Benefits & You

2015 OPEN ENROLLMENT NEWSLETTER

A Special Benefits Edition for the Employees of Miami-Dade County • http://enet.miamidade.gov • October 2014

SNAPSHOT

Attend a Benefit Fair
Oct. 27 - Nov. 20, 2014

Enroll Online
*Oct. 27 – Nov. 14, 2014
*Non-Bargaining, AFSCME Aviation, AFSCME General,AFSCME Solid Waste, GSAF, and IAFF
**Nov 17 – Dec. 4, 2014
**All other unions not listed above. These dates are tentative.

Enrollment Website
http://enet.miamidade.gov

New Elections are Effective
January 1, 2015

INSIDE THIS ISSUE

Open Enrollment Is Here

Open Enrollment is your annual opportunity to review and update your benefit elections for the upcoming year. All employees must make an important decision regarding their medical plan for 2015. Even if you decide to stay with the same plan, you will still be required to access the online web enrollment and confirm your medical plan election. Use the enrollment website to:

1. Enroll in a new benefit plan, change or confirm current 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 2015?

Miami-Dade County is committed to improving the benefit plans and providing options to employees and their families. For 2015, employees will be making an important decision regarding their medical coverage and evaluating the plan design that most closely meets their needs.

Every effort was made to bring you the most current information available as of this newsletter's print date. Any subsequent changes to employee benefits for 2015 will be posted online at **www.miamidade.gov/benefits**.

New Plans in 2015

A new Select Network HMO option will be offered to non-bargaining employees and eligible bargaining unit employees in accordance with their respective Collective Bargaining Agreement.

A new MetLife Vision Plan with enhanced benefits will replace the current Optix Vision Plan. Refer to page 7 for additional information.

2015 Premiums

Premiums are listed on page 2 for non-bargaining unit employees and for those employees whose unions have incorporated Benefits Redesign in their current Collective Bargaining Agreements.

For those employees who are covered by a collective bargaining agreement for which tentative agreements have not yet been reached, premium contributions are listed on page 5.

The good news is that rates for Delta Dental, Humana Dental, MetLife Disability, MetLife Optional Life and the ARAG Legal Plan will remain flat (no increase). The vision plan rates will be reduced by 7%. The 2015 MetLife DHMO Dental Plan rates will increase 15%.

Continued on page 2

MIAMI-DADE COUNTY

What's New for 2015?

Continued from page 1

New Select Network HMO & Plan Redesign

Who is Eligible? Non-Bargaining Employees and Eligible Bargaining Unit Employees in Accordance With Their CBA.

Who is eligible for the NEW MDC Select Network HMO Plan? The Select Network Plan will be a new plan option in 2015 for employees living in Miami-Dade, Broward, or Palm Beach Counties. The plan will be offered to non-bargaining unit employees and eligible bargaining unit employees according with their respective Collective Bargaining Agreement.

What do plan design changes mean to me? The New MDC Select Network HMO is just one plan option. The Point of Service (POS) and High Option HMO plans will also continue to be offered in 2015. Please review the three plan options on the next page and decide which one closest matches your needs. The Low Option HMO will not be offered to this group in 2015.

Just remember that the services you use the most will remain unchanged. There is NO increase to physician copays, generic pharmacy copays or Urgent Care Center visits. The design changes are being implemented to direct members to more cost efficient services to reduce healthcare costs.

What are the differences between the New MDC Select Network HMO Plan and the High Option HMO? The Select Network Plan has the same benefits (copays) as those currently offered in the (2014) High Option HMO plan, except for the Emergency Room copay. The main difference is that the Select Plan was designed with a smaller (select) network of providers in Miami-Dade, Broward and Palm Beach Counties. The reduced network resulted in cost savings that are being passed on to employees in the form of lower dependent premiums. Refer to chart below for the applicable copayments. The amounts highlighted reflect changes for 2015.

Medical Rates

Refer to page 6 for all other 2015 plan rates.

TIER LEVEL	AVMED POS	AVMED HMO HIGH OPT	AVMED SELECT NETWORK
EMPLOYEE ONLY	$100.00	$75.00	$0.00
EMPLOYEE + CHILD (REN)	$285.86	$180.17	$141.00
EMPLOYEE + SPOUSE	$344.54	$208.35	$166.00
EMPLOYEE + FAMILY	$595.59	$287.77	$236.00

New Select Network HMO Copayments

2015 PLAN DESIGN	2015 COPAYS HIGH HMO / POS	2015 COPAYS NEW SELECT PLAN
Inpatient Hospital Copay per Admit*	$200	$0
Emergency Room Copay	$100	$50
Urgent Care Copay	$25/ $50	$25
Outpatient Hospital Copay*	$100	$0
Freestanding Diagnostic Center Copay	$0	$0
Ambulatory Surgical Center Copay	$0	$0
Physician Copays (PCP/Specialist)	$15/$30	$15/ $30
Retail Pharmacy Copays (Generic/Pref Brand/Non-Pref Brand)	$15/ $40/ $55	$15/ $25/ $35
Mail Order Pharmacy Copays (Generic/Pref Brand/Non-Pref Brand)	$30/ $80/ $110	$30/ $50/ $70
Specialty Pharmacy Copay HMO) Specialty Pharmacy Copay (POS)	$100	$15/ $25/ $35
**Out-Of-Pocket Maximum – Individual (2x for dependent)	$3,000	$2,500

*Copay waived at Jackson Health System Facility

**In 2015, pharmacy copays will count towards the Out-of-Pocket maximum

Note: Diagnostic Tests & Imaging (x-ray, blood work, CT, MRI, etc.) Outpatient $100 copay will apply, if test conducted at a hospital affiliated facility. No copay if conducted at Jackson or non-hospital facility.

