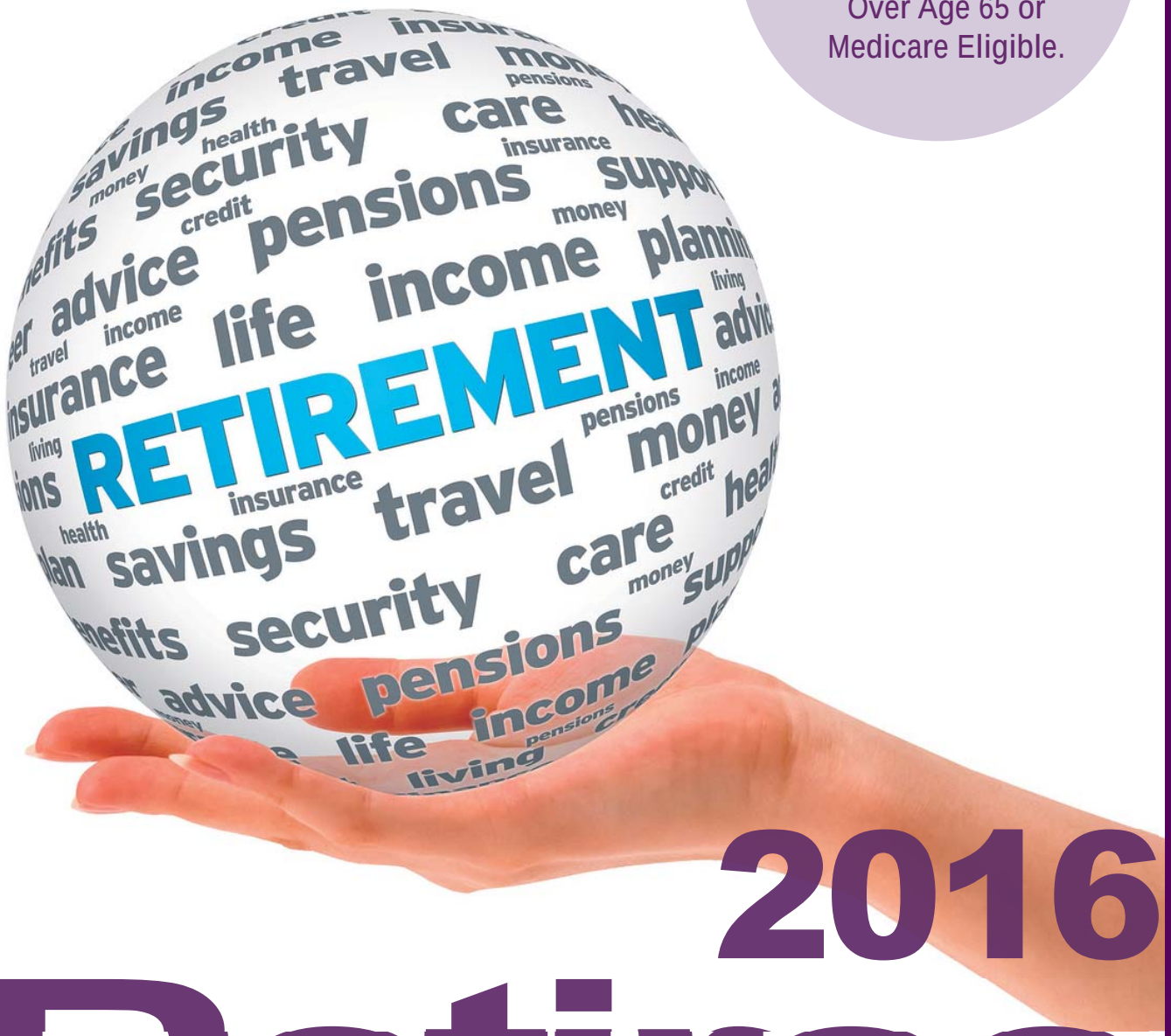
Handbook 2

for Retirees and/or Dependent(s) Over Age 65 or Medicare Eligible.



2016 Retiree Insurance Benefits

MIAMI-DADE COUNTY

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 2016 Under 65 Election Form, if you are under the age of 65. Complete the 2016 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 2016 Under 65 Election Form; however, consult Handbook 2 for detailed Medicare plan benefit information for your dependent. The 2016 Retiree Group Health Plan election Forms are available at: www.miamidade.gov/humanresources/retirees.asp

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

Congratulations and best wishes for your retirement years.

