In-Network co-pay only Plan. The very high $10,000 annual deductible and 50% co-insurance for out of network services makes it cost prohibitive for out of network use. This plan is strictly meant to be used in-network with payment of applicble co-payments.

In-network copays for UHC High and Low Option

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

Do I need to enroll in optional vision through UnitedHealthCare?
Our group offers under medical High and Low Plans one eye exam per year. Any ailment or disease of the eye is covered under medical. The optional vision is specially for those in need of annual vision exam and coverage of hardware such as prescription glasses and contact lens.

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

How do I access prescription coverage through Express Scripts?
You and your covered dependents may fill your short term prescriptions at any participating pharmacy (CVS, Publix, Target, Walgreens or Walmart to name a few). Every year retiree, spouse and covered dependent child must meet the first $25, prescription deductible, before applicable tier copay apply.

All maintenance (daily) medications must be filled as 90 day supply either locally at Walgreens or mail order directly with ExpressScripts. Make sure your provider writes prescription correctly for 90 day quantity and proper refills.

If I am not making any changes to coverage or dependents covered. Do I need to do anything?
Your current medical, dental and vision will automatically renew, if we do not receive completed paperwork with changes in our office by January 10, 2025. Your optional dental and vision coverage will be cancelled retroactively to December 31, 2024 if full annual premium is not received by January 31, 2025. Dental and vision premium is only able to be paid monthly if you are enrolled automatic pension deductions through FRS (Florida Retirement System).

What do I need to provide if adding a new dependent?
If you are adding a dependent, you must provide supporting documentation that the dependent meets the eligibility requirement for coverage. Our Plan is unable to provide coverage of domestic partners. You must provide with completed enrollment form a copy of your marriage certificate to add spouse and a birth certificate for each child added to your coverage in addition to Social Security number.

How do I pay my premium for medical plus optional dental and vision?
If you are enrolled in automatic premium deductions through your Florida Retirement System (FRS) pension, your deduction will continue in the new year. Retirees participating in the pension plan can have premium for medical/prescription plus optional dental and vision deducted monthly.

If you are a self pay retiree medical premium is due by the first day of every month. Payments received after the 10th are late.
Self-pay retirees may remit payments quarterly, bi-annually or annually. The only automatic payment option available is through FRS pension. You may schedule monthly payments for medical through your banking institution's online bill pay provider. Consistent and timely payments are imperative to maintaining your benefits in force.

Premium payments for medical/prescription and optional dental or vision are made payable to **DCFF Insurance Trust.**

Do I have to enroll/participate in Medicare at age 65?
Our Plan requires that you, your spouse or covered dependent upon acquiring Medicare eligibility for Part A & B either based on reaching age 65 or approved for disability Medicare that you enroll and maintain Part A & B active. Our Plan coordinates with traditional Medicare Part A (hospital) and Part B (medical) with continued coverage of prescriptions through Express Scripts. There is no need to enroll in Part D.

Feel free to contact our office with any specific questions during open enrollment and throughout the year.

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

Important Notices

Eligible Dependents:

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

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

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

When Coverage Begins:

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

When Coverage Ends:

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

When Can You Enroll?

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

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

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

Worker's Compensation

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

Qualified Family Status Change:

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

Educational Videos:

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

Medical Benefits

Welcome - We're Glad You're Here

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

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

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

Before You Enroll

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

The UnitedHealthcare Network:

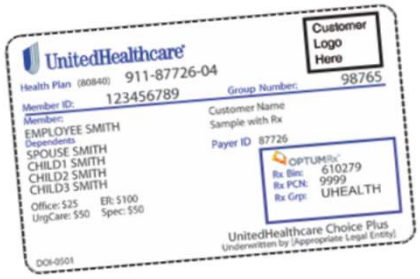
Find a network doctor or hospital.

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

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

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

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



Always carry your ID Card!

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

These Extras Are Part of Every Plan

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

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

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

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

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

Medical Benefits

DCFF Insurance Trust offers medical benefits through UnitedHealthcare. Please refer to the carrier benefit summary for complete plan details. To locate providers within your network, visit www.myuhc.com. Please be advised that the Plan's Summary of Benefits & Coverage (SBC) as well as the Summary Plan Description (SPD) are available to you on-line at www.local1403.org or a copy can be provided upon request.