Benefits Redesign and Select Network Frequently Asked Questions (FAQ's)

Q: How do I know if my physician is in the Select Network?

A: Go to **http://avmed.prismisp.com/?tab=doctor&plan=jhs&visitor=member** and perform a physician search.

For the best search results, enter the doctor's specialty or category of Primary Care Physician to enhance the search results. You may also search by city, state, or zip code without specifying the doctor's name.

- If you enter the doctor's name alone and do not spell it correctly you may not get the desired results.
- As a result of additional enhancements to the MDC Select Network, additional doctors may be added to the directory.

If you have any questions or are having difficulty with the search, please contact the AvMed Dedicated Service Unit at 1-800-682-8633, 24 hours a day, 7 days a week.

Q: What if my physician is not in the Select Network... can he/she be added?

A: In order to be in the Select Network, the physician must be an AvMed contracted physician and have privileges at a participating Select Hospital. A physician may decide to apply for "privileging" at a participating Select Hospital in order to become part of the Network.

Q: If I choose the Select Network Option, can I receive services at an out-of-network provider/physician?

A: No. You must use participating providers and facilities for non-emergency services. In order to receive services from out-of-network providers you need to choose the Point of Service (POS) plan.

Q: Are the participating Pharmacies and Urgent Care Centers still the same under the Select Network?

A: Yes.

Q: My child attends college outside of the tri-county area. Will the Select Network Option cover medical services outside of the tri-county area?

A: Yes. During Open Enrollment (or at the time your child is scheduled to go away to college) you must complete an "Away from Home" form and submit to AvMed. Download the form from **www.avmed.org/mdc**. The "Away from Home" program allows college students with a temporary arrangement to be able to receive services while away at college.

Q: I will be traveling outside of AvMed's service area, what kind of coverage will I have while I'm gone?

A: While you are traveling outside of AvMed's service area, you will only be covered for emergency services, unless you are enrolled have out of network benefits (Point of Service (POS) option).

Q: Is it true that the Benefits Redesign will be providing employees with "less generous" benefits?

A: The actuarial value of a health plan is a measure of the percent of in-network services that are covered under the plan design that are paid by the plan (Miami-Dade County) rather than the employee. A plan with an actuarial value of 90% (a **"platinum"** plan under the Affordable Care Act (ACA) definition) would cover, on average, 90% of the cost of in-network services, meaning that the member would pay, on average, 10% of the cost in the form of copays, deductibles, and co-insurance. Currently (in 2014), the High HMO and POS plans are at the "platinum" level. **All three options included in the Benefits Redesign which will be available to employees in 2015 will remain at a "platinum" level**

Q: What hospitals are in the Select Network?

A: The following hospitals are included in the Select Network:

Miami-Dade County	Broward County	Palm Beach County
Baptist Hospital of Miami	Broward Health Medical Center	Bethesda Hospital West
Doctor's Hospital	Chris Evert Children's Hospital	Bethesda Memorial Hospital
Holtz Children's Hospital	Holy Cross Hospital	Boca Raton Regional Hospital
Homestead Hospital	Joe DiMaggio Children's Hospital	Palms West Hospital
Jackson Memorial Hospital	Memorial Hospital West	West Palm Hospital
Jackson South Community Hospital	Memorial Hospital Miramar	
Jackson North Hospital	Memorial Hospital Pembroke	
Kendall Regional Medical Center	Memorial Regional Hospital	
Miami Children's Hospital – NEW in 2015 for MDC	Memorial Regional Hospital South	
Mt. Sinai Medical Center	Northwest Medical Center	
South Miami Hospital		
University of Miami Hospital - NEW in 2015 for MDC		
Sylvester Comprehensive Cancer Center		
Bascom Palmer Eye Institute		
West Kendall Baptist Hospital		

Q: Where can I find more frequently asked questions?

A: Visit the Human Resources web page at: **http://www.miamidade.gov/humanresources/open-enrollment.asp**

No Plan Redesign

As of October 20, 2014, **AFSCME 121 (Water and Sewer), Police Benevolent Association (PBA) (Rank and File and Supervisory Units) and the Transport Workers Union (TWU)** do not have tentative agreements with the County with regards to healthcare redesign and will therefore be offered the same benefit options currently offered in 2014 (No Plan Redesign). The current medical plan options (POS, High Option HMO, Low Option HMO) will still be available. The POS single premium and dependent premiums for the POS, High HMO and Low HMO Plans will increase by 10% as noted in the chart below.

Medical Rates

Refer to page 6 for all other 2015 plan rates.

