2026 Active Member Benefit Booklet

January 1, 2026 – December 31, 2026

Inside the Guide

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

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

DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST FUND

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Open enrollment is your annual opportunity to make changes to your medical, dental and vision elections for January to December 2026. This is the only time of the year you may change your type of coverage High or Low Option medical, PPO or HMO dental or terminate/add optional vision. **UnitedHealthCare** continues as our medical, dental and vision provider with **ExpressScripts** as our pharmacy/prescription provider.

All uniform personnel, transporters and dispatchers under Local 1403 bargaining unit are eligible to participate in **Dade County Fire Fighters Insurance Trust** medical/prescription, dental and optional vision.

As an active Trust member, you are afforded the opportunity to receive subsidized retiree health insurance at an attainable premium upon ending your employment with MDFR, meeting FRS definition of retiree (25 years of service or age 55) and participating a minimum of ten (10) years in our health plan to receive minimum 40% of our retiree subsidy. The benefit accrues an additional 4% per year once you reach ten (10) years, vesting in Plan to achieve full benefit at reaching twenty-five (25) years in Plan. The full retiree subsidy for 2026 is $460.00 monthly.

All participating active Trust members are provided a life insurance benefit equal to one-time basic annual salary for normal death (illness or age) or two-times basic annual salary for accidental death & dismemberment underwritten by Standard Life Insurance. The benefit is for off or on duty death.

We are pleased to inform you that there are no Plan changes or Premium increases for 2026.

ACTIVE EMPLOYEES
Bi-Weekly Premium

	Choice Plus Low Option	Choice Plus High Option	Dental Plan DHMO or PPO
Employee Only	$34.95	$34.95	$0.00
Employee +Spouse	$249.95	$324.95	$10.00
Employee +Child	$219.95	$289.95	$5.00
Family	$324.95	$394.95	$15.00

	UnitedHealthCare/Spectera/Vision
Employee Only	$2.47
Employee+1	$4.93
Employee+2 or more	$8.16

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

When are open enrollment changes effective?
All open enrollment changes are effective January 1, 2026

Can I have medical/prescription through UnitedHealthCare and choose dental through Miami Dade provider or vice versa?
No, choosing either medical or dental through Miami Dade will end your Health Trust coverage. You must have both medical and dental under Health Trust or Miami Dade County.

Can I enroll dependents in dental without medical coverage?
No, we require dependent enrollment in both medical and dental coverage.

Can I add my domestic partner to my health insurance through Health Trust?
No, unfortunately, our Plan's tax-free status prohibits the coverage of domestic partners. Miami Dade County as a government entity can tax your premium and provide coverage to domestic partners.

How do I make changes to my 2025 coverages for 2026?
All changes to UnitedHealthCare medical, dental or vision must be completed in writing. Forms are posted under Resources on www.local1403.org . You can submit changes to our office in person or via email.

All updates, additions, changes to coverage or dependents for those covered under Health Trust through **UnitedHealthCare** must be completed through our office **NOT Miami Dade County's INFORMS.**

Please provide copy of marriage certificate to add spouse or birth certificate for dependent children.

If you are not making changes and wish to continue same coverage as you have in 2025, do not remit any paperwork. Your medical, dental, and vision will renew for 2026.

What is the difference between UHC High and Low Option medical Plans?
Both Plans use **UnitedHealthCare's** national network of providers, UHC Choice Plus.

The High Option allows medical coverage in and out of network. Co-pays apply without meeting annual deductible in-network on visits to primary or specialist, virtual visits (provided under myuhc.com), urgent care and emergency room. The $300 in-network deductible and 10% coinsurance will apply if hospitalized or receive hospital-based services. The $500 out-of-network deductible must be met plus 20% coinsurance thereafter upon receiving services from out-of-network providers, facilities, massage therapy and acupuncture. The High Option also provides employees only reimbursement of $800 per eye corrective surgery.

The Low Option is in-network only coverage, out of network use is cost prohibitive with a $10,000 deductible and 50% coinsurance. You are responsible for verifying the providers participation in Choice Plus network through myuhc.com or UHC customer service. The Low Option provides low out of pocket expenses and lower bi-weekly premium for dependent coverage.

Are co-pays and annual deductible applied to maximum out of pocket for the year?
No, our Plan excludes in-network copays in addition to in and out of network deductible from maximum out of pocket. The only amount calculated in the annual maximum out of pocket is coinsurance (10% or 20% after deductible).

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 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.

