Benefits & You

2013 OPEN ENROLLMENT NEWSLETTER

A Special Benefits Edition for the Employees of Miami-Dade County • http://enet.miamidade.gov • November 2012

SNAPSHOT

Attend a Regional Meeting
Nov. 5 - Nov. 16, 2012

Enroll Online
Nov. 5 - Nov. 20, 2012

Enrollment Website
http://enet.miamidade.gov

Enrollment Deadline
November 20, 2012

New Elections are Effective
January 1, 2013

INSIDE THIS ISSUE

Open Enrollment Is Here

Open Enrollment is your once-a-year opportunity to make changes to your current plan elections for the upcoming year. The Open Enrollment website will be available to all benefits eligible Miami-Dade County employees 24/7 from November 5 to November 20, 2012. No need to submit an online form unless you want to:

1. Enroll in a new benefit plan or change existing plan elections
2. Add dependents to existing coverage or delete dependents no longer eligible
3. Enroll/re-enroll for a Healthcare or Dependent Care Spending Account
4. Opt-out of insurance

Go to http://enet.miamidade.gov to make the changes. Additional benefits information, can be found in the Benefits Handbook, at www.miamidade.gov/benefits.

What's New for 2013?

Every effort was made to bring you the most current information available as of the print date. Any subsequent changes to employee benefits for 2013 will be posted online at www.miamidade.gov/benefits.

2013 Premiums

The cost of health insurance continues to rise and the Miami area continues to have the highest healthcare costs in the country! If you are represented by a collective bargaining unit, you had a choice to decide whether to pay a 20% premium increase for the AvMed Health Plans or pay an increase in provider and prescription co-payments.

The following plan rates will remain the same as 2012: MetLife DHMO Dental, Delta Dental, Optix Vision, ARAG Legal Plan, MetLife Optional Life, and Short-Term Disability Plans. The MetLife Long-Term Disability Plan premiums were reduced by 5%. Humana-OHS Dental rates will increase by 3% in 2013.

Healthcare Reform in 2013

- Flexible Spending Accounts (FSA) – Due to Healthcare Reform, Medical Expense FSAs will be capped at $2,500 for the 2013 Plan Year. No change to the Dependent Care FSA maximum; it's $5,000, unless you are married and filing separate tax returns, then the Dependent Care FSA maximum is $2,500.
- Preventive Care – Many preventive care services will now be available without a co-pay. For a full list of the applicable preventive services go to www.healthcare.gov/prevention/index.html.
- Reporting Healthcare Cost on W-2 Tax Form – In January 2013, when you receive your 2012 W-2 tax form, you will notice that the value of your health insurance benefit is now reported. This information is intended to advise employees about healthcare costs. The healthcare cost reported is not taxable.

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MIAMI-DADE COUNTY

2013 Biweekly Employee Cost

Medical Rates

No increase in medical rates for all non-bargaining and bargaining unit employees.

TIER LEVEL	AVMED POS	AVMED HMO HIGH OPT	AVMED HMO LOW OPT
EMPLOYEE ONLY	$14.90	$0.0	$0.0
EMPLOYEE + CHILD (DREN)	$285.86	$180.17	$169.83
EMPLOYEE + SPOUSE	$344.54	$208.35	$196.42
EMPLOYEE + FAMILY	$595.59	$287.77	$271.36

Dental Rates

PLAN	TYPE	EMPLOYEE ONLY		EMPLOYEE+1		EMPLOYEE + FAMILY	
		STD	ENR	STD	ENR	STD	ENR
DELTA	Indemnity Dental	$.00	$4.45	$14.09	$22.89	$31.53	$45.72
HUMANA-OHS	Prepaid Dental	$.00	$3.24	$2.49	$7.89	$5.82	$14.76
METLIFE DHMO	Prepaid Dental	$.00	$1.83	$2.62	$5.67	$6.14	$11.39

Other Plan Rates

OPTIX VISION PLAN		ARAG LEGAL PLAN		FLEXIBLE SPENDING ACCOUNTS (FSA) Administrative Fees Per Pay Period	
EMPLOYEE ONLY	$2.06	EMPLOYEE ONLY	$7.29	Health Care FSA Only	$1.98
EMPLOYEE + 1	$4.12	EMPLOYEE + 1	$9.34	Dependent Care FSA Only	$1.98
EMPLOYEE + FAMILY	$7.57	EMPLOYEE + FAMILY	$9.61	Both Health & Dependent Care	$1.98

METLIFE STD	Premium Per $100 Weekly Benefit
Low Option ($500 max weekly benefit)	$1.54
High Option ($1,000 max weekly benefit)	$1.54

METLIFE LTD	Premium Per $100 of Covered Monthly Payroll
Low Option ($2,000 max monthly benefit)	$0.247
High Option ($4,000 max monthly benefit)	$0.295

How to apply for Short/Long Term Disability and Basic Life Insurance during open enrollment

If you are a current employee who did not elect the MetLife Short or Long-Term Disability coverage during your initial benefits eligibility, or you wish to upgrade to the High Option, enrollment is now subject to medical review. The medical review process also applies to employees re-applying for Basic Life Insurance coverage (e.g. lost coverage for failing to pay premiums during a suspension/personal leave, or transferring from the Dade County Fire Fighters Insurance Plan, etc.). You must complete the applicable Statement of Health (SOH) form and submit to MetLife for approval. Both SOH forms are available online. STD, LTD and Basic Life coverage will not be effective until approved by MetLife.

What's New for 2013?

