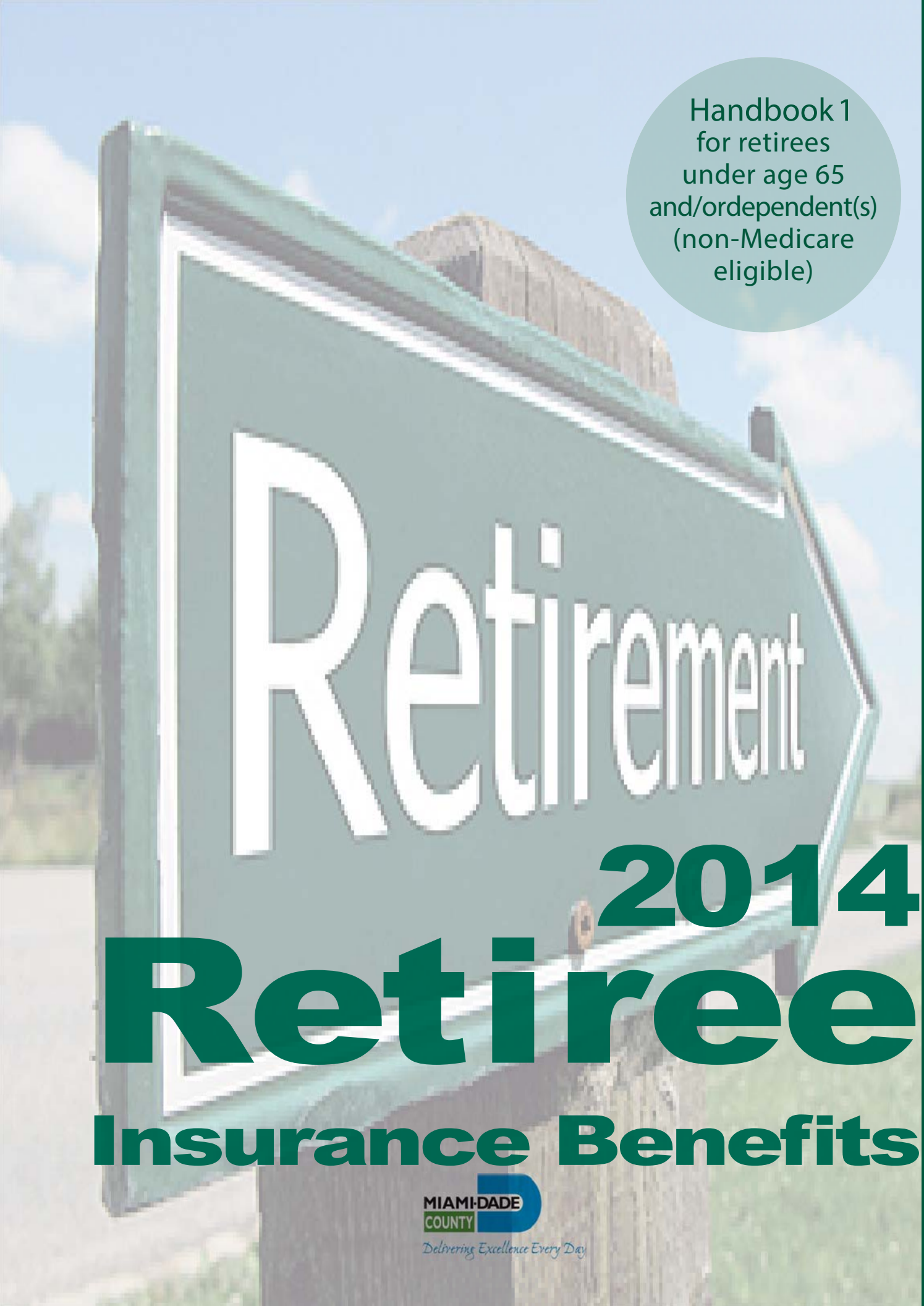

Handbook 1
for retirees
under age 65
and/ordependent(s)
(non-Medicare
eligible)

2014 Retiree Insurance Benefits

MIAMI-DADE COUNTY
Delivering Excellence Every Day

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 2014 Under 65 Election Form, if you are under the age of 65. Complete the 2014 Over 65 Election Form, if you are 65 or older, or Medicare eligible. If you are under age 65, but have a Medicare eligible dependent, complete the 2014 Under 65 Election Form; however, consult Handbook 2 for detailed Medicare plan benefit information for your dependent. The 2014 Retiree Group health Plan election forms are available at www.miamidade.gov/humanresources/retirees.asp.

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

Congratulations and best wishes for your retirement years.

2014 Retiree Insurance Benefits

MIAMI-DADE COUNTY
Delivering Excellence Every Day

HANDBOOK 1

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

OUR ADDRESS:

Miami-Dade County
Human Resources
Benefits Administration
111 NW 1st Street, Suite 2340
Miami, Florida 33128-1979

SR. EMPLOYEE BENEFITS SPECIALISTS:

Telephone Numbers: (305) 375-5633 (305) 375-4288

Retiree's last name starting with letters A-C	Mike Ellis mellis@miamidade.gov
Retiree's last name starting with letters E-H	Sharon Subadan shy@miamidade.gov
Retiree's last name starting with letters I-M	Lourdes Pupo lpupo@miamidade.gov
Retiree's last name starting with letters D, N-R	Rina Gomez rinag@miamidade.gov
Retiree's last name starting with letters S-Z	Marti Garcia marti@miamidade.gov

http://www.miamidade.gov/humanresources/retirees.asp

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Table of Contents

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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.

To enroll under the Retiree Group, you must complete and return to Benefits Administration the following form(s):

2014 New Retiree Insurance Benefits Election Form

Available online at: http://www.miamidade.gov/humanresources/retirees.asp

FRS Insurance Payroll Deduction Authorization Form

Complete this form to have insurance premiums deducted from your monthly pension benefit. After the initial payment is received it takes approximately sixty (60) days for automatic FRS premium deductions to begin. This option is available to Investment Plan Members if the premiums do not exceed the value of the Health Insurance Subsidy. This form will be mailed to you along with your billing statement.

