

2009 Retiree Insurance Benefits

MIAMI-DADE
COUNTY

Delivering Excellence Every Day

Handbook 1
for retirees
under age 65
and/or dependent(s)
(non-Medicare
eligible)

The Difference Between *Handbook 1* and *Handbook 2*

Retiree Insurance Handbook 1 outlines the benefits available to retirees under 65 and/or their eligible dependents under age 65. ***Retiree Insurance Handbook 2*** outlines the benefits available to retirees age 65 or older, and/or their eligible dependents who are 65 or older. The benefits (except life insurance) described in Handbook 2 will also apply if you and/or your eligible dependent are under 65, but Medicare eligible.

If you wish to continue your coverage through the Retiree Group, complete the election form in Handbook 1, if you are under the age of 65. Complete the election form in Handbook 2, if you are 65 or older, or Medicare eligible. If you are under age 65, but have a Medicare eligible dependent, complete the election form in Handbook 1; however, consult Handbook 2 for detailed Medicare plan benefit information for your dependent.

Please submit your election form to the Benefits Administration Unit at least two (2) weeks prior to your anticipated retirement date.

Again congratulations and best wishes for your retirement years.

2009 Retiree Insurance Benefits



HANDBOOK 1

For retirees and/or dependent(s) under age 65 (Non-Medicare Eligible)

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Introduction

This handbook gives you a summary of medical, dental, and life insurance benefits available to retirees and/or eligible dependent(s) **under age 65** who are **not Medicare eligible**. If you are under age 65, but have a Medicare eligible dependent, please consult Retiree Handbook 2 for detailed Medicare plan benefit information.

In order to enroll in the Retiree Group, you must complete and return to the Benefits Administration Unit of Risk Management Division, General Services Administration the following form(s):

2009 Retiree Insurance Election Form

Complete this form if you are under age 65. If you are 65 or older, with an under 65 dependent, please complete the application in Retiree Handbook 2.

Payroll Authorization Form

Complete this form if you would like to have your premiums withheld from your Florida Retirement System (FRS) pension check. This form will be mailed to you along with your billing if this option is checked on your retiree insurance application. Note that after initial payment, it takes sixty (60) days from receipt of form for automatic FRS premium deductions to begin.

Life Insurance Beneficiary Designation Form

Complete this form if electing continuation of life insurance after retirement. Please complete an updated beneficiary form if the named beneficiary predeceases you, or if you wish to change beneficiaries at any time. This form will be mailed to you along with your billing if this option is checked on your retiree insurance application. Please remember to update your beneficiary as circumstances change.

NOTICE:

The information contained in this handbook is prepared for the benefit of our retirees and their covered dependents. It represents the highlights of the currently available programs. Retirees should consult their Certificate of Coverage or Summary Plan Description for exact details and conditions of coverage. Precise benefits will be governed by the contracts and not by the information contained herein.

Retirement Overview

Congratulations on your retirement. As a retiree, you may elect to continue your group medical, dental and basic life coverage under our Retiree Group.

Health Insurance Continuation— Eligibility Criteria

You are eligible to continue coverage under the Retiree Group, if you retire from Miami-Dade County with a retirement code of EG (Normal Retirement), and meet one of the following requirements:

FRS Pension Plan – 1) Normal retirement eligibility, which is the earlier of either age 62 with at least 6 years of service, or 30 years of service. If Special Risk, age 55 with 6 years, or 25 years of service; or 2) Federal normal retirement eligibility of age 59 1/2 with at least 6 years service.

Your covered dependents may continue insurance coverage through the retiree group if you die while in DROP.

You are also eligible to continue coverage under the Retiree Group if approved for disability retirement (retirement code EI).

FRS Investment Plan – 1) Meet the age and service requirements to qualify for normal retirement as indicated above, or 2) Attain age 59 1/2 as specified by s.72(t)(2)(A)(I) of the IRS Code, with 6 years of creditable service.

If you do not take a distribution and decide to defer your retirement, you will not be considered retired and may not be entitled to continue your County-sponsored health insurance coverage.

Election Process

To summarize, coverage continuation is not automatic. Your employee group coverage is cancelled the last day of the pay period in which the retirement date falls and for which the employee experiences a regular insurance deduction or made direct payments to the Benefits Administration Unit (if on an unpaid leave of absence). Coverage under the Retiree Group will not be activated until the first retiree premium is received. **The insurance carriers will be notified to reinstate your coverage under the Retiree Group upon receipt of your initial premium payment.**

To continue your medical, dental and basic life insurance coverage, complete the Retiree Insurance Election form and submit it within thirty (30) days of your retirement date. Coverage for your eligible dependent(s) may be continued under the Retiree Group, but only if the dependent was enrolled immediately prior to your retirement date. To assure a smooth transition, especially if you have scheduled ongoing treatment or need prescriptions filled, submit the election form and initial premium within ten (10) days of your retirement date. Once the initial retiree premium is received, medical, dental, and/or life insurance (if elected) become effective retroactive to the date your coverage as an active employee expired (without a gap), assuming premiums were paid through that date. Your election form must be received by the Benefits Administration Unit no later than thirty (30) days following your retirement date, otherwise you forfeit Retiree Group coverage. If the Retiree Group election period lapses, you may still exercise your rights under COBRA; please refer to the COBRA section in this handbook.

Leave of Absence - The same election process applies to employees on leave of absence (or no-pay status) who terminate County employment with EG or EI status, without physically returning to work. Group insurance coverage will end as of the retirement date pay period, assuming premiums were paid through that date. If coverage is cancelled for non-payment of premiums, while on leave status, you will not have the opportunity to continue coverage under the Retiree Group or COBRA.

DCFF Union Members - If you are a member of the DCFF Union-sponsored plan you may change to one of the County-sponsored medical and/or dental plans upon retirement, however, enrollment in the basic life insurance is subject to medical approval and coverage is not guaranteed. Contact the Fire Union office if you wish to continue participation in the Fire Union-sponsored plan, after retirement.

Coverage Available

The County no longer contributes the employer portion on your behalf, consequently, you will pay the full monthly premium cost. Your dependent spouse or domestic partner (DP) and/or children including the children of a DP, currently covered under your medical and/or dental plan as of the date you retire, may continue under your coverage at retirement.

THE BENEFIT OPTIONS AVAILABLE ARE:

Medical, Dental, and Life	Medical Only	Medical & Life	Medical & Dental
	Dental & Life	Dental Only	Life Only

THE HEALTH PLANS AVAILABLE AFTER RETIREMENT ARE:

Medical Plans		Dental Plans
AvMed Point of Service (POS)	JMH High Option HMO	MetLife Standard or Enriched Dental
AvMed High Option HMO	JMH Low Option HMO	ADP Standard or Enriched Dental
AvMed Low Option HMO		OHS Standard or Enriched Dental

PLAN CONTACT INFORMATION

AvMed Health Plan	www.avmed.org/go/mdpht	(800) 682-8633
JMH Health Plan	www.jmhph.com	(800) 721-2993
American Dental Plan	www.compbenefits.com	(800) 432-3376
MetLife Dental Plan	www.metlife.com/mybenefits	(800) 845-1870
Oral Health Services	www.compbenefits.com	(800) 432-3376

Changing Health Plans

You have a one-time opportunity to change plans at the time you retire. Once you submit your election form, you cannot change plans until the annual retiree open enrollment period, unless you move out of the plan's geographic service area.

Electing Health Coverage Under Your Spouse/DP's Plan

If your spouse/DP is a County employee, you have the option of enrolling as a dependent under your spouse/DP's County medical and/or dental plan. Your spouse/DP must submit the family status change forms (CIS) within forty-five (45) days of your retirement date. You can download the forms from the County benefits website or contact your spouse/DP's department personnel representative (DPR). You can transfer your medical/dental coverage to the Retiree Group at a later date, as long as you have been continuously covered under a County-sponsored medical/dental plan without a break, since your retirement date.

Important note: Continuation of basic life insurance cannot be postponed. You must elect the coverage at retirement otherwise you forfeit the coverage.

Adding/Dropping Dependents After Retirement

You may add eligible dependents only in cases of qualifying events (QE) such as marriage, entering into a new domestic partnership, birth (or adoption/placement) of a child, eligible dependent's loss of employment, etc. En-

rollment must take place within forty-five (45) days, sixty (60) days for newborns of the qualifying event. Proof of the qualifying event must be submitted to the Benefits Administration Unit. Existing dependents cannot be added during the retiree open enrollment.

—**You may make a written request to delete your dependent(s) at anytime. This change will be effective at the end of the month the request is made or received in the Benefits Administration Unit.**

Important information regarding Dependents Age 25-30 and Domestic Partners

Please note that the County subsidizes premium rates for retirees and their covered dependents. However, since the Internal Revenue Service generally does not recognize dependents age 25-30 and domestic partners and/or their child(ren) as tax dependents, any subsidies attributable to coverage for these groups must be declared as income to the retiree (referred to as imputed income) and becomes taxable to the retiree. It is recommended that you consult with your financial planner or tax consultant to see how this impacts your particular situation.

Please see imputed income sample on page 28 or contact your Employee Benefits Specialist for more information.