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Change in Co-Payments for 2013

1. Bargaining Units that accepted the plan redesign: Your premiums will remain the same as 2012, all co-pays remain the same except for provider visits and prescription co-pays. Refer to chart below.

2. Bargaining Units that declined the plan redesign: All co-pays remain the same as 2012, but your premiums will increase by 20%.

HMO HIGH	CURRENT CO-PAY	2013 CO-PAY	DIFFERENCE
Primary Care Physician (PCP) [1]	$10	$15	$5
Specialist [2]	$10	$30	$20
Prescriptions (30-Day Supply) Generic [3]	$10	$15	$5
Preferred Brand [4]	$20	$25	$5
Non-Preferred Brand [5]	$30	$35	$5
Mail Order (90-day Supply)	2 Co-Pays for a 90-day supply	2 Co-Pays for a 90-day supply	None

POS	CURRENT CO-PAY	2013 CO-PAY	DIFFERENCE
Primary Care Physician (PCP) [1]	$10	$15	$5
Specialist [2]	$10	$30	$20
Prescriptions (30-Day Supply) Generic [3]	$5	$15	$10
Preferred Brand [4]	$10	$25	$15
Non-Preferred Brand [5]	$15	$35	$20
Mail Order (90-day Supply)	2 Co-Pays for a 90-day supply	2 Co-Pays for a 90-day supply	None

LOW HMO	CURRENT CO-PAY	2013 CO-PAY	DIFFERENCE
Primary Care Physician (PCP)[1]	$25	$30	$5
Specialist [2]	$25	$45	$20
Prescriptions (30-Day Supply) Generic [3]	$15	$20	$5
Preferred Brand [4]	$30	$35	$5
Non-Preferred Brand [5]	$50	$55	$5
Mail Order (90-day Supply)	2 Co-Pays for a 90-day supply	2 Co-Pays for a 90-day supply	None

[1] PCP: Co-pay applies to Mental & Nervous, Substance Abuse, and Chiropractic services.

[2] SPECIALIST: Co-pay includes Therapy (for example: physical, occupational, or speech) and specialties such as Obstetrics, Cardiology and Orthopedics, etc.

[3] GENERIC: Generic Medications contain identical active ingredients, have the same indication for use, meet the same manufacturing standards, and are identical in strength and dosage form as brand name medications.

[4] PREFERRED: These are typically brand name medications and are in the middle range for out-of-pocket expense. These medications typically do not have a generic equivalent.

[5] NON-PREFERRED: These are non-preferred brand medications and are in the higher range for out-of-pocket expense. These medications typically have a generic equivalent and/or another brand option.

Consider These Cost or Time Saving Options in 2013

Generic Prescriptions

Everyone is looking for ways to save right now. One of the easiest ways to keep prescription drug expense down is to choose generic medications when available. Generic medications contain identical active ingredients, have the same indication for use, meet the same manufacturing standards, and are identical in strength and dosage form as brand name medications.

Most people believe that if something costs more, it has to be better quality. In the case of generics, this is not true. The standards of quality are the same for generics as brand-name. When a drug maker develops a new drug and gets it approved by the FDA, they are granted a patent. During the period that the patent is in effect, no other drug maker can sell a drug that has the same mix of active ingredients as that drug. This is called a brand drug, and because there is no other drug exactly like it, the maker charges more for it (they claim they have a lot of research and development costs to cover).

Finally, when a brand drug loses its patent, other drug makers are free to make the same drug. The new drugs that are sold that have the same active ingredients as the original brand drug are called generic drugs. Generic drugs are much cheaper, typically around 1/5th the cost of a brand. Generic drug makers don't have to go through all the research and development that brand drug makers have to go through – they just copy an existing drug – so they can afford to sell their products at a much lower price.

Did you know that certain pharmacies (example: Walmart, Walgreens, CVS and Publix) give free or discounted generic prescriptions? Check out the pharmacy's website to find out which generic medications fall in this category.

Mail Order Prescriptions

Another way to save money is to use mail order for your maintenance prescriptions. Get a 3-month supply for only 2 co-payments and it's conveniently delivered to your home, so you save on gas too! Go to www.avmed.org/go/mdpht to download the Medco mail order form.

Healthcare Flexible Spending Accounts (FSA)

A Healthcare FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. With the Healthcare FSA, you get the convenience of myFBMC Card®. When you swipe the myFBMC Card® at the doctor's office or drug store, funds are electronically deducted from your HFSA account to pay for co-payment or other eligible expenses. For a list of other eligible expenses and other important information go to www.myFBMC.com.

Urgent Care or the ER?

While emergency rooms are great for true emergencies, they're not always the best choice for non-life threatening health issues. Compared to urgent care centers, which are designed and equipped for non-emergencies, ERs offer no advantage. In fact, the cost and wait time in most ERs is significantly more than that of a standard urgent care center. The wait time in urgent care centers is typically quick: 57 percent of patients wait less than 15 minutes to see a medical professional, while 36 percent wait between 15 and 45 minutes, according to the Urgent Care Association of America. But how do you know what kind of care you or a loved one needs? Here are a few tips:

BEST USE OF URGENT CARE CENTERS		
Urgent Care Center *Know where they are*	Emergency Room *Know How to get there fast*	Ambulance *Call 9-1-1*
Ear Infections	Sudden, Sharp Abdominal Pain	Chest Pain
Bronchitis\Pharyngitis	Uncontrolled Bleeding	Difficulty Breathing
Fever		Unconsciousness
Urinary Tract Infection		

If you are not sure whether it's an emergency, AvMed's Nurse On Call is ready to help 24 hours a day, 7 days a week. Just dial the toll-free number: 1-888-866-5432 (TTY 711). Their experts are always available to answer your questions or help with triage conditions.