Life Insurance Beneficiary Designation Form

Complete this form if electing continuation of life insurance after retirement. You may change your beneficiary at any time. Please update your beneficiary if your named beneficiary predeceases you, or if you experience a change in family status. This form will be mailed to you along with your billing statement.

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.

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Retirement Overview

Congratulations on your retirement. As a retiree, you may elect to continue your group medical, dental and basic life insurance 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 in good standing with a retirement code of EG and meet one of the following requirements:

FRS Pension Plan – 1) If enrolled in the FRS prior to July 1, 2011, normal retirement eligibility 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. If enrolled in the FRS on or after July 1, 2011, normal retirement eligibility is the earlier of either age 65 with at least 8 years of service or 33 years of service. If Special Risk, age 60 with 8 years of Special Risk service; or 2) Have at least 6 years of service (8 years if enrolled in the FRS on or after July 1, 2011) and begin collecting a reduced pension benefit from the FRS.

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 or EM).

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 with at least 6 years of creditable service (8 years if enrolled in the FRS on or after July 1, 2011). Investment Plan participants who separate due to a hardship and do not satisfy the above criteria, should contact Benefits Administration for special consideration.

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 Benefits Administration (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 Benefits Administration 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, EI or EM status, without physically returning to work. Group insurance coverage will end the last day of the pay period in which you retire, 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)	**Delta Dental Standard or Enriched Plan**
AvMed High Option HMO	**MetLife DHMO Standard or Enriched Plan**
AvMed Low Option HMO	**Humana-OHS Standard or Enriched Plan**

PLAN CONTACT INFORMATION

AvMed Health Plan	www.avmed.org/go/mdpht	(800) 682-8633
MetLife DHMO	www.metlife.com/dental	(877) 638-2055
Delta Dental PPO	www.deltadentalins.com/mdc	(800) 471-1334
Humana-OHS	www.humana.com/miami-dade-co-govt	(800) 380-3187

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 and will not have another opportunity to re-enroll.

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 for adoption) of a child, eligible dependent's loss of employment, etc. Enrollment must take place within forty-five (45) days, sixty (60) days for newborns, adoption or placement for adoption of the qualifying event. Only events that trigger a loss or gain in eligibility for you/your dependents are considered qualifying events. Proof of the qualifying event must be submitted to Benefits Administration. 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 received in Benefits Administration.

Important information regarding Dependents Age 26+ - 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 26 through age 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 contact your Employee Benefits Specialist for more information.

Relocating Outside the Tri-County Area

If you plan to relocate, be aware that Humana-OHS and MetLife DHMO dental coverage are generally not available outside Miami-Dade, Broward, and Palm Beach Counties. Additionally, although the AvMed Elite and Private Healthcare Systems, Inc. (PHCS) 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 Delta 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 medical insurance carrier's Member Services 800# to inquire about the "Away From Home Program."

Coverage Not Available After Retirement

Optional life insurance, Disability, Group Legal and Optix Vision coverages are not available after retirement.

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 Plan
Attn: Vision Claims
P.O. Box 14313
Lexington, KY 40512-431
(800) 393-2873

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 to age 65, at which time it is reduced. The coverage amount for retirees under age 65 is equivalent to their pre-retirement annual base salary.

If you elect to continue your basic life insurance, remember to update your beneficiary designation whenever you experience a change in family status. 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 Designation Form. The form must be legible, completed in ink, and contain no erasures or cross-out marks; specify the percentage of proceeds for each named beneficiary. The total percent allocation among the beneficiaries must add up to 100%. In the event of your death, your designated beneficiary(ies) must contact Benefits Administration to process this benefit.

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 from the health plans 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 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 Benefits Administration (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 online at www.avmed.org/go/mdpht . The PHCS providers are identified by the symbol <> in the printed directory and in the online directory. When contacting one of these providers to verify participation, you should ask whether they participate in the "PHCS 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)
AvMed High Option HMO
AvMed Low Option HMO

Dental Plans
Delta Dental Standard or Enriched Plan (Indemnity)
MetLife DHMO Dental Standard or Enriched Plan (Prepaid)
Humana-OHS Standard or Enriched Dental Plan (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 coverage for Miami-Dade County retirees is available in your new area of residence. You will find a summary of benefits, applicable rates and the 2014 Retiree Insurance Election Form online at http://www.miamidade.gov/humanresources/retirees.asp.

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

Dental
Delta Dental Standard or Enriched Plan (Indemnity)
MetLife DHMO Dental Standard or Enriched Plan (Prepaid)
Humana-OHS Standard or Enriched Dental Plan (Prepaid)

You will find a summary of benefits offered to Medicare eligible retirees (and/or dependents) 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 in 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.

2) Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) 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 twenty-six (26).

One of the major changes brought on by Health Care Reform in 2011 was to allow young adults to stay on their parents health plan to age 26 (end of the calendar year - December 31). Financial dependency, full-time student or marital status no longer applies to covered dependent child(ren) under the health plans. A separate provision allows premiums to be payroll deducted pre-tax, except for child(ren) of domestic partners. Although married children are eligible for coverage, their spouse and child(ren) are excluded. The extension applies to medical coverage only. The limiting age for dependent dental coverage is age 25 (end of calendar year).

Dependent children who are incapable of sustaining employment because of mental or physical disability, and are dependent upon the retiree for support, may continue to be covered beyond the limiting age, providing the child was enrolled prior to age 26. Proof of disability must be submitted to the health plan each year on an ongoing basis.

The Florida Statute (FSS 627.6562) governing dependent insurance extends the limiting age of dependent child(ren) from age 26 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 domestic partner and/or their child(ren)?

A. To enroll your domestic partner and the domestic partner's dependent child(ren) for health insurance, you must file a Declaration of Domestic Partnership with the Miami-Dade County Regulatory and Economic Resources Department and pay the applicable fee. Submit a copy of the Certificate of Domestic Partnership and the birth certificates of the dependent child(ren).

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. You must notify the Retiree Group in writing regarding this change within forty-five (45) days. A change of medical and/or dental plans will be allowed. Proof of your change of residency is 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, AvMed Health Plan has contracted with PHCS to provide nationwide coverage. As a retiree, if you utilize your plan's extended providers network you will receive the same HMO benefits. For more information on accessing PHCS, providers contact AvMed's 24/7 dedicated Member Services at 1(800) 682-8633.