2016 Retiree Insurance Benefits

HANDBOOK 2

For Retirees and/or Dependent(s) Over Age 65 or Medicare Eligible.

OUR ADDRESS:

Miami-Dade County
Human Resources
Benefits Administration
111 NW 1st Street, Suite 2324
Miami, Florida 33128-1979

SR. EMPLOYEE BENEFITS SPECIALISTS:

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

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

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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) enrolled under Medicare Parts A, B, and D. If you (or your covered dependent) are age 65 or Medicare eligible, please contact the Social Security Office to apply for Medicare Parts A, B and D at least sixty (60) days before your retirement date.

If you (or your covered dependent) are age 65 or Medicare eligible and enrolling in an HMO Medicare Plan (non-County plan), you must contact the HMO directly at least thirty (30) days prior to your retirement date, or request a visit from their Medicare HMO representative for assistance with the enrollment process. You must have Medicare Parts A & B coverage in effect to be covered by a Medicare HMO Plan; consult the plan to determine if you need Medicare Part D also.

AvMed offers Medicare eligible retirees three (3) Supplement plans. Under the Low Option Plan, you are only covered for hospital deductibles not covered by Medicare and for outpatient/prescriptions drug expenses. Physician office visits are not covered under the Low Option Plan. The High Option Plan, will pay the 20% physician and out-patient charges not paid by Medicare, hospital deductibles not covered by Medicare and for out-patient prescription drugs. The No RX Plan offers the same benefits as the High Option Plan, without prescription drug coverage.

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

2016 Retiree Insurance 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 basic 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 the Miami-Dade County 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 (code EG) or under disability (codes EI or EM) 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.

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 ten (10) days prior to 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 Low Option Plan	Delta Dental Standard or Enriched Dental Plan (Indemnity)
AvMed High Option Plan	MetLife DHMO Standard or Enriched Dental Plan (Prepaid)
AvMed No RX Plan	Humana-OHS Standard or Enriched Dental Plan (Prepaid)

PLAN CONTACT INFORMATION

AvMed Health Plan	https://www.avmed.org/MDC/Index.aspx	(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 enrollment period, unless you move out of the plan's geographic service area.

Electing Health Coverage Under Your Spouse's or Domestic Partner's Plan

If your spouse or 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 of the qualifying event, sixty (60) days for newborns, adoption or placement for adoption. 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 annual enrollment period.

—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 through age 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

The AvMed Select Network and AvMed MDC Jackson First HMO are **only** available to Miami-Dade County retirees and dependents under age 65 who reside in Miami-Dade, Broward and Palm Beach counties. The Humana-OHS and MetLife DHMO dental coverage are generally not available

outside Miami-Dade, Broward, and Palm Beach Counties. Additionally, although the AvMed Elite (POS/High Option HMO) 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 AvMed and/or the pre-paid dental plans to obtain information about existing networks in your geographic area. If in-network benefits are not available in your area, you will have the option to switch to the AvMed High Option HMO medical plan or 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 MetLife 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 MetLife to inquire about a COBRA policy at the following address:

MetLife Vision Plan
P.O. Box 997565
Sacramento, CA 95899-4565
www.metlife.com/mybenefits
1-877-638-2055

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 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. As long as the coverage was in force prior to retirement, the benefit may be continued. Retirees age 65+ may elect either $15,000 or $20,000 of life insurance coverage. 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 thirty (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 https://www.avmed.org/MDC/Index.aspx. 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 Supplement 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 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
AvMed High Option Plan
AvMed No RX Plan

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

A summary of benefits offered to Medicare eligible retirees (and/or dependents) and applicable rates is available at http://www.miamidade.gov/humanresources/retirees.asp. If you and/or your covered dependent are 65 years or more, you and/or your covered dependent 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. 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.

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 applicable), if applied for within sixty (60) days following your retirement date. In the event a retiree terminates his/her employment on a retroactive basis (EI, EG or EM 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. I am under the age of 65, but enrolled for Medicare Parts A & B due to disability. May I remain enrolled in an AvMed under age 65 plan?

A. Yes, you can remain in an AvMed Under age 65 Plan, until age 65; Medicare will be the primary payor. This will apply whether you are enrolled in the AvMed POS, High Option HMO, MDC Select Network HMO or MDC Jackson First HMO plans.

Q. Who are eligible dependents?

A. Miami-Dade County recognizes eligible dependents as:

1) Your spouse or registered domestic partner.