To find a listing of urgent care centers, visit AvMed's website at www.avmed.org and select Urgent Care Centers to the right of the home page.

Health Reform in 2013 - How does it impact you?

Did you know?

In accordance with federal guidelines, your AvMed benefits include Preventive Care Services at NO CHARGE to you.

Preventive Care Services include, but are not limited to:

- Well-woman exam, including Pap smears
- Annual physical examinations
- Well-child care & immunizations
- Colorectal cancer screening, including colonoscopies
- Mammograms
- Blood pressure, diabetes and cholesterol testing
- Obesity screenings
- Counseling on quitting smoking
- Osteoporosis screening
- Depression screening
- Tests to screen for HIV and other sexually transmitted diseases

Note: Your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

For additional preventive services, go to www.healthcare.gov/prevention/index.html.

HMO Myths

MYTH #1

I cannot enroll for the HMO because I have dependent children attending school outside Florida.

Truth: AvMed offers an extended network of participating providers through an arrangement with PHCS. If your dependent resides outside of the AvMed service area and chooses to receive services from a PHCS provider, his/her co-pay will be the same as required for in-network services. There are over 725,000 providers participating in the PHCS network throughout the USA.

MYTH #2

I must choose the POS to assure coverage in retirement, in case I move outside of the south Florida tri-county area.

Truth: Retiring employees have the option to change plans within 30 days of retirement. Also, as noted in response to Myth #1, AvMed offers PHCS' extended network of participating providers throughout the USA.

MYTH #3

The POS plan has more participating providers than the HMO plans

Truth: The POS plan and the HMO plans have the same participating provider network and same choice of network providers.

MYTH #4

I choose to enroll in the POS plan since I want to be covered in the event of an emergency while visiting outside Florida.

Truth: Emergency visits are covered in and out of Florida for a co-payment whether or not services are received from a participating provider/hospital.

MYTH #5

Most POS Plan members access medical services using non-participating providers (out-of-network).

Truth: The majority, or 92 percent of claims are in-network. Only 8 percent of the POS Plan claims are out-of-network.

AVMED PLAN DIFFERENCES

BENEFIT	POS*	HIGH HMO
GASTRIC BYPASS	Covered	Not Covered
ALLERGY SHOTS	No charge	$15 co-payment
DURABLE MEDICAL EQUIPMENT	No co-payment Unlimited benefit	$50 co-payment, $2,000 benefit max per calendar year
PRIVATE DUTY NURSE - OUTPATIENT	Covered	Not Covered
ACUPUNCTURE	Covered, Out of network	Not Covered
PRESCRIPTION	If brand selected when generic equivalent is available there's no penalty, pays brand co-payment only	If brand selected when generic equivalent is available, must pay cost differential plus brand co-payment
TRAVEL VACCINES	Covered	Not Covered
OUT OF NETWORK SERVICES	Covered	Not Covered
INFERTILITY RELATED SURGERY	Limited Coverage	Not Covered

*POS Plan - The only benefit which is potentially lower under the POS Plan is chiropractor services. This service is combined with other therapies to a maximum of 60 visits per calendar year. The HMO plans do not include chiropractor services under the therapy category.

Online Enrollment Overview

All County employees who wish to make a change, or re-enroll in a healthcare or dependent care spending account are required to use the online enrollment at http://enet.miamidade.gov. Contact your DPR for assistance, if you do not have access to a computer.

Enrolling online is easy! No forms to fill out or worry about paperwork getting misplaced. All you need is 10-15 minutes of uninterrupted time to make your elections. Then print your confirmation page for your records and you are finished! If you need to go back online and change your selections, no problem. The website is secure and available from November 5 – November 20, 2012.

Before You Start Your Web Enrollment

Be sure to review the reference materials available online. Once you have the answers you need, begin the enrollment process. The deadline to change your plan elections for 2013 is November 20, 2012. Once the deadline expires, you are locked into the plan elections you made until the next open enrollment.

Don't wait until the last minute! If you have questions regarding plan benefits attend an open enrollment regional meeting, review the online benefits information (Q & A, Plan Comparison, etc.) or contact the plan directly during business hours for specific plan benefits and limitations. The Help Desk (305-596-Help) will assist only with technical issues (web access, password reset, etc.) and is available Monday - Friday, 8am to 5pm.

What's Online?

- Link to Plan Websites
- Medical Plan Comparison
- Dental Plan Comparison
- Benefits Handbook
- Medical & Dental Provider Directories
- Frequently Asked Questions (FAQs)

Checklist For Web Enrollment

Obtain this information before you begin:

- Your eNet User ID and Password
- Name of Dependent (s) to be added
- Dependent's Date of Birth & Social Security Number
- Primary Care Physician (PCP) – Only if enrolling in the AvMed Low Option HMO
- Participating Dental Provider (PDP) – Only if selecting MetLife DHMO or Humana-OHS Dental Plans
- Annual Contribution Amount – If enrolling/re-enrolling in a Flexible Spending Account

What if I do not have a computer or Internet access available?