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. Please note that once you qualify for Medicare, your retiree medical coverage becomes secondary. You may elect to continue with your current coverage (HMO or POS) until age 65 instead of enrolling in one of the Medicare supplement plans.

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 your domestic partnership. Former spouse/DP 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 their 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 Benefits Administration 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 received. Your spouse/DP can continue indefinitely and your dependent child(ren) until the limiting age. This applies to the AvMed 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 medical coverage upon becoming eligible for Medicare, dependents covered under your retiree medical insurance may continue, as long as timely premium payments are received. However, your dependent(s) may not continue dental coverage if you do not elect to continue dental coverage yourself. All cancellations are irrevocable; once cancelled, coverage will not be reinstated. This applies to the AvMed plans as well as the dental plans.

Q. If I have a qualifying event (marriage, new domestic partnership, birth or adoption/placement for 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, adoption/placement for adoption. 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. Benefits Administration 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. Thereafter, premiums are due on the first of each month.

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 applicable, you will receive information from us approximately three (3) months prior to you and/or your covered dependent's 65th birthday. A revised billing statement will be mailed to you prior to the month

your premium changes.

Q. What is the cost to continue with medical, dental and/or life insurance after I retire?

A. For premium information please visit http://www.miamidade.gov/humanresources/retirees.asp or refer to page 25 of this handbook.

Q. How do I pay for my insurance?

A. If you retire under the FRS Pension Plan, your premiums will be deducted from your retirement check; FRS deductions begin approximately sixty (60) days after your retirement date. You are responsible for sending your payments until FRS deductions begin. Insurance premiums are deducted from your FRS pension benefit in advance to pay for the upcoming month's insurance coverage.

If you retire under the FRS Investment plan and your premiums do not exceed the value of the Health Insurance Subsidy this option may also be available to you. Otherwise, payments must be made by check, Cashier's Check or Money Order, only. Full payment is due on the first day of each month to avoid cancellation of coverage. Make checks payable to **Miami-Dade County** and indicate your retiree ID number to expedite processing. The insurance carriers will be notified to activate your coverage under the Retiree Group upon receipt of your initial premium payment.

Note: Coverage cannot be verified if the account is not current.

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 effective date of cancellation is at the end of the month the written request is received, except when a future date is specified. Otherwise, the insurance carriers or the County will not cancel your coverage unless:

a) Your payment is not received by the due date; a cancellation notice will be mailed to you.
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.

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 Benefits Administration at least 2 weeks prior to your retirement date.

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, EM, 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. Optional Life insurance is not available through the Retiree Group. You can convert this optional benefit directly with the life insurance carrier. Information about the process will be mailed to you with your billing statement.

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. Once cancelled, the coverage will not be reinstated.

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

A. No. During the retiree enrollment period you will only be allowed to change plans, and only eligible en-

rolled 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.

Q. What is the Health Insurance Subsidy?

A. Eligible retirees receive a monthly Health Insurance Subsidy (HIS) from the FRS. The HIS payment is calculated by multiplying $5 by the total years of creditable service at retirement. The minimum HIS payment is $30 per month with six years of creditable service at retirement, the maximum is $150 per month with 30 years of creditable service at retirement. It is intended to help offset the cost of your health insurance coverage.

You may contact the Division of Retirement at (888) 377-7687 for any subsidy questions, or write to:

Division of Retirement
PO BOX 9000
Tallahassee FL 32315-9000
E-mail: retired@dms.myflorida.com

Q. Who qualifies for the $3,000 tax savings for health insurance premiums?

A. Retired public safety officers may withdraw up to $3000 tax-free from their 457 account each year to pay for premiums for health, accidental, or long-term care insurance (consult with your plan provider or tax professional to find out if you should consider taking advantage of this benefit.)

Important Notice: Prescription Coverage & Medicare

2014 Important Notice About Your Prescription Drug Coverage and Medicare From Miami-Dade County to Medicare Eligible Retirees & Dependents Participating in the Following County-Sponsored Health Plans

AvMed POS • AvMed High Option HMO • AvMed Low Option HMO
AvMed High Option Plan - AvMed High Option No RX Plan - AvMed Low Option Plan

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 prescription drug coverage for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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 above listed County plans, on average for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Miami-Dade County prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Miami-Dade County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll.

For more information about your current prescription drug coverage, refer to your certificate of coverage issued by your medical insurance plan, or visit www.miamidade.gov/benefits.

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available 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 prescription drug plans. More information about Medicare prescription drug plans is available from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Last Updated: October 15, 2013
Name of Entity: Miami-Dade County
Contact-Position/Office: Human Resources Department,
Benefits Administration
Address: 111 NW 1st Street, Suite 2340
Phone Number: (305) 375-4288, (305) 375-5633

MIAMI-DADE COUNTY HEALTH BENEFITS NOTICE OF PRIVACY PRACTICES

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

This Notice describes how Miami-Dade County's (the "County's") medical and flexible spending account benefits programs, collectively referred to as the "Plans," may use and disclose Protected Health Information ("PHI" or "health information"). Protected Health Information is individually identifiable information about your past, present or future health or condition, health care services provided to you, or the payment for health services, whether that information is written, electronic or oral. This notice also describes your rights under federal law relating to that information. It does not address medical information relating to disability, workers' compensation or life insurance programs, or any other health information not created or received by the Plans.

HOW THE PLANS MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

For Treatment. While the Plans generally do not use or disclose your PHI for treatment, the Plans are permitted to do so if necessary. For example, the Plans may disclose PHI if your doctor asks for preauthorization for a medical procedure, the Plan may provide PHI about you to the company that provides preauthorization services to the Plan.

For Payment. The Plans may use and disclose your health information for payment of claims. Such purposes include, but are not limited to, eligibility, claims management, precertification or pre-authorization, medical review, utilization review, adjustment of payments, billing, and subrogation. For example, a detailed bill or an "Explanation of Benefits" may be sent to you or to the primary insured or "subscriber" by a third-party payor that may typically include information that identifies you, your diagnosis, and the procedures you received.