TIER LEVEL	AVMED POS	AVMED HMO HIGH OPT	AVMED HMO LOW OPT
EMPLOYEE ONLY	$16.39	$0.00	$0.00
EMPLOYEE + CHILD (REN)	$314.45	$198.19	$186.81
EMPLOYEE + SPOUSE	$378.99	$229.19	$216.06
EMPLOYEE + FAMILY	$655.15	$316.55	$298.50

2015 Copayment Schedule – No Plan Redesign:

PLAN DESIGN	POS	HIGH OPTION HMO	LOW OPTION HMO
Inpatient Hospital Copay per Admit	$0	$0	$150 \1st 3 days
Emergency Room Copay	$50	$25	$100
Urgent Care Copay	$50	$25	$50
Outpatient Hospital Copay	$0	$0	$0
Freestanding Diagnostic Center Copay	$0	$0	$0
Ambulatory Surgical Center Copay	$0	$0	$0
Physician Copays (PCP/Specialist)	$15/ $30	$15/ $30	$30/ $45
Retail Pharmacy Copays	$15/ $25/ $35	$15/ $25/ $35	$20/ $35/ $55
Mail Order Pharmacy Copays	$30/ $50/ $70	$30/ $50/ $70	$40/ $70/ $110
Specialty Pharmacy Copay	$10/ $16.66/ $23.33	$15/ $25/ $35	$20/ $35/ $55
*Out of Pocket Maximum (Single\dependent)	$1,500/ $4,500	$1,500/ $3,000	$6,350/ $12,700
*Out of Pocket Maximum - Pharmacy (Single\Family)	$1,500/ $3,000	$1,500/ $3,000	
* In 2015, pharmacy copays will count towards the Out of Pocket expenses for in network services			

2015 Biweekly Cost – All Employees

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	$3.15	$2.42	$7.65	$5.64	$14.32
METLIFE DHMO	Prepaid Dental	$.00	$2.10	$3.01	$6.52	$7.06	$13.10

Other Plan Rates

METLIFE VISION PLAN		ARAG LEGAL PLAN		FLEXIBLE SPENDING ACCOUNTS (FSA) Administrative Fees Per Pay Period	
EMPLOYEE ONLY	$1.91	EMPLOYEE ONLY	$7.29	Healthcare FSA Only	$1.98
EMPLOYEE + 1	$3.83	EMPLOYEE + 1	$9.34	Dependent Care FSA Only	$1.98
EMPLOYEE + FAMILY	$7.03	EMPLOYEE + FAMILY	$9.61	Both Health & Dependent Care	$1.98

METLIFE STD	Premium Per $100 Weekly Benefit
Low Option ($500 max weekly benefit)	$1.20
High Option ($1,000 max weekly benefit)	$1.20

METLIFE LTD	Premium Per $100 of Covered Monthly Payroll
Low Option ($2,000 max monthly benefit)	$0.192
High Option ($4,000 max monthly benefit)	$0.230
Premier LTD ($7,000 max monthly Benefit)	$0.320

Imputed Income

The Internal Revenue Service (IRS) allows "tax free" health insurance subsidies for employees and their eligible dependents as defined under IRS guidelines, but excludes amounts attributable to coverage of adult children above age 26, a domestic partner (DP), and dependents of a domestic partner. 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 additional information regarding imputed income tax. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

What's New for 2015?

Continued from page 2

MetLife Vision Plan

Regular visits to your eye care professional can do more than just protect your eyesight — they can help protect your overall health. Through a routine exam, eye doctors can spot serious health problems like diabetes, high blood pressure, heart disease, certain cancers and more. That's where a good vision plan steps in to support you— it can help significantly lower your costs and make it easier to get the care you need. The new **MetLife Vision plan includes the same benefits as the current plan, plus enhancements to help reduce copayment expense.** The plan is simple and convenient to use. There are no claim forms to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service. To find a participating vision specialist call 877) 638-2055, or go to: **www.metlife.com/mybenefits**

VISION SERVICES	OUT OF POCKET COSTS WITH METLIFE VISION	*OUT OF POCKET COSTS WITHOUT INSURANCE
Eye exam	No copayment	$140
Glasses	$10 copayment	N/A
Frame	$0	$130
Lenses (Single Vision)	$0	$84
Ultraviolet coating	$0	$23
Polycarbonate lenses	$0	$52
Annual Premium (single coverage)	$50	N/A
Total Cost of Services	$60	$429

*Out of pocket cost (without insurance) is based on national averages.

New Plan Enhancements:

- This plan allows the purchase of new frames once every 12 months instead of 24 months.
- Out of network allowance for bifocal lenses increased from $50 to $60 and for trifocal lenses from $60 to $80.
- Panel frame allowance increased from $117 to $160
- Dependent children covered to age 26.

For additional information, go to **www.miamidade.gov/benefits.**

Important Note: The Humana Optix Vision Plan will terminate effective December 31, 2014. If you have been using out-of-network vision services, please submit your claim to the Optix Vision Plan as soon as possible. Download an Optix claim form: **www.compbenefits.com/custom/miamidade/**

Healthcare Reform in 2015 - How does it impact you?

Who is a "Variable Hour" Employee (VHE) under the Affordable Care Act?

As a result of the Affordable Care Act (ACA), you may now be eligible for health benefits, depending on the number of hours you work. Under the ACA rules, full-time employees are generally defined as those who work on average at least 30 hours per week. A variable hour employee (VHE) is defined as someone whom the employer cannot reasonably determine the number of hours to be worked per week at the time of hire. ACA's employer shared responsibility rules require large employers (50 or more full-time and full- time equivalent employees) to provide affordable minimum essential health insurance coverage to at least 70% of full-time employees or face financial penalties. This mandate becomes effective **January 1, 2015.**

If you are a variable hour employee *hired prior to **October 14, 2013** and averaged at least 30 hours per week during the measurement period ending **October 12, 2014**, you may be eligible for medical coverage effective January 1, 2015.