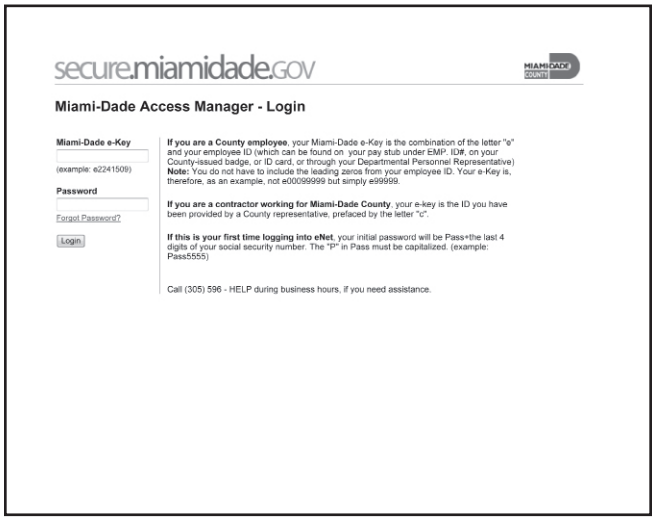
If you do not have access to the Internet, contact your Department Personnel Representative (DPR) for assistance.

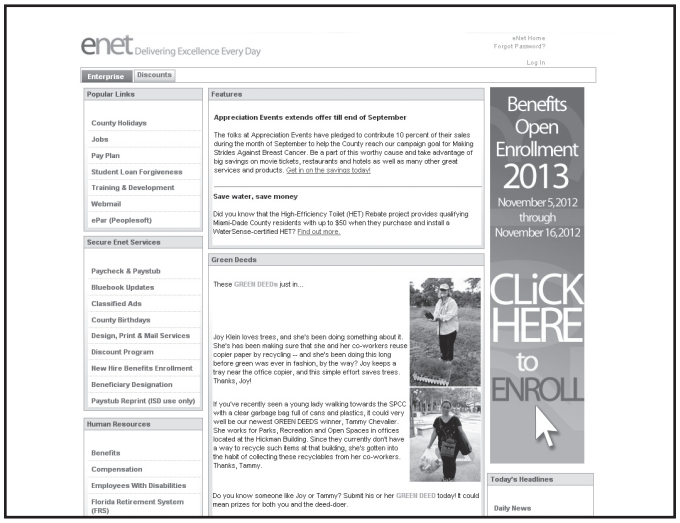
After Open Enrollment

Open Enrollment is scheduled to end on November 20. There is no post-Open Enrollment reprieve for employees who miss the deadline! If you do not submit your enrollment/changes online by the deadline, you will have to wait until the 2014 open enrollment.

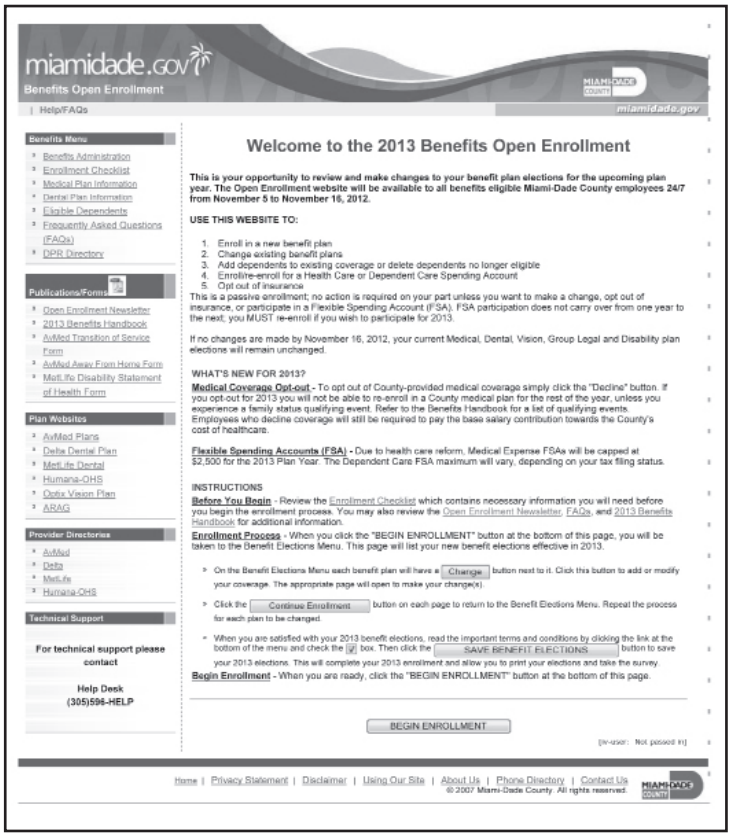
Logon Instructions

The 2013 Open Enrollment Benefits website must be accessed through the County's eNet portal (http://enet.miamidade.gov). To begin, logon to eNet using your user ID and password. Forgot your password? Click "forgot password" link to reset it. Remember that multiple incorrect logon attempts will result in your user ID (e-Key) being disabled. Contact the Help Desk at 305-596-Help (Mon-Fri, 8am to 5pm) if you have technical difficulties.