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

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

Medical Benefits - Continued

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

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

Click to view: HMO Plans Overview

Click to view: PPO Plan Overview

Your benefit at a glance

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

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

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

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

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

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

Choose your way to save with a 3-month supply

EXPRESS SCRIPTS®

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

OR

Walgreens

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

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

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

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

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

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

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

We're glad to help. 866-890-1419 <express-scripts.com/90day>

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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 Pharmacy℠ or from any Walgreens or Duane Reade™ pharmacy.[1]

2. How many Walgreens pharmacies are available to me?

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

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

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

4. What does "full cost" mean?

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

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

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

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

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

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

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

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

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

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

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

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

[3] Price may vary slightly for coinsurance plans.

Express Scripts manages your prescription plan.

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Get more out of your health plan benefits with these 2 handy digital tools

The UnitedHealthcare® app and myuhc.com®

Whether on the go or online, you'll have access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Quickly compare cost estimates before you get care
- Learn about covered preventive care
- Access your health plan ID card and add your plan details to your smartphone's digital wallet

Register once to access both tools

Start by downloading the UnitedHealthcare app or going to **myuhc.com** and then:

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication—then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now you're registered for—and connected to—the app and the website.

Get connected

Scan this code to download the app and register, or visit **myuhc.com**

United Healthcare

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.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under the Find Care & Costs section. Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

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

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

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

Visit with a provider 24/7 - whenever, wherever

With 24/7 Virtual Visits, you can connect to a provider by phone or video[1] through **myuhc.com** or the UnitedHealthcare app

Another way to get care

Providers can treat a wide range of health conditions-including many of the same conditions as an emergency room (ER) or urgent care-and may even prescribe medications, if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is $25 copay.°**

Consider 24/7 Virtual Visits for these common conditions and more

- Cough
- Headache
- Sore throat
- Fatigue/weakness
- Nasal discharge
- Difficulty sleeping
- Congestion/sinus pain
- Fever
- Loss of appetite

$25

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit – Must receive services thru myuhc.com or the app

Get started

Sign in at **myuhc.com/virtualvisits** | Call the number on your health plan ID card | Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.

• Average allowed amounts charged by United Healthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated urgent care savings are based on a $131 difference between an average urgent care visit cost of $180 and a Virtual Visit cost of $54; $2,000 difference between the average emergency room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and are not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

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

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 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.

Insurance coverage provided by or through United Healthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a United Healthcare company.

Stressed? Anxious? With virtual therapy, getting help may now be easier than ever.

Reaching out may be hard—especially if you might not want anyone to know you're hurting. From the privacy of home and the convenience of your mobile device* or computer, you can receive caring support from a licensed therapist.

Virtual therapy offers confidential counseling and includes:

Private video sessions
Get 1-on-1 support—in your home and at a time that's convenient for you.

Help with coping—for children, teens and adults
Your licensed therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits
You can see the same therapist with each appointment and establish an ongoing relationship.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Mental health disorders

A quicker way for the whole family to get care

A virtual visit for mental health care may be a great way for children and teens to get an appointment.

To find a provider and schedule a visit

Sign in or register on **myuhc.com®**. Then, go to **Find Care & Costs > Virtual Care > Behavioral Health Care > Get Started** and call the provider to set up an appointment. Or call the telephone number on your health plan ID card.

*Data rates may apply.

Costs and coverage may vary. Check your plan for details.

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

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

United Healthcare

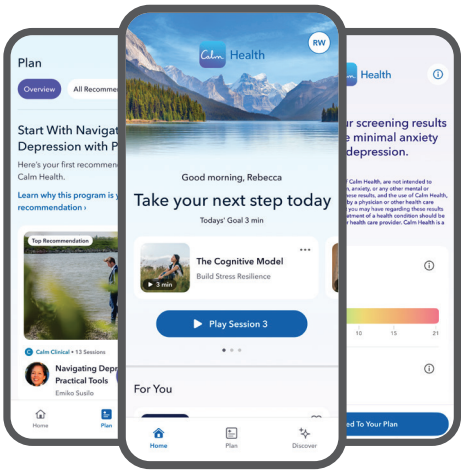
Mind. Body. You.