VHE Standard Measurement Period	**October 14, 2013 - October 12, 2014**
VHE Enrollment Window	**Oct. 27 – Nov. 14, 2014** Non-Bargaining, AFSCME Aviation, AFSCME General, AFSCME Solid Waste, GSAF, and IAFF **Nov 17 (Tentative) – December 4, 2014** All other unions not listed above
Coverage	**January 1 – December 31, 2015**

* Employees hired after October 14, 2013 are subject to an individual measurement period of 26 pay periods from their hire date.

Department Personnel Representatives (DPRs) are responsible for tracking their "variable hour" employees' work hours during the established measurement period to determine if the employee meets the definition of "full time" as defined under the Affordable Care Act. The DPR will also notify employees when they reach eligibility for benefits and provide instructions on how to enroll for health insurance coverage online.

If you have met the eligibility criteria for health benefits, as defined by ACA, logon to eNet **(http://enet.miamidade.gov)** and use the New Hire Benefits Enrollment link on the Secure eNet Services Menu to enroll. Do not use the 2015 Open Enrollment website to enroll for benefits. Contact your DPR if you have any questions.

Online Enrollment Overview

For the 2015 Open Enrollment, participation is very important. Please take this opportunity to review your current plan elections and decide if they still meet your needs. Employees may change existing elections, add coverage or simply confirm that you wish to remain with the same plan. To use the online web enrollment go to **http://enet.miamidade.gov**. Contact your Department Personnel Representative (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 24/7 during the Open Enrollment period. Refer to page 1 for exact dates.

Before You Start Your Online 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 2015 depends on your bargaining unit, refer to page 1. 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.

Assistance for Employees Without Computer or Internet Access

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

Checklist For Online Enrollment

Obtain this information before you begin:

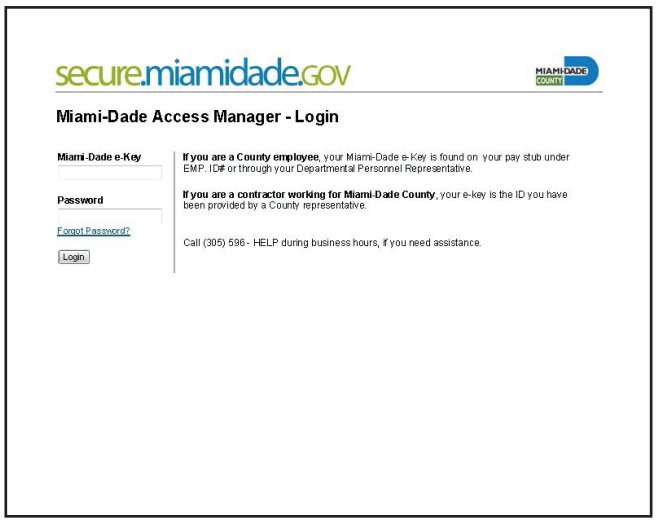
- Your eNet User ID and Password
- Name of Dependent (s) to be added
- Dependent's Date of Birth & Social Security Number
- Primary Care Physician (PCP) *– Only if enrolling in the AvMed Low Option HMO*
- Participating Dental Provider (PDP)* – Only if selecting MetLife DHMO or Humana-OHS Dental Plans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

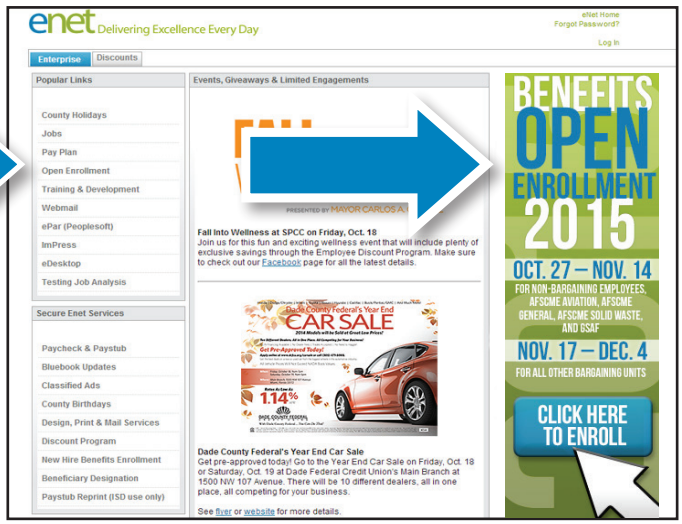
Participating Dental Provider (PDP)

Reporting your PDP once, when initially enrolling in a pre-paid dental plan (MetLife DHMO, OHS Dental), is sufficient. Do not reconfirm provider information on the online enrollment website every year. Repeating may lead to unintentional consequences, if you enter an incorrect ID the second time around. The field is blank because PDP numbers are not retained in our database from one open enrollment to another, but the insurance carrier will have the most current information.

Logon Instructions

The 2015 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.

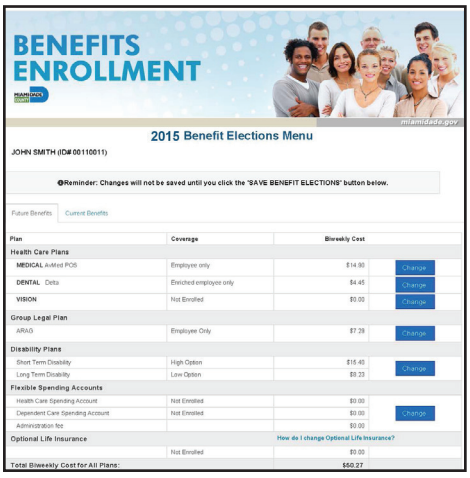




Once you are in eNet, click the 2015 Open Enrollment link or banner to begin your enrollment.