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	In-Network	Out-of-Network
Deductible (Individual/Family)	In-Network: None *Out-of-Network: $10,000 / $20,000**	$300 / $600	$500 / $1,000
Coinsurance (Member Pays)	In-Network: None *Out-of-Network: 50%**	10%	20%
Maximum Out-Of-Pocket (includes coinsurance only) (Individual/Family)	In-Network: $1,500 / $3,000 *Out-of-Network: $10,000 / $20,000**	$1,000 / $2,000	$2,000 / $3,000
Office Visits			
Virtual Visits (must access through myuhc.com)	Primary Care: $25 Copay Specialty Care: $35 Copay	Primary Care: $25 Copay Specialty Care: $35 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) (includes LabCorp & Quest)	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	

***While the Choice Plus Low Plan includes out-of-network benefits, this plan is designed and intended for use of in-network providers only.**

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

UnitedHealthcare

Benefits Description	Choice Plus Low Plan	Choice Plus High Plan	
	In-Network	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

Questions about your health plan? We've got answers.

Help is just a call away

Whether you have questions about a new claim, need to find a doctor or just want to better understand your plan benefits, our Advocates are here to help. Get help finding care, making sense of a bill, accessing plan benefits you didn't know were there and a whole lot more.

We simplify the health care experience and help you:

- Understand your benefits and claims
- Learn more about your prescriptions*
- Find support if you have a child with complex needs**
- Get answers about a bill or payment
- Locate care and cost options
- Explore your plan's health and well-being benefits

Lean on us

Advocacy support is easy to access and focused on you. Get the most out of your plan benefits—and your health.

Care whenever you need it
Try 24/7 Virtual Visits to speak with a doctor anytime, virtually anywhere, from your mobile device or computer. To get started, sign in at **myuhc.com®**.

Connect with us
Call the number on your health plan ID card, sign in to **myuhc.com** and click on Chat, or open the UnitedHealthcare® app for assistance on the go.

United Healthcare

There for what matters™

Your benefit at a glance

EXPRESS SCRIPTS®

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

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

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

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

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

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

Choose your way to save with a 3-month supply

EXPRESS SCRIPTS®

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

OR

Walgreens

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

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

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

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

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

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

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

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

EXPRESS SCRIPTS®

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

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

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

2. How many Walgreens pharmacies are available to me?

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

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

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

4. What does "full cost" mean?

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

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

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

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

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

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

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

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

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

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

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

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

[3] Price may vary slightly for coinsurance plans.

Express Scripts manages your prescription plan.

DON'T MISS YOUR SHOT TO PROTECT YOURSELF

Get your vaccinations today.

To help you stay healthy, you can receive vaccinations, **including the COVID-19 vaccine,** covered by your prescription plan at a participating retail pharmacy.[1]

Call your local pharmacy to:

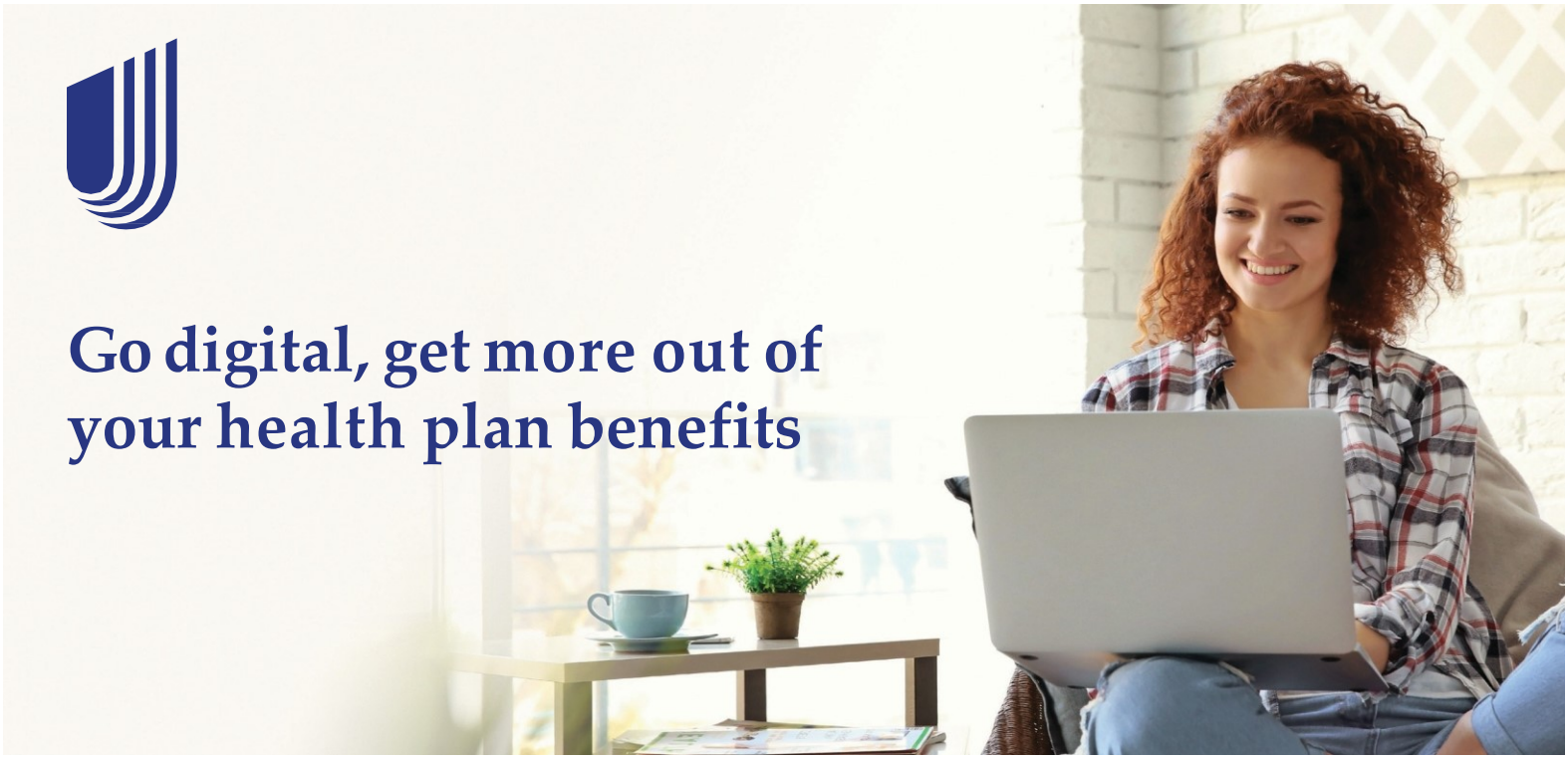
- Ask your pharmacist which vaccines are right for you
- Find out if your pharmacist can administer the recommended vaccinations
- Learn which vaccinations are covered by your plan

Don't forget to present your member ID card to the pharmacist.

The following vaccines are available from pharmacists at participating retail pharmacies:

- COVID-19
- Flu (seasonal influenza)
- Tetanus, diphtheria, pertussis
- Hepatitis
- Human papillomavirus (HPV)
- Meningitis
- Pneumonia
- Shingles/zoster
- Travel vaccines (rabies, typhoid, yellow fever, etc.)
- Childhood vaccines (MMR, etc.)

There's more information about the COVID-19 vaccine and additional vaccines you may need on the next page.



Go digital, get more out of your health plan benefits

Digital tools to keep you connected

Your personalized digital tools —the **UnitedHealthcare® app** and **myuhc.com®** — give you 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
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Compare cost estimates before you get care, which may help you save money

Register once to access both tools

Start by opening 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 that you're registered, you'll be able to manage your plan all year long.

Get connected

Scan this code to download the **UnitedHealthcare app** 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,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $25.[3]**

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—bringing a potential $2,000[4] cost down to $54 or less

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.

