

2027 Retirees Under 65

Benefit Booklet

January 1, 2027 – December 31, 2027



Inside the Guide

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

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

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 41 for more details.

DADE COUNTY FIRE FIGHTERS
INSURANCE TRUST FUND

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All eligible retired Trust Plan members and their spouses under the age of sixty-five (65) or dependent children under the age of 26 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 **ExpressScripts/Evernorth**. 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 2027. All changes are effective January 1, 2027. 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.

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.

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

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/Evernorth**. 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, 2027. Your optional dental and vision coverage will be cancelled retroactively to December 31, 2026, if full annual premium is not received by January 31, 2027, 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 and mail to 8000 NW 21 Street, Suite 223, Miami, FL 33122-1605.**

Feel free to contact our office with any questions you or your dependents may have regarding coverage, premium or clarification of claims processing.

2027 Optional Dental and Vision Annual Premiums

Dental Plan

Coverage Level	PPO Dental	DHMO Dental
Retiree Only	$555.00	$210.00
Retiree + 1 Dependent	$980.00	$400.00
Retiree + Family	$1,430.00	$552.00

UnitedHealthCare / Spectera / Vision Plan

Coverage Level	Annual Premium
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

UnitedHealthcare

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

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

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

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

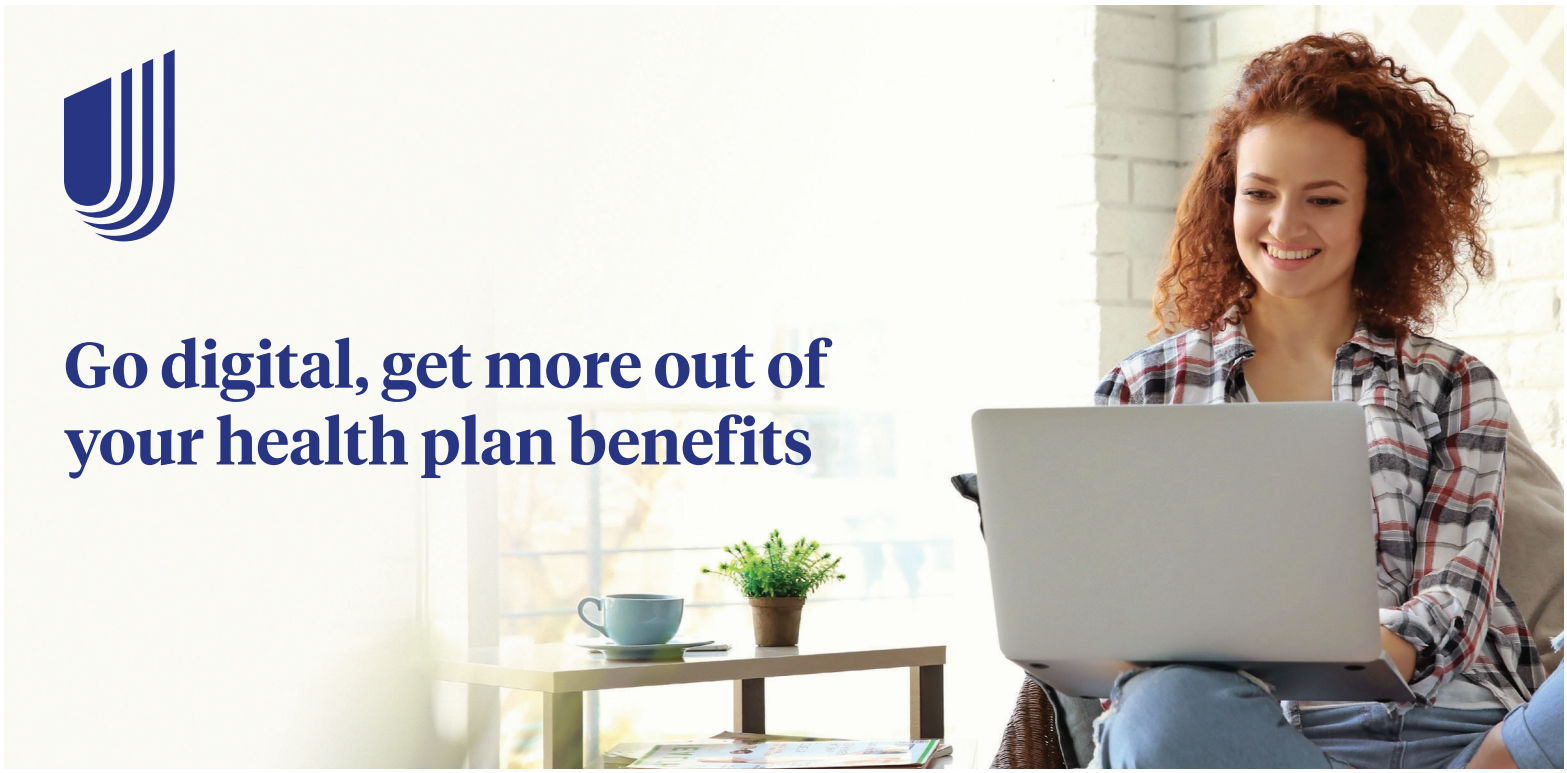
Medical Benefits

UnitedHealthcare

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

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

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



Go digital, get more out of your health plan benefits

Digital tools to keep you connected

Your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – give you access to resources designed to help you:

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

Register once to access both tools

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

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

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

Get connected

Scan this code to download the **UnitedHealthcare app** or visit **myuhc.com**

United Healthcare®