Step 1

On the Benefit Election Menu, each benefit plan will have a "CHANGE" button next to it. Select the plan you wish to modify. The appropriate benefit plan page will open to allow you to make change(s).



Special Note

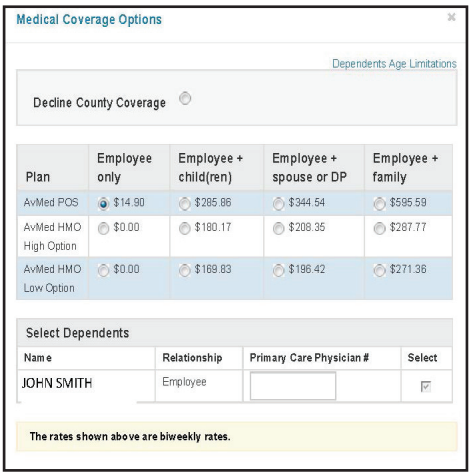
Medical, Dental and Vision Plan Screens:

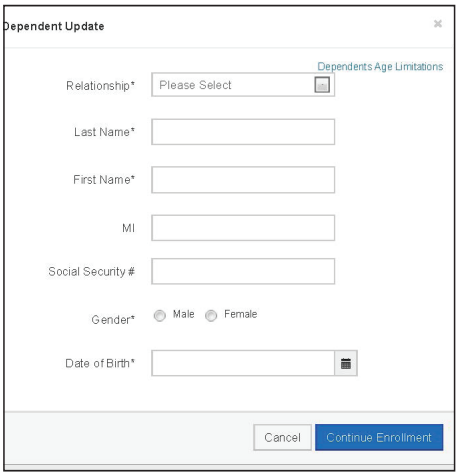
You may add a dependent at the same time directly on the medical, dental or vision plan screens, by clicking the ADD DEPENDENT button. Fill in the dependent information in the pop-up screen. Click the "CONTINUE ENROLLMENT" button to return to the plan page. The newly added dependent will show in the dependent section. To facilitate enrollment, the dependent information will also display in the other two plans (medical, dental or vision), but the dependent enrollment is not activated until you click the box next to the name.

To cancel a dependent's coverage simply deselect the check mark next to the dependent's name on the plan page. Remember that the level of coverage selected must match the number of dependents enrolled.

Step 2

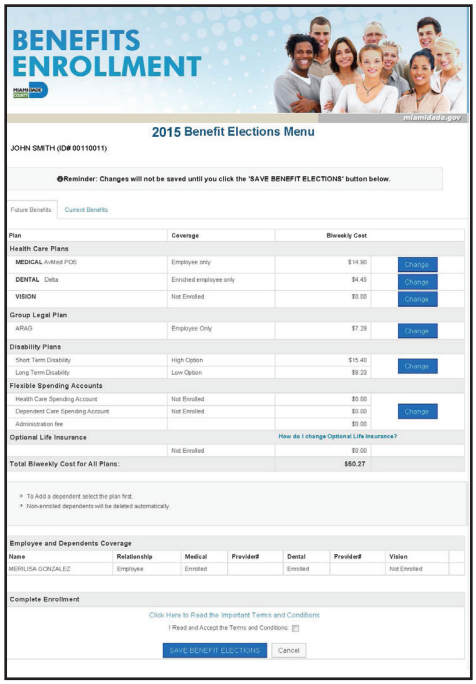
Select your plan or enrollment option and click the "CONTINUE ENROLLMENT" button to return to the Benefit Elections Menu. Repeat this process for each benefit election to be changed.





Step 3

When you are satisfied with your 2015 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 2015 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 prior to the deadline.



Open Enrollment Benefit Fairs

October 27 - November 20, 2014

Representatives from the Group Medical, Dental, Vision, Disability Income Protection, Group Legal and Deferred Compensation Plans will be available to answer questions on the dates and locations listed below:

DATE	SITE	LOCATION	ADDRESS	START	END
10/27/14	**Stephen P. Clark Center**	Lobby - West Entrance (near Bottega Café)	111 NW 1st Street	8:30 AM	12:30 PM
10/27/14	**Miami-Dade Police**	HQ Cafetorium	9105 NW 25 St.	1:30 PM	3:30 PM
10/28/14	**Fire Rescue**	MDFR Training Facility, Rm 2-002	9300 NW 41 St.	9:00 AM	11:00 AM
10/28/14	**Overtown Transit Village**	Lobby	701 NW 1st Court	1:00 PM	3:30 PM
10/29/14	**Miami-Dade Transit**	Lehman Center, E. Mezzanine Training Rm	6601 NW 72 Ave	9:00 AM	11:00 AM
10/29/14	**ITD**	Break Room, 2nd Fl.	5680 SW 87 Ave.	2:00 PM	3:30 PM
10/30/14	**Public Works & Waste Mgmt**	3A Garbage & NE Transf., Trailer	18701 NE 6th Ave.	6:30 AM	8:00 AM
10/30/14	**Aviation**	Concourse D-Auditorium, 4th FL	North Terminal, MIA	1:00 PM	3:00 PM
10/31/14	**Building & Permitting Ctr.**	Conference Rooms I\J	11805 S.W. 26th Street (Coral Way)	7:30 AM	9:00 AM
10/31/14	**So. Dade Govt. Ctr.**	Rm 104	10710 SW 211 St.	11:00 AM	1:00 PM
11/03/14	**Public Works & Waste Mgmt**	58th St Garbage & Trash, Assembly Rm	8831 NW 58th St	6:30 AM	8:00 AM
11/03/14	**Miami-Dade Transit**	Coral Way - Driver's Rm 1st FL	2775 SW 74 Ave.	9:30 AM	11:30 AM
11/03/14	**Seaport**	2nd Floor Conference Rm	1015 North America Way	1:00 PM	2:30 PM
11/04/14	**Miami-Dade Transit**	Central Garage Driver's Rm, 1st FL	3300 NW 32 Avenue (Bus Ops.)	12:00 PM	1:30 PM
11/05/14	**Stephen P. Clark Center**	Lobby - Atrium	111 NW 1st Street	8:30 AM	12:30 PM
11/05/14	**Water & Sewer**	Douglas Rd Bldg. - Rm 156 A	3071 SW 38 Avenue	12:00 PM	3:00 PM
11/06/14	**Public Works & Waste Mgmt**	3B Garbage & Trash, Auditorium	8000 SW 107 Ave.	6:30 AM	8:00 AM
11/06/14	**Miami-Dade Transit**	Bus Op NE Garage, Driver's Rm, 1st FL	360 NE 185 St.	11:00 AM	12:30 PM
11/07/14	**Courts**	Justice Building (Jury Pool Rm 700)	1351 NW 12 Street, 7th FL	1:30 PM	3:00 PM
11/12/14	**Martin Luther King Bldg.**	2nd Floor Conf Rm #1-2	2525 NW 62nd Street	10:00 AM	12:00 PM
11/12/14	**Public Works & Waste Mgmt**	Traffic Signal & Signs, Conf. Room	7100 NW 36 Street	2:30 PM	4:00 PM
11/13/14	**Stephen P. Clark Center**	Lobby - Atrium	111 NW 1st Street	9:30 AM	1:00 PM
11/13/14	**Public Works & Waste Mgmt**	Road, Bridge & Canal - Lunch Rm	9301 NW 58th Street	2:30 PM	4:30 PM
11/17/14	**Miami-Dade Police**	HQ Cafetorium	9105 NW 25 St.	1:30 PM	3:30 PM
11/18/14	**Miami-Dade Transit**	Bus Op NE Garage, Driver's Rm, 1st FL	360 NE 185 St.	10:30 AM	12:30 PM
11/18/14	**Miami-Dade Transit**	Central Garage Driver's Rm, 1st FL	3300 NW 32 Avenue (Bus Ops.)	11:00 AM	1:30 PM
11/19/14	**Water & Sewer**	Douglas Rd Bldg. - Rm 156	3071 SW 38 Avenue	10:30 AM	1:30 PM
11/20/14	**Miami-Dade Transit**	Coral Way - Driver's Rm 1st FL	2775 SW 74 Ave.	9:30 AM	11:30 AM

Consider These Cost or Time Saving Options in 2015

Rising healthcare costs are hard to ignore. In today's challenging economic climate, it pays to take a proactive approach when it comes to your healthcare. Start by reviewing your coverage carefully to understand your specific plan and its benefits. Investing a few minutes now can translate into substantial savings over time. Here are some ways to keep your healthcare costs in check while maintaining the quality coverage you expect and deserve.

Generic Medications

If you take medications on a regular basis, you know how expensive medicines can be. One of the easiest ways to keep prescription drug expenses down is to choose generic medications over brand name drugs whenever possible. Typically sold at substantial discounts, generic manufacturers can offer lower prices for their drugs because they don't have to factor in the huge costs for research and development, marketing and advertising. What's more, when a generic drug product is approved and placed on the market, it has met the rigorous standards established by the FDA with respect to identity, strength, quality, purity, and potency.

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 copayments and it's conveniently delivered to your home, so you save on gas too! Go **www.avmed.org/mdc** to download the mail order form.

Urgent Care or the ER?

if you or a family member has a non-emergency illness or injury like a sprain, earache, flu-like symptoms or a sore throat, Urgent Care Centers can provide you with the medical attention you need— while saving you time and money. To find the urgent care center nearest you, go to **www.avmed.org/mdc** and click on "Urgent Care Centers" on the right-hand side of the home page under "Quick Links." :

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.

Utilization of Services

Since the County's medical plan is self-insured, it is important to remember the premium you pay is directly related to the amount of money the County pays in claims and that each member's usage of the plan affects the claims and your future premium. Consider the following when you need to use these services:

Emergency Room/Urgent Care - A review of emergency room utilization by employees shows that a number of diagnoses could have been directed to an urgent care facility or a primary care doctor. The total claims costs of seven non-emergency related diagnoses e.g., headache, dizziness, acute pharyngitis, were used to show the average costs when services were rendered at an emergency room, an urgent care center and a primary care physician's office.

Advanced Imaging - Imaging services delivered in a "free standing" facility are a fraction of the cost of services delivered in an outpatient hospital setting. You can find a free standing facility on the AvMed website. Go to the provider search engine at http://avmed.prismisp.com/?tab=doctor&plan=jhs&visitor=member select the tab for "Facility, Hospital and Other Provider Search, enter your zip then scroll and select "Diagnostic Testing Facility (independent\ nonhospital affiliated).