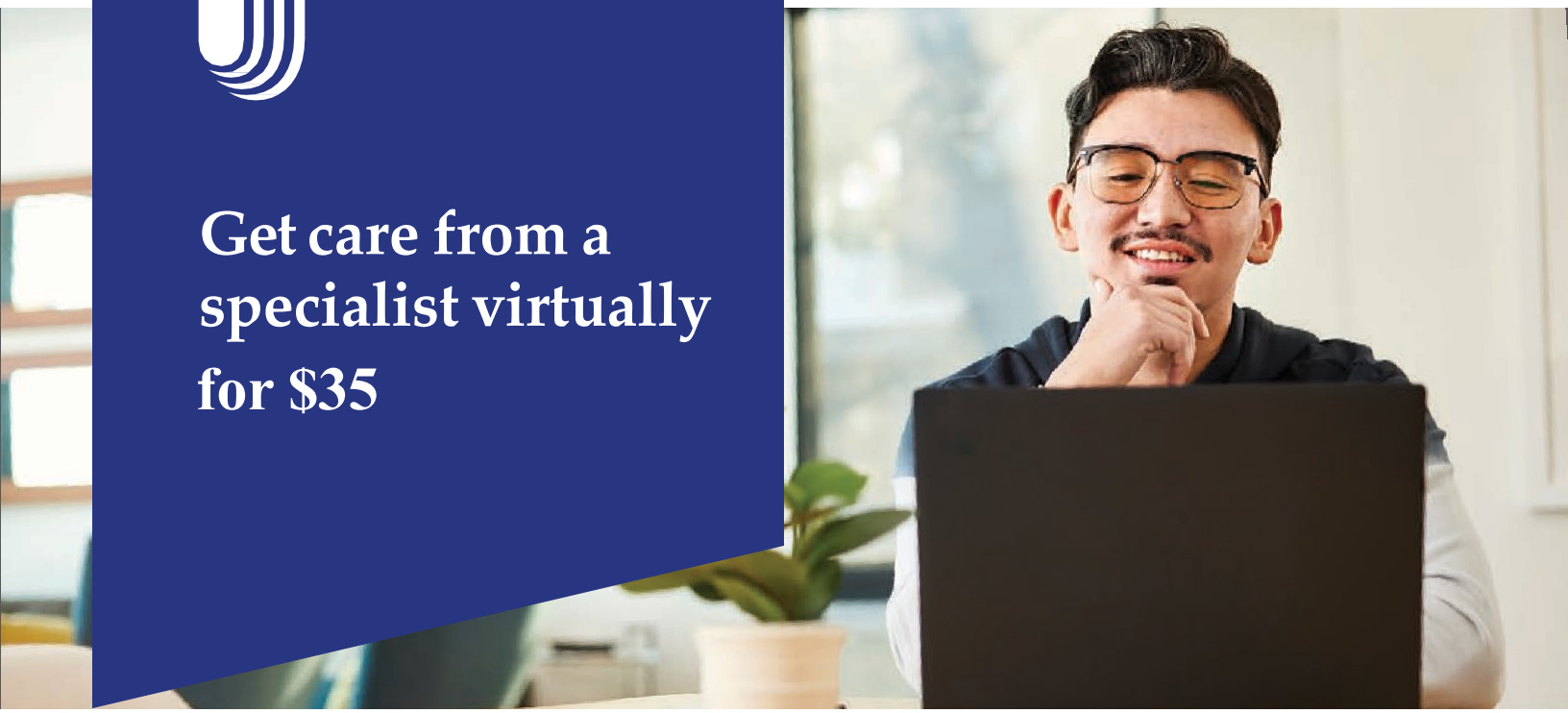
[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.

[4] Average allowed amounts charged by UnitedHealthcare 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 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.

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



Get care from a specialist virtually for $35

Specialized care at your fingertips

Virtual care is accessible from anywhere, on your schedule, and is designed for affordability. With UnitedHealthcare, members have access to quality virtual specialists who may help you create a personalized care plan, eliminating the inconvenience of travel and waiting rooms.

Built for easy access

Get a care plan from the comfort of your home, or anywhere on the go, through secure video, chat or email.

Works on your schedule

Request a visit and get care sooner, as early as the same day for some providers. Virtual care revolves around you, helping you find support when you need it, in a way that may work best for you.

Designed for affordable, quality care

Get access to care from specialists trained to understand your condition and deliver personalized care wherever you are.

Meet online with a specialist for these conditions and more

- Dermatology
- Gastroenterology
- Migraine care
- Sleep conditions
- Speech therapy
- Women's health*

Get started

Go to myuhc.com/virtualcare or download the UnitedHealthcare® app to find the right care for you

United Healthcare®

*"Women's health" is a broader term used to describe conditions, services or supportive programs and resources, not to describe those supported. UnitedHealthcare provides supportive resources for all eligible individuals, regardless of gender identity or expression.

Virtual Specialists are services available with a provider or coach via video, chat, email, or audio-only where permitted under state law. It is not an insurance product or a health plan. Virtual Specialists 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 states, or for all members. Certain prescriptions may not be available, and other restrictions may apply.

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

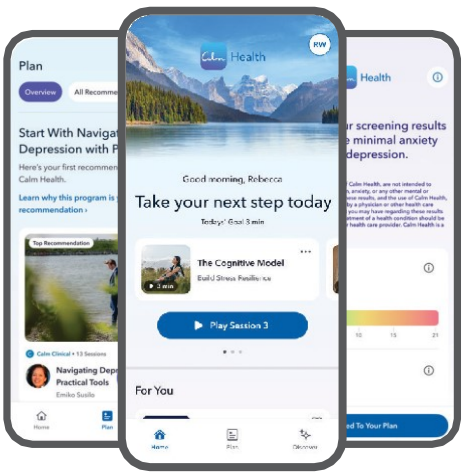
Mind. Body. You.

