



2026 Retirees Under 65 Benefit Booklet

January 1, 2026 – December 31, 2026



Inside the Guide

Important Notices	7
Medical Benefits	8
Dental Benefits	18
Vision Benefits	22
Trust Office & Insurance Contacts	26
Disclosure Notices	27

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**.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 34 for more details.

DADE COUNTY FIRE FIGHTERS INSURANCE TRUST FUND

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

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

You are afforded an opportunity to opt out of our health Plan under open enrollment should you have coverage available under another carrier. Should you elect to opt out, you'll receive your monthly retiree subsidy directly, provided you submit proof of other medical coverage and provide an annual affidavit. Opting out of Plan is irreversible. Once you leave the Plan, you cannot re-enroll. You may contact our office for more information on ending participation in our health insurance Plan and forms to complete.

Our Plan allows survivor spouse to continue in medical/prescription and optional dental or vision if spouse is enrolled in our Plan at time of retiree's death. Survivor spouse coverage under the Plan ends upon remarrying.

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

Every year during the month of December retired members can make changes to medical and dental plan type, add or remove dependents from coverage, enroll or end optional vision. Your elections are in effect for the entire year of 2026. All changes are effective January 1, 2026. Forms only need to be completed and sent into our office if you are making a change.

What is the difference between UHC High and Low Option medical?

The High Option allows medical coverage at In-Network with applicable copay per visit, \$300 In-Network deductible plus 10% co-insurance for hospital services & in-patient, \$500 out of network deductible & 20% co-insurance applies to out of network provider services including 30 annual massage therapy and acupuncture visits.

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

The Low Option is an In-Network co-pay only Plan. The very high \$10,000 annual deductible and 50% co-insurance for out of network services makes it cost prohibitive for out of network use. This plan is strictly meant to be used in-network with payment of applicable co-payments.

In-network copays for UHC High and Low Option

ER - \$225

PCP - \$25

Specialist - \$35

\$35 – Urgent Care

Make note that in-network copays **DO NOT APPLY** to the annual maximum out of pocket only coinsurance (10% or 20% after meeting deductible) is used in calculation.

Do I need to enroll in optional vision through UnitedHealthCare?

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

How do I access prescription coverage through Express Scripts?

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

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

If I am not making any changes to coverage or dependents covered. Do I need to do anything?

Your current medical, dental and vision will automatically renew, if we do not receive completed paperwork with changes in our office by January 10, 2026. Your optional dental and vision coverage will be cancelled retroactively to December 31, 2025 if full annual premium is not received by January 31, 2026 for self-pay members. Dental and vision premium is only paid monthly if you are enrolled automatic pension deductions through FRS (Florida Retirement System).

What do I need to provide if adding a new dependent?

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

How do I pay my premium for medical plus optional dental and vision?

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

If you are a self pay retiree medical premium is due by the first day of every month. Payments received after the 10th are late.

Self-pay retirees may remit payments quarterly, bi-annually or annually. The only automatic payment option available is through FRS pension. You may schedule monthly payments for medical through your banking institution’s online bill pay provider. Consistent and timely payments are imperative to maintaining your benefits in force.

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

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

2026 Annual Retiree Premiums

Dental Plan	DPPO	DHMO
Retiree Only	\$555.00	\$210.00
Retiree + 1 Dependent	\$980.00	\$400.00
Retiree + Family	\$1,430.00	\$552.00
UnitedHealthCare/Spectera/Vision Plan		
Retiree Only	\$65.00	
Retiree + 1 Dependent	\$128.00	
Retiree + Family	\$212.00	

Important Notices

Disability and Medicare:

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

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 Can You Enroll?

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

- During annual open enrollment
- Upon retirement (age 55 or 25 years of MDFR employment)
- Within 30 days of a qualified family status change

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

Qualified Family Status Change:

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

Educational Videos:

- To learn about [Key Insurance Terms](#)
- To learn about [Balance Billing](#)
- To learn about [How to read an EOB](#)
- To learn about [How to Budget](#)
- To learn about [How to stretch your healthcare dollars](#)

Medical Benefits

Welcome – We're Glad You're Here

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

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

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

Before You Enroll

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 online 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 <i>Out-of-Network: \$10,000 / \$20,000*</i>	\$300 / \$600	\$500 / \$1,000
Coinsurance (Member Pays)	In-Network: None <i>Out-of-Network: 50%*</i>	10%	20%
Maximum Out-Of-Pocket (includes coinsurance only) (Individual/Family)	In-Network: \$1,500 / \$3,000 <i>Out-of-Network: \$10,000 / \$20,000*</i>	\$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



Benefits Description	Choice Plus Low Plan	Choice Plus High Plan	
	In-Network	In-Network	Out-of-Network
Behavioral Health Services: Mental Health & Substance Abuse	<u>Outpatient</u> : \$25 copay per visit <u>Inpatient</u> : \$150 copay per day <u>Residential Treatment</u> : \$150 copay per day (\$600 maximum per admission)	<u>Outpatient</u> : \$25 copay per visit <u>Inpatient and Residential Treatment</u> : 10% of eligible expenses	<u>Outpatient, Inpatient and Residential Treatment</u> : 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.