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

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

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

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

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

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Compare options, help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to $1,500 compared to an emergency room (ER) visit.*

Care options to consider	START HERE **Primary care provider (PCP)** The provider who may know you best	**24/7 Virtual Visits** A care provider over the phone, video or chat	**Convenience care** Nurse practitioners and physician assistants at retail pharmacy clinics	**Urgent care** Physicians and care teams at walk-in clinics	**Emergency room** Physicians and care teams at hospital emergency departments
Average Cost		$	$$	$$$	$$$$
Allergies	✔	✔			
Bladder infection/UTI	✔	✔		✔	
Broken bone				✔	✔
Bronchitis	✔	✔		✔	
Chest pain					✔
Cough	✔	✔	✔		
COVID-19 symptoms	✔	✔		✔	
Earache	✔	✔	✔		
Fever	✔	✔			
Flu/common cold	✔	✔	✔		
Migraine/headache	✔	✔			
Muscle ache/sprain	✔			✔	
Pinkeye	✔	✔			
Shortness of breath					✔
Sinus infection	✔	✔			
Skin rash	✔	✔	✔		
Sore throat	✔	✔			
Stomach pain (nausea, vomiting, diarrhea)	✔	✔		✔	
Yeast infection	✔	✔			

✔ **Indicates the care option to consider for the common conditions listed**

Learn more

Visit **uhc.com/quickcare**

United Healthcare®

EVERNORTH
HEALTH SERVICES

Make sure your prescription benefits truly benefit you

Use this flyer during your next doctor visit to collaborate and find ways to stress less and save more.

Ask your doctor to connect to the **Real-Time Prescription Benefit** portal. This portal will let them connect to your formulary benefit so they can check for the most affordable pricing for your medications and help avoid a coverage review, like prior authorization.

What you'll pay after meeting your deductible

	3-Month Supply - Walgreens or Home delivery from Express Scripts® Pharmacy	Up to 1-Month Supply - Retail pharmacy (in network)
Generics	$5.00	$15.00
Preferred brands	$67.50	$30.00
Nonpreferred brands (no generic)	$130.00	$55.00
Nonpreferred brands (generics available)	10%*	10%*

*Penalties may be applied when filling "brand-name" medications when a generic equivalent is available.

Maintenance Medication Requirement
Express Scripts/Evernorth manages the prescription drug benefit for active and retired members.

If you take a medication on an ongoing basis, the Plan requires that after your first three 30-day fills, future prescriptions be filled as a **90-day supply**. Once established on the medication, you may obtain your 90-day supply at **Walgreens** or through **Express Scripts mail order**. This requirement applies to members and covered dependents taking long-term maintenance medications.