Relocating Outside the Tri-County Area

If you plan to relocate, be aware that CompBenefits (OHS

and ADP) dental coverage is not available outside Miami-Dade, Broward, and Palm Beach Counties. Additionally, although the AvMed Elite and Beech Street combined networks offer extensive nationwide coverage, some remote geographic areas may not be included. If relocating your permanent residence, please contact your HMO or pre-paid dental plan to obtain information about existing networks in your geographic area. If in-network benefits are not available in your area, your only option is to switch to the Point-of-Service (POS) medical plan and MetLife dental plan, to access out-of-network benefits. You have forty-five (45) days from the relocation date to request the plan change. Proof of permanent residence change will be required (new service utility bill, rental agreement, etc.).

Retirees traveling outside their geographic service areas for extended periods should contact the insurance carrier's Member Services 800# to inquire about the "Away From Home Program."

Coverage Not Available After Retirement

Optional life insurance and Optix Vision coverage are not available after retirement. Refer to information below.

Optix Vision Plan (Vision Care, Inc.)

The Optix Vision coverage is not available through the Retiree Group, but may be continued through COBRA. If enrolled at the time of your retirement, you may contact Optix to inquire about a COBRA policy at the following address:

OPTIX Vision (Vision Care Inc.)

P.O. Box 769729

Roswell, Georgia 30076

(800) 749-5855

Optional Life Insurance

Optional life coverage is not available through the Retiree Group. If enrolled at the time of your retirement, you may elect to convert this coverage to an individual policy. The policy is available to you without medical approval, but will be provided by Metropolitan Life at their prevailing individual insurance rates. You may convert up to the amount of coverage in force at retirement. Contact the insurance carrier to obtain rates and policy options.

MetLife Advice Resource Center

solutions@metlife.com

(877) 275-6387

Basic Life Insurance for Retirees Under Age 65

The group basic life insurance coverage provided to active employees at no cost may be continued at retirement, at your expense. The coverage amount for retirees

under age 65 is equivalent to their pre-retirement annual base salary. As long as the coverage was in force prior to retirement, the benefit may be continued.

If you elect to continue your basic life insurance, remember to maintain your beneficiary designation current. A new beneficiary may be named at any time. To update your beneficiary call our office at (305) 375-5633 and request a Life Insurance Beneficiary Update Form. Make sure your beneficiary designation form is legible and contains no erasures or cross-out marks. Specify the percentage of benefits for each named beneficiary to receive. The total percent allocation among the beneficiaries must add up to 100%. Please be sure your beneficiary is aware of the benefit and knows how to contact our office in the event of your death.

COBRA

Federal law (COBRA) provides that insured employees and their covered dependents may elect to continue group health coverage for up to 18 months from the date employment terminates or until the employee is covered under another group plan, whichever is first. We are required by law to notify you of your COBRA rights, as a result, you will receive a COBRA mailing in addition to information regarding Retiree Group coverage. You can only maintain COBRA coverage for a limited time, whereas you may continue health and basic life coverage indefinitely, under the retiree group.

You may elect continuation of medical/dental coverage under COBRA instead of participating under the Retiree Group. The choice is yours to make. However, the election period for the Retiree Group coverage expires 30 days from your retirement date. The COBRA election period expires sixty (60) days from the date benefits terminate under the active group. You have forty-five (45) days from your COBRA election date to pay the first premium. Your life insurance coverage may be converted directly with Metropolitan Life Insurance Company, at their prevailing rates.

The insurance carriers mail the COBRA information packets directly to the retiree's home address, usually within fourteen (14) days from the date your final check is processed. Group medical, dental, vision, and basic/optional life insurance coverage (if enrolled) cease the last day of the pay period in which the retirement date falls and for which the employee experiences a regular insurance deduction or made direct payments to the Benefits Administration Unit (if on an unpaid leave of absence). Contact the insurance carrier directly for information regarding COBRA.

Frequently Asked Questions

Q. How do I confirm that my doctor participates in the AvMed Health Plans?

A. All participating providers may be found in the AvMed provider directories or online at www.avmed.org/go/mdpht. The Beech Street providers are identified by the symbol **◆** in the printed directory, and the symbol **B** in the online directory. When contacting one of these providers to verify participation, you should ask whether they participate in the “Beech Street Network,” rather than the AvMed network. This applies only to retirees on the HMO or POS plans. Medicare eligible retirees on a Medicare plan may use any provider. The appropriate logos will be included on your ID card. As always, you must verify the participating status of any provider you plan to use, before you access their services. You may also contact AvMed’s dedicated line at (800) 682-8633 (24/7) or the onsite representatives at 305-375-5306 (Mon-Fri, 8:30 a.m. - 4:30 p.m.)

Q. What Medical/Dental Insurance Plans are available for retirees and/or eligible dependents under age 65 (not Medicare eligible)?

A.

Medical Plans	
AvMed Point of Service (POS)	JMH High Option HMO
AvMed High Option HMO	JMH Low Option HMO
AvMed Low Option HMO	

Dental Plans	
MetLife Standard or Enriched Dental (Indemnity)	
ADP Standard or Enriched Dental (Prepaid)	
OHS Standard or Enriched Dental (Prepaid)	

Retirees (under 65 and not Medicare eligible) plus eligible dependents, including domestic partners and their eligible child(ren), have the same medical and dental plan options offered to active employees until the age of 65 or Medicare eligibility. If residing outside the Miami-Dade, Broward, and Palm Beach Counties, check with the HMO/prepaid dental plans to verify if cover-

age for Miami-Dade County retirees is available in your new area of residence. You will find a summary of benefits, applicable rates and the 2009 Retiree Insurance Election Form in Handbook 1.

Q. What County-sponsored medical/dental insurance plans are available for retirees and/or eligible dependents age 65 or Medicare eligible?

A.

Medical
AvMed Low Option Plan for Medicare Eligible Retirees
AvMed High Option Plan for Medicare Eligible Retirees
AvMed No RX Plan for Medicare Eligible Retirees
JMH High Option HMO
JMH Low Option HMO

Dental
MetLife Standard or Enriched Dental (Indemnity)
ADP Standard or Enriched Dental (Prepaid)
OHS Standard or Enriched Dental (Prepaid)

You will find a summary of benefits offered to Medicare eligible retirees (and/or dependents) and applicable rates in Retiree Handbook 2. If you and/or your spouse/DP are 65 years or more, you and/or your spouse/DP are responsible for enrolling in Medicare Parts B & D through the Social Security Administration prior to your retirement. To obtain information regarding the AvMed Medicare Preferred Plan (Medicare HMO), contact their Medicare section at (800) 535-9355. You must enroll with the HMO directly, not through Miami-Dade County.

You may also want to explore Medicare supplement programs not affiliated with Miami-Dade County. These programs, offer comprehensive coverage with low (or no) monthly premium. To obtain a list of Medicare HMO carriers, contact the Dept. of Financial Services Consumer Help Line (800) 342-2762, or log on to www.fldfs.com.

Q. I am under the age of 65, but enrolled for Medicare Parts A & B due to disability. May I remain enrolled in the POS plan?

A. Yes, you can remain in the POS plan, until age 65, but Medicare will be the primary payor. This will apply whether you are enrolled in the POS or HMO plan.

Q. Who are eligible dependents?

A. Miami-Dade County recognizes eligible dependents as:

- 1) Your spouse or registered domestic partner, as recognized by the State of Florida.
- 2) Your unmarried natural children, stepchildren, adopted children, children of a domestic partner, or a child for whom you have been appointed legal guardianship, pursuant to a court order until the end of the calendar year in which they turn age nineteen (19).

Coverage for dependents (except for foster children in court-ordered custody/guardianship) may be continued until the end of the calendar year in which they turn age twenty-five (25), provided they are primarily dependent upon the retiree for financial support and residing in the retiree's household, or are full/part-time students. Proof of eligibility may be requested at any time by the plans.

The Florida Statute (FSS 627.6562) governing dependent insurance was recently modified to extend the limiting age of dependent children from age 25 to age 30 (end of the calendar year), if the child meets the following criteria: a) The child is unmarried and does not have any dependent(s) of his or her own, and b) The child is a resident of the state of Florida or is a full-time/part-time student, and c) The child is not provided coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. **Coverage for this group applies to medical coverage only.**

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree [F.S. Section 817.234 (1) (b) (2000)].

Q. How do I enroll my new registered domestic partner and/or their children?

A. To enroll your domestic partner and the domestic partner's dependent children for health insurance, you must file a Declaration of Domestic Partnership with the Miami-Dade County Consumer Services Department and pay the applicable fee. Submit a copy of the Certificate of Domestic Partnership and the birth certificates of the dependent children of the domestic partner you wish to enroll.

Q. May I change insurance carriers after I retire?

A. You may change insurance carriers at the point of retirement, as long as you are enrolled in a County administered insurance plan or the Fire Union-sponsored plan. Thereafter, the circumstances under which the Retiree Group will allow retirees to change medical and/or dental plans are as follows:

- a) If you are enrolled in an HMO or pre-paid dental plan and move out of the plan's service area, this change of residency is a qualifying event. If you notify the Retiree Group regarding this change within forty-five (45) days, a change of medical and/or dental plans is allowed. Proof of your change of residency will be required.
- b) If Miami-Dade County changes insurance carriers, affected members will be allowed the opportunity to select another group plan.
- c) In the fall of each year, you will be given an opportunity to change medical plans if enrolled.