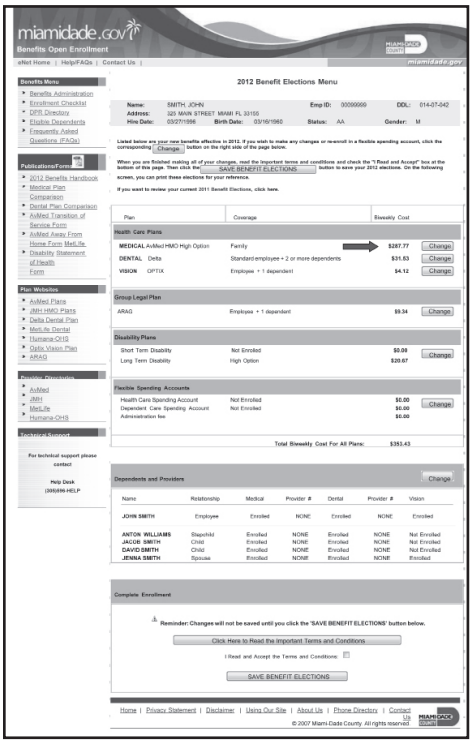


Once you are in eNet, click the 2013 Open Enrollment link or Banner to begin your enrollment.



Step 1

On the Benefit Elections Menu each benefit plan will have a "CHANGE" button next to it. Select the corresponding button to add or to modify coverage. The appropriate page will open to make your change(s).



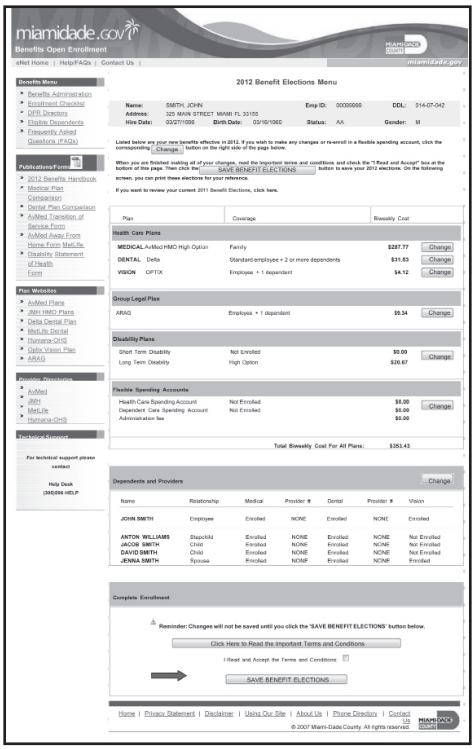
Step 2

Select your plan/enrollment option, then click the "CONTINUE" button to return to the Benefit Elections Menu. Repeat this process for each benefit election to be changed. Note, if you modify your medical, dental or vision coverage, before you return to the main page, the next screen will be the Dependent & Provider screen. This will allow you to add/cancel a dependent or enter a provider ID number (ID# optional, except for new enrollees in the AvMed Low Option, MetLife Dental, or Humana-OHS Dental).

To return to the Benefit Elections Menu from the Dependent & Provider screen, click the "CONTINUE ENROLLMENT" button.

Step 3

When you are satisfied with your 2013 benefit elections, go to the bottom of the Benefit Elections Menu, check the "I read and accept" box (once you have read the important terms and conditions, of course), then click the "SAVE BENEFIT ELECTIONS" button to save your elections. This will complete your 2013 enrollment, allow you to print an enrollment confirmation and take the survey. You can return to the enrollment website at any time to make changes until November 20.



Dependent Eligibility

Annual Open Enrollment - The health plans will continue to screen for the eligibility of newly enrolled dependents with last names that differ from the employee's. It is your responsibility to provide the health plans with the required documentation by December 1. Proof of dependent eligibility may be forwarded to your DPR for transmittal to the health plan. Failure to comply will result in the dependent's cancellation retroactive to January 1. If you are sending documents directly to the health plan, obtain proof of mailing or fax transmission. New employees enrolling for benefits during their initial eligibility must submit dependent documentation for all enrolled dependents (not just dependents with a different last name).

Eligible Dependents	Documentation Required During Open Enrollment (If adding dependent(s) with a different last name)
Spouse*	Official certified or registered Marriage Certificate (religious certificates are not acceptable).
Domestic Partner (DP)*	A Domestic Partnership certificate issued by the MDC Department of Regulatory and Economic Resources (RER), Consumer Services.
Natural Child	Official Birth Certificate listing employee as the parent (birth cards are not acceptable)
Child of Domestic Partner	Official certified Birth Certificate listing DP as the parent (birth cards are not acceptable) and domestic partnership certificate issued by the MDC Department of Regulatory and Economic Resources (RER), Consumer Services.
Stepchildren	Official certified Birth Certificate(s) AND copy of official State certified or registered Marriage Certificate listing employee's current spouse as parent.
Child under Legal Guardianship Custody or Foster Care	Permanent Legal Guardianship/Custody document from the Courts or copy of Foster Care documentation from Courts.
Adopted Child or child in the process of adoption	Legal Adoption documentation showing relationship to employee and placement in employee's home or copy of Adoption Certificate issued through the Courts
Grandchild	Official certified Birth Certificate(s) of child AND copy of Permanent Legal Guardianship, Adoption/placement for adoption. A dependent of a dependent (child born to an enrolled child dependent) may remain on the plan for up to 18 months from the date of birth. Thereafter, permanent legal guardianship is required for the grandchild to remain covered.

*Your spouse or Domestic Partner (DP) is not an eligible dependent if also a County or Public Health Trust/Jackson Health System employee and eligible for own group medical/dental coverage. Ex-spouses may not be enrolled for group benefits under any circumstance.

Coverage Limiting Age for Dependent Children

Medical – Age 26 (ends December 31)	Dental & Vision – Age 25 (ends December 31)
Medical coverage may be extended to age 30. **Refer to page 11.	There is no extension beyond 25 unless the dependent is deemed disabled by the plans

Dependent children incapable of sustaining employment because of mental or physical disability may continue coverage beyond the limiting age, if enrolled for medical prior to age 26 (or 25 for dental and vision). Proof of disability must be submitted to the insurance plan on an ongoing basis.