Deductible	$25 for you	You pay all your medical expenses until you meet this amount
Copayment or Coinsurance	The amount shown in the table.	This is what you pay after the deductible is met.

Or log into your online account.

These three steps will help you maximize your savings.

STEP 1
Get the right medication.

STEP 2
Get the right days' supply.

STEP 3
Use the right pharmacy.

If you don't have an online account, visit **express-scripts.com** to create one. It takes just five clicks and two minutes to create one powerful way to save.

Scan the QR code on the right to get started. An online account gives you anytime, anywhere access to manage your pharmacy benefits.



EVERNORTH
HEALTH SERVICES

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You could **save an average of 32%** with 3-month supplies compared to a 1-month supply from your local pharmacy[2] Stress less and stay on track with a convenient 3-month supply of your medication.

Choose your way to save with a 3-month supply

Express Scripts® Pharmacy

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

OR

Walgreens

- Choose from over 8,250 convenient locations, many open 24/7 (see reverse side for additional information)
- Transfer your prescriptions easily in-store, by phone, online or via the Walgreens mobile app
- Auto refills and refill reminders available
- myWalgreens members receive 1% Walgreens Cash rewards per $1 on every purchase (even at the pharmacy) and 5% Walgreens Cash rewards per $1 on Walgreens-branded prescriptions[4]

Don't pay more than you need to for a medication. To choose a 3-month supply, log in or register at **express-scripts.com/90day**. Or if you'd like to have your prescriptions conveniently delivered, call **(855) 747-5794,** and we'll contact your doctor to get your new prescription. Please see the back for more details.

Why pay more? Make the move to a 3-month supply.

Filling a 3-month supply of your long-term medication can help you save time, money and trips to the pharmacy. Please note that if you keep filling a 1-month supply at a nonparticipating pharmacy, you could pay more. For example, if a medication costs $75, even if your copay or coinsurance is only $20, you could pay up to the full $75.

Pay the most
- 1-month supply
- Nonparticipating pharmacy

→

Still pay more
- 1-month supply
- Participating pharmacy

→

Pay the least
- 3-month supply
- Participating pharmacy or home delivery

Choose home delivery from Express Scripts Pharmacy, Evernorth's home delivery pharmacy

- Log in or register at express-scripts.com/90day and choose which medication(s) you want delivered.
- Call **(855) 747-5794** and tell us which medication(s) you want delivered.

OR

Get a 3-month supply at a participating Walgreens location:

- Log in to your Express Scripts account or contact us to find participating pharmacies in your area.

We recommend having a 1-month supply of your medication on hand before making the change.

We're here to help.

Express Scripts®
Pharmacy Benefit Services

Don’t miss your shot to protect yourself.



Get your vaccinations today at no cost to you.

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 UHC medical card, which includes your Express Scripts pharmacy information.

Vaccines available from pharmacists at participating retail pharmacies include:

+ COVID-19
+ Flu (seasonal influenza)
+ Tetanus, diphtheria, pertussis
+ Childhood vaccines (MMR, HIB, etc.)
+ Hepatitis
+ Human papillomavirus (HPV)
+ Meningitis
+ Dengue
+ Pneumonia
+ Shingles/zoster
+ Respiratory syncytial Virus (RSV)

Please refer to your plan specifications for additional details on the coverage of vaccines at $0 copay.

1. Certain age restrictions may apply; please refer to your plan details.

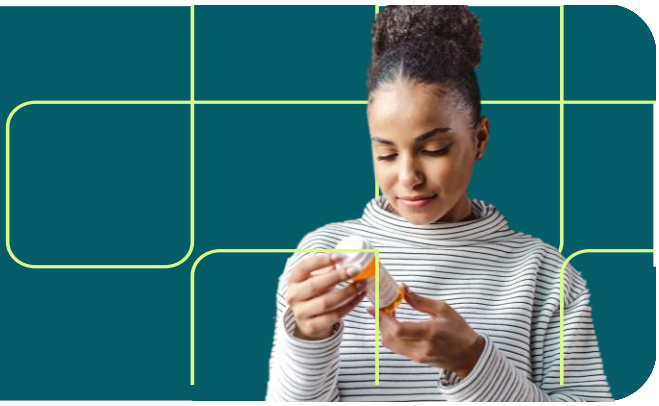
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EVERNORTH HEALTH SERVICES