Q. If enrolled in an HMO plan, may I utilize providers outside the South Florida network and still receive HMO coverage?

A. Yes, both AvMed Health Plans and JMH Health Plan, have contracted with Beech Street providers to provide nationwide coverage. As a retiree, if you utilize a participating Beech Street provider you will receive the same HMO benefits. For more information on accessing Beech Street providers contact AvMed's 24/7 dedicated Member Services at 1(800) 682-8633 or the JMH Health Plan at 1(800) 721-2993.

Q. What benefits am I eligible for if I am under 65 and receiving disability benefits through the Social Security Administration?

A. If you are under age 65, deemed disabled by the Social Security Administration and have qualified for Medicare Parts A, B and D, you may be eligible for the options available to Medicare eligible retirees described in Retiree Handbook 2. For more information, contact the Employee Benefits Specialists at (305) 375-5633. Be aware that once you qualify for Medicare, your retiree medical coverage becomes secondary, even if you elect to continue with your current coverage (HMO or POS) until age 65 instead of enrolling in one of the Medicare supplement plans.

Q. If I or a covered dependent qualify for Medicare Part B due to End Stage Renal Disease (ESRD) disability, will my AvMed premiums change?

A. Please contact your Employee Benefits Specialist to discuss your eligibility for reduced monthly premiums. You will need to provide a copy of your Medicare Part B card, showing the coverage effective date.

Q. What happens to the medical coverage for my ex-spouse/DP if I should divorce or terminate my domestic partnership?

A. Your ex-spouse/DP's Retiree Group coverage ends as of the date of the divorce or termination of domestic partnership. Former spouse/DPs cannot continue to be covered under the Retiree Group. *There is no exception to this rule, regardless of the stipulations in the divorce settlement.* Your ex-spouse or former domestic partner and their children will have the opportunity to continue the coverage through COBRA for thirty-six (36) months or until age 65, whichever occurs first. To exercise the COBRA option, you or your ex-spouse/DP must submit a written request to the Benefits Administration Unit as soon as possible, but no later than sixty (60) days from the divorce or domestic partnership termination date asking for the COBRA package and attach a copy of the divorce decree or domestic partnership termination certificate.

Q. What happens to the medical and/or dental coverage for my covered dependent(s) if I should die?

A. If you die, dependents covered under your retiree medical and/or dental insurance, may continue their coverage, as long as timely premium payments are re-

ceived. Your spouse/DP can continue indefinitely and your dependent children until the limiting age. This applies to the AvMed and JMH plans as well as the dental plans.

Q. What happens to the medical and/or dental coverage for my covered dependent(s) if I cancel only my coverage upon becoming eligible for Medicare?

A. If you cancel your coverage upon becoming eligible for Medicare, dependents covered under your retiree medical and/or dental insurance may continue, as long as timely premium payments are received. All cancellations are irrevocable. Once cancelled, coverage will not be reinstated. This applies to the AvMed and JMH plans as well as the dental plans.

Q. If I have a qualifying event (marriage, new domestic partnership, birth or adoption of a child, or loss of group insurance coverage for spouse/DP) am I able to add my eligible dependent(s) to my retiree health insurance plan?

A. Yes, if you have a qualifying event, you may add your eligible dependent(s) to your medical and/or dental insurance plan(s). A written request for the change must be received in our office no later than forty five (45) days following the date of the qualifying event, sixty (60) days for newborns. To add the dependent, send a letter requesting the addition of your dependent(s) with a copy of the applicable documentation (i.e. marriage certificate, certificate of domestic partnership, birth certificate or adoption papers, letter from spouse/DP's employer certifying termination of insurance benefits, etc.). Your premium will be adjusted to reflect the change in coverage.

Q. How will I be billed for Retiree Group coverage?

A. You must submit a Retiree Insurance Election form within thirty (30) days of your retirement. The Benefits Administration Unit will mail you an annual Retiree Billing Statement. This billing statement will include a monthly premium breakdown for the calendar year. You will be responsible for paying your insurance premiums through the current billing month, and no later than fifteen (15) days from the date of the billing notice.

Your coverage is not reinstated under the Retiree Group until receipt of your initial premium payment. There-

after, premiums are due on the first of each month. For that reason, we recommend that you budget for approximately three months of insurance premiums, since your first pension check may not arrive for approximately sixty (60) days from the date of retirement.

If you and/or your covered dependent turn 65, subsequent to your retirement, there will be a change in your premium due to Medicare and/or life insurance coverage. If a medical plan election is required you will receive information from us approximately three (3) months prior to you/or your spouse/DP's 65th birthday. No election is required if you don't have medical coverage; you will be sent a new billing calendar prior to the month your premium changes.

When you turn 70 or 75, your life insurance premium will be adjusted if you are maintaining this coverage. You will receive a new billing calendar prior to the month your premium changes.

Q. How do I pay for my insurance?

A. You may pay your monthly premium by check, money order, or through automatic deduction from your Florida Retirement System (FRS) pension check. When you pay by check or money order, the payment is due in our office on the first day of each month. Accounts are subject to cancellation, if your payment is not received by the end of the month for which payment is due. We are unable to accept cash for security reasons. Make checks payable to the **Board of County Commissioners**. To expedite processing, indicate your retiree ID number (refer to your Billing Statement) on all checks. The insurance carriers will be notified to reinstate your coverage under the Retiree Group upon receipt of your initial premium payment. Note: Coverage cannot be verified if the account is not current.

To have your insurance premiums deducted from your FRS pension check, you must complete a Payroll Authorization Form and submit it to the Benefits Administration Unit with your Retiree Insurance Election form, or with your first premium payment. FRS deductions begin approximately sixty (60) days thereafter. You are responsible for sending your check payments directly to this office until FRS deductions begin. Insurance premiums are deducted from your FRS pension benefit in advance, to pay for the upcoming month's insurance

coverage. The insurance deductions will be reflected on your FRS check stub or statement.

Q. What is the Health Insurance Subsidy?

A. Eligible retirees receive \$5.00 per month for each year of FRS service credit earned at retirement. The subsidy is at least thirty dollars (\$30) per month, but no more than one hundred fifty dollars (\$150) per month. It is intended to help offset the cost of your health insurance coverage.

The Florida Retirement System mails you a form to enroll for the subsidy. If you have elected to continue medical coverage under the Retiree Group, you may forward your subsidy application, after completing Part I, to the Benefits Administration Unit. We will verify coverage and forward your completed form to the Division of Retirement. The subsidy will not appear on your pension check until approximately sixty (60) days from the date the Division of Retirement receives it. You may contact the Division of Retirement at (888) 377-7687 for any subsidy questions, or write to:

Division of Retirement
1317 Winewood Boulevard, Building 8
Tallahassee, Florida 32399-1560
email: retired@dms.myflorida.com

Q. Can my insurance under the Retiree Group be cancelled?

A. You may cancel your medical, dental or life insurance coverage at any time. The insurance carriers or the County will not cancel your coverage unless:

- a) any premiums payable by you are not received within thirty (30) days following the premium due date. If this happens, a cancellation notice will be mailed to you. You are responsible for notifying the Benefits Administration Unit if there is a change in your mailing address.
- b) the group insurance coverage under the Master Contract for your particular type of insurance is cancelled.
- c) you are enrolled in an HMO or pre-paid dental plan and move out of the service area.
- d) you are enrolled in an AvMed HMO and become Medicare eligible. You may transfer to a supplement plan at that time.

All cancellations are irrevocable. Once cancelled, coverage may not be requested again.

Q. How do I apply to continue coverage through the retiree group?

A. To continue medical, dental, and/or life insurance coverage as a retiree, complete, sign, and submit a Retiree Insurance Election form. To assure a smooth transition, the application must be received in the Benefits Administration Unit at least 2 weeks prior to your retirement date. Retirees under age 65 must complete the application contained in Handbook 1. Retirees age 65 or over must complete the application contained in Handbook 2.

Retiree Insurance Election forms received more than thirty (30) days after the retirement date will not be accepted; you will only be entitled to health insurance continuation under COBRA, if applied for within sixty (60) days following your retirement date. In the event a retiree terminates his/her employment on a retroactive basis (EI, EG status only) after being on a leave of absence, the Retiree Insurance Election form must be received within thirty (30) days of the date the retiree's department processes the status change.

Q. May I continue my Optional Life insurance?

A. You can convert this optional benefit directly with the life insurance carrier. Information about the process will be mailed to you with your billing calendar.

Q. May I continue my Optix Vision insurance?

A. The Optix Vision coverage is not available through the Retiree Group. You may continue this vision benefit directly with the insurance carrier by electing COBRA.

Q. If I cancel my medical coverage, may I retain the dental and/or life insurance? When will the change in premium take effect?