Dependent Eligibility For Coverage

ELIGIBLE DEPENDENTS	
Spouse *	Your legal spouse
Domestic Partner (DP)*	Your Domestic Partner in accordance with County Ordinance 08-61.
Child	Your biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.
Child with a disability	Your dependent child incapable of sustaining employment because of a mental or physical disability may continue coverage beyond the limiting age, if enrolled for medical prior to age 26 (or 25 for dental). Proof of disability must be submitted to the insurance plan on an ongoing basis.
Stepchild	The child of your spouse for as long as you remain legally married to the child's parent.
Foster child	A child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible to their age of maturity.
Legal guardianship	A child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible until his or her age of maturity.
Grandchild	A newborn dependent of your covered child; coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered. After 18 months, the grandchild must meet the criteria of permanent legal guardianship by the employee.
Over-age dependent	Your adult child after the end of the calendar year he\she turned age 26, through the end of the calendar year that the child turned 30. Must be unmarried, without dependents, lives in Florida or attends school in another state, and has no other health insurance.

Coverage Limiting Age for Dependent Children - Your dependent child's coverage ends on:

Medical - December 31 of the calendar year the child turns 26. May be continued to age 30, see extended coverage note below.

Dental & Vision - December 31 of the calendar year child turns 25 (26 for vision). There is no extension for dental and vision coverage unless the adult child is disabled.

***Your spouse or Domestic Partner (DP)** is not an eligible dependent for coverage under your insurance, if also a County or Public Health Trust/Jackson Health System employee. Eligible employees are not allowed to cover each other on their group medical/dental plans. Ex-spouses may not be enrolled for group benefits under any circumstance.

**** Adult Children (FSS 627.6562) –** Eligibility For Extended Medical Coverage
Medical coverage may be continued beyond December 31 of the year the adult child turns 26 until the end of the calendar year (December 31) the child turns age 30. Only medical coverage is available to this group. Once your dependent child reaches age 26, you are required to submit an **Affidavit of Eligibility** every year, no exceptions, to continue medical coverage. Failure to provide the documentation will result in termination of coverage retroactive to January 1.

To enroll a new dependent age 26+ in your 2015 medical coverage, you must also provide proof the adult child was continuously covered by other creditable insurance, without a gap in coverage of more than 63 days.

Verification of Eligibility

Annual Open Enrollment - The health plans will continue to screen for the eligibility of newly enrolled dependents with a different last name (than the employee's). It is your responsibility to provide the health plans with the required documentation by December 1. Refer to the online Benefits Handbook **www.miamidade.gov/benefits** for information regarding acceptable dependent documentation for enrollment in a County plan.

No documentation will be required during open enrollment to enroll a new dependent child under the age of 26, unless you are enrolling a new dependent with a different last name. Proof of financial dependency on the employee, and residency\ student status requirements have been eliminated for this group.

Document Transmittal

If you are enrolling dependents with a different last name, 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 adult children ages 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 on the document for identification purposes.

If you prefer to send documents directly to the health plan:

AvMed Health Plan
On site Service Representative SPCC -111 NW 1st Street, Suite 2340 Miami, FL 33128 Phone: (305) 375-5306 Fax: (305) 372-6097 Representatives are available Monday to Friday, 8:30am - 5:00pm

You must 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, 2015.

Pharmacy Benefits Manager (PBM)

Effective January 1, 2015, AvMed will change its Pharmacy Benefits Managers (PBM) from Catamaran Rx to CVS Caremark. This change will allow AvMed and its clients to enjoy significant savings, and greater formulary management. The mail order vendor will also change from Medco Mail to CVS Caremark. We will have the same pharmacy network, formularies, pharmacy claim processing codes, and contact information as today. The member ID cards will indicate a new BIN (Bank Identification Number) to facilitate proper claim processing. AvMed's specialty drug contractor, Accredo, may also change as of January 1, 2015. You will be notified once a decision has been made regarding the specialty drug contractor.

Important Note: Any mail order prescriptions you fill as of January 1, 2015 must be on the new CVS Caremark mail order form. Do not use the Medco form for new prescriptions after December 31, 2014.

Change In Status (CIS)

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 Benefit Election 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 (QEs)

- 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

The Affordable Care Act 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 to maintain coverage. Consequently, you cannot remove a dependent child from coverage due to marriage, or initial employment, unless the child gains and enrolls in other group coverage. 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 Internal Revenue Code (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 Benefit Election 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 a 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.

After Open Enrollment

If you do not submit your enrollment/changes online by the deadline (refer to page 1), you will have to wait until the 2016 Open Enrollment.

Opt-Out of Medical Coverage

You 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.

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.

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

How to Apply for Basic Life Insurance During Open Enrollment

Employees who lost their Basic Life Insurance coverage, may re-apply during the 2015 Open Enrollment period, by completing a Life Insurance Statement of Health (SOH) form.

The SOH form can be downloaded from www.miamidade.gov/benefits "Other Forms and Notices" page. Be aware that enrollment is subject to MetLife's medical review process.

Typical reasons why your coverage is not active are: Failing to pay the insurance premiums during a suspension/personal leave, or not applying for the County Basic Life Insurance coverage after transferring from a union plan.

What Must I Remember to Do Before January 1?

Submit an **Affidavit of Eligibility** to continue medical coverage for your adult child age 26 – 29. You are required to do this every year, no exceptions. Failure to provide the documentation will result in termination of coverage retroactive to January 1. Be sure to retain proof of mailing.