EVERNORTH
HEALTH SERVICES

EXPRESS SCRIPTS® PHARMACY BENEFIT SERVICES

Get the most from your prescription benefits



Prescription benefits can feel complicated. Express Scripts® Pharmacy Benefit Services helps make them **easier to understand**, so you can feel **more confident** about your medications, know what's covered and **avoid surprises** at the pharmacy.

Just like your medical plan helps cover doctor visits, your pharmacy benefits help cover the cost of prescription medications. Express Scripts is there to help you understand your options and navigate your coverage – **before you need a prescription and along the way if you already have one** – so you can make the choices that work for you. Learn more at **express-scripts.com.**

Pharmacy benefits that benefit you.

Each icon represents a common question – and the answers are explained alongside.

Understand What's Covered Before You Fill

Avoid Delays With Prior Authorization Updates

Save by Staying in Your Pharmacy Network

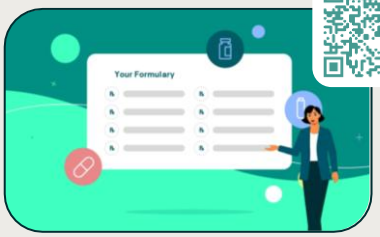
Getting Started Is Simple

CRP1654903A

Is my medication covered by my plan?

A **formulary** is your plan's list of covered medications. With hundreds of options available, most conditions have treatments that are **safe**, **effective** and **affordable**.

In many cases, a **lower-cost generic** may be available – generics are FDA approved and just as safe and effective as brand-name medications.



Scan the QR code to watch this short video to learn how formularies work.

Will my prescription need approvals or reviews?

Some medications may need reviews and approval before they're covered. Understanding this step can help prevent delays.



Scan the QR code to watch to see what to expect when a coverage review, also called a prior authorization, is needed.

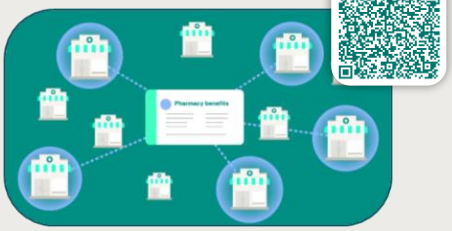
Experience pharmacy care you can count on

When it comes time to fill a prescription, **small choices can make a big difference**. Choosing the right medication, in the right quantity, and at the right pharmacy based on your plan can help keep costs more predictable and avoid unnecessary delays. That's why Express Scripts focuses on helping you understand what's covered by your plan and what options may be available – so you're not left guessing at the pharmacy counter.

Registering for an online account gives you easy access to tools that help put this information at your fingertips. When you're registered, you can **compare medication prices at pharmacies in your networks, see prior authorization requirements and understand what to expect before you fill** – whether you're planning ahead or managing prescriptions today. We work to help you simplify these moments and support more confident decisions.

Which pharmacy makes the most sense for me?

Using **in-network pharmacies** and making choices that work with your plan can help keep your costs more predictable. Knowing **where to fill your prescription** can make it easier to get the most from your pharmacy benefits.



Scan the QR code to watch this short video to see how you can benefit by staying in your pharmacy network.

How can I feel more prepared before I fill?

Register for an account so we can share important **benefit information at the right time**, help you **understand your coverage** before you even need a prescription and **send guidance** when an action or choice may be needed!

You don't need a prescription to register!

Scan the code above to get started.

CRP1654903A

Understand What's Covered Before You Fill

Avoid Delays With Prior Authorization Updates

Save by Staying in Your Pharmacy Network

Getting Started Is Simple

Depend on Express Scripts for simpler, more affordable pharmacy care.

Accredo Specialty Pharmacy

Making the complex care journey simpler.



We're there to make sure every moment counts.