Make the connection with Calm Health.

The Calm Health app provides programs and tools to help support your mental health and well-being – all at your own pace. As a UnitedHealthcare member, Calm Health is included in your health plan and available at no additional cost.

Resources to help support your mental health

To help tailor your Calm Health experience, you'll begin with a short mental health screening. Then, Calm Health will suggest certain programs for you to consider based on where you are in your well-being journey.



Tap into tools and support

The Calm Health app brings you a library of support – including mindfulness content and programs created by psychologists – for a variety of health experiences and life stages. This information is designed to help you:

- **Learn techniques to improve well-being** – Find tools, music and sounds to help you meditate, improve focus, move mindfully and feel calm
- **Work toward goals** – Join self-guided self-care programs, and track your progress along the way
- **Support your mind and body** – Access mental health information and support to help you strengthen the mind-body connection

Scan this code to get started

You'll first need to sign in to your account on **myuhc.com®** or the UnitedHealthcare® app. If you don't have an account, select Register to create one.

United Healthcare® | Calm Health

continued

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

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

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

Covered at $0 out-of-pocket

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

More important this year

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

Helping communities and health systems

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

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

Choose where to get your flu shot

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

continued

United Healthcare

Retail pharmacies: Pharmacists associated with these retail pharmacies can administer flu shots. No appointments are necessary.	
Albertsons® Companies including Albertsons Osco, Albertsons Sav-on, Acme Sav-on, Jewel-Osco, Safeway, Shaws Osco and Star Markets **Safeway®** including Carrs, Pavilions, Randalls, Tom Thumb and Vons **United Supermarkets®** including Albertsons Market, Amigos and Market Street	**ACME:** acmemarkets.com/pharmacy/pharmacy-services/immunizations **Albertsons:** albertsons.com/pharmacy/pharmacy-services/immunizations **Carrs:** carrsqc.com/pharmacy/pharmacy-services/immunizations **Haggen:** pharmacy.haggen.com/hgweb/#/home **Jewel Osco:** jewelosco.com/pharmacy/pharmacy-services/immunizations **Pavilions:** pavilions.com/pharmacy/pharmacy-services/immunizations **Randalls:** randalls.com/pharmacy/pharmacy-services/immunizations **Safeway:** safeway.com/pharmacy/pharmacy-services/immunizations **Shaws:** shaws.com/pharmacy/pharmacy-services/immunizations **Star Market:** starmarket.com/pharmacy/pharmacy-services/immunizations **Tom Thumb:** tomthumb.com/pharmacy/pharmacy-services/immunizations **Vons:** vons.com/pharmacy/pharmacy-services/immunizations **United:** unitedsupermarkets.com/page/pharmacy#immunizations
Costco Pharmacy	costco.com/pharmacy/adult-immunization-program
Harris Teeter®	harristeeter.com/pharmacy-services/#/app/cms
H-E-B®	heb.com/pharmacy/services/immunizations.jsp
Hy-Vee®	hy-vee.com/health/pharmacy/flu-shots
Kmart®	pharmacy.kmart.com/newrx-immunization
The Kroger Co. including Baker's, City Market, Copps, Dillons, Fred Meyer, Fry's, Gerbes, Jay C, King Soopers, Kwik Shop, Mariano's, Metro Market, Owen's, Payless, Pick 'n Save, QFC, Ralph's Grocery, Roundy's and Smith's Food & Drug Center	kroger.com/d/flu
Meijer®	meijer.com/services/pharmacy/pharmacy-services.html
Publix®	publix.com/pharmacy-wellness/pharmacy/pharmacy-services/vaccinations
Rite Aid®	riteaid.com/pharmacy/services/vaccine-central
Walgreens® including Duane Reade, Jim Meyers, Kerr Drug, May's Drug, Parkway Drug, Super D Drug, The Ryan Pharmacy and USA Drug	walgreens.com/flu
Walmart Inc. and Sam's Club®	walmart.com/cp/1228302
Network convenience care clinics: Convenience care clinics are typically located in retail stores and don't require appointments.	
The Little Clinic®	thelittleclinic.com
MinuteClinic®	minuteclinic.com/services/vaccination
RediClinic®	rediclinic.com/riteaid
Walmart Care Clinic®	walmart.com/careclinic