2) Your natural children, stepchildren, adopted children, children of a domestic partner or a child for whom you have been appointed legal guardianship, pursuant to a court order until the end of the calendar year in which they turn age twenty-six (26).

One of the major changes brought on by Health Care Reform in 2011, is to allow young adults to stay on their parents health plan to age 26 (end of the calendar year). Financial dependency, full-time student or marital status will no longer apply to covered dependent children under the health plans. Although married children are eligible for coverage, their spouse and children are excluded. Effective January 1, 2016 the limiting age for dependent dental coverage is also age 26 (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 and approved 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 children 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, 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**.

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

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, Social Security number(s) and the Birth Certificate(s) 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.

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. 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 this Handbook. For more information, contact the Employee Benefits Specialists at (305) 375-5633. Be aware that once you qualify for Medicare, your retiree medical coverage becomes secondary. You may elect to continue with your current coverage (POS, High Option HMO, Select Network HMO or MDC Jackson First HMO plan) until age 65, instead of enrolling in one of the Medicare supplement plans.

Q. If enrolled in the High Option 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 providers to provide nationwide coverage. As a retiree, if you utilize your plan's extended network of providers, 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. If enrolled in the AvMed MDC Select Network HMO plan, may I utilize providers outside the South Florida network and still receive HMO coverage?

A. No, the Select Network HMO plan is only available to retirees who reside in Miami-Dade, Broward and Plam Beach Counties (the Tri-county area). It was designed with a smaller (Select) network of providers and is comprised of conveniently located hospitals, facilities and physicians. For more information contact AvMed's 24/7 dedicated Member Services at 1(800) 682-8633.

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

A. No, participants must use Jackson First Network Providers and reside in Miami-Dade, Broward, or Palm Beach Counties. The Away From Home Program is not available for dependents residing outside the tri-county area. AvMed contracted providers with privileges at the JHS and UMHS facilities are included. For more information contact AvMed's 24/7 dedicated Member Services at 1(800) 682-8633.

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

A. Please contact your benefits specialist for information regarding ESRD disability. You will need to provide proof of your Medicare Part B coverage.

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 covered dependent can continue indefinitely and your dependent children until the limiting age. This applies to the AvMed plan 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 plan as well as the dental plans.

Q. If I have a qualifying event (marriage, new domestic partnership, birth, adoption or placement for adoption of a child, or loss of group insurance coverage for a covered dependent) 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,). 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, subse-

quent 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.

At age 70 and 75, your life insurance premium will be adjusted if you are maintaining this coverage. You will receive a new billing statement 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. 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 enrolled dependents will be allowed to continue coverage under the Retiree Group.

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

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

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. 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 (844) 377-1888 for any subsidy questions, or write to:

Division of Retirement
PO BOX 9000
Tallahassee FL 32315-9000
E-mail: retirement@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

2016 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 MDC Select HMO • AvMed MDC Jackson First HMO
AvMed High Option Plan - AvMed High Option No RX Plan - AvMed 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, 2015

Name of Entity: Miami-Dade County
Contact-Position/Office: Human Resources Department, Benefits Administration
Address: 111 NW 1st Street, Suite 2324
Phone Number: (305) 375-4288, (305) 375-5633

HIPPA Notice of Privacy Practices

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, pre- certification 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-to-day 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 specifically designated employees of 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 without your express authorization. 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 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.

Prohibition on Use or Disclosure of Genetic Information. The Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

No Other Uses. Other uses and disclosures will be made only with your prior written authorization. You may revoke this authorization in writing 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. We are not required to agree to a requested restriction or limitation, unless your request is made to restrict disclosure to an insurance carrier for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a health care item or service for which you have paid the healthcare provider out of pocket in full. If we do agree to a restriction or limitation, we must abide by it unless you revoke it in writing.

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, to friends or family in your presence or due to an emergency, for national security purposes, or incidental to an otherwise permissible use or disclosure. 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. Your request should indicate in what form you want the accounting (for example, paper or electronic).

Right to be Notified of a Breach. You have the right to be notified in the event that the Plan (or a Busi¬ness Associate) discovers a breach of your unsecured protected health information. Business Associates include the Business Associates themselves and their subcontractors.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 (see Contact Information below). You may also file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.