Adult Children – Eligibility

**Adult Children (Chapter 627.6562 Florida Statutes) - Medical coverage may be continued beyond December 31 of the year the adult child turns 26. Coverage ends the end of the calendar year the child turns 30 (December 31). Only medical coverage is available to this group. Employees are required to submit the documentation listed below every year, before the start of the plan year.

Eligibility For Medical Coverage Beyond Age 26	Documentation Required Every Year
1. Adult child is not married, and	• Affidavit of Eligibility (form available online at www.miamidade.gov/benefits), and
2. Has no dependents (i.e. children, spouse/domestic partner), and	• Proof of Florida residence (i.e. Driver's License), or proof of student status (school registration)
3. Is either a resident of Florida or is a student in another state, and	Note: If enrolling a new adult child age 26+ you must also provide proof the child was continuously covered by other creditable coverage without a coverage gap of more than 63 days.
4. Is not provided or otherwise have available other major medical health insurance	

Imputed Income

The Internal Revenue Service allows the employee to receive "tax free" health insurance subsidies for themselves and their eligible dependents as defined under IRS guidelines, but excludes those amounts attributable to coverage of adult children above age 26, domestic partner (DP), and dependents of a domestic partner. In light of this, the County must include the fair market value of this coverage in the employee's income, referred to as "imputed income" and this imputed income will be taxed accordingly. Go to www.miamidade.gov/benefits for information regarding the post-tax premium breakdown and imputed income tax. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

Dependent Documentation Transmittal

The health plans must receive dependent documentation by December 1. If you are enrolling dependents with a different last name (than yours), or they are already enrolled but you changed insurance carriers during open enrollment, you must submit documentation for those dependents to be covered. If you cover an adult dependent child age 26 – 29, regardless of last name, you must provide proof of eligibility every year. Forward the document copies to your Department Personnel Representative (DPR) for transmittal to the health plans. Remember to enter your name and employee ID for identification purposes. If you prefer to send documents directly to the health plan, please obtain proof of mailing or fax transmittal. Failure to provide acceptable documentation will result in cancellation of the dependent's medical, dental and or vision coverage (if enrolled), retroactive to January 1, 2013. To submit directly to the health plan:

AvMed Health Plan
Onsite Service Representative SPCC -111 NW 1st Street, Suite 2340 Miami, FL 33128 Phone: (305) 375-5306 Fax: (305) 372-6097

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. (Section 817.234 (1) (b) Florida Statutes)

Change In Status (CIS)

How do I make a change to my health plan mid-year? Once the open enrollment period closes, you may add or delete dependents to your health plan only under limited circumstances (a qualifying event). Changes must be reported within 45 days of a qualifying event (60 days to add newborns/adoption, or placement for adoption). Complete and submit a Change in Status (CIS) form and Plan Status Change form to the Benefits Administration Unit. Election changes must be consistent with the event and result in loss or gain of insurance coverage. Mid-year changes from one health plan to another are not permitted. A partial list of permitted mid-year changes appears below.

Qualifying Events (QE)

- Marriage/Divorce
- Employment change from full-time to part-time or vice versa (employee or spouse)
- Birth of a child
- Unpaid LOA (employee or spouse)
- Adoption of a child or placement for adoption
- Medicare/Medicaid/Florida Kid Care
- Change in Number of Tax Dependents
- Spouse's employer's open enrollment
- Beginning or end of employment of a spouse (resulting in gain or loss of insurance coverage)
- Significant change in health coverage due to spouse's employment

Loss of Eligibility for Dependent Children – Under Age 26

For this group, the only qualifying event that makes the child ineligible for coverage is enrolling in another group health plan. The Patient Protection and Affordable Care Act (PPACA) extended the limiting age for dependent children to the end of the calendar year the dependent turns age 26. Marital status, financial dependency, or student status are no longer applicable. Consequently, you cannot remove a dependent child from coverage due to marriage, or initial employment, unless the child gains other group insurance and enrolls in it. Moving out of the employee's home and losing financial dependency on the parent are not QEs that would permit the dependent's coverage to be canceled.

Loss of Eligibility – Adult Children Age 26+ to 30

- Marriage/Domestic Partnership
- Acquiring dependent children
- Becoming eligible for group medical coverage
- Relocating outside of Florida (unless FT/PT student)
- Entering Military Service

For additional information and IRC Section 125 QEs, go to www.miamidade.gov/benefits to access the online Benefits Handbook. You may also download the Flex Benefits and Health Plans Change in Status forms from this website.

Your election change request (CIS) must include documentation supporting the loss or gain of insurance coverage. Do not delay submission of your Change in Status and Health Plan Status Change forms while you gather your documentation. Simply forward the forms to your DPR and present your documentation as soon as it becomes available. Your existing elections will be stopped or modified (as appropriate) upon approval of your election change request. Generally, mid-year pre-tax election changes are made prospectively. That is, no earlier than the beginning of the pay period following receipt by the Benefits Administration Unit (BAU), unless otherwise provided by law. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption or placement for adoption which become effective as of birth or the earlier of: a) adoption or b) placement for adoption.

CIS Premium Changes

The Benefits Administration Unit (BAU) will process the change in premium the beginning of the pay period following receipt of your CIS request. The full premium is charged for the affected pay period, regardless of the number of days you (or dependent) had coverage. The payroll deduction will not be prorated based on the number of days coverage was active in the affected pay period. Refer to the Benefits Handbook for additional information.