For Health Care Operations. The Plans may use and disclose health information about you regarding day-today Plan operations. Such purposes include, but are not limited to, business management and administration, business planning and development, cost management, customer service, enrollment, premium rating, care management, case management, audit functions, fraud and abuse detection, performance evaluation, professional training, provider credentialing, formulary development, and quality assurance or other quality initiatives. For example, the Plans may use or disclose information about your claims history for your referral for case management services, project future benefit costs, handle claims appeals or audit the accuracy of the claims processing performed by a third party payor.

To the Plan Sponsor. The Plans may disclose health information to the County, but the County has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes. For example, the County may become involved in resolving claim disputes or customer service issues.

As Required by Law. The Plan may use or disclose health information about you as required by state and federal law. For example, the Plan may disclose information for the following purposes:

- for judicial and administrative proceedings;
- to report information regarding victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in the performance of their law enforcement duties.

To Business Associates. There are some services the Plan provides through contracts with business associates. We may disclose your health information to our business associates so that they can perform the jobs we have asked them to do, for example, claims payment or appeals on behalf of the County by a third-party payor and claims audits by third-party firms to assure contract compliance. To protect the privacy of your health information, we contractually require business associates to appropriately safeguard that information.

For Health-Related Products and Services. The Plans may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities in the prevention or control of disease, injury, or disability, or for other activities relating to public health.

For Health Oversight. We may disclose your health information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other government regulatory programs and civil rights laws.

For Research. We may disclose your confidential information for research purposes, subject to strict legal restrictions.

To Personal Representatives and Some Relatives. We may use or disclose your information to a personal representative formally designated by you or designated by law or, under circumstances, to a close relative such as the subscriber primarily responsible for your coverage or the parent of a minor child.

For Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or another person pursuant to applicable law.

For Governmental Functions. Specialized governmental functions such as the protection of public officials or reporting to various branches of the armed services may require the use or disclosure of your health information.

For Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws and regulations relating to workers compensation or other similar programs established by law.

No Other Uses. Other uses and disclosures will be made only with your prior written authorization. You may revoke this authorization except to the extent a Plan has already made a disclosure in reliance on such authorization.

YOUR LEGAL RIGHTS

The federal privacy regulations give you the right to make certain requests regarding health information about you:

Right to Request Restrictions. You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment, and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom that restriction would apply. The Plan is not required to agree to a restriction that you request.

Right to Request Confidential Communications. You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plans will accommodate any reasonable request if the normal method of communication would place you in danger.

Right To Access Your Protected Health Information. You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions. The Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

Right to Request Amendment. You have the right to request that your PHI created by the Plan and maintained in a designated record set be amended, if that information is in error. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement, in which case, a copy will be provided to you.

Right to Receive An Accounting of Disclosures. You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any. This accounting does not include disclosures for payment, health care operations or certain other purposes, or disclosures to you or with your authorization. Any such request must be made in writing and must include a time period, not to exceed six (6) years. The Plan is only required to provide an accounting of disclosures made on or after April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

All requests listed above should be submitted in writing to the County's Chief Privacy Officer (see Contact Information below).

THE PLANS' OBLIGATIONS

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

THIS NOTICE IS SUBJECT TO CHANGE

We may change the terms of this Notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future. Revised Notices will be made available to you in writing as required.

COMPLAINTS

You have a right to file a complaint if you believe your privacy rights have been violated. You may file a complaint by writing to the County's Chief Privacy Officer, Human Resources 111 NW 1 Street, Suite 2340, Miami, FL 33128. You may also file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

SOCIAL SECURITY NUMBER - DISCLOSURE NOTICE

Benefits Administration, Human Resources is responsible for the administration of all employee benefits including medical, dental, vision, life, group disability income protection, group legal, deferred compensation, pension benefits, IRS Section 125 plans and executive benefits. All employee records are reported to the plans using social security numbers because it is imperative for us to be able to identify members properly and definitively, and to meet state and federal reporting requirements.

Social security numbers are confidential and exempt from public records requests under section 119.07(1), Florida Statutes, and Section 24(a), Article I of the Florida Constitution.

The Florida Public Records Law (specifically, section 119.07(5)2.a., Florida Statutes (2007), provides that Miami-Dade County must give you a written statement describing the law under which the County is collecting your Social Security Number. The law may specifically direct the County to collect your Social Security Number or the County finds that it is imperative to collect your Social Security Number.

Miami-Dade County, Human Resources must collect your Social Security Number to perform its duties and responsibilities including;

1. Group insurance enrollment, eligibility and claims processing
2. Pension plan administration
3. FBMC Spending accounts reporting
4. Deferred compensation reporting
5. Group Legal reporting
6. Group Disability reporting
7. Facilitate tax reporting
8. Disclosure to contracted vendors in the normal course of business
9. Identifying and preventing fraud
10. Matching, identifying and retrieving information
11. Research activities

HEALTH CARE REFORM - DISCLOSURE NOTICE

Miami-Dade County's medical insurance plans are considered "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan does not have to include certain consumer protections of the Affordable Care Act that apply to other health plans. For example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply or do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to: Plan Administrator, Human Resources, Benefits Administration, 111 NW 1st Street, Suite 2340, Miami, FL 33178. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or the U.S. Department of Health and Human Services at www.healthcare.gov. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductible and coinsurance and applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, call AvMed at (800) 682-8633.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

For further information on eligibility in Florida:

FLORIDA – Medicaid & KidCare

Website: http://ahca.myflorida.com/medicaid/

Phone: 1-866-762-2237

http://www.floridahealth.gov/AlternateSites/KidCare/

Phone: 1-888-540-5437

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272)	Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

HEALTH INSURANCE MARKETPLACE
WHAT DOES THAT MEAN?

The Marketplace (or Exchange) is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium. The Marketplace Open Enrollment period is from October 1, 2013 through March 31, 2014, but you must apply by December 15, 2013, for coverage to be effective January 1, 2014. If you are an employee ineligible for County health insurance, this may be an option for you.