Find a nearby location

uhc.com/flushot

United Healthcare

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

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

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

OnePass Select

Rediscover your passion for health

With One Pass Select, we're on a mission to make fitness engaging for everyone. One Pass Select can help you reach your fitness goals, while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. Choose a membership tier that fits your lifestyle and provides everything you need for whole body health in one easy, affordable plan. You and your eligible family members (18+) can get started with One Pass Select on January 01, 2025.

Find your fit with One Pass Select

At the gym

Choose from our large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.

At home

Work out at home with live or on-demand online fitness classes. Try our workout builder to get routines created just for you, no matter what your fitness level and interests are.

In the kitchen

Get groceries and household essentials delivered to your home. We make it easy to plan for everything you need to enjoy delicious, nutritious meals.

$34/Mo

Classic

12,000+ gym locations

$69/Mo

Standard

14,000+ gym and premium locations

$109/Mo

Premium

16,000+ gym and premium locations

$159/Mo

Elite

20,000+ gym and premium locations

Enroll beginning: January 1, 2025

1. Scan QR code below or visit: https://member.uhc.com/coverage/additional/
2. Sign in or register
3. Select the One Pass Select tile

An enrollment fee may apply

Or get started with a digital-only plan for $10/Mo

All tiers Classic or above come with grocery and home essentials delivery at no extra cost.

United Healthcare®

One Pass Select is a voluntary program featuring a subscription based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.

Administrative services provided by UnitedHealthcare Services, Inc. or their affiliates

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.

Walmart

$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

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 CostPlus DRUG COMPANY

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

GoodRx

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.

GoodRx

Save $$$ on your prescriptions!

GoodRx makes it easy to find the lowest price on your prescriptions and it's FREE!

- In under 15 seconds, instantly compare local pharmacy prices for any FDA-approved prescription drug
- Find discount coupons - Save up to 80% or more on cash prices at over 60,000 U.S. pharmacies.
- Reduce your out-of-pocket costs - Prices are often lower than insurance co-pays - great for those with high deductibles.
- Pay no fees - GoodRx is 100% free with no obligation or registration.

Saving up to 80% on all your prescription drugs is as simple as...

1 Click
Visit goodrx.com, enter the drug name & local zip code

2 Compare
Instantly view and compare prices for the prescription at local pharmacies

3 Save
Take the GoodRx coupon to the at pharmacy with the lowest price and save up 80%!

GoodRx

Put GoodRx in the palm of your hand.
DOWNLOAD OUR AWARD-WINNING MOBILE APP!
Instantly compare & save up to 80% on your prescriptions at over 60,000 U.S. pharmacies!

Important GoodRx Reminder:
Any medications purchased through GoodRx will not apply towards the medical/prescription plan or maximum out-of-pocket.

Which Do I Choose*?

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

Primary Care Physician

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

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

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

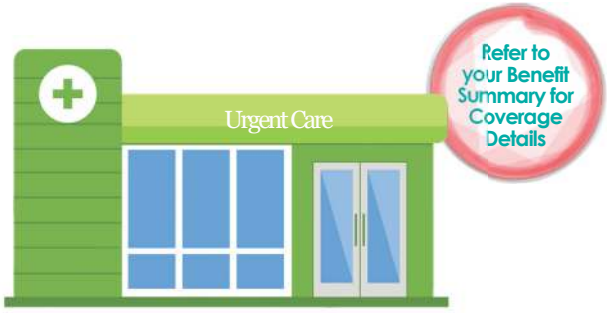
Online Telehealth

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

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

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

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



Urgent Care

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

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

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

Emergency Room

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

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

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

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

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

Telehealth

Places of Care

Dental Benefits

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

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

2025
Optional PPO Dental Annual Premium

Retiree Only	$505
Retiree + 1 Dependent	$890
Retiree + Family	$1,300

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

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

Giving you simplicity and lower costs.