For any questions or complaints, please contact:

Chief Privacy Officer,
Human Resources Department
Stephen P. Clark Center,
111 NW 1st Street, 21st Floor,
Miami, FL 33128

Last updated October 2015

HIPAA SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision." Special enrollment rights apply when you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact:

Miami Dade County
Human Resources Department\Benefits Administration
111 NW 1st Street, Suite 2324
Miami, FL 33128
(305) 375-4288, (305) 375-5633

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 2324, 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 you 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
http://www.floridakidcare.org/
Phone: 1-888-540-5437

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 November 15, 2015 through February, 2016, for coverage to be effective January 1, 2016. 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 November 15 to December 15 for coverage to be effective January 1, 2016. If you apply on December 16, 2015 the coverage will be effective February 1, 2016 and so forth. The 2016 Open Enrollment period closes on February 15, 2016. 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.

Benefit Summary

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited
DEDUCTIBLE AMOUNT PER CALENDAR YEAR Per Individual	$166 for certain benefits **only** (Private Duty Nursing and Blood)	$166 for Private Duty Nursing $250 for Foreign Travel Emergency Care	$166 for Private Duty Nursing $250 for Foreign Travel Emergency Care
CHOICE OF HOSPITALS	Unlimited	Unlimited	Unlimited
MEDICARE PART B DEDUCTIBLE: $166.00 PER CALENDAR YEAR	Not Covered	Not Covered	Not Covered
INPATIENT HOSPITAL FACILITY *Covered by Medicare Part A. Medicare covers:* ***Days 1 to 60**: All but $1,288* ***Days 61 to 90**: All but $322 per day* ***Days 91 -150*:** *All but $644 per day* **Days 91-150 are the 60 Lifetime Reserve Days. Medicare will cease until a new Benefit Period begins. A new Benefit Period begins after you have been out of the hospital or facility for at least 60 days. In a new Benefit Period, all Medicare Part A will renew except for the Lifetime Reserve Days.*	100% up to $1,288 100% up to $322 per day 100% up to $644 per day *No additional Reserve Days	100% up to $1,288 100% up to $322 per day 100% up to $644 per day *365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted Covered at 100% of Medicare eligible expense Must be medically necessary	100% up to $1,288 100% up to $322 per day 100% up to $644 per day *365 additional lifetime days after Medicare Lifetime Reserve Days are exhausted Covered at 100% of Medicare eligible expense Must be medically necessary
HOSPITAL OUTPATIENT/PHYSICIAN *Covered by Medicare Part B*	Remainder 20% of Medicare approved amount for these services only: Physician hospital visits (inpatient/outpatient) Surgical services (inpatient/outpatient) Anesthesia services (inpatient/outpatient)	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
SKILLED NURSING FACILITIES *Days 1 - 20: Covered by Medicare Part A* *Days 21 - 100: Covered all but $161 per day.* *Days 101 & beyond: all costs*	Not Covered	Days 1 - 20: Not Covered Days 21 - 100: Up to $161 per day Days 101 & beyond: Not Covered	Days 1 - 20: Not Covered Days 21 - 100: Up to $161 per day Days 101 & beyond: Not Covered

AV-MDC RETIREE LOW & HIGH PLANS COMPARISON-16
SF-3690(01/16)

Benefit Summary

AvMed Embrace better health.

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
PHYSICIAN VISITS/ILLNESS *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
DURABLE MEDICAL EQUIPMENT *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
X-RAYS *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
PHYSICAL THERAPY SERVICES *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
SHORT-TERM REHABILITATION *Covered by Medicare Part B* Includes: Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)	Not Covered	Remainder 20% of Medicare approved amount Limited to $1,960 per calendar year for Physical Therapy (PT) and Speech Therapy Language Pathology (SLP) services combined Limited to $1,960 per calendar year for Occupational Therapy (OT) services	Remainder 20% of Medicare approved amount Limited to $1,960 per calendar year for Physical Therapy (PT) and Speech Therapy Language Pathology (SLP) services combined Limited to $1,960 per calendar year for Occupational Therapy (OT) services
AMBULANCE *Covered by Medicare Part B*	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
HOME HEALTH CARE *When covered by Medicare* *When not covered by Medicare*	No Charge Not Covered	No Charge Plan will pay up to $40 per visit limited to $1,600 per calendar year	No Charge Plan will pay up to $40 per visit limited to $1,600 per calendar year
FOREIGN TRAVEL/EMERGENCY CARE *Not covered by Medicare*	Not Covered	80% of covered expenses after $250 calendar year deductible, up to a lifetime maximum of $50,000	80% of covered expenses after $250 calendar year deductible, up to a lifetime maximum of $50,000