A. Yes, you may cancel the medical coverage without disrupting your dental and/or life insurance. Simply submit a written request to your Employee Benefits Specialist, indicating the plan (or plans) you wish to cancel. The premium reduction will take effect the 1st of the month following receipt of your cancellation request. Premiums must be paid through the cancellation

date. Cancellations are irrevocable. Once cancelled, the coverage will not be reinstated.

Q. May I add a dependent during the retiree open enrollment?

A. No. During the annual open enrollment you will only be allowed to change plans, and only eligible enrolled dependents will be allowed to continue coverage under the retiree group.

Q. My spouse/DP is also employed by Miami-Dade County. Upon my retirement, may I continue basic life insurance only under the Retiree Group and have my spouse/DP add me as his/her dependent for medical, dental and/or vision coverage under the Active Employee Group?

A. Yes, you may elect to continue basic life insurance only through the Retiree Group. Your spouse/DP must contact his/her Department Personnel Representative (DPR) to complete the Change in Status (CIS) forms required to add you as a dependent as soon as possible, but no later than forty-five (45) days after your loss of coverage under the Active Employee Group.



2009 Important Notice From Miami-Dade County To Medicare Eligible Retirees 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 Miami-Dade County 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Miami-Dade County has determined that the prescription drug coverage offered by the County's AvMed Plans for Medicare eligible retirees (and Medicare eligible dependents), is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage through the County's medical plan.
3. You can keep your current coverage from Miami-Dade County. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 November 15th through December 31st. However, if you decide to drop your current Miami-Dade County medical coverage for Medicare eligible retirees, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. Be aware that you may be subject to a higher premium (a penalty) because you did not have creditable coverage. Note, if you are currently enrolled in either the County's POS or HMO Plans (which have creditable prescription drug coverage) and become Medicare eligible, since you are losing creditable prescription drug coverage you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Since coverage under the **County's AvMed Plans for Medicare eligible retirees** is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to



join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

If you (or your dependent) do decide to join a Medicare drug plan and drop your current AvMed Plan for Medicare eligible retirees, be aware that you (or your dependent whichever is applicable) will not be able to get the County coverage back. However, if you join a Medicare drug plan when you first become Medicare eligible, you can select the AvMed No RX Plan for Medicare eligible retirees (medical plan without prescription drug coverage), and continue to receive coverage for other medical services through Miami-Dade County.

You need to make a decision.....

NOTE: You'll get this notice each year, or you can download it from the Miami-Dade County website at www.miamidadecounty.gov/benefits. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Miami-Dade County changes. You may also request a copy 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)**.

Date:	October 8, 2008
Name of Entity/Sender:	Miami-Dade County
Contact--Position/Office:	Risk Management Division, General Services Administration
Address:	111 NW 1 ST Street, Suite 2340, Miami, FI 33128
Phone Number:	(305) 375-4288

AVMED (POS) Plan

AVMED HEALTH PLANS (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.avmed.org/go/mdpht	
COVERAGE PLAN DESCRIPTION	<p>IN NETWORK A managed care program which offers employees, covered dependents and retirees (under age 65) the ability to use a large network of providers in the State of Florida. In addition, the Beech Street nationwide network is included. 100% benefits for covered charges, after applicable co-payments. Members are encouraged but not required to select a primary care physician. No referrals are required to see participating Specialists. AvMed offers 24/7 Member Services, Nurses on Call hot line, Care Management programs, discounted Mail Order Prescriptions.</p> <p>OUT OF NETWORK A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice outside of the network. Payments are based on reasonable and customary (R & C) charges. Providers who do not participate in the network may balance bill you for the amount which exceeds R & C. Coverage is subject to deductibles and co-insurance.</p>
DEDUCTIBLES/ COPAYMENTS	<p>IN NETWORK Co-payments \$10 Physician office visit 100% Hospital admission coverage - no copay \$50 Emergency Room (waived if admitted) \$5/\$10/\$15 Prescriptions for 30 day supply Mail Order: \$10/\$20/\$30 for 90 day supply.</p> <p>OUT OF NETWORK Deductible \$200 per individual; \$500 per family Max out-of-pocket limit is \$1500 per individual (not including deductible) \$50 Emergency Room Co-payment (waived if admitted) Same in-network prescription benefits apply if participating pharmacy is used. Benefits payable at 70% of reasonable & customary (R & C) after deductible is met.</p>
PHYSICIANS	<p>IN NETWORK Access any primary care physician or specialist from the Elite Access Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician. Physician services are covered in full after \$10 co-payment.</p> <p>OUT OF NETWORK Choose any licensed physician; covered charges payable at 70% of reasonable & customary (R & C) after deductible is met.</p>
A. IN-HOSPITAL PHYSICIAN SERVICES: Surgery/Visits & Consultations Anesthesiologist B. OUT-PATIENT PHYSICIAN SERVICES: Office visits for illness Office visits for injury Diagnostic X-Rays, Lab Tests, X-Ray treatments Pediatrician 1) Medically Necessary 2) Preventive (Child Health Supervision Services) Routine Physical Obstetrical/Gynecological	<p>Benefits payable at 100% when received at participating hospitals and rendered by participating physicians.</p> <p>\$10 co-payment; then 100%</p> <p>\$10 co-payment; then 100%</p> <p>100%</p> <p>\$10 co-payment; 100% thereafter.</p> <p>\$10 co-payment; then 100% Covers Child Health Supervision Services up to age 15.</p> <p>\$10 co-payment; then 100%</p> <p>\$10 co-payment, then 100%. Mammograms, PAP smears payable at 100%. Maternity Care: \$10 co-pay for 1st visit, 100% thereafter.</p> <p>Benefits are payable at 70% of reasonable & customary (R & C) covered charges, after deductible is met.</p> <p>Plan pays 70% of R & C covered charges, after deductible is met.</p> <p>Plan pays 70% of R & C covered charges, after deductible is met.</p> <p>Plan pays 70% of R & C covered charges, after deductible is met.</p> <p>Plan pays 70% of R & C covered charges, after deductible is met.</p> <p>100% of R & C covered charges, no deductible. Covers Child Health Supervision Services through age 15.</p> <p>Not covered</p> <p>Plan pays 70% of R & C covered charges, after deductible is met.</p>

Benefits Comparison Chart

Benefits Comparison Chart

AVMED (POS) Plan

AVMED HEALTH PLANS (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.avmed.org/go/mdpht	
Hospitalization:	Benefits payable at 100% at following affiliated hospitals when admitted with PCP authorization: MIAMI-DADE COUNTY Anne Bates Leach Eye Hospital • Aventura • Baptist • Cedars • Coral Gables • Doctor's Hospital • Hialeah Hospital • Homestead Hospital • Jackson Memorial Hospital • Jackson South Community Hospital • Jackson North Medical Center • Kendall Regional Medical Center • Larkin Community Hospital • Mercy Hospital • Miami Children's • Mt. Sinai Medical Center • North Shore Medical Center • Palm Springs Hospital • Palmetto General • South Miami Hospital • University of Miami Hospital & Clinic BROWARD COUNTY Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Medical Center • Florida Medical Center • Hollywood Medical Center • Holy Cross Hospital • Imperial Point • Joe Di Maggio Children's Hospital • Memorial Regional Hospital • Memorial Miramar • Memorial Pembroke • Memorial West • North Broward Medical Center • Northwest Medical Center • North Ridge Medical Center • Plantation General • University Hospital • Westside Regional Medical Center
Hospital/Surgical Requirements: Precertification of hospital confinements	Handled by admitting physician.
Drug & Alcohol Treatment: Inpatient Outpatient	\$25 per day. Maximum of 45 days per year. \$10 co-payment, up to a maximum of 30 visits per calendar year.
Mental & Nervous Disorders: Inpatient Outpatient	100%. Maximum of 45 days per year. \$10 co-payment, up to 30 outpatient visits per calendar year.
Ambulance Vision	100% when medically necessary Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%. after \$10 co-payment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.
	Plan pays 70% of R & C covered charges, after deductible is met.
	Precertification required or benefits will result in a \$500 penalty. This is the responsibility of the member, not the providers.
	Benefits payable at 70% of R & C, after deductible is met. Maximum of 45 days per year. 70% of R & C charges after deductible is met to a maximum of 30 visits per calendar year.
	Benefits payable at 70% R & C covered charges, after deductible is met. Maximum of 45 days per year. Benefits payable at 70% of R & C charges after deductible is met to a maximum of 30 visits per calendar year. *
	100% when medically necessary Coverage provided for diseases of the eye and/or injuries to the eye at 70% of R & C after deductible is met. Eye exams, glasses, contact lenses not covered.