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

See any network dentist and save.

Discounted specialist care with no referrals.

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

Preventive care is covered 100% in our network.

Get coverage on hundreds of services.

No deductibles and annual maximums.

Helping you stay healthier.

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

Oral cancer screenings.

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

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

Extra care during pregnancy.

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

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

How your teeth affect your health.

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

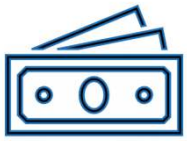
- ✓ **Diabetes**
- ✓ **Heart disease**
- ✓ **Pregnancy complications**
- ✓ **Respiratory conditions**
- ✓ **Rheumatoid arthritis**

Search for local dentists.

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

Visit **myuhc.com**

The network in Florida that you will want to search is called FL Managed Care - Solstice S 100B.



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® or through the UnitedHealthcare 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.

Dental Benefits

DCFF Insurance Trust offers a managed dental plan (DHMO) through **UnitedHealthcare.** The DHMO provides in-network only benefits. The chart below illustrates some of the more common services provided and associated copays. Please refer to the carrier schedule of benefits for full benefit details. The full schedule can be found at www.local1403.org. 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.

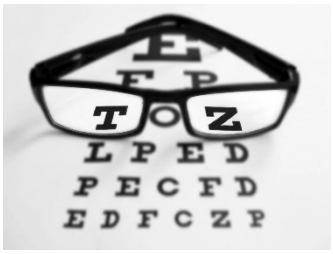
UnitedHealthcare Dental HMO Plan	
Annual Deductible	None
Annual Maximum Benefit	Unlimited
Service Description	You Pay
D0120 Periodic Oral Evaluation (1 per 6 months)	No Charge
D0150 Comprehensive Oral Evaluation (1 per 36 months)	No Charge
D1110/1120 Prophylaxis- Adult/Child (1 per 6 months)	No Charge
D1206 Topical Fluoride Varnish (1 per 12 months)	$5
D1351 Sealant – Per tooth (1 per tooth every 3 years)	No Charge
D0210 X-Rays – Intraoral, Comprehensive Series	No Charge
D1510 Space Maintainers (Children under age 16)	No Charge
D2330-2394 Fillings	No Charge
D3310/D3330 Root Canal – Anterior/Molar	$100 / $210
D7111 – Extraction Primary Tooth	$45
D4210 Gingivectomy/Gingivoplasty	$175
D9230 – Inhalation of Nitrous Oxide	$20
D2930 – Crown - Prefab Stainless – Primary	$35
D2750 – Crown – Porcelain Fused High Noble Metal	$195 Additional Lab/Material Fees Apply
D6750 – Retainer Crown Porcelain Fused to High Noble Metal	$195 Additional Lab/Material Fees Apply
D6010 – Surgical placement of Endosteal Implant	$950
D6060/6061 – Implant related services	$695
D5110/5120 – Dentures – Maxillary/Mandibular	$210 Additional Lab/Material Fees Apply
Orthodontia D8080/8090 – Comprehensive Orthodontic Treatment – Child / Adult D8660 – Pre-Orthodontic Treat Exam D8680 – Orthodontic Retention D8999 – Unspecified Orthodontic Procedure by Report	 $1,850 / $1,950 $35 $300 $250

2025
Optional HMO Dental Annual Premium

Retiree Only	$210
Retiree + 1 Dependent	$400
Retiree + Family	$552

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

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

2025
Optional Vision Annual Premium

Retiree Only	$65
Retiree + 1 Dependent	$128
Retiree + Family	$212

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

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.

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 10p.m. CT or Saturday 8 a.m. to 5:30 p.m. CT.

Find out what your vision plan covers.

Eye exam.

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

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

Frame allowance.[1]

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

Contact lens benefit.[1]

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

Lens options.[1]

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

Additional pairs of glasses.

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

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

Take steps to protect your eyes.

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

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

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

America's Best Contacts & Eyeglasses

Costco Optical

Eyeglass World

For Eyes by GrandVision

Visionworks

Warby Parker

No network eye doctor in your area?

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

2 Schedule your annual eye exam.

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

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

Get a complete eye exam.