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

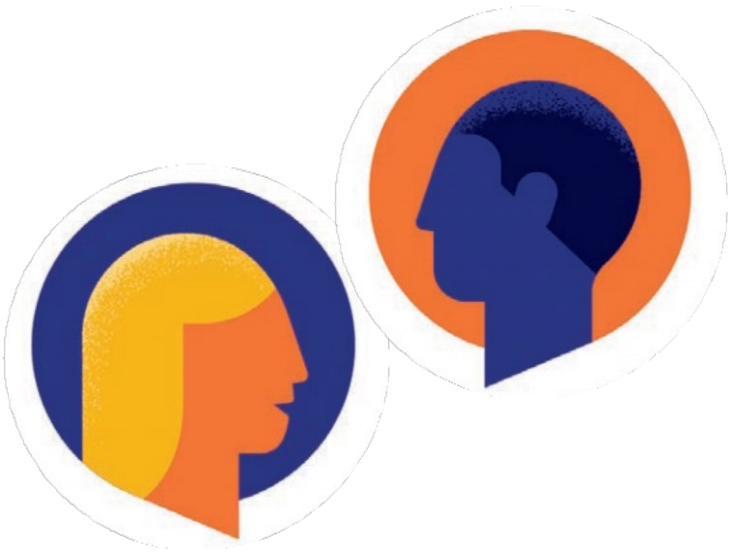
Scan this code to get started or visit uhc.app/calm

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

continued

United Healthcare® | Calm Health

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.

United Healthcare

United Healthcare

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 can get started with One Pass Select today. Call 1-877-515-9364 to learn more!

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.

Get started with One Pass Select today

To enroll in One Pass Select:

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

Membership is instant, and you will be charged for the full current calendar month on the day you sign up (One Pass Select does not offer proration).

Prescription Discounts

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

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

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

https://www.publix.com/pharmacy

$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

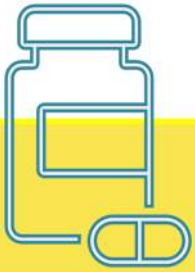
MARK CUBAN CostPlus DRUG COMPANY

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

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.

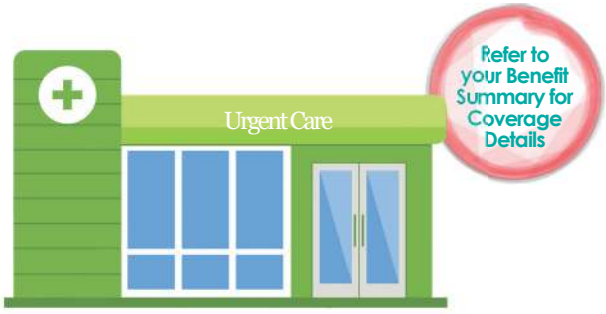
Online Telehealth

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 – PPO Plan

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.

Benefits Description	UnitedHealthcare Dental PPO Plan	
	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

Dental Benefits – HMO Plan

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 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

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

Here to help you thrive with easier access to convenient, quality dental care

UnitedHealthcare dental is built for:

Ease

We're working to make it easier to stay on top of your benefits by letting you know what to expect— and providing tips for better dental health

Savings

Your plan is designed to help you get ahead of dental health conditions before they start, and keep tabs on developing ones— all to save time and money

Network access

You have access to the fastest-growing dental network with quality providers right in— or near— your community

Your life

UnitedHealthcare dental benefits grow with you, offering extra support during life stages like childhood, pregnancy and even while managing conditions like diabetes

Preventive services are covered at little to no cost when you see a network dentist, and include:

2 routine checkups in a 12-month period— 1 every 6 months*

- Includes cleanings
- Some plans cover more cleanings for an additional copay

Annual oral cancer screenings for adults

Screenings may include:

- Light contrast screening – a test that uses light to help your dentist find healthy and unhealthy tissue
- Brush biopsy – a tissue sample taken from a suspicious area

Care after oral surgery

To help reduce the risk of opioid complications:

- Follow federal guidelines if opioids are recommended
- Tell your dentist about other medications you may be taking

Enhanced pregnancy benefits, such as:**

- Additional cleanings
- Deep scaling
- Gum maintenance

*Please check your health plan for specific coverage details.