At Accredo® Specialty Pharmacy, taking care of you is our focus. You might be newly diagnosed and beginning with a specialty medication, or you might just be new to Accredo. Either way, our specialty-trained pharmacists, nurses, pharmacy technicians and patient care advocates understand chronic and complex conditions. We're here to help you navigate this journey, every step of the way.

What is a specialty medication?

A medication typically used to treat chronic, complex conditions like multiple sclerosis, cystic fibrosis and cancer. Specialty medications may come in various forms, such as oral, injectable, infusion or inhaled therapies, and often require special handling, like refrigeration.

We provide personalized clinical support and care for a wide range of complex conditions, including:

+ Age-related macular degeneration
+ Alpha-1 antitrypsin deficiency
+ Anemia
+ Severe asthma
+ Cancer
+ Crohn's disease
+ Cystic fibrosis
+ Deep vein thrombosis
+ Growth hormone deficiency
+ Hemophilia
+ Hepatitis C
+ Hereditary angioedema
+ Hereditary tyrosinemia
+ Immune deficiency
+ Infertility
+ Lysosomal storage disorders
+ Multiple sclerosis
+ Neutropenia
+ Osteoarthritis
+ Osteoporosis
+ Psoriasis
+ Pulmonary arterial hypertension
+ Respiratory syncytial virus
+ Rheumatoid arthritis
+ And many more, including rare and ultra-rare conditions

EVERNORTH® HEALTH SERVICES

One journey.
Three ways we focus on supporting you.

Your Accredo team is here to make your path as smooth as possible and help you along the way.

1. Specialty clinicians are your guide

+ Our specialty-trained pharmacists and nurses are **available 24/7** for any questions about your therapy
+ You'll receive **one-on-one clinical support** to help you administer your medication safely and effectively
+ Your Accredo team helps you **manage possible side effects**
+ For certain conditions, **Accredo nurses help you administer your medication** in the comfort of your home, when appropriate

2. An easy route for getting your medication

+ **Free shipping** to where you choose[1], when you choose
+ **Additional supplies**, like syringes and sharps containers, included at no additional charge[2]
+ Medication is **handled with care**, including refrigeration if needed (plus information on how to properly store your medication at home)
+ **Refill reminders** and shipment update by email or text[3] to make sure you don't run out
+ **Order refills** at accredo.com, on our mobile app or by calling the number on your prescription label

3. Navigate insurance and financial assistance

+ Get help **understanding your insurance coverage** and coordinating with your health plan on approvals and eligibility
+ **We'll find financial assistance programs** that may be available from drug manufacturers and community organizations
+ In 2024, Accredo coordinated **$2.7 billion in copay assistance** for qualified patients[4]

Take charge of your journey with Accredo.

With our tools, you can manage your medications how you want, when you want. Visit **Accredo.com** or download our mobile app; go to your mobile device's app store and search for "Accredo." You can order refills[5], check order status, view medication history and much more.

1. As allowable by law.
2. Where permitted by benefit plan design.
3. Based on enrollment.
4. Based on 2025 Accredo book of business data.
5. Not available for all specialty medications.

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AHG-00527d

EVERNORTH® HEALTH SERVICES

CRP1592902

EXPRESS SCRIPTS®
PHARMACY BENEFIT SERVICES

Go digital

For **fast, trusted and transparent** access to your prescription benefits

Express Scripts® Pharmacy Benefit Services manages the pharmacy portion of your health plan coverage to help make medication safer and more affordable. Just like your health plan covers your doctor's visit, your pharmacy benefits or prescription plan covers the medication your doctor prescribes. Through your pharmacy benefits, you have access to a network of covered pharmacies and medications.

Unlock more from your benefits

Save on medications

Check the price of a medication before and during a doctor's visit.

Find a pharmacy

Locate the most convenient network pharmacy for your needs.