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

At your appointment, be sure to:

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

Use your ID card.

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

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

Laser vision correction.

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

Contact lenses.

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

You can also save on hearing aids!

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

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

How to Use Your Vision Care Benefits

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

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

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

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

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

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

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

UnitedHealthcare®

Member Name:
Member ID:

Member Web: www.myuhcvision.com

Customer Service: (800)638-3120

Vision Identification Card

Powered by Spectera Eyecare Networks

fold here

Vision Care Benefits

Exam Copay: $10.00
Material Copay: $15.00

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

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

OnlineID-rev.2/2014

Out-of-network benefits are not available on allplans. Please check your benefit summary forplan specifics before going to an out-of• network provider.

Because your hearing health is part of your overall health

Please note that the hearing aid benefit is **ONLY** available to retired members who are enrolled in the optional **Vision Plan**.

UnitedHealthcare Hearing offers two ways forward

Get help from a hearing care professional

An expert-guided path means you'll have a no-cost hearing exam and consultation, then have help finding the right hearing aid for your lifestyle. You'll also get in-person fittings and adjustments for your prescription hearing aids.

Start by visiting
uhchearing.com/prescription

Take the self-guided path

Don't want the hassle of appointments or prescriptions? If you have mild-to-moderate hearing loss, you can shop for over-the-counter hearing aids that are covered by your benefits.

Start by visiting
uhchearing.com/otc

Plan details

Thank you for being a UnitedHealthcare Vision member. Through UnitedHealthcare Hearing, you'll save up to 50% off a wide selection of hearing aids and services.
Go to uhchearing.com/employee to log in and view your coverage.

Learn more about your hearing health

Scan using your smartphone's camera.
uhchearing.com/employee

United Healthcare Hearing

Good-to-know details

- Hearing aids today typically are smaller, less noticeable, and more comfortable than they used to be
- Both prescription and over-the-counter (OTC) hearing aids come in a variety of styles to fit your lifestyle, budget and goals
- A convenient, national network of hearing care professionals offer support for prescription devices

Choose from a broad array of high quality hearing aids from major brands.

What to expect from hearing aids

Innovative new hearing aids help you stay connected and engaged, from versatile over-the-counter devices to the cutting-edge technology of prescription hearing aids.

Prescription devices include:

- An expert-guided path with in-person support
- Personalized recommendations and follow-up

Over-the-counter devices allow you to:

- Shop online and have your devices shipped to your door
- Set up and fine-tune your devices on your own

Ready to start with an expert?

1-866-926-6632, TTY 711
Call 8 a.m. to 8 p.m. CT, Monday through Friday. Use promo code **UHC MYVISION** to access your no-cost hearing exam and consultation and special pricing

Want to take the self-guided path?

Visit uhchearing.com/otc
Learn more about the different styles and features.

Please note that the hearing aid benefit is **ONLY** available to retired members who are enrolled in the optional **Vision Plan**.

United Healthcare Hearing

Annual Coverage for Optional Benefits Premiums 2025

RETIREES		
	UnitedHealthcare DHMO	UnitedHealthcare DPPO
Retiree Only	$210	$505
Retiree + 1 Dependent	$400	$890
Family	$552	$1,300

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

Trust Office Contacts

Contact	Phone #	Direct Line	Email Address
Local 1403 (main line)	305-593-6100 Press "2" for health insurance	-----	-----
Dale E. Sutton - Administrator	Ext. 114	786-437-2560	Dale.Sutton@local1403.org
Jacqueline Hernandez	Ext. 108	786-437-2563	Jackie.Hernandez@local1403.org
Gloria Munoz	Ext. 107	786-437-2565	Gloria.Munoz@local1403.org
Teresita Rodriguez	Ext. 110	-----	Teresita.Rodriguez@local1403.org

Insurance Contacts

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	877-816-3596	www.myuhc.com
Vision	UnitedHealthcare / Spectera Vision	800-638-3120	www.myuhcvision.com
TeleHealth	UnitedHealthcare	855-615-8335	Myuhc.com/virtualvisits
Employee Medical Accounts	Anchor Benefit Consulting	800-845-7629	www.anchorbenefit.com

☐ NEW COVERAGE
☐ REQUEST FOR CHANGE

Enrollment Application and Change Form

PLEASE READ INSTRUCTIONS ON REVERSE SIDE. PLEASE PRINT CLEARLY.