The Affordable Care Act, among other benefits, increased access to healthcare for individuals without coverage. The Health Insurance Marketplace will be an important part of that. Marketplaces are State-based (or Federal) competitive exchanges where individuals and small businesses can shop for and buy private health insurance. With an online application, consumers can find out if they qualify for health plans in the marketplace, and other programs like Medicaid and the Children's Health Insurance Program (CHIP), tax credits, and cost-sharing reductions. Consumers can apply for coverage through the Marketplace starting October 1 to December 15 for coverage to be effective January 1, 2014. If you apply on December 16, 2013 the coverage will be effective February 1, 2014 and so forth. The Marketplace Open Enrollment period closes on March 31, 2014. The Marketplace aims to make it easy to compare health plans, similar to online sites for booking hotel and airline tickets.

To help make shopping easier, health plans on a public exchange will be labeled platinum, gold, silver, or bronze. The metallic level helps shoppers understand the level of coverage a plan offers – how much they will need to pay and what the plan pays. Platinum plans will have the lowest out of pocket cost for members but the premiums will generally be higher. Bronze plans, on the other hand, will have the highest out of pocket costs for members, but will typically feature lower premiums. All plans on an exchange have to offer some core benefits – called "essential health benefits" - like preventive and wellness services, prescription drugs, and coverage for hospital stays. For more information, go to www.healthcare.gov.

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2014 Benefits Summary

AVMED POS PLAN

This Schedule of Benefits reflects the higher provider and prescription co-payments for 2014. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/go/mdpht.

SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
LIFETIME MAXIMUM	Unlimited	Unlimited
CO-INSURANCE LEVELS	Plan pays 100%; Member Pays 0%	Plan pays 70% of Maximum Allowable Payment (MAP); member pays 30% co-insurance after deductible
CALENDAR YEAR DEDUCTIBLE		
Individual (per contract year)	Not Applicable	$200 per individual
Family (per contract year)	Not Applicable	$500 per family
Deductible does not apply toward the Out-of-Pocket Maximum Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan co-insurance; if the family deductible was met prior to their individual deductible being met, their claims will be paid at the plan co-insurance.		
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual Maximum	$1,500 per individual	$1,500 per individual
Family Maximum	$4,500 per family	
Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%.		
PHYSICIAN SERVICES		
Services at Physician's offices include, but are not limited to:		
Primary Care Physician's Office Visit	$15 per visit	30% co-insurance after deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	$30 per visit	30% co-insurance after deductible
Allergy Injections	No charge	30% co-insurance after deductible
Allergy Skin Testing	$30 per visit	30% co-insurance after deductible
PREVENTIVE CARE		
Preventive Care (as required by the Patient Protection Affordable Care Act "PPACA")	No charge	30% co-insurance after deductible
MAMMOGRAM, PSA, PAP SMEAR		
Preventive care related services (i.e. "routine" services)	No charge	30% co-insurance after deductible
Diagnostic related services (i.e. "non-routine")	Subject to the plan's x-ray and laboratory benefit, based on place of service	Subject to the plan's x-ray and laboratory benefit, based on place of service

2014 Benefits Summary

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
INPATIENT HOSPITAL SERVICES		
Pre-Certification of Hospital Confinements	Handled by admitting physician	Pre-certification required
Hospital inpatient care includes: Room and board – unlimited days (semi-private)	No charge	30% co-insurance after deductible
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	No charge	30% co-insurance after deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	30% co-insurance after deductible
Inpatient/Outpatient Hospital Professional Services	No charge	30% co-insurance after deductible
OUTPATIENT FACILITY SERVICES		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	No charge	30% co-insurance after deductible
Diagnostic Testing	No charge	30% co-insurance after deductible
EMERGENCY AND URGENT CARE SERVICES		
PCP's Office	$15 per visit	30% co-insurance after deductible
Specialist's Office	$30 per visit	30% co-insurance after deductible
Hospital Emergency Room	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
Outpatient Professional Services (radiology, pathology, ER physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
LABORATORY/ RADIOLOGY SERVICES		
(includes pre-admission testing)		
Physician's office visit	No charge	30% co-insurance after deductible
Outpatient hospital facility	No charge	30% co-insurance after deductible
Independent x-ray and/or laboratory facility	No charge	30% co-insurance after deductible
ADVANCED RADIOLOGICAL IMAGING		
(i.e. MRI, MRA, CAT scan , PET scan, etc.) The scan co-payment/deductible applies per type of scan per day		
Outpatient Facility	No charge	30% co-insurance after deductible
Inpatient Facility	No charge	30% co-insurance after deductible
Physician's Office	No charge	30% co-insurance after deductible
OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES		
IN \OUT: Limited to 60 visits per calendar year: chiro services, rehab pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined; 36 visits per calendar year for cardiac rehab.		
Chiropractor	$15 per visit	30% co-insurance after deductible
Physical\ Speech\ Occupational Therapies, Pulmonary Rehab, Cognitive Therapy, Resp.Therapy	$30 per visit	30% co-insurance after deductible

2014 Benefits Summary

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	**Out-of-Network***
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	30% co-insurance after deductible
All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee)	No charge	30% co-insurance after deductible
Delivery facility (inpatient hospital, birthing center)	No charge	30% co-insurance after deductible
DURABLE MEDICAL EQUIPMENT		
Contract Year Maximum: Unlimited	No charge/ device for DME and Orthotics. External prosthetic appliance in network: no charge after $200 contract year deductible.	Not Covered
ACUPUNCTURE	Out-of-network coverage only	30% co-insurance after deductible
MENTAL HEALTH		
Outpatient	$15 per visit	30% co-insurance after deductible
Inpatient	No charge	30% co-insurance after deductible
Intensive Outpatient	$15 per visit	30% co-insurance after deductible
SUBSTANCE ABUSE		
Outpatient	$15 per visit	30% co-insurance after deductible
Inpatient	No charge	30% co-insurance after deductible
Intensive Outpatient	$15 per visit	30% co-insurance after deductible
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER		
Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year.		
Applied Behavioral Analysis (ABA)	$15 per visit	30% co-insurance after deductible
Physical, Speech, Occupational Therapy	$15 per visit	30% co-insurance after deductible
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$15	30% of charges
Preferred Brand	$25	30% of charges
Non-Preferred Brand	$35	30% of charges
SPECIALTY (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY)		
Generic	$10.00	30% of charges
Preferred Brand	$16.66	30% of charges
Non-Preferred Brand	$23.33	30% of charges
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$30	30% of charges
Preferred Brand	$50	30% of charges
Non-Preferred Brand	$70	30% of charges
Generic: medication on the Prescription medication list - **Preferred Brand**: medication designated as preferred on the prescription medication list with no Generic equivalent - **Non-Preferred Brand**: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.		
* Member may be responsible for all Out-Of-Network charges in excess of the Maximum Allowable Payment (MAP).		
** There is no co-payment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).		