Coverage review

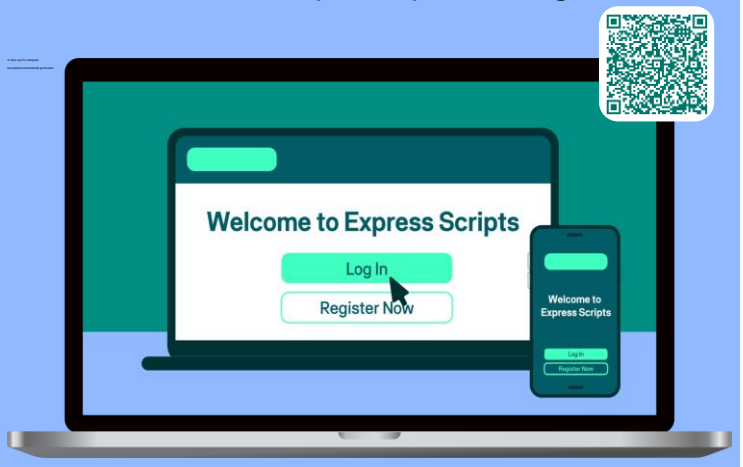
Before a doctor prescribes a medication, check to see if it needs a coverage review.

Set reminders

Set reminders to take your medication and sign up for text alerts.

Feel more prepared even before you fill. Registering for an account allows us to share important benefit information at the right time and send guidance when an action or choice may be needed.

You don't need a prescription to register!



Scan the QR code to watch this short video to **see how you can benefit with our digital tools**.

EVERNORTH HEALTH SERVICES

Getting started is simple.

Visit **express-scripts.com or the Express Scripts® mobile app** to learn more about our pharmacy benefit services, so you can stress less and save more.

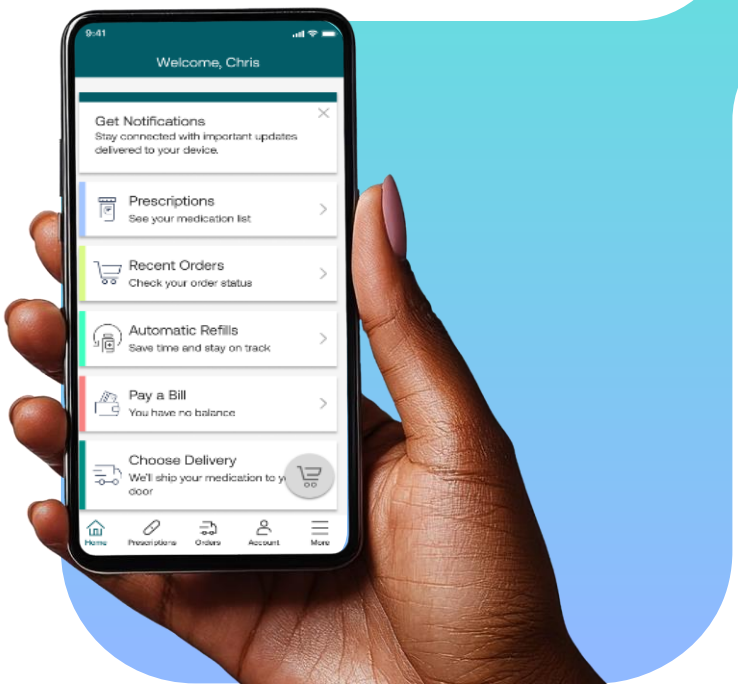
Download our mobile app

Use the QR code or search Express Scripts® in your **app store**.

Download the app for free, then tap Register Now to get started.

Download on the App Store | GET IT ON Google Play





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All pictures are used for illustrative purposes only.

EVERNORTH HEALTH SERVICES

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.

Publix

Publix Low-Price Medication Program
Select generic 90-day medications for $7.50. Available to anyone, regardless of insurance.

www.publix.com/pharmacy
Call your local Publix Pharmacy (numbers vary by store).