**Your enhanced benefits are available immediately once you're pregnant and for 3 months following delivery. There's no deductible to meet, and these enhanced benefits don't count toward your plan's annual limit. Ask your dentist to include your obstetrician's name and your due date on your dental claim. We'll handle it from there.

Better dental care made easier

Help your kids start good habits early[1]

- When your child's teeth first appear, brush them twice daily with a soft toothbrush or wipe with a washcloth or soft gauze
- Make the first dental appointment at age 1
- At age 3, add a pea-sized dab of fluoride toothpaste and continue to brush their teeth twice a day
- Floss when teeth start touching
- Limit sugary snacks and drinks
- Provide meals from the 5 basic food groups
- Schedule regular dental checkups— they're important for a healthy mouth and your child's overall health

Regular screenings may help protect you from:

Diabetes
People with diabetes have a weakened immune system, which may make it harder to keep bacteria from causing gum disease and raising blood glucose levels.[2]

Heart disease
Gum disease allows bacteria to get into the bloodstream, increasing the risk for heart attack and stroke.[2]

Respiratory conditions
Gum disease bacteria can be inhaled and may increase the risk of pneumonia and infections.[2]

Rheumatoid arthritis
Gum disease can increase the severity of arthritis.[2]

Discover the mouth-body connection

Your mouth reflects your overall health › **Your dentist can detect signs of disease** › **Infections in your mouth can affect your entire body**

Vision Benefits

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

Your vision network is the **Spectera Vision Network**.

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

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

See what our vision plans can do for you

Taking care of your eyes is an important part of your overall health. That is why our vision plans are designed to offer more affordable benefits that keep your needs in focus.

There's clearly a lot to love, including:

- Complete eye exams
- Frame allowances*
- Contact lenses*
- Lens options*
- Additional pairs of glasses*

A trusted provider is always in sight

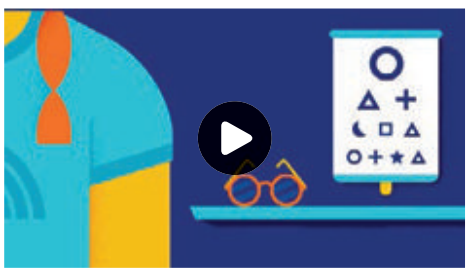
With our large national eye care network, you can take advantage of personalized care from a private practice, convenient retail chain or specialty online retailer. Search for network vision providers near you at **myuhcvision.com.**

Well-known practices and brands in our large national network include:**

- 1-800 Contacts
- America's Best
- Costco Optical
- Express Exam
- Eyeglass World
- For Eyes
- GlassesUSA.com
- LensCrafters, including lenscrafters.com
- MyEyeDr.
- Sam's Club Optical Center
- Target Optical, including targetoptical.com
- **uhcglasses.com**
- Visionworks
- Walmart
- Warby Parker, including warbyparker.com

You don't need a vision ID card to use your benefits

If you'd like a copy of your ID card once you've enrolled, you can sign in to **myuhcvision.com** anytime to view a digital copy.



Watch this video on vision benefits

*Plans may vary. Check your coverage at myuhcvision.com to verify benefits.

**The examples provided are for general knowledge purposes only and should not be interpreted as a preference or recommendation of any particular provider, brand or company. We encourage members to choose providers based on their individual needs and preferences.

United Healthcare®

Vision plan benefits and savings that focus on your needs

Eyeglasses and contact lenses

Save on everyday eyewear

Shop and save on a wide variety of contact lenses, eyeglasses and sunglasses. Get 10% off contacts and free shipping when you spend $99 or more. Try on new frame styles using the virtual mirror, find popular lenses and coatings—some available at no additional cost—plus, access 24/7 customer support. Visit **uhcglasses.com** to get started.

Laser vision correction

Enjoy the freedom of LASIK

If you're ready to break up with your glasses or contacts, get up to 35% off the national average prices of laser vision correction at more than 800 QualSight®* LASIK locations nationwide. Learn more at **myuhcvision.com.**

*LASIK is not a covered benefit but a discount available to vision members.

Pregnancy and children's vision benefits

Benefits designed with families in mind

Get more benefits when they're needed most. Those who are pregnant or breastfeeding may experience eye or vision changes. Growing kids may also have more frequent vision needs. Vision plans include expanded benefits for those who are pregnant or breastfeeding, as well as covered children up to age 19, at no additional premium cost.