2014 Benefits Summary

AVMED HMO PLANS

This Schedule of Benefits reflects the higher provider and prescription co-payments for 2014. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/go/mdpht.

SCHEDULE OF BENEFITS	AVMED HMO HIGH COST TO MEMBER	AVMED HMO LOW COST TO MEMBER
LIFETIME MAXIMUM	Unlimited	Unlimited
CALENDAR YEAR DEDUCTIBLE		
Individual /Family	Not Applicable	Not Applicable
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual	$1,500	$6,350
Family	$3,000	$12,700
PRIMARY CARE PHYSICIAN		
Routine office visits	$15 per visit	$30 per visit
Preventive care-routine physicals/pediatric well baby care (and other preventive services required by the Patient Protection Affordable Care Act "PPACA")	No Charge	No Charge
Pediatrician	$15 per visit	$30 per visit
SPECIALIST'S SERVICES	Open Access	Referral Required For Most Services
Office Visits	$30 per visit	$45 per visit
Annual gyn exam when performed by participating specialist	No Charge	No Charge
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	$45 per visit
Subsequent visits	No charge	No charge
ALLERGY TREATMENTS		
Allergy Injections	$15 per visit	$30 per visit
Skin testing (per course of treatment)	$30 per visit	$45 per visit
HOSPITAL SERVICES - Inpatient care at participating hospitals includes:		
Room and board - unlimited days (semi-private)	No charge	$150 per day for the first 3 days, per admission. No charge thereafter.
Physicians', specialists' and surgeons' svces	No charge	
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication	No charge	
Intensive care unit and other special units, general and special duty nursing	No charge	
Laboratory and diagnostic imaging	No charge	

2014 Benefits Summary

AVMED HMO PLANS - SCHEDULE OF BENEFITS		
SCHEDULE OF BENEFITS	AVMED HMO HIGH	AVMED HMO LOW
	COST TO MEMBER	COST TO MEMBER
CHIROPRACTIC	$15 per visit	$30 per visit
PODIATRY	$15 per visit	$30 per visit
OUTPATIENT SERVICES		
Outpatient surgeries, including cardiac catheterizations and angioplasty	No charge	No charge
OUTPATIENT DIAGNOSTIC TESTS		
Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging) Mammogram	No charge	No charge
Other diagnostic imaging tests and Laboratory	No charge	No charge
Mammogram	No charge	No charge
EMERGENCY SERVICES		
An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care.	Co-payment waived if admitted. Plan must be notified within 24 hours of emergency inpatient admission.	Co-payment waived if admitted. Plan notification required within 24 hours of emergency inpatient admission.
Emergency svces at participating hospitals	$25 co-payment	$100 co-payment
Emergency services - non-participating hospitals, facilities and/or physicians	$25 co-payment	$100 co-payment
URGENT /IMMEDIATE CARE		
Medical Services at a participating Urgent/Immediate Care facility or svces rendered after hours in your Primary Care Physician's office	$25 co-payment	$50 co-payment
Medical Services at a participating retail clinic	$15 co-payment	$30 co-payment
Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic	$50 co-payment	$50 co-payment
AMBULANCE		
When pre-authorized or in the case of emergency	No charge	No charge
DRUG AND ALCOHOL REHABILITATION PROGRAMS		
Outpatient	$15 per visit	$30 per visit
Inpatient	No charge	$150 per day, first 3 days p/admission. No charge thereafter.
MENTAL / NERVOUS DISORDERS		
Outpatient	$15 per visit	$30 per visit
Inpatient	No charge	$150 per day, first 3 days p/admission. No charge thereafter.
Inpatient	No charge	$150 per day, first 3 days p/admission. No charge thereafter.

2014 Benefits Summary

AVMED HMO PLANS - SCHEDULE OF BENEFITS

SCHEDULE OF BENEFITS	AVMED HMO HIGH COST TO MEMBER	AVMED HMO LOW COST TO MEMBER
PHYSICAL, SPEECH, RESPIRATORY & OCCUPATIONAL THERAPIES		
Short-term Physical, Speech, Respiratory and Occupational therapy for acute conditions. Coverage is limited to 60 visits combined per Calendar year	$30 per visit	$45 per visit
DURABLE MEDICAL EQUIPMENT Equipment includes but not limited to: Hospital beds, walkers, crutches,wheelchairs	$50 per episode of illness	$50 per episode of illness
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER		
Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year.		
Applied Behavioral Analysis (ABA)	$15 per visit	$30 per visit
Physical, Speech, Occupational Therapy	$15 per visit	$30 per visit
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$15 co-payment	$20 co-payment
Preferred Brand	$25 co-payment	$35 co-payment
Non-Preferred Brand	$35 co-payment	$55 co-payment
NOTE: Specialty Drugs (example: self injectables, etc.) - Available only on a 30-day supply basis from a specialty pharmacy for the applicable copayment.		
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$30 co-payment	$40 co-payment
Preferred Brand	$50 co-payment	$70 co-payment
Non-Preferred Brand	$70 co-payment	$110 co-payment
DEFINITIONS: Generic - medication on the Prescription medication list. Preferred Brand - medication designated as preferred on the prescription medication list with no Generic equivalent. Non-Preferred Brand - medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.		
BRAND ADDITIONAL CHARGE - When Brand is requested and a generic equivalent is available: Member pays the difference between the cost of the Brand medication and Generic medication, plus the Non-Preferred Brand co-payment.		
❋ There is no co-payment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).		
PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO: All Inpatient Services, Observation Services, Residential Treatment, Outpatient Surgery, Intensive Outpatient Programs, Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging), Non-Emergency Ambulance, Dialysis Services, Transplant Services, use of Non-Participating Providers, Select Medications Including Injectables		