UnitedHealthcare®

1 EMPLOYEE INFORMATION

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

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER
				( )

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

2 TYPE OF COVERAGE

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

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

3 WHO SHOULD BE COVERED

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

4 TYPE OF CHANGE

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

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

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

6 OTHER INSURANCE

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

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

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

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

7 AUTHORIZATION

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

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

NOTICE OF ENROLLMENT RIGHTS

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

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

X Signature _____ **Date** _____

8 TO BE COMPLETED BY EMPLOYER

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

Enrollment Application and Change Form

Instructions

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

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

SECTION 1 Complete all information.

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

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

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

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

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

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

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

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

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

UnitedHealthcare®

Vision Enrollment Form

Dade County Firefighters Insurance Trust

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

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

INFORMATION FOR DEPENDENT COVERAGE

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

EMPLOYER INFORMATION - TO BE FILLED OUT BY EMPLOYER

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

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

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

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

SIGNATURE:_____ DATE: _____

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*

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 30days 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 the 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.

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

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

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

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 has determined that the prescription drug coverage offered by the Dade County Fire Fighters Insurance 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 from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose your creditable plan coverage.
- You may stay in the plan and also enroll in a Medicare prescription drug plan. The plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Express Scripts and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Express Scripts, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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:	1/1/2025
Name/Entity of Sender:	Dade County Fire Fighters Insurance Trust
Contact Position/Office:	Dale Sutton / Personnel Manager
Address:	8000 NW 21st Street, Suite 222, FL 33122
Phone Number:	(305) 593-6100

Your Information. Your Rights. Our Responsibilities.

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****.*
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/hipaa/filing-a-complaint/index.html.
- 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/hipaa/for-individuals/guidance-materials-for-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/hipaa/for-individuals/guidance-materials-for-consumers/index.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.

Other Instructions for Notice

- January, 1st 2025
- 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 **cannot** 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.

In the state of Florida, there are comprehensive balance billing protections (found at Florida Statute 627.64194) in addition to those provided by the federal No Surprises Act. Florida law states that insurance companies are not allowed to bill you for amounts beyond your plan's in-network cost-sharing amount. That protection applies to HMO and PPO insurance plans for emergency services by out-of-network providers and facilities, as well as non-emergency services provided by out-of-network providers at in-network facilities. For PPOs, the state payment standard applies to emergency services and non-emergency services provided by out-of-network providers at in-network facilities. For HMOs, the state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place. Under Florida law, these protections do not apply to ground ambulance services for PPO insurance plans, patients enrolled in PPO insurance plans who consent to non-emergency out-of-network services, and patients with self-funded insurance plans. The laws put in place by the state of Florida work together with the requirements of the No Surprises Act to ensure that you are protected from surprise medical bills. [link to corresponding Florida statute]

Certain services at an in-network hospital or ambulatory surgical center
When receiving services from an in-network hospital or ambulatory surgical center, certain providers 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 **cannot** 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 **cannot** balance bill you, unless you give written consent and give up your protections.

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

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

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

- Your health plan generally must:

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

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

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

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

If you believe you've been wrongly billed, or for more information about your rights, you may contact the Consumer Services at the Florida Department of Agriculture and Consumer Services at 800-435-7352 or visit their website at:
https://csapp.fdacs.gov/CSPublicApp/ Complaints/FileComplaint.aspx

You may also visit the Centers for Medicaid and Medicare Services No Surprises Consumers website at https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer
does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also
be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded
from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same coverage;, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage; it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaidchip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender: **Dade County Fire Fighters Insurance Trust**
Contact--Position/Office: **Dale Sutton**
Address: **8000 NW 21st Street, Miami, Fl 33122 - 1605**
Phone Number: **305-593-6100**

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

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

  - [ ] Some employees. Eligible employees are :

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

    Legal Spouse and Dependent Children up to Age 26

  - [ ] We do not offer coverage .

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

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

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

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

Notes

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.