AVMED (POS) Plan

AVMED HEALTH PLANS (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.avmed.org/go/mdpht	
Prescription Drugs:	<p>\$5 Generic/\$10 Preferred Brand/\$15 Non-Preferred Brand prescriptions for 30 day supply including prescription contraceptives at participating pharmacies nationwide. See plan literature for participating pharmacies. Mail order: 2x co-pay for 90-day supply.</p> <p>\$5 Generic/\$10 Preferred Brand/\$15 Non-Preferred Brand prescriptions for 30 day supply including prescription contraceptives at participating pharmacies nationwide. Mail order: 2x co-pay for 90-day supply. See plan literature for participating pharmacies. Plan pays 70% after deductible at non-participating pharmacies.</p>
Durable Medical Equipment (DME):	<p>Covered at 100%.</p> <p>70% of R & C charges after deductible is met.</p>
Out of Area: 1) Emergency 2) Non-Emergency	<p>\$50 co-pay, waived if admitted/100% thereafter. Out of network applies: 70% of R & C charges after deductible is met.</p> <p>\$50 co-pay, waived if admitted/100% thereafter. 70% of R & C charges after deductible is met.</p>
<p>* Coverage for drug/alcohol rehabilitation and for mental/nervous disorder (s) limits are per contract year combined in or out of network. This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary Plan Description. Maximum lifetime benefits is unlimited in-network, \$1 million out-of-network. Out-of-network annual out-of-pocket maximum is \$1,500 per individual (no family maximum). Non-participating out-of-network providers have not agreed to accept AvMed's reasonable and customary standard (R & C) as payment in full for covered services. Therefore, if a non-participating provider is used the member is also responsible for the difference between R & C and the non-participating provider's actual charges.</p>	

Benefits Comparison Chart

Benefits Comparison Chart

AVMED and JMH High Option (HMO) Plans

	AVMED HEALTH PLANS HIGH OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN HIGH OPTION (HMO) Visit our website at www.jmhhp.com
COVERAGE PLAN DESCRIPTION	AvMed offers Miami-Dade County employees, covered dependents and retirees under age 65 "no referral" access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable co-payments. Members are encouraged, but not required, to select a primary care physician. AvMed offers 24 hour Member Service, 24 hour Nurse on Call hot lines, discounted health and wellness programs, "Healthy Living" and care management programs personalized to improve the member's health, discounted Mail Order Prescriptions and more.	An Open-Access, "no-referral" managed care program which offers Miami-Dade County employees access to a broad network of providers across South Florida through our Premier Access Network and access to the Beech Street nationwide network as well. Members are encouraged, but not required, to select a primary care physician. Benefits covered at 100% after applicable co-payments. Other benefits include health and wellness discount programs, access to a 24-hour on-call nurse, and three months of prescriptions for the price of two – right at your local participating pharmacy. The JMH Health Plan is a not for profit, full service health maintenance organization.
DEDUCTIBLES/ COPAYMENTS	<p>Co-payments</p> <ul style="list-style-type: none"> \$10 Physician office visit 100% Hospital admission coverage - no co-payment \$25/\$50 co-payment Emergency Room (waived if admitted) \$25/\$50 co-payment Urgent Care \$10/ \$20/ \$30 prescription for 30-day supply based on formulary \$20/\$40/\$60 Mail order prescription available for 90-day supply based on formulary 	<p>Co-payments</p> <ul style="list-style-type: none"> \$10 Physician office visit \$0 Hospital admission co-pay \$50 co-payment Emergency Room (waived if admitted) \$25 co-payment Urgent Care \$7/\$20/\$35 Prescriptions for 30 day supply - Open Formulary Mail Order: \$14/\$40/\$70 for 90 day supply
PHYSICIANS	Access any primary care physician or specialist from the Elite Access Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician. Physician services are covered in full after \$10 co-payment.	Choose any physician, primary care or specialist, from the Premier Access Network. Members are encouraged, but not required, to select a primary care physician. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES: Surgery/Visits & Consultations Anesthesiologist B. OUT-PATIENT PHYSICIAN SERVICES: Office visits for illness Office visits for injury Diagnostic X-Rays, Lab Tests, X-Ray treatments Pediatrician 1) Medically Necessary 2) Preventive (Child Health Supervision Services) Routine Physical Obstetrical/Gynecological	Benefits payable at 100% when received at participating hospitals and rendered by participating physicians. \$10 co-payment; then 100% \$10 co-payment; then 100% 100% \$10 co-payment; 100% thereafter. \$10 co-payment; then 100% \$10 co-payment; 100% thereafter for annual exam. \$10 co-payment; then 100%. Mammograms, PAP smears payable at 100%. Maternity Care: \$10 co-pay for 1st visit, 100% thereafter.	100% \$10 co-payment per visit, 100% thereafter \$10 co-payment per visit, 100% thereafter 100% 1) \$10 co-payment per visit. 2) \$10 co-payment per visit. \$10 co-payment per visit. \$10 co-payment per visit.

AVMED and JMH High Option (HMO) Plans

	AVMED HEALTH PLANS HIGH OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN HIGH OPTION (HMO) Visit our website at www.jmhhp.com
Hospitalization:	<p>Benefits payable at 100% at following affiliated hospitals when admitted with PCP authorization:</p> <p>MIAMI-DADE COUNTY</p> <p>Anne Bates Leach Eye Hospital • Aventura • Baptist • Cedars • Coral Gables • Doctor's Hospital • Hialeah Hospital • Homestead Hospital • Jackson Memorial Hospital • Jackson South Community Hospital • Jackson North Medical Center • Kendall Regional Medical Center • Larkin Community Hospital • Mercy Hospital • Miami Children's • Mt. Sinai Medical Center • North Shore Medical Center • Palm Springs Hospital • Palmetto General • South Miami Hospital • University of Miami Hospital & Clinic</p> <p>BROWARD COUNTY</p> <p>Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Medical Center • Florida Medical Center • Hollywood Medical Center • Holy Cross Hospital • Imperial Point • Joe Di Maggio Children's Hospital • Memorial Regional Hospital • Memorial Miramar • Memorial Pembroke • Memorial West • North Broward Medical Center • Northwest Medical Center • North Ridge Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>	<p>Benefits payable at 100% at following affiliated hospitals:</p> <p>MIAMI-DADE COUNTY</p> <p>Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital • Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holtz Children's Hospital • Jackson North Community Hospital • Jackson South Community Hospital • Kendall Regional • Kindred Hospital Coral Gables • Mercy Hospital • Miami Children's • Mt Sinai Medical Center • North Shore • Palmetto General • Palm Springs Hospital • South Miami Hospital • University of Miami/ Hospital & Clinic • West Gables Rehabilitation Hospital</p> <p>BROWARD COUNTY</p> <p>Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Hospital • Florida Medical Center • Holy Cross Hospital • Hollywood Medical Center • Imperial Point • Joe DiMaggio Children's Medical Center • Kindred Hospital Ft Lauderdale • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital West • Memorial Regional • North Ridge Medical Center • North Broward Medical Center • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>
Hospital/Surgical Requirements: Precertification of hospital confinements	Handled by admitting physician.	All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.
Drug & Alcohol Treatment: Inpatient	Covered at 100% up to a maximum of 30 days per year* with prior authorization.	Covered at 100% up to 30 days inpatient per year.
Outpatient	Covered at 100% up to a maximum of 60 visits per year. Lifetime limit of 2 programs	\$10 co-payment per visit, limited to 60 outpatient visits per calendar year.
Mental & Nervous Disorders: Inpatient	Covered at 100% up to 30 inpatient days per year* with prior authorization.	Covered at 100% up to 30 days inpatient per year.
Outpatient	\$5 co-payment per visit, up to a maximum of 30 outpatient visits per year.	\$10 co-payment per visit, limited to 30 outpatient visits per calendar year.
Ambulance Vision	100% when medically necessary Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after \$10 co-payment. AVMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.	100% when medically necessary 100% for eye exam per 12 months. ** \$10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.

Benefits Comparison Chart

Benefits Comparison Chart

AVMED and JMH High Option (HMO) Plans

	AVMED HEALTH PLANS HIGH OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN HIGH OPTION (HMO) Visit our website at www.jmhhp.com
Prescription Drugs:	\$10 Generic/\$20 Brand/\$30 Non-Preferred for 30 day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand co-payment. See plan literature for other participating pharmacies. Mail order: 2x co-pay for 90-day supply.	\$7 Generic/\$20 Brand/\$35 Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppe, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).
Durable Medical Equipment (DME):	\$50 co-payment per episode of illness. Limited to a maximum of \$2000 per calendar year. Please refer to brochure for limitations and restrictions.	100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. \$25 co-payment per medical condition. Maximum benefit \$500 per year.****
Out of Area: 1) Emergency 2) Non-Emergency	1) \$25 participating, \$50 non-participating co-payment, waived if admitted, 100% thereafter. 2) Not covered.	1) 100% after \$50 co-payment (worldwide). 2) Covered within the JMH Health Plan's Premier Access Network.
	This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary Plan Description. *Coverage for inpatient days for drug/alcohol rehabilitation and for mental/nervous disorder (s) combined is limited to 30 days per contract year.	** See plan literature for details regarding vision benefits limitations and exclusions. *** See plan literature regarding purchase of non-Generics drugs. **** See plan literature for benefits and limitations of DME products.