There
for what
matters™



Your benefit at a glance



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

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

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

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

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

You could **save an average of 29%** with 3-month supplies compared to 1-month supplies from your local pharmacy². A convenient 3-month supply makes it easier to stay on track with your medicine.

Choose your way to save with a 3-month supply



EXPRESS SCRIPTS®

OR

Walgreens

- Delivered to your door with FREE standard shipping³
- Transfer prescriptions easily online, by phone or via Express Scripts® mobile app
- Auto-refills and refill reminders available
- Talk with a pharmacist by phone 24/7

- More than 8,500 convenient locations, many open 24/7 (see back for additional information)
- Transfer your prescriptions easily in-store, by phone, online or via Walgreens mobile app
- Auto-refills and refill reminders available
- Get 300 Balance Rewards® points for filling a 3-month prescription⁴

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

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

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

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

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

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

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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 PharmacySM or from any Walgreens or Duane ReadeTM pharmacy.¹

2. How many Walgreens pharmacies are available to me?

There are more than 9,800 Walgreens pharmacies. To locate one, visit [express-scripts.com](https://www.express-scripts.com) and click "Prescriptions," then "Find a Pharmacy"; participating Walgreens pharmacies will be noted in your search results.

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

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

4. What does "full cost" mean?

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

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

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

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

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

You can have the Express Scripts PharmacySM deliver it (with FREE standard shipping) by visiting [express-scripts.com/90day](https://www.express-scripts.com/90day). You can also fill your prescription at a Walgreens pharmacy.

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

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

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

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

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

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

³ Price may vary slightly for coinsurance plans.

Express Scripts manages your prescription plan.



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

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®](https://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.

B2C E1232735050.2 2/25 © 2025 United HealthCare Services, Inc. All Rights Reserved. 25-3783381-A

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'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



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 pharmacy with the lowest price and save up to 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.

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 <i>(Does not apply towards the annual maximum)</i>		
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		
Implants		
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	\$1,850 / \$1,950
D8660 – Pre-Orthodontic Treat Exam	\$35
D8680 – Orthodontic Retention	\$300
D8999 – Unspecified Orthodontic Procedure by Report	\$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 early¹

- 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

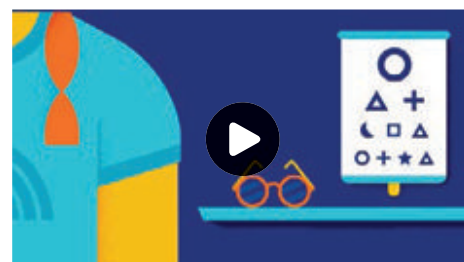
With our large national eye care network, you can take advantage of personalized care from a private practice, convenient retail chain or specialty online retailer. Search for network vision providers near you at myuhcvision.com.

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.

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®

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, 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 either your broker or the company.



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*

 United Healthcare Member Name: Firstname Lastname Member ID: 123456789-00 Member Web: www.myuhcvision.com Customer Service: (XXX) XXX-XXXX	fold here	Vision Care Benefits Exam Copay: \$XX.XX Material Copay: \$XX.XX Submit Out-of-Network Claims to: UnitedHealthcare Vision Claims Department P.O. Box 30978 Salt Lake City, UT 84130 Note to Providers: For more information about this UnitedHealthcare Vision plan, please visit us online at www.Spectera.com or call 1-800-638-3120.
Vision Identification Card <i>Powered by UnitedHealthcare Vision Network</i>		

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.

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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



Important Legal Notices Affecting Your Health Plan Coverage

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

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

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

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

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

To request special enrollment or obtain more information, contact 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

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

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

You are protected from balance billing for:

Emergency services

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

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been 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 21 st 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 21 st 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:
☒ All employees. Eligible employees are:
All Full-Time Employees averaging a minimum of 30 hours per week and Retirees.

☐ Some employees. Eligible employees are:

- With respect to dependents:
☒ We do offer coverage. Eligible dependents are:
Legal Spouses and Dependent Children up to age 26.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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This brochure summarizes the benefit plans that are available to Dade County 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.