Did You Experience a Life Event Recently?

Did you get married, divorced, have a new baby? No matter where you are in life, one thing is certain, if someone depends on you financially, you should make sure they are protected. Review your life insurance beneficiary designations periodically to make sure your wishes are properly recorded. You can update you beneficiary designation online by logging on to eNet **http://enet.miamidade.gov** and selecting the Beneficiary Designation link.

Reporting Healthcare Cost on the 2014 W-2 Tax Form

When you receive your W-2 tax form in January 2015, once again the value of your health insurance benefit is reported. This information is intended to advise employees about healthcare costs. The healthcare cost reported is not taxable. The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan. Reporting the cost on the Form W-2 does not mean that the coverage is taxable. The value of the employer's contribution to health coverage continues to be excludable from an employee's income, and it is not taxable. This reporting is for informational purposes only and will provide employees useful and comparable consumer information on the cost of their healthcare coverage.

Maintaining Group Benefits While on an Unpaid Leave of Absence (LOA)

Employees beginning an unpaid leave (medical related, personal, workers compensation, or suspension, etc.) must take steps to ensure their benefits remain active. Since you will not receive a paycheck during your unpaid leave, the premiums\contributions to cover your employee-paid plan elections cannot be payroll deducted. Your Department Personnel Representative (DPR) will provide you with an LOA information package and billing notice.

To continue these benefits, you must submit payments by check or money order, or your benefits will be cancelled. Premiums and contributions are due in advance of the pay period to be covered. The first payment is due within two weeks of your last payroll deduction. Be proactive, contact your DPR before the onset of the leave to get the premium information and budget accordingly.

If your leave is illness related (i.e. Family Medical Leave, disability, worker's compensation, maternity etc.), you will only be responsible for the biweekly insurance contributions that are usually withheld from your paycheck. If your leave is other than illness related (i.e. educational, suspension, personal, etc.), you will be responsible for both the biweekly employee premium and County contributions.

Important Note: Taking an unpaid leave of absence is a qualifying event which allows you to temporarily stop participation in any benefit plan, or drop to single coverage to reduce your insurance cost. Your request must be received by Benefits Administration\Human Resources Dept. within 45 days of the onset of the unpaid leave.

Wellness

If you think good health just means treating illnesses when they occur, then you probably are not at your best. Good health means achieving and maintaining a healthy weight, getting optimal nutrition, exercising and staying fit, and taking steps to prevent disease. Taking control of your health and well-being gives you the best chance for living a full and rewarding life.

Are you ready to improve your health but not sure how to get there? Get started by taking your free Personal Health Assessment. Just follow these two easy steps:

1. Log on to the AvMed Web Site at www.avmed.org/mdc
2. Select Personal Health Assessment under Embrace Better Health.

Assess your current physical condition, access interactive tools and obtain valuable information to minimize your health risks. This confidential, user-friendly tool helps identify potential problem areas through a comprehensive review that combines gender-specific screening information with personal medical histories, along with questions about diet and lifestyle habits. Once you've completed the survey, you'll receive a personal health improvement score and a personal plan of action. Starting down a healthier path has never been easier.

Additional Tools on

www.avmed.org/mdc

- AvMed's Weight Watchers® Reimbursement Program. Lose weight and keep it off!
- Care Management for Living Healthier – for members with chronic conditions

Other health and fitness resources:

Employee Wellness Center
www.miamidade.gov/wellness/home.asp

Community Information and Outreach
www.miamidade.gov/healthcare/wellness.asp

Disclosure Notices

Please refer to the 2015 Benefits Handbook at **www.miamidade.gov/benefits** for the following important notices:

1. New Health Insurance Marketplace Coverage
2. Notice of Creditable Coverage - Prescription Coverage/Medicare
3. Women's Health & Cancer Rights Act
4. HIPAA Privacy & HIPAA Special Enrollment Notice
5. Medicaid and the Children's Health Insurance Program (CHIP)
6. Why We Collect SSN Information

Important Notes

1. Print and retain the online benefits confirmation notice after you make your elections for the 2015 plan year and take the online benefits survey. The online benefits confirmation notice will be the required proof of your 2015 benefit elections, 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, 2015. Employees are not permitted to switch plans during the year.

3. All 2015 plan year benefit elections are in effect January 1, 2015 through December 31, 2015 (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, 2014 must submit their benefits selections online through the County's eNet portal New Hire Benefits Enrollment link. Your 2014 new hire plan selections will carry over into 2015. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of 2014 and a separate amount for the 2015 plan year. If you are eligible for coverage under the New MDC Select Network HMO in 2015 and wish to enroll, contact your DPR for further instructions.

Remember These Dates

October 27 - November 20, 2014	Benefit Fairs At Various County Facilities
October 27 – November 14, 2014	Online Enrollment Period for Non-bargaining employees, AFSCME Aviation, AFSCME General, AFSCME Solid Waste, and GSAF (Website closes 12:00 AM)
November 17 – December 4, 2014	All other unions not listed above (Website closes 12:00 AM)
December 1, 2014	Deadline to Submit Dependent Documentation
January 16, 2015	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 On site Representatives	(305) 375-5306	SPCC 23rd Floor--M-F, 8:30a - 5:00p
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
MetLife Vision Plan	(877) 638-2055	www.metlife.com/mybenefits
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

The material contained in this newsletter does not constitute an insurance certificate or policy. It is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusions of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies to enrollees.

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)