AVMED and JMH Low Option (HMO) Plans

	<p>AVMED HEALTH PLANS LOW OPTION (HMO) Visit our website at www.avmed.org/go/mdpht.</p>	<p>Visit our website at www.jmhhp.com</p>
<p>COVERAGE PLAN DESCRIPTION</p>	<p>AvMed offers Miami-Dade County employees, covered dependents and retirees under age 65 access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges after applicable co-payments. Members are required to select a primary care physician. Referrals are required to see participating Specialists. AvMed offers 24 hour Member Service, 24 hour Nurse on Call hot lines, discounted health and wellness programs, "Healthy Living" and care management programs personalized to improve the member's health, discounted Mail Order Prescriptions and more.</p>	<p>A managed care program which offers Miami-Dade County employees access to a broad network of providers across South Florida through our Premier Access Network and access to the Beech Street nationwide network as well. Members are required to select a primary care physician. Benefits covered at 100% after applicable co-payments. Other benefits include health and wellness discount programs, access to a 24-hour on-call nurse, and three months of prescriptions for the price of two – right at your local participating pharmacy. The JMH Health Plan is a not for profit, full service health maintenance organization.</p>
<p>DEDUCTIBLES/ COPAYMENTS</p>	<p>Co-payments \$25 Physician office visit \$150/day Hospital Admission copay; max \$450 per adm \$100 co-payment Emergency Room (waived if admitted); \$50 co-payment Urgent Care \$15/\$30/\$50 prescription for 30-day supply based on formulary \$30/\$60/\$100 Mail order prescriptions available for 90-day supply based on formulary</p>	<p>Co-payments \$25 Physician office visit \$150/day Hospital admission co-pay; max \$450 per/adm. \$100 co-payment Emergency Room (waived if admitted) \$50 co-payment Urgent Care \$15/\$30/\$50 Prescriptions for 30 day supply - Open Formulary Mail Order: \$30/\$60/\$100 for 90 day supply</p>
<p>PHYSICIANS</p>	<p>Choose any primary care physician from the Elite Access Network. Change primary care physician at any time. Covered family members may choose their own primary care physician. Physician services are covered in full after \$25 co-payment, when provided or arranged by the PCP.</p>	<p>Choose any physician from the network of over 2,000 primary care physicians in Miami-Dade and Broward counties.</p>
<p>A. IN-HOSPITAL PHYSICIAN SERVICES: Surgery/Visits & Consultations Anesthesiologist</p> <p>B. OUT-PATIENT PHYSICIAN SERVICES: Office visits for illness Office visits for injury Diagnostic X-Rays, Lab Tests, X-Ray treatments Pediatrician 1) Medically Necessary 2) Preventive (Child Health Supervision Services)</p> <p>Routine Physical Obstetrical/Gynecological</p>	<p>Benefits payable at 100% when received at participating hospitals and rendered by participating physicians.</p> <p>\$25 co-payment; then 100% \$25 co-payment; then 100% 100%</p> <p>1) \$25 co-payment; then 100% 2) \$25 co-payment; then 100%</p> <p>\$25 co-payment; 100% thereafter for annual exam. \$25 co-payment per visit, 100% thereafter. Maternity - \$25 co-payment for 1st visit only.</p>	<p>100%</p> <p>\$25 co-payment per visit, 100% thereafter \$25 co-payment per visit, 100% thereafter</p> <p>100%</p> <p>1) \$25 co-payment per visit. 2) \$25 co-payment per visit.</p> <p>\$25 co-payment per visit. \$25 co-payment per visit.</p>

Benefits Comparison Chart

AVMED and JMH Low Option (HMO) Plans

Benefits Comparison Chart

	<p>AVMED HEALTH PLANS LOW OPTION (HMO) Visit our website at www.avmed.org/go/mdpht.</p>	<p>Visit our website at www.jmhhp.com</p>
<p>Hospitalization:</p>	<p>\$150/day hospital admission /\$450 max per admission at following affiliated hospitals: MIAMI-DADE COUNTY Anne Bates Leach Eye Hospital • Aventura • Baptist • Cedars • Coral Gables • Doctor's Hospital • Hialeah Hospital • Homestead Hospital • Jackson Memorial Hospital • Jackson South Community Hospital • Jackson North Medical Center • Kendall Regional Medical Center • Larkin Community Hospital • Mercy Hospital • Miami Children's • Mt. Sinai Medical Center • North Shore Medical Center • Palm Springs Hospital • Palmetto General • South Miami Hospital • University of Miami Hospital & Clinic BROWARD COUNTY Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Medical Center • Florida Medical Center • Hollywood Medical Center • Holy Cross Hospital • Imperial Point • Joe Di Maggio Children's Hospital • Memorial Regional Hospital • Memorial Miramar • Northwest Medical Center • North Ridge Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>	<p>\$150/day limit \$450 per/adm at following affiliated hospitals: MIAMI-DADE COUNTY Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital • Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holz Children's Hospital • Jackson North Community Hospital • Jackson South Community Hospital • Kendall Regional • Kindred Hospital Coral Gables • Mercy Hospital • Miami Children's • Mt Sinai Medical Center • North Shore • Palmetto General • Palm Springs Hospital • South Miami Hospital • University of Miami/ Hospital & Clinic • West Gables Rehabilitation Hospital BROWARD COUNTY Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Hospital • Florida Medical Center • Holy Cross Hospital • Hollywood Medical Center • Imperial Point • Joe DiMaggio Children's Medical Center • Kindred Hospital Ft Lauderdale • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital West • Memorial Regional • North Ridge Medical Center • North Broward Medical Center • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>
<p>Hospital/Surgical Requirements: Precertification of hospital confinements</p>	<p>Handled by admitting physician.</p>	<p>All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.</p>
<p>Drug & Alcohol Treatment: Inpatient Outpatient</p>	<p>\$150/day, \$450 maximum per admission* up to 30 days per year* with prior authorization. \$10 co-pay per visit up to a maximum of 60 visits per year. Lifetime limit of 2 programs</p>	<p>\$150 per admission co-pay; max \$450 per admission up to 30 days inpatient per year. \$10 co-payment per visit, limited to 60 outpatient visits per calendar year.</p>
<p>Mental & Nervous Disorders: Inpatient Outpatient</p>	<p>\$150/day, \$450 maximum per admission* 30 day limit, with prior authorization \$10 co-payment per visit, up to a maximum of 30 visits per year.</p>	<p>\$150 per admission co-pay; max \$450 per admission up to 30 days inpatient per year. \$10 co-payment per visit, limited to 30 outpatient visits per calendar year.</p>
<p>Ambulance Vision</p>	<p>100% when medically necessary. Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after \$25 co-payment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.</p>	<p>100% when medically necessary 100% for eye exam per 12 months.** \$10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.</p>

AVMED and JMH Low Option (HMO) Plans

	<p>AVMED HEALTH PLANS LOW OPTION (HMO) Visit our website at www.avmed.org/go/mdpht.</p>	<p>Visit our website at www.jmhph.com</p>
<p>Prescription Drugs:</p>	<p>\$15 Generic/\$30 Brand/\$50 Non-Preferred for 30 day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand co-payment. See plan literature for other participating pharmacies. Mail order: 2x co-pay for 90-day supply.</p>	<p>\$15 Generic/\$30 Brand/\$50/ Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppes, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).</p>
<p>Durable Medical Equipment (DME):</p>	<p>\$50 co-payment per episode of illness. Limited to a maximum of \$500 per calendar year. Please refer to brochure for limitations and restrictions.</p>	<p>100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. \$50 co-payment per medical condition. Maximum benefit \$500 per year.****</p>
<p>Out of Area: 1) Emergency 2) Non-Emergency</p>	<p>1) \$100 co-pay, waived if admitted, 100% thereafter. \$50 urgent care center co-pay. 2) Not covered.</p>	<p>1) 100% after \$100 co-payment (worldwide). 2) Covered within the JMH Health Plan's Premier Access Network.</p>
	<p>This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary Plan Description. *Coverage for inpatient days for drug/alcohol rehabilitation and for mental/nervous disorder (s) combined is limited to 30 days per contract year.</p>	<p>** See plan literature for details regarding vision benefits limitations and exclusions. *** See plan literature regarding purchase of non-Generic drugs. **** See plan literature for benefits and limitations of DME products.</p>