Dental Plan Comparison

SCHEDULE OF BENEFITS	Delta Standard Plan Pays	Delta Enriched Plan Pays
CHOICE OF DENTIST	Choose any dentist you wish for services and receive applicable benefits. Save the most with a Delta Dental PPO network participating dentist. Percentages below are based on Delta's applicable allowances and not the dentist's actual charge. Payments to non-Delta Dental dentists are based on the PPO fee schedule.	
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	100%	100%
0120 Periodic Oral Exam	100%	100%
X-rays	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1203 Fluoride Treatment (children up to the age 19)	100%, 2x per year	100%, 2x per year
1351 Sealant - per tooth	100% to age 16	100% to age 16
1510 Space Maintainers	100% to age 19	100% to age 19
TYPE II		
Fillings:		
2330 - One Surface	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2331 - Two Surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2332 - Three Surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2335 - Four Surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP
2390 - Resin Crown, Anterior	100% PDP/ 75% Non PDP (1 per tooth / 24 mo.)	100% PDP/ 75% Non PDP (1 per tooth / 24 mo.)
2394 - Resin, Four Or More Surfaces	100% PDP/ 75% Non PDP (1 per tooth / 24 mo.)	100% PDP/ 75% Non PDP (1 per tooth / 24 mo.)
Root Canals:		
3310 - Anterior	75%	75%
3320 - Bicuspid	75%	75%
3330 - Molar	75%	75%
3410 - Apicoectomy	75%	75%
Extractions:		
7111 - Single Tooth	75%	75%
7140 - Extraction, erupted tooth or exposed tooth	75%	75%
7210 - Surgical Extraction of erupted tooth	75%	75%
Periodontics: (gum treatment)		
4341 - Periodontal Scaling & Root Planning - per quadrant	75%	75%
4210 - Gingivectomy / Gingivoplasty - per quadrant	75%	75%
4910 - Periodontal Maintenance Procedures	75%	75%
TYPE III		
Crown & Bridge		
2930 - Prefabricated Stainless Steel Primary Tooth	50%	50%
2791 - Crown Full Cast Predominately Base Metal	50%	50%
2750 - Crown Porcelain Fused to High Noble Metal	50% (1 per tooth within a 5 year period)	50% (1 per tooth within a 5 year period)
2751 - Crown Porcelain Fused to Base Metal	50%	50%
Pontics:		
6210 - Full Cast	50%	50%
6240 - Porcelain Fused to Metal	50%	50%
6750 - Crown Porcelain Fused to High Noble Metal	50% (1 per tooth within a 5 year period - age 16+)	50% (1 per tooth within a 5 year period - age 16+)
Prosthodontics:		
5110 - Complete Upper	50%	50%
5120 - Complete Lower	50%	50%
5213/14 - Partial Upper/ or Lower - Cast Metal Base	50%	50%
ORTHODONTIA		
Consultation	Not Covered	Adults & Children covered at 50% after one-time deductible of $50 per person. $1,000 Lifetime Maximum.
Evaluation	Not Covered	
Records	Not Covered	
Children - Normal Class II	Not Covered	
Adult - Normal Class II	Not Covered	
8750 - Retention	Not Covered	

*All Type II and III charges subject to annual

*The above reimbursements are exclusive of gold.

Benefits Comparison Chart

Dental Plan Comparison

Benefits Comparison Chart

SCHEDULE OF BENEFITS	MetLife DHMO (SafeGuard)		Humana OHS	
CHOICE OF DENTIST	Limited to participating Dentists within the DHMO Network.		Limited to participating Dentists in Private Practice.	
MAXIMUM BENEFIT / DEDUCTIBLE	No Maximum / No Deductible		No Maximum / No Deductible	
	Standard *You Pay	Enriched *You Pay	Standard *You Pay	Enriched *You Pay
TYPE I				
0150 Comprehensive Oral Evaluation -New or Estab.	No Charge	No Charge	No Charge	No Charge
0120 Periodic Oral Exam	No Charge	No Charge	No Charge	No Charge
X-rays	No Charge	No Charge	No Charge	No Charge
1110/20 Prophylaxis	No Charge (2/12mo)	No Charge (2/12 mo)	No Charge (1/6 mo.)	No Charge (1/6 mo.)
	$15 ea. (2 add'l/12 mo)	$14ea. (2 add'l/12 mo)		
1203 Fluoride Treatment (children to age 19)	No Charge	No Charge	No Charge	No Charge
1351 Sealant - per tooth	No Charge	No Charge	$ 6.00	No Charge
1510 Space Maintainers	$25.00	No Charge	$40.00	No Charge
			No Charge	
TYPE II				
Fillings: (silver)				
2330 - One Surface	$10.00	No Charge	$10.00	No Charge
2331 - Two Surfaces	$18.00	No Charge	$18.00	No Charge
2332 - Three Surfaces	$23.00	No Charge	$23.00	No Charge
2335 - Four Surfaces	$25.00	No Charge	$60.00	$60.00
2390 - Resin Crown, Anterior	$30.00	$30.00	$90.00	$90.00
2394 - Resin, Four Or More Surfaces, Posterior	$65.00	$65.00	$130.00	$130.00
Root Canals:				
3310 - Anterior	$90.00	$45.00	$90.00	$45.00
3320 - Bicuspid	$155.00	$90.00	$155.00	$90.00
3330 - Molar	$200.00	$145.00	$200.00	$145.00
3410 - Apicoectomy	$75.00	$65.00	$75.00	$65.00
Extractions:				
7111 - Single Tooth	No Charge	No Charge	No Charge	No Charge
7140 - Extraction, erupted tooth or exposed tooth	No Charge	No Charge	No Charge	No Charge
7210 - Surgical Extraction of erupted tooth	$15.00	No Charge	$15.00	No Charge
Periodontics: (gum treatment)				
4341 - Periodontal Scaling & Root Planning - per quadrant	$40.00	$40.00	$40.00	$40.00
4210 - Gingivectomy / Gingivoplasty - per quadrant	$120.00	$90.00	$120.00	$90.00
4910 - Periodontal Maintenance Procedures	$25.00//ea (2/12 mo)	$25.00	$25.00	25% Discount
TYPE III				
Crown & Bridge				
2930 - Prefabricated Stainless Steel Primary Tooth	$25.00	No Charge	$25.00	No Charge
2791 - Crown Full Cast Predominately Base Metal	$210.00	$175.00	$210.00*	$175.00*
2750 - Crown Porcelain Fused to High Noble Metal	$290.00	$290.00	$275.00 + Lab Fees	$275.00 + Lab Fees
2751 - Crown Porcelain Fused to Base Metal	$210.00	$175.00	$210.00	$175.00
Pontics:				
6210 - Full Cast	25% Discount	25% Discount	25% Discount*	25% Discount
6240 - Porcelain Fused to Metal	25% Discount	25% Discount	25% Discount*	25% Discount
6750 - Crown Porcelain Fused to High Noble Metal	$290.00	$290.00	$275.00 + Lab Fees	$275.00 + Lab Fees
Prosthodontics:				
5110 - Complete Upper	$230.00	$205.00	$230.00	$205.00
5120 - Complete Lower	$230.00	$205.00	$230.00	$205.00
5213/14 - Partial Upper/ or Lower - Cast Metal Base	$245.00	$240.00	$275.00	$240.00
ORTHODONTIA				
Consultation	25% Discount	No Charge	25% Discount	No Charge
Evaluation	25% Discount	No Charge, (D8660)	25% Discount	$25.00
Records	25% Discount	$250.00	25% Discount	$200.00
Children - Normal Class II	25% Discount	$1400.00	25% Discount	$1400.00
Adult - Normal Class II	25% Discount	$1950.00	25% Discount	$1950.00
Retention	25% Discount	$300.00 (D8680)	25% Discount	25% Discount
	Additional Costs: High Noble Metal fees capped at $150 per crown. Porcelain fees capped at $75 per crown.		Cost of High Noble Metal additional.	
	Self Referral Plan: The following co-payments apply only when services are performed by your selected SafeGuard dentist. If you choose to receive services from a SafeGuard contracted dentist whose practice is limited to specialty care (periodontics, oral surgery, endodontics, pedodontics, orthodontics), your co-payment will be 75% of that dentist's usual fee for those services	Direct Referral Plan: During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist. Your selected general dentist may refer you directly to a contracted SafeGuard specialty care provider; no referral or pre-authorization from SafeGuard is required	Humana OHS does not require prior authorization or referrals to seek treatment with a participating Humana OHS Specialist.	