AV-MDC RETIREE LOW & HIGH PLANS COMPARISON-16
SF-3690(01/16)

Benefit Summary

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
PRIVATE DUTY NURSING *Covered by Medicare Part B* (While Inpatient in a Hospital or Other Health Care Facility only)	80% of Reasonable & Customary charges after $166 calendar year deductible Lifetime maximum $10,000 combined with blood and blood products	80% of Reasonable & Customary charges after $166 calendar year deductible	80% of Reasonable & Customary charges after $166 calendar year deductible
BLOOD *First three pints of blood not covered by Medicare*	First three pints of blood covered at 80% of Reasonable & Customary charges after $166 calendar year deductible Lifetime maximum of $10,000 combined with Private Duty Nursing	First three pints of blood covered at 100% of Reasonable & Customary charges	First three pints of blood covered at 100% of Reasonable & Customary charges
ROUTINE FOOT DISORDERS *Covered by Medicare Part B*	Not Covered	Not covered except for services associated with foot care for diabetes and peripheral vascular disease	Not covered except for services associated with foot care for diabetes and peripheral vascular disease
MENTAL HEALTH /SUBSTANCE ABUSE INPATIENT *Covered by Medicare Part A* Mental Health Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Substance Abuse Acute detoxification: requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab: requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1	Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage	Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage	Plan pays 100% of amount approved but not paid by Medicare; if charges not approved by Medicare, there is no coverage
MENTAL HEALTH/SUBSTANCE ABUSE OUTPATIENT HOSPITAL/FACILITY *Covered by Medicare Part B*	Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved but not paid by Medicare Part B and member has $0 responsibility.	Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved but not paid by Medicare Part B and member has $0 responsibility.	Coverage assumes enrollment in Medicare Part B; Plan pays remainder of charges approved but not paid by Medicare Part B and member has $0 responsibility.

AV-MDC RETIREE LOW & HIGH PLANS COMPARISON-16
SF-3690(01/16)

Benefit Summary

AvMed Embrace better health.

MEDICARE ELIGIBLE RETIREES/DEPENDENTS: COMPARISON OF RETIREE LOW AND HIGH OPTION PLANS FOR MIAMI-DADE COUNTY

BENEFIT HIGHLIGHTS	LOW	HIGH WITH RX	HIGH W/O RX
MATERNITY SERVICES			
Covered by Medicare Part B			
Initial Visit to confirm pregnancy	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
Physician's Office Visits in addition to the global maternity fee when performed by an OB or Specialist	Not Covered	Remainder 20% of Medicare approved amount	Remainder 20% of Medicare approved amount
Covered by Medicare Part A			
Delivery - Facility (Inpatient Hospital, Birthing Center)	Days 1 to 60: 100% up to $1,288 Days 61 to 90: 100% up to $322 per day Days 91 -150: 100% up to $644 per day	Days 1 to 60: 100% up to $1,288 Days 61 to 90: 100% up to $322 per day Days 91 -150: 100% up to $644 per day	Days 1 to 60: 100% up to $1,288 Days 61 to 90: 100% up to $322 per day Days 91 -150: 100% up to $644 per day
EYEGLASSES *Covered by Medicare Part B*	Not Covered	Not Covered	Not Covered
PRESCRIPTION DRUG COVERAGE			
Retail (30-day supply)	80% after $200 calendar year deductible	80% after $200 calendar year deductible	Not Covered
Specialty (30-day supply at Participating Specialty Pharmacy)	$100 copayment per prescription for Specialty drugs	$100 copayment per prescription for Specialty drugs	Not Covered
Mail Order (90-day supply at participating pharmacy)	100% after $10 copayment for Generic; 100% after $20 copayment for Preferred Brand; 100% after $30 copayment for Non-Preferred Brand	100% after $10 copayment for Generic; 100% after $20 copayment for Preferred Brand; 100% after $30 copayment for Non-Preferred Brand	Not Covered
Mail Order at Non-Participating Pharmacy	Not Covered	Not Covered	Not Covered

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633)

For specific information on benefits, exclusions and limitations please see your Summary Plan Description (SPD).