Benefits Comparison Chart

METLIFE Dental Plan

Benefits Comparison Chart

	METLIFE	
Choice of Dentist	Program allows you to choose any dentist you wish. Payments to Preferred Dental Providers (PDP) are based on negotiated fees. Payments to non preferred providers are based on Reasonable and Customary (not billed) charges.	
Maximum Benefit/Deductible	\$1,000 per year per person \$50 deductible per year per person; \$150 family maximum	\$1,500 per year per person \$50 deductible per year per person; \$150 family maximum
Type I 0150 Comprehensive Oral Evaluation -New or Established 0120 Periodic Oral Exam X-rays 1110/20 Prophylaxis 1203 Fluoride Treatment (children up to the age 19) 1351 Sealant - per tooth 1510 Space Maintainers	STANDARD Plan Pays (No deductible) 100% 100% 100% 100% (Twice per calendar year) 100%, 1x per year Not Covered 100% to age 19	ENRICHED Plan Pays (No deductible) 100% 100% 100% 100% (Twice per calendar year) 100%, 1x per year Not Covered 100% to age 19
Type II Fillings: (silver) 2140 one surface 2150 two surfaces 2160 three surfaces 2161 four or more surfaces Root canals: 3310 Anterior 3320 Bicuspid 3330 Molar 3410 Apicoectomy Extractions: 7111 Single tooth 7140 Extraction, erupted tooth or exposed tooth 7210 Surgical extraction of erupted tooth Periodontics: (gum treatment) 4341 Periodontal scaling & root planning-per quadrant 4210 Gingivectomy/gingivoplasty - per quadrant 4910 Periodontal maintenance procedures	* 75% Non PDP/100% PDP 75% Non PDP/100% PDP 75% Non PDP/100% PDP 75% Non PDP/100% PDP 75% 75% 75% 75% 75% 75% 75% 75% 75% 75%	* 75% Non PDP/100% PDP 75% Non PDP/100% PDP 75% Non PDP/100% PDP 75% Non PDP/100% PDP 75% 75% 75% 75% 75% 75% 75%
Type III Crown & Bridge 2930 Prefabricated stainless steel primary tooth 2791 Crown full cast predominately base metal 2751 Crown Porcelain fused to base metal Pontics: 6210 Full cast 6240 Porcelain fused to metal Prostodontics (Dentures) 5110 Complete upper 5120 Complete lower 5213/14 Partial upper or lower - cast metal base	* 50% 50% 50% 50% 50% 50% 50% 50%	* 50% 50% 50% 50% 50% 50% 50% 50%
ORTHODONTIA Consultation Evaluation Records Children - Normal Class II Adult - Normal Class II 8750 Retention	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Adult & Children covered at 50% after a one time deductible of \$50 per person. \$1,000 lifetime maximum
VISION Examination Single Vision Lenses Bifocal Lenses Trifocal Lenses Contact Lenses - Non-Elective Contact Lenses - Elective Frames	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

* All Type II and III charges subject to annual deductible

* The above reimbursements are exclusive of gold.

ADP & OHS Dental Plans

AMERICAN DENTAL PLAN (ADP) Now known as CompBenefits		ORAL HEALTH SERVICES (OHS) Now known as CompBenefits	
Limited to Participating Dentists in Private Practice		Limited to Participating Dentists in Private Practice	
No Maximum No Deductible		No Maximum No Deductible	
STANDARD You Pay* No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	ENRICHED You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	STANDARD You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 6.00 40.00	ENRICHED You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge No Charge No Charge
No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 UCR Less 25%	No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 35.00	No Charge \$11.00 \$16.00 \$18.00 90.00 155.00 200.00 75.00 No Charge No Charge 15.00 40.00 120.00 25.00	No Charge No Charge No Charge No Charge 45.00 90.00 145.00 65.00 No Charge No Charge No Charge 40.00 90.00 25% Discount
35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	25.00 \$210.00 \$210.00 25% Discount 25% Discount 230.00 230.00 275.00	No Charge \$175.00 \$175.00 25% Discount 25% Discount 205.00 205.00 240.00
No Charge UCR Less 25% UCR Less 25% UCR Less 25% UCR Less 25% Additional	No Charge 35.00 250.00 1400.00 1950.00 Additional	25% Discount 25% Discount 25% Discount 25% Discount 25% Discount 25% Discount	No Charge 25.00 200.00 1,400.00 1,950.00 25% Discount
Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	10% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount

* STD Plan fee apply to participating General Dentist only.

** Co-payments are exclusive of gold.

* Cost of high noble metal additional.

Benefits Comparison Chart

2009 Monthly Premium Rates

Medical Insurance

Monthly Rates for:	AvMed POS (308R)	AvMed High Opt HMO (307R)	AvMed Low Opt HMO (309R)	JMH High Opt HMO (305R)	JMH Low Opt HMO (313R)
Retiree Only	\$ 714.24	\$ 257.03	\$ 242.38	\$ 539.69	\$ 488.29
Retiree & Spouse/DP Under 65	\$ 1,395.49	\$ 608.03	\$ 573.40	\$ 1,095.25	\$ 990.96
Retiree & Child(ren)	\$ 1,381.26	\$ 557.50	\$ 525.75	\$ 974.02	\$ 881.28
Retiree & Spouse/DP Under 65, plus Child(ren)	\$ 1,593.79	\$ 762.58	\$ 719.17	\$ 1,599.26	\$ 1,494.97

Retiree Under 65 & Spouse/DP Medicare Eligible	AvMed POS (308R)	AvMed High Opt HMO (307R)	AvMed Low Opt HMO (309R)
Retiree & Spouse/DP on Low Opt Plan	\$ 1,084.99	\$ 660.77	\$ 646.12
Retiree & Spouse/DP on High Opt Plan	\$ 1,133.35	\$ 709.13	\$ 694.48
Retiree & Spouse/DP on No RX Plan	\$ 877.76	\$ 453.54	\$ 438.89
Retiree & Child(ren), Spouse/DP on Low Opt Plan		\$ 909.29	\$ 880.53
Retiree & Child(ren), Spouse/DP on High Opt Plan		\$ 957.65	\$ 928.89
Retiree & Child(ren), Spouse/DP on No RX Plan		\$ 702.06	\$ 673.30

Retiree Under 65 & Spouse/DP Medicare Eligible	JMH High Opt HMO (305A)	JMH Low Opt HMO (313A)
Retiree & Spouse/DP	\$ 913.13	\$ 826.18
Retiree & Child(ren), Spouse/DP	\$ 1,417.14	\$ 1,330.20

Dental Insurance

	METLIFE DENTAL PLAN		AMERICAN DENTAL PLAN*		ORAL HEALTH SERVICES*	
	STANDARD (382)	ENRICHED (392)	STANDARD (381)	ENRICHED (391)	STANDARD (380)	ENRICHED (390)
Retiree Only	\$ 32.85	\$ 42.99	\$ 8.62	\$ 11.33	\$ 8.62	\$ 11.33
Retiree & one dependent	\$ 64.96	\$ 85.00	\$ 14.25	\$ 18.78	\$ 14.25	\$ 18.78
Retiree & dependents	\$ 104.69	\$ 137.04	\$ 21.82	\$ 29.86	\$ 21.82	\$ 29.86

* ADP & OHS plans are not available outside Miami-Dade, Broward & Palm Beach Counties.

Life Insurance

The monthly life insurance rate is 24¢ per thousand dollars of your pre-retirement annual salary.

Example: Annual Salary \$30,000.00 x .00024 = \$7.20 monthly premium.

Your life insurance coverage is reduced to either \$15,000 or \$20,000 when you reach age 65.

Imputed Income Sample

AvMed POS		AvMed High Opt HMO	
Retiree + Domestic Partner	\$ 124.95	Retiree + Domestic Partner	\$ 156.02
Retiree + DP Child	\$ 0.0	Retiree + DP Child (and/or 25+ Child)	\$ 135.11
Retiree + DP Child (and/or 25+ Child)	\$ 533.57	Retiree + DP & DP Child (and/or 25+ Child)	\$ 214.07

New Retiree Insurance Checklist

1. If you (or your covered dependent) are age 65 or Medicare eligible, please contact the Social Security Office to apply for Medicare Parts A, B and D at least 60 days before your retirement date.
2. If you (or your covered dependent) are age 65 or Medicare eligible and enrolling in an HMO Medicare Plan, you must contact the HMO directly at least 30 days prior to your retirement date, or request a visit from their Medicare HMO Representative for assistance with the enrollment process. You must have Medicare Parts A & B coverage in effect to be covered by a Medicare HMO Plan; consult the plan to determine if you need Medicare Part D also.
3. Obtain the Retiree Insurance Handbook and Retiree Election Form from the Benefits Administration Unit (Tel. 305-375-4288). Read the information provided in Retiree Handbook 1, for retirees under age 65, or Retiree Handbook 2 for retirees over age 65, or Medicare eligible. If you will be residing outside the Tri-County area (Miami-Dade, Broward and Palm Beach Counties), please contact the health plans to verify if there is coverage in that area for Miami-Dade County retirees.
4. If you are requesting medical, dental, and/or basic life insurance coverage under the Retiree Group, please complete the election form. Call the Sr. Employee Benefits Specialist assigned to your last name (see staff directory on page 1) to make an appointment 2-4 weeks prior to your retirement date, or submit your election form to the Benefits Administration Unit at the address on the application. The election form is due no later than 30 days after your retirement date. If received after the 30-day deadline, the form will not be processed and you will only be entitled to COBRA continuation, if applied for within 60 days following your retirement date.
5. Complete a Florida Retirement System (FRS) payroll authorization form to have insurance premiums deducted from your monthly retirement check. By completing an FRS deduction form you will be saving time, money, and have the assurance your premium payments will be received on a timely basis. If this option is checked on your application, a form will be enclosed in the mailing with your Monthly Payment Schedule.
6. Update the Life Insurance Beneficiary Designation Form, if enrolling for life insurance. If this benefit is elected, a form will be enclosed in the mailing with your Monthly Payment Schedule.
7. After receiving your Retiree Insurance Election Form (refer to item #4) we will mail you a Billing Calendar within 10 days. The first premium payment is due upon receipt of the Billing Calendar, even if you elected automatic deductions from your retirement check. Subsequent payments are due on the first day of each month until FRS deductions begin (if applicable). Make your check payable to **BOARD OF COUNTY COMMISSIONERS**. Please write your retiree ID number on your check. **Your coverage will not be reinstated under the retiree group unless your first payment is received in a timely manner.**