If a request to delete an ineligible dependent is received after the 45-day deadline, the dependent's coverage will be cancelled, but the dependent premium payroll deduction will continue through the end of the plan year.

Regional Meeting Schedule

November 5, 2012 - November 16, 2012

Representatives from the Group Medical, Group Dental, Group Vision, Disability Income Protection, Group Legal and Deferred Compensation Plans will be available to answer questions.

DATE	SITE	LOCATION	ADDRESS	START	END
11/05/12	Public Works & Waste Mgmt	58th St Garbage & Trash, Breeze Way	8831 NW 58th St	6:30 AM	8:00 AM
11/05/12	Stephen P. Clark Center	Lobby Atrium	111 NW 1st Street	8:30 AM	12:30 PM
11/05/12	Seaport	2nd Floor Conference Rm	1015 North America Way	1:00 PM	2:30 PM
11/06/12	Miami-Dade Transit	Lehman Ctr, Training Rm	6601 NW 72 Ave	9:00 AM	11:00 AM
11/06/12	Aviation	Concourse D-Auditorium, 4th FL	Miami Intl. Airport	1:00 PM	3:00 PM
11/07/12	Fire Rescue	MDFR Training Facility, Rm 2-002	9300 NW 41 St.	9:00 AM	11:00 AM
11/07/12	Overtown Transit Village	Lobby	701 NW 1st Court	1:00 PM	3:00 PM
11/07/12	Public Works & Waste Mgmt	Traffic Signal & Signs, Conf. Rm	7100 NW 36 Street	2:30 PM	4:00 PM
11/08/12	Public Works & Waste Mgmt	3B Garbage & Trash, Auditorium	8000 SW 107 Ave.	6:30 AM	8:00 AM
11/08/12	Water & Sewer	Douglas Rd Bldg. - Rm 156 - A&B	3071 SW 38 Avenue	12:30 PM	3:30 PM
11/09/12	Stephen P. Clark Center	Lobby Atrium	111 NW 1st Street	8:30 AM	12:30 PM
11/09/12	Miami-Dade Police	HQ Cafetorium	9105 NW 25 St.	1:30 PM	3:30 PM
11/13/12	Building & Permitting Ctr.	Conference Rm I/J	11805 S.W. 26th Street (Coral Way)	7:30 AM	9:00 AM
11/13/12	Miami-Dade Transit	Central Garage, Driver's Rm, 1st FL	3300 NW 32 Avenue (Bus Ops.)	12:00 PM	1:30 PM
11/13/12	Public Works & Waste Mgmt	Road, Bridge & Canal - Lunch Rm	9301 NW 58th Street	2:30 PM	4:30 PM
11/14/12	Martin Luther King Bldg.	2nd Floor Conf Rm #1-2	2525 NW 62nd Street	9:30 AM	11:30 AM
11/14/12	Miami-Dade Transit	NE Garage, Driver's Rm, 1st FL	360 NE 185 St. (Bus Ops)	11:00 AM	12:30 PM
11/14/12	ETSD	Break Room, 2nd FL	5680 SW 87 Ave.	2:00 PM	3:30 PM
11/15/12	Public Works & Waste Mgmt	3A Garbage & NE Transf., Trailer	18701 NE 6th Ave.	6:30 AM	8:00 AM
11/15/12	Miami-Dade Transit	Coral Way - Driver's Rm 1st FL	2775 SW 74 Ave.	10:30 AM	12:30 PM
11/15/12	So. Dade Govt. Ctr.	Rm 203	10710 SW 211 St.	1:00 PM	3:00 PM
11/16/12	Stephen P. Clark Center	Lobby Atrium	111 NW 1st Street	9:30 AM	12:30 PM
11/16/12	Courts	Justice Building (Jury Pool Rm 700)	1351 NW 12 Street, 7th FL	1:30 PM	3:00 PM

Opt-Out of Medical Coverage

In 2013 employees may opt-out of County-provided medical coverage during open enrollment. If you decline coverage, you cannot re-apply until the next open enrollment, unless you experience a family status or HIPAA qualifying event. Important Note: Opting-out of County-provided medical coverage will not eliminate your base salary contribution (if any) towards the County's cost of healthcare.

Cancelling Plan Participation After Open Enrollment

After open enrollment, you may cancel any post tax benefit plan (Group Legal, Short-Term, or Long-Term Disability Plans) without a penalty. If you cancel a pre-tax benefit plan subject to the IRC Section 125 salary reduction provisions, such as medical, dental and vision, you will still be required to pay the employee premium (if any) for the remainder of the year. Also, cancelling your medical plan will not eliminate the required base salary contribution towards the County's cost of healthcare.

All plan cancellations requests must be submitted to your DPR in writing and will be processed prospectively (next pay period from date request is received).

Delta Dental Participating and Non-participating Dentists

What is the difference?

USING IN-PPO NETWORK	USING OUT OF PPO-NETWORK
You will usually pay the lowest amount for services when you visit a Delta Dental PPO dentist. PPO dentists agree to accept a reduced fee for PPO patients.	You are responsible for the difference between the amount Delta Dental pays and the amount your out-of network dentist bills. You will usually have higher out-of pocket costs when you visit an out of network dentist.
You are charged only the patient's share* at the time of treatment. Delta Dental pays its portion directly to the dentist.	Your dentist may require you to pay the entire amount of the bill in advance and wait for reimbursement.
PPO dentists will complete claim forms and submit them for you at no charge.	You may have to complete and submit your own claim forms, or pay your non-Delta Dental dentist a service fee to submit them for you.