Get more info

Call 800-638-3120

United Healthcare®

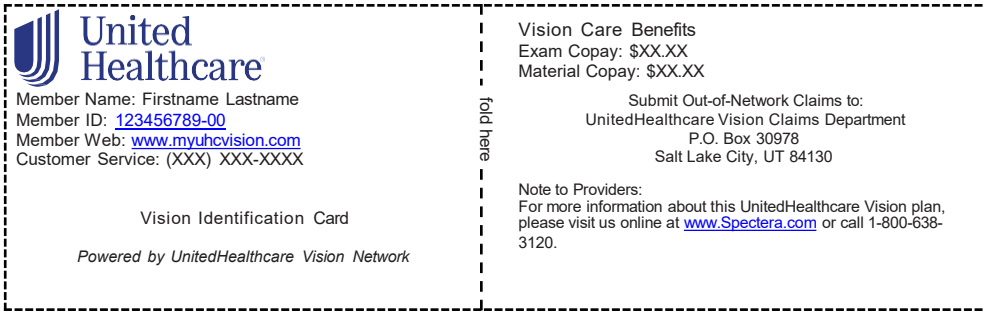
How to access your Vision ID card

Although you don't need an ID card to use your vision benefits, you can view and print or download it for easier access.

Start by choosing your coverage type

	UnitedHealthcare medical and vision coverage		UnitedHealthcare vision coverage
	View via app	**View via myuhc.com®**	**View via myuhcvision.com**
1	Download and open the **UnitedHealthcare® app**.	Go to **myuhc.com** and sign in or register using your HSID.	Go to **myuhcvision.com** and log in or register using your HSID.
2	Log in or register using your HealthSafe ID® (HSID).	Click **Coverage & Benefits** > **Vision** > **View vision plan** > **Print Your ID card**. (If you don't see **Print Your ID card**, click **Select** near plan name.)	Click **Print Your ID card**. (If you don't see this option, click **Select** near plan name.)
3	Click **Member cards** and scroll down to your vision ID card.	Choose the member on the drop-down menu and click **View**.	Choose the member on the drop-down menu and click **View**.
4	**Print or download** your vision ID card.	**Print or download** the "How to use your vision care benefits" document that appears.	**Print or download** the "How to use your vision care benefits" document that appears.

Sample vision ID card*



Learn more

Visit your member website for more information about your vision benefits

United Healthcare®

*Your vision ID card may look different. Vision ID cards vary based on the actual plan and how the card is accessed.

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.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact the company.

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

USI®

☐ 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	EMPLOYEE ID #
			☐ Male ☐ Female			

HOME ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE NUMBER
				( )

EMPLOYER NAME	EMAIL ADDRESS:		MARITAL STATUS	WORK PHONE NUMBER
DADE COUNTY FIRE FIGHTERS INSURANCE TRUST		**ACTIVE**	☐ Single ☐ Married ☐ Widow	( )

2 TYPE OF COVERAGE

Medical
- ☐ **High Option**
- ☐ **Low Option**

Dental
- ☐ **DPPO**
- ☐ **DMO**

3 WHO SHOULD BE COVERED

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus Child/ren
- ☐ Employee Plus Family

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 (Choice Plus Plan Low Option (former HMO Plan) or High Option (former PPO Plan)

SECTION 3 Select who should be covered on the plan.(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 The employee must sign and date this form in order for it to be processed.

SECTION 8 This section is to be completed by the employer's benefit representative.

Change In Status/Mid-Year Plan Changes

How do I make a change to my health plan mid-year? Once the open enrollment period closes, you may add or delete dependents to your health plan only under limited circumstances (a qualifying event). Changes must be reported within 30 days of a qualifying event. You must provide proper documentation and complete a Miami-Dade Change in Status (CIS) form and a UHC Enrollee Change form to the Trust Office. Election changes must be consistent with the event and result in loss or gain of insurance coverage. Mid-year changes from one health plan to another are not permitted. A partial list of permitted mid-year changes appears below.

- Marriage\Divorce (Ex-spouse & step-children cease to be eligible as of the last day of month final divorce decree is signed by Judge
- Birth of a child
- Adoption of a child or placement for adoption
- Beginning or end of employment of a spouse (resulting in gain or loss of insurance coverage)
- Ineligibility of dependent child – (Eligibility for employer issued health coverage or active military dury)
- Employment change from full-time to part-time or vice versa (employee or spouse)
- Unpaid LOA (employee or spouse)
- Medicare/Medicaid/Florida Kid Care
- Spouse's employer open enrollment
- Significant change in health coverage due to spouse's employment.