AV-MDC RETIREE LOW & HIGH PLANS COMPARISON-16
SF-3690(01/16)

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	
VISION		
Examination	Not Covered	Not Covered
Single Vision Lenses	Not Covered	Not Covered
Bifocal Lenses	Not Covered	Not Covered
Trifocal Lenses	Not Covered	Not Covered
Contact Lenses - Elective and Non-Elective	Not Covered	Not Covered
Frames	Not Covered	Not Covered
	*All Type II and III charges subject to annual deductible.	*The above reimbursements are exclusive of gold.

Dental Plan Comparison

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 Established	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
	Up to 4 per year	Up to 4 per year		
	No Charge (2x/12 mo)	No Charge (2x/12 mo)		
	$15 ea. (2 add'l/12 mo)	$15 ea. (2 add'l/12 mo)	No Charge (1/6 mo.)No Charge	No Charge (1/6 mo.)
1110/20 Prophylaxis	No Charge	No Charge	$ 6.00	No Charge
1203 Fluoride Treatment (children up to the age 19)	No Charge	No Charge	$40.00	No Charge
1351 Sealant - per tooth	$25.00	No Charge		No Charge
1510 Space Maintainers				
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	$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.	

2016 MONTHLY PREMIUM RATES

FOR RETIREES OVER AGE 65 AND/OR MEDICARE ELIGIBLE

MEDICAL COVERAGE

Monthly Rates	AvMed Low Opt. Plan	AvMed High Opt Plan	AvMed High Opt No RX Plan
Retiree over 65 Only	$ 576.49	$ 645.55	$ 280.59
Retiree over 65 & Spouse/Domestic Partner Over 65		$ 1,245.96	$ 541.59
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed POS Plan		$ 1,810.78	$ 1,445.82
Retiree over 65 & Spouse/Domestic Partner Under 65 on AvMed High Opt. HMO		$ 1,135.85	$ 770.89
Retiree over 65 & Child(ren) on AvMed High Opt. HMO		$ 1,166.24	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed POS Plan		$ 2,239.52	
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed High Opt. HMO		$ 1,514.92	$ 1,149.96
Retiree over 65 & Spouse/Domestic Partner Under 65, Child(ren) on AvMed MDC Select Network HMO		$ 1,439.09	

Dependent Coverage Only For Retiree over 65 w/ Non-County Medicare Plan	AvMed POS	AvMed HMO High Opt	AvMed MDC Select HMO*	AvMed MDC Jackson First HMO*
Spouse/Domestic Partner Under 65	$ 1,165.23	$ 490.30	$ 441.65	$ 409.35
Child(ren)		$ 520.69	$ 474.79	$ 444.29
Spouse/Domestic Partner Under 65 and Child(ren)	$ 2,168.07	$1,010.99	$ 916.44	$ 853.64

**AvMed plans not available outside Miami-Dade, Broward & Palm Beach Counties*

DENTAL COVERAGE

	Delta Dental Plan		MetLife* DHMO (Safeguard)		Humana* - Oral Health Services	
Monthly Rates	Standard	Enriched	Standard	Enriched	Standard	Enriched
Retiree Only	$ 31.22	$ 40.87	$ 11.51	$ 16.76	$ 8.00	$ 14.82
Retiree & one dependent	$ 61.76	$ 80.80	$ 19.02	$ 27.77	$ 13.24	$ 24.58
Retiree & dependents	$ 99.55	$ 130.30	$ 29.11	$ 44.15	$ 20.22	$ 39.02

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

LIFE INSURANCE COVERAGE

Your life insurance coverage is reduced when you reach age 65. The coverage options are $15,000 or $20,000.

Life Insurance Benefit	Monthly Rates		
	Age 65-69	Age 70-74	Age 75+
$15,000	$ 10.26	$ 16.92	$ 23.40
$20,000	$ 13.68	$ 22.56	$ 31.20

New Retiree Checklist

1. ☐ If you (or your covered dependent) are age 65 or Medicare eligible, please contact the Social Security Office regarding 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 Handbook and the 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 schedule an appointment at least three months prior to your retirement date. If requesting medical, dental and/or basic life insurance coverage under the Retiree Group, submit the 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. However, you may exercise your options under COBRA.

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 age 65 or Medicare eligible and 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 are not eligible for Medicare, and 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.

   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.

New Retiree Checklist

(Continued)

8. ☐ CHANGES: Always notify our office in writing immediately upon changing your address or telephone number. If you have a change in status such as marriage, divorce, disolution of domestic partnership, 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 Administration • 111 NW 1st Street, Suite 2324 • Miami, Florida 33128-1979

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