(continued)

New Retiree Insurance Checklist

(continued)

8. If you have completed a Florida Retirement System Payroll Authorization Form, premium deductions should begin with your 2nd FRS pension check and will cover your 3rd monthly premium (assuming your prior payments were received on time). For example, if you retire on 1/31/2009 your first FRS deduction should be taken from your 3/2009 FRS payroll check to pay your 4/2009 premium. If you are uncertain regarding your FRS deduction start date, you may call the Benefits Administration Unit to confirm.
9. If changing insurance plans at retirement, the medical and/or dental insurance carrier will mail a New Member's Kit and ID cards directly to your home address within 2-3 weeks following payment of your first retiree premium. If this is not received, please contact your insurance carriers directly.
10. The Florida Retirement System will mail you a Health Insurance Subsidy (HIS) Certification Form approximately 8 weeks after your retirement. Upon processing the form, the Division of Retirement will add \$5.00 per year of credited service under the FRS, to your monthly retirement check (minimum \$30.00 per month, maximum \$150.00 per month).
- a. If you are 65+ or Medicare eligible and enrolled in Medicare Parts A, B and D, please complete and sign the form and return to the Division of Retirement with a photocopy of your Medicare Card showing the effective date of Medicare Parts A, B and D.
- b. If you are not eligible for Medicare, and elected medical and/or dental coverage through the Retiree Group, please complete your portion of the HIS form and forward to the Benefits Administration Unit. We will certify medical and/or dental coverage and mail or fax completed form to the Division of Retirement for processing.
- Approximately 8 weeks following your retirement, the FRS will also mail you a Direct Deposit Authorization Form and a Federal Tax Deduction Authorization Form (W4-P). Please follow their instructions and mail these forms back to the FRS.
11. **CHANGES:** Always notify our office in writing immediately upon changing your address or telephone number. If you have a change in status (i.e. marriage, addition of new eligible dependent), or change of residence outside of the plan service area, notify the Retiree Group in writing within 45 days of the event (60 days for newborns).
12. If relocating (permanent residence only) outside Miami-Dade, Broward, and Palm Beach Counties and enrolled in the ADP or OHS dental plans, you may not have coverage in your new area of residence. You will be allowed to change to the MetLife dental plan, but you must notify the Retiree Group in writing within 45 days of the change of residence. Proof of permanent residence change will be required (new service utility bill, rental agreement, etc.).

2009 Medical, Dental and/or Life Insurance Election Form

For Retirees Under Age 65 & Not Medicare Eligible



RETIREE:

Name _____ Emp ID _____ Date of Retirement _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone _____ E-Mail Address _____

STEP ONE: MEDICAL INSURANCE

SELECT MEDICAL COVERAGE DECLINE MEDICAL COVERAGE

If yes, please select (✓) one of the following options:

2009 Monthly Rates for:	AvMed POS (308R)	AvMed High Opt HMO (307R)	AvMed Low Opt HMO (309R)	JMH High Opt HMO (305R)	JMH Low Opt HMO (313R)
Retiree Only	<input type="checkbox"/> \$ 714.24	<input type="checkbox"/> \$ 257.03	<input type="checkbox"/> \$ 242.38	<input type="checkbox"/> \$ 539.69	<input type="checkbox"/> \$ 488.29
Retiree & Spouse/DP Under 65*	<input type="checkbox"/> \$ 1,395.49	<input type="checkbox"/> \$ 608.03	<input type="checkbox"/> \$ 573.40	<input type="checkbox"/> \$ 1,095.25	<input type="checkbox"/> \$ 990.96
Retiree & Child(ren)*	<input type="checkbox"/> \$ 1,381.26	<input type="checkbox"/> \$ 557.50	<input type="checkbox"/> \$ 525.75	<input type="checkbox"/> \$ 974.02	<input type="checkbox"/> \$ 881.28
Retiree & Spouse/DP Under 65, plus Child(ren)*	<input type="checkbox"/> \$ 1,593.79	<input type="checkbox"/> \$ 762.58	<input type="checkbox"/> \$ 719.17	<input type="checkbox"/> \$ 1,599.26	<input type="checkbox"/> \$ 1,494.97

* Must complete step 4 on reverse side if dependent coverage is selected

Retiree Under 65 & Spouse/DP Medicare Eligible	AvMed POS (308R)	AvMed High Opt HMO (307R)	AvMed Low Opt HMO (309R)
Retiree & Spouse/DP* on Low Opt Plan	<input type="checkbox"/> \$ 1,084.99	<input type="checkbox"/> \$ 660.77	<input type="checkbox"/> \$ 646.12
Retiree & Spouse/DP* on High Opt Plan	<input type="checkbox"/> \$ 1,133.35	<input type="checkbox"/> \$ 709.13	<input type="checkbox"/> \$ 694.48
Retiree & Spouse/DP* on No RX Plan	<input type="checkbox"/> \$ 877.76	<input type="checkbox"/> \$ 453.54	<input type="checkbox"/> \$ 438.89
Retiree & Child(ren), Spouse/DP* on Low Opt Plan		<input type="checkbox"/> \$ 909.29	<input type="checkbox"/> \$ 880.53
Retiree & Child(ren), Spouse/DP* on High Opt Plan		<input type="checkbox"/> \$ 957.65	<input type="checkbox"/> \$ 928.89
Retiree & Child(ren), Spouse/DP* on No RX Plan		<input type="checkbox"/> \$ 702.06	<input type="checkbox"/> \$ 673.30

* Must complete step 4 on reverse side if dependent coverage is selected

Retiree Under 65 & Spouse/DP Medicare Eligible	JMH High Opt HMO (305A)	JMH Low Opt HMO (313A)
Retiree & Spouse/DP*	<input type="checkbox"/> \$ 913.13	<input type="checkbox"/> \$ 826.18
Retiree & Child(ren), Spouse/DP*	<input type="checkbox"/> \$ 1,417.14	<input type="checkbox"/> \$ 1,330.20

* Must complete step 4 on reverse side if dependent coverage is selected

STEP TWO: DENTAL INSURANCE

SELECT DENTAL COVERAGE DECLINE DENTAL COVERAGE

If yes, please select (✓) one of the following options:

	METLIFE DENTAL PLAN		AMERICAN DENTAL PLAN*		ORAL HEALTH SERVICES*	
	STANDARD (382)	ENRICHED (392)	STANDARD (381)	ENRICHED (391)	STANDARD (380)	ENRICHED (390)
Retiree Only	<input type="checkbox"/> \$ 32.85	<input type="checkbox"/> \$ 42.99	<input type="checkbox"/> \$ 8.62	<input type="checkbox"/> \$ 11.33	<input type="checkbox"/> \$ 8.62	<input type="checkbox"/> \$ 11.33
Retiree & one dependent	<input type="checkbox"/> \$ 64.96	<input type="checkbox"/> \$ 85.00	<input type="checkbox"/> \$ 14.25	<input type="checkbox"/> \$ 18.78	<input type="checkbox"/> \$ 14.25	<input type="checkbox"/> \$ 18.78
Retiree & dependents	<input type="checkbox"/> \$ 104.69	<input type="checkbox"/> \$ 137.04	<input type="checkbox"/> \$ 21.82	<input type="checkbox"/> \$ 29.86	<input type="checkbox"/> \$ 21.82	<input type="checkbox"/> \$ 29.86

* ADP and OHS enriched plans are not available outside Miami-Dade, Broward & Palm Beach Counties

Continued on reverse side

STEP THREE: LIFE INSURANCE

 SELECT LIFE INSURANCE COVERAGE DECLINE LIFE INSURANCE COVERAGE

The value of the Miami-Dade County Retiree Group Life Insurance Policy is **one-time your base annual salary** at the time of retirement. The 2009 rate is **24 cents per thousand dollars** per month.

STEP FOUR: DEPENDENT INFORMATION

Complete this step if dependent medical and/or dental coverage is selected.

Name	Relationship (See below)*	SSN	DOB	Sex M/F	Indicate Coverage Selected
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental

*SP-Spouse, CH-Child, DP-Domestic Partner, DPCH-Child of Domestic Partner

STEP FIVE: CERTIFICATION OF ELECTION

- ▶ As a member of a protected class, I do or do not (*check one*) object to having my address released to other County insurance carriers.
- ▶ I do or I do not (*check one*) wish to have insurance premiums deducted from my monthly Florida Retirement System pension check. (Does not apply to FRS Investment Plan members)
- ▶ I have read and understood all the information contained in the Retiree Insurance Benefits Package.

Retiree's Name

Retiree's Signature

Date

STEP SIX: SUBMIT YOUR REQUEST

Please sign, date, and mail or fax this form to:

Miami-Dade County
General Services Administration
Risk Management Division • Benefits Administration Unit
111 NW 1st Street, Suite 2340
Miami, Florida 33128-1979
Fax: 305-375-1633 or 305-375-1368

FOR OFFICE USE ONLY

FRS IPDAF: Needed NOT Needed

Conv. Letter: Yes _____ No _____

Basic Life Conv. Amt. \$ _____

Opt Life Conv. Amt. \$ _____



Delivering Excellence Every Day