MARK CUBAN CostPlus DRUG COMPANY

Mark Cuban Cost Plus Drug Company
Transparent pricing: manufacturer cost + small markup + pharmacy fee.
Cash-pay only; ships medications directly to your home.

www.costplusdrugs.com
Customer Service: 1-971-251-4425
info@costplusdrugs.com

TrumpRX

Discounted cash-pay pricing on select brand-name medications. Provides manufacturer coupons or directs you to the manufacturer's site for discounted purchasing. Requires a valid prescription; insurance is not used.

https://trumprx.gov/

Walmart

Walmart $4 Generic Prescription Program
$4 for a 30-day supply or $10 for a 90-day supply on select generics. No insurance needed. Visit Walmart Pharmacy for the list of eligible medications.

www.walmart.com/pharmacy or
www.walmart.com/cp/4-prescriptions/1078664
Walmart Pharmacy: 1-800-273-3455

GoodRx

GoodRx
Compare prices across nearby pharmacies. Provides coupons you can show at checkout for lower cash-pay pricing. Savings vary by location and pharmacy. GoodRx is 100% free. No registration required.

www.goodrx.com
GoodRx Support: 1-855-268-2822

amazon pharmacy

Amazon Pharmacy / RxPass
Additional savings available through Prime Rx discounts. Insurance not required for RxPass.

https://pharmacy.amazon.com/
Amazon Pharmacy Support: 1-855-745-5725

Dental Benefits – PPO Plan

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

Benefits Description	UnitedHealthcare Dental PPO Plan	
	In-Network	Out-of-Network
Calendar Year Maximum (Individual)	$2,000	$2,000
Calendar Year Deductible		
Individual / Family	$25 / $75	$50 / $150
Preventive Services		
Oral Exam	100% Covered by plan; Deductible does not apply	Member pays 20%; Deductible does not apply
Cleanings		
Routine X-Ray		
Fluoride Application		
Sealants		
Basic Services		
Fillings	Member pays 20% After Deductible	Member pays 20% After Deductible
Oral Surgery / Simple Extractions		
Root Canal / Endodontics		
Minor & Major Periodontics		
Space Maintainers		
Surgical Extraction Incl Impacted Wisdom Teeth		
General Anesthesia		
Palliative Treatment (Relief of Pain)		
Major Services		
Crowns / Inlays / Onlays	Member pays 50% After Deductible	Member pays 50% After Deductible
Stainless Steel / Resin Crowns		
Full and Partial Dentures		
Relining Dentures		
Bridges		
Repairs to Full Dentures, Partial Dentures, Bridges		
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 D8660 – Pre-Orthodontic Treat Exam D8680 – Orthodontic Retention D8999 – Unspecified Orthodontic Procedure by Report	 $1,850 / $1,950 $35 $300 $250

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

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

UnitedHealthcare dental is built for:



Ease

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



Savings

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



Network access

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



Your life

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

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

2 routine checkups in a 12-month period

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

Annual oral cancer screenings for adults

Screenings may include:

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

Care after oral surgery

To help reduce the risk of opioid complications:

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

Enhanced pregnancy benefits, such as:**

- Additional cleanings
- Deep scaling
- Gum maintenance

*Please check your health plan for specific coverage details.

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



Better dental care made easier

Help your kids start good habits early[1]

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

Regular screenings may help protect you from:

Diabetes

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

Heart disease

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

Respiratory conditions

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

Rheumatoid arthritis

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

Discover the mouth-body connection

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

Vision Benefits

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

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

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

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

See what our vision plans can do for you

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



There's clearly a lot to love, including:

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

A trusted provider is always in sight

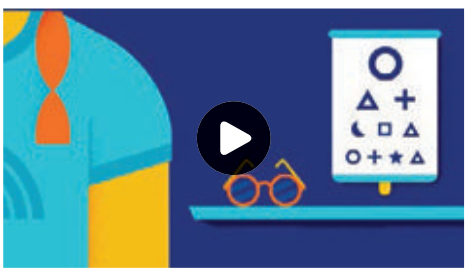
With our large national eye care network, you can take advantage of personalized care from a private practice, convenient retail chain or specialty online retailer. Search for network vision providers near you at **myuhcvision.com.**

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

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

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

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



Watch this video on vision benefits

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

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

United Healthcare®

Vision plan benefits and savings that focus on your needs



Eyeglasses and contact lenses

Save on everyday eyewear

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



Laser vision correction

Enjoy the freedom of LASIK

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

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



Pregnancy and children's vision benefits

Benefits designed with families in mind

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

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.