Important Notice: Effective January 1, 2013, non-Delta Dental dentists will be reimbursed based on PPO contracted fees. As a result, enrollees who visit a non-Delta Dental dentist may see a change in their out-of-pocket costs. The claim example below assumes that the deductible and contract provisions are met. Actual costs may vary.

SAMPLE CLAIM SAVINGS	IN-NETWORK	OUT-OF NETWORK
Amalgam (filling), two surfaces, primary or permanent (Procedure Code #D2150)	Delta PPO Dentists	Non-Delta Dentists
Dentist bills	$185.00	$185.00
Dentist accepts as payment in full (contracted fee)	$89.00	$185.00
100% for PPO or 75% (of PPO contracted fee) for non-Delta Dentist	$89.00	$66.75
Patient share	$0.00	$118.25
Patient saves	$118.25	$0.00

Save money by using a Delta Dental PPO dentist. If you have a great dentist who isn't in the Delta network you can recommend your dentist for membership by completing an online form. Delta will reach out to the dentist and begin the membership screening process.

Disclosure Notices

Please refer to the 2013 Benefits Handbook at www.miamidade.gov/benefits for the following important notices:

1. Notice of Creditable Coverage - Prescription Coverage/Medicare
2. HIPAA Privacy Notice
3. Why We Collect SSN Information
4. Early Retiree Reinsurance Program (ERRP)

Federal law requires these notices be included in employee benefit communications.

Important Notes

1. Print and retain the online benefits confirmation notice after you make your benefits elections for the 2013 plan year and take the online benefits survey. The online benefits confirmation notice will be the required proof of your 2013 benefit selections, in the event there are any discrepancies. Once the Open Enrollment deadline passes, the only plan election changes permitted will be those resulting from a processing error. A processing error is defined as the unlikely event of a computer system malfunction that failed to process the employee's elections, as recorded on the final confirmation notice submission.

2. Review your benefit plan options carefully, because once you submit your final selections online you are locked into these plan choices until December 31, 2013. Employees are not permitted to switch plans during the year.

3. All 2013 plan year benefit elections are in effect January 1, 2013 through December 31, 2013 (except for new hires and those benefits subject to medical approval).

4. New hires with a benefits eligibility date of November 1 or December 1, 2012 must submit their benefits selections online through the County's eNet portal New Hire Benefits Enrollment link. Your 2012 new hire plan selections will carry over into 2013. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of 2012 and a separate amount for the 2013 plan year.

Remember These Dates

November 5 to November 16, 2012	Regional Meetings
November 5 to November 20, 2012	Access to the Open Enrollment Website
December 1, 2012	Deadline to submit dependent documentation
January 18, 2013	Deadline for reporting system errors in the processing of online benefit elections

Contact Information

Online Enrollment Website http://enet.miamidade.gov

Benefits Administration Unit (BAU)	(305) 375-4288 or 5633	www.miamidade.gov/benefits
MEDICAL PLANS		
AvMed Health Plans	(800) 682-8633	www.avmed.org/go/mdpht
AvMed Onsite Representatives	(305) 375-5306	SPCC 23rd Floor--M-F, 8:30a - 4:30p
DENTAL & VISION PLANS		
Delta Dental	(800) 471-1334	www.deltadentalins.com/mdc
Humana-OHS Dental	(800) 380-3187	www.humana.com/miami-dade-co-govt
MetLife DHMO Dental	(877) 638-2055	www.metlife.com/mybenefits
Optix Vision Plan	(800) 393-2873	www.humana.com/miami-dade-co-govt
OTHER		
ARAG Legal Plan	(800) 667-4300	www.ARAGLegalCenter.com code:10277mdc
FBMC	(800) 342-8017	www.myFBMC.com
MetLife Disability Plans	(888) 463-2023	www.metlife.com/mybenefits
ICMA-RC - Deferred Comp.	(305) 375-4710	www.icmarc.org/miamidade
NACo - Deferred Comp.	(866) 986-4264	www.miamidade457.com

What are my options if I do not qualify for Miami-Dade County Health Benefits?

Part-time, temporary and seasonal employees who do not qualify for Miami-Dade County health insurance benefits, may have other affordable options available. Go to www.miamidade.gov/humanresources/alternative-medical-plans.asp for a list of health insurance providers offering alternative limited benefits programs.

In addition, you and your family may qualify for the Miami-Dade Health Insurance Assistance (MD-HIA) program to help pay a portion of your monthly health insurance premium. MD-HIA is for low to moderate income individuals between 19-64 years of age and is also available to the general public. Find out if you qualify for premium assistance by going to the online pre-screening tool at http://feedback.miamidade.gov/Community/se.ashx?s=57F3145855CA1B48. MD-HIA is subject to available funding. For more information, please call 305-375-5444 x12 or go to http://www.miamidade.gov/managementandbudget/countywide-healthcare.asp.

Confirmation Notices

As part of the County's Green Pledge, the Benefits Administration Unit eliminated the printing and mass distribution of open enrollment confirmation notices. You may print your confirmation notice upon completing your online enrollment. After the 2013 Open Enrollment website is disabled on November 20, employees may still view their 2013 plan elections through the 2013 Benefit Summary link on eNet (http://enet.miamidade.gov). That link is active until December 24, when the information is transferred to eNet-Employee Self Service (ESS) Benefit Summary screen, which displays your current benefit elections.