UnitedHealthcare®

Vision Enrollment Form

Dade County Firefighters Insurance Trust

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER	❑ Enroll ❑ Cancel ❑ Change ❑ Address Change ❑ Number Change Date of Change / /
LAST NAME	FIRST NAME / MI	ENROLLEE'S DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP	
TELEPHONE NIMBER Cell ( ) Work ( )		❑ Male ❑ Female ❑ Single ❑ Married

PLAN COVERAGE	❑ Employee Only	❑ Employee Plus 1 Dependent	❑ Employee Plus 2 or More Dependent
Biweekly Premium	$ 2.47	$ 4.93	$ 8.16

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 _____/_____/ _____	CLASS CODE: **ACTIVE**
ENROLLMENT: ❑ New Hire ❑ Other	DATE OF HIRE: (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
STANDARD LIFE INSURANCE COMPANY
ACTIVE MEMBER POLICY #645783

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

Date of Birth:_____/_____/_____ **Social Security #** _____ - _____ - _____**Employee ID#**_____

Station:_____ **A B C 40 hr**. Hire Date:____/_____/_____ **Cell#** (_____) _____ - _____

Home Phone: (_____) _____ - _____ **E-mail Address**_____

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

As a participant/member of the **Dade County Fire Fighters Insurance Trust** you are entitled to a Life Insurance benefit equal to:

One Time your **Annual Salary** for **Normal Death Benefit**
Two Times your **Annual Salary** for **Accidental Death (ON & OFF DUTY)**

Primary Beneficiary (ies)

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

Contingent Beneficiary (ies)

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

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

★ **Signature** _____ **Date** _____

State of Florida

SS:

County of Miami-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 Florida**

☐ Personally Known ☐ Produced Identification ☐ Identification Produced _____

Any person who knowingly & with intent to defraud, submits an application, files a statement of claim containing any material false or misleading information, commits a fraudulent act, which is a crime. Subject to revocation by me by written notice to my employer, I request the coverage provided from time to time by my employers group plan(s), as elected above and authorize deductions (if any) from my wages.

*****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 you 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 within30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

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

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

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

NOTICE OF GRANDFATHERED STATUS

Dade County Fire Fighters Insurance Trust 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 the contact information below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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. Dade County Fire Fighters Insurance Trust’s group health plan extends dependent coverage beyond the ACA requirements, to age 30, 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.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Dade County Fire Fighters Insurance Trust
8000 NW 21st Street
Suite 222
Miami, FL 33122-1605
305-593-6100
Dale.Sutton@local1403.org

Your 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

- Effective: January 1, 2025
- Contact: Dade County Fire Fighters Insurance Trust
  8000 NW 21st Street
  Suite 222
  Miami, FL 33122-1605
  305-593-6100
  Dale.Sutton@local1203.org

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

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

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. Dade County Fire Fighters Insurance Trust has determined that the prescription drug coverage offered by the UnitedHealthcare Medical Plans for the plan year January 1, 2026 – December 31, 2026 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 UnitedHealthcare Medical Plans 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 UnitedHealthcare Medical Plan creditable coverage.
- You may stay in the UnitedHealthcare Medical Plans and also enroll in a Medicare prescription drug plan. The UnitedHealthcare Medical Plans will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the UnitedHealthcare Medical Plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the UnitedHealthcare Medical Plans, 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:	January 1, 2026
Name/Entity of Sender:	Dade County Fire Fighters Insurance Trust
Contact Position/Office:	Dale Sutton
Address:	8000 NW 21st Street Suite 222 Miami, FL 33122-1605
Phone Number:	305-593-6100

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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-ne twork" 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- ne twork 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
OMB No. 1210-0149
(expires 12-31-2026)

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 Employment-Based 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.

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

[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.

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 time period, 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/medicaid-chip/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, Suite 222, 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.

3. Employer Name Dade County Fire Fighters insurance Trust		4. Employer Identification Number (EIN) 59-2185490
5. Employer address 8000 NW 21st Street, Suite 222		6. Employer phone number 305-593-6100
7. City Miami	8. State FL	9. ZIP code 33122-1605
10. Who can we contact about employee health coverage at this job? Dale Sutton		
11. Phone number (if different from above)	12. 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 Spouses and Dependent Children up to age 26.

  - [ ] We do not offer coverage.

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

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

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

Notes:

Notes:

Notes:

This brochure summarizes the benefit plans that are available to Dade Country Firefighters eligible team members and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.