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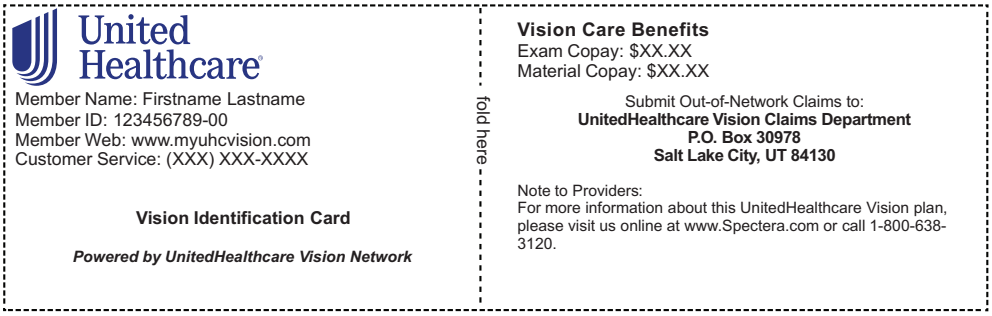
How to access your Vision ID card

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

Start by choosing your coverage type

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

Sample vision ID card*



Learn more

Visit your member website for more information about your vision benefits

United Healthcare®

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

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

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

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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
Tere Rodriguez	Ext. 110	-----	Tere.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	www.express-scripts.com/rx
Dental HMO	UnitedHealthcare / Solstice	800-955-4137	www.myuhc.com
Dental PPO	UnitedHealthcare	877-816-3596	www.myuhc.com
Vision	UnitedHealthcare / Spectera Vision	800-638-3120	www.myuhcvision.com
TeleHealth	UnitedHealthcare	855-615-8335	myuhc.com/virtualvisits
Employee Medical Accounts	Anchor Benefit Consulting	800-845-7629	www.anchorbenefit.com



USI®

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. Therefore, the following 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 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 United Healthcare 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 United Healthcare website at www.uhc.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. 2021

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

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

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

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

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, office, or mobile 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, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

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 someone has authority to act as your personal representative, such as if someone has your 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. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena. 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/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Effective: January 1, 2027
- Contact : Dade County Fire Fighters Insurance Trust
  8000 NW 21st Street
  Suite 222
  Miami, FL 33122-1605
  305-593-6100
  Dale.Sutton@local1403.org

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

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 United Healthcare Medical Plans for the plan year January 1, 2027 – December 31, 2027 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 United Healthcare Medical Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose United Healthcare Medical Plan creditable coverage.
- You may stay in the United Healthcare Medical Plans and also enroll in a Medicare prescription drug plan. The United Healthcare Medical Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the United Healthcare Medical Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the United Healthcare Medical Plan, 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 01,2027
Name/Entity of Sender:	Dade County Fire Fighters Insurance Trust
Contact Position/Office:	Dale Sutton
Address:	8000 NW 21st Street, Suite 222, Miami, FL 33122-1605
Phone Number:	305-593-6100

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	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
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/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)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
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)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
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, 2026, 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 5/31/2029)

Your Rights and Protections Against Surprise Medical Bills

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

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

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

"Out-of-ne twork" describes providers and facilities that haven't signed a contract with your health pl an. Out-of-network providers may be permitted to bi ll you for the difference between what your pl an agre ed to pay and the full amount charged for a servic ce . This is cal led "**balance billing**." This amount i s l i kely more than i n-network costs for the same service and might not count toward your annual out-of-pocke t l imit.

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

You are protected from balance billing for:

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

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

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

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

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

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

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

- Your health plan generally must:

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

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

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

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

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

Name of Entity/Sender**:** Dade County Fire Fighters Insurance Trust
Contact--Position/Office: Dale Sutton
Address: 8000 NW 21st Street, Suite 222 Miami, FL 33122-1605
Phone Number: 305-593-6100

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Dade County Fire Fighters Insurance Trust			4. Employer Identification Number (EIN) 59-2185490
5. Employer address 8000 NW 21st Street, Suite 222			6. Employer phone number 305-593-6100
7. City Miami	8. State Florida	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** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notes:

Notes:

Notes:



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