2014 MONTHLY PREMIUM RATES
FOR RETIREES UNDER AGE 65

MEDICAL INSURANCE

Monthly Rates for:	AvMed POS	AvMed High Opt HMO	AvMed Low Opt HMO
Retiree Only	$ 1,052.74	$ 432.10	$ 406.96
Retiree & Spouse/Domestic Partner Under 65	$ 2,039.94	$ 975.50	$ 919.01
Retiree & Child(ren)	$ 1,971.83	$ 897.89	$ 845.87
Retiree & Spouse/Domestic Partner Under 65, plus Child(ren)	$ 2,468.52	$ 1,210.75	$ 1,140.71

Retiree Under 65 & Spouse/Domestic Partner Medicare Eligible	AvMed POS	AvMed HMO HO
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible - High Opt Plan	$ 1,598.61	$ 977.97
Retiree under 65 & Spouse/Domestic Partner over 65 and/or Medicare Eligible - No RX Plan		$ 669.37

Additional rates/options available upon request.

DENTAL INSURANCE

Monthly Rates for:	Delta Dental Plan		MetLife* DHMO (Safeguard)		Humana* - Oral Health Services	
	Standard	Enriched	Standard	Enriched	Standard	Enriched
Retiree Only	$ 31.22	$ 40.87	$ 8.70	$ 12.67	$ 8.00	$ 14.82
Retiree & one dependent	$ 61.76	$ 80.81	$ 14.38	$ 21.00	$ 13.23	$ 24.57
Retiree & dependents	$ 99.55	$130.30	$ 22.01	$ 33.38	$ 20.22	$ 39.02

** Metlife DHMO and Humana OHS plans are not available outside Miami-Dade, Broward & Palm Beach Counties*

LIFE INSURANCE

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 2014 rate is 17 cents per thousand dollars per month.

Example: Annual Salary $30,000.00 x 0.00017 = $5.10 monthly premium.

Your Life Insurance coverage is reduced to either $15,000.00 or $20,000.00 when you reach age 65.

New Retiree Checklist

1. ☐ If you (or your covered dependent) are age 65 or Medicare eligible, please contact the Social Security Office to activate your Medicare benefits 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 schedule an appointment with a 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.

3. ☐ Obtain the Retiree Insurance Benefits Handbook and Retiree Group Health Plan Election Form online at http://www.miamidade.gov/humanresources/retirees.asp . Review the information provided in Retiree Handbook 1, for retirees under age 65, or Retiree Handbook 2 for retirees over age 65, or Medicare eligible.

4. ☐ Contact Benefits Administration at 305-375-4161 to make an appointment at least two months prior to your retirement date, or if you are requesting medical, dental, and/or basic life insurance coverage under the Retiree Group, submit your election form to Benefits Administration 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 pension benefit. 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. This option is available to Investment Plan Members if the premiums do not exceed the value of the Health Insurance Subsidy.

6. ☐ Update the Life Insurance Beneficiary Designation Form, if enrolling for life insurance.

7. ☐ The Florida Retirement System (FRS) will mail you a Health Insurance Subsidy (HIS) Certification Form approximately 8 weeks after your retirement. The subsidy will be added to your monthly pension benefit (minimum $30.00, maximum $150.00 per month).

    a. If you are enrolled in Medicare, 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 and B.

    b. If you elected medical and/or dental coverage through the Retiree Group, complete your portion of the HIS form and forward to Benefits Administration for certification and processing.

(Continued)

New Retiree Checklist

(Continued)

The FRS will also mail you a Direct Deposit Authorization Form and a Federal Tax Deduction Authorization Form (W-4P). Please follow their instructions to return these forms to the FRS.

8. ☐ 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, adoption/ placement for adoption).

Notes

Miami-Dade County • Benefits Section • 111 NW 1st Street, Suite 2340 • Miami, Florida 33128-1979

http://www.miamidade.gov/humanresources/retirees.asp.