2018 YourBeneFITS

MIAMI-DADE COUNTY EMPLOYEE ANNUAL BENEFITS ENROLLMENT GUIDE

www.miamidade.gov/OpenEnrollment

OPEN ENROLLMENT

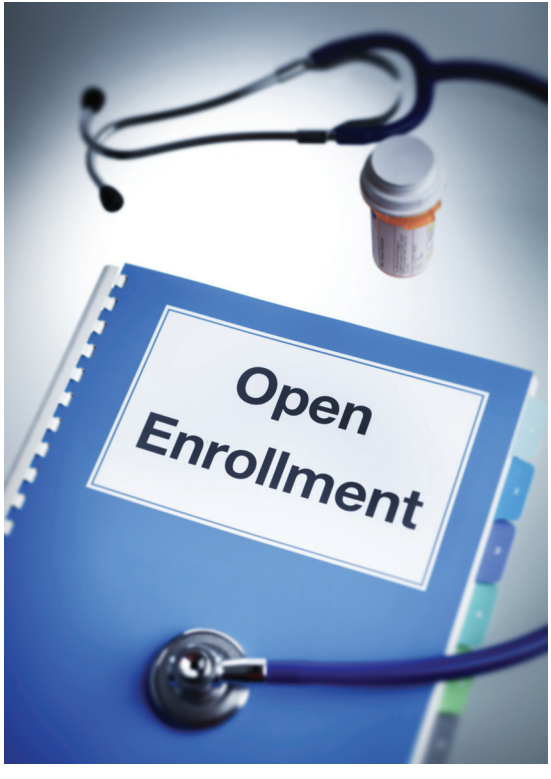
MIAMI-DADE COUNTY

Open Enrollment Is Here

The annual Open Enrollment period for County employees will run from October 1 through October 15. During this period, benefits-eligible employees may elect or make changes in plans, levels of coverage and update beneficiary and dependent elections. All changes made become effective on January 1, 2019.

The County will continue to offer the three self-insured HMO plans and one POS plan managed by AvMed, and two dental plans managed by Delta Dental.

The information provided in this guide is designed to help you make the best selection of Healthcare Plans for you and your family. Please take time to fully read the information provided, attend one of the on-site Open Enrollment regional meetings and contact the vendors or the benefits staff with any questions or clarifications you need to make the right choice to meet your needs and budget. You can also visit **www.miamidade.gov/openenrollment**.



Assess your needs:

- Are you single with no dependents or do you need coverage for yourself and your family?
- Are you relatively healthy, maintain a healthy lifestyle?
- Do you have a chronic medical condition that you are able to manage with annual exams and medication?
- Are your physicians and facilities all in-network or do you access a number of out-of-network providers?
- What medical services have you accessed in the past 12 months?
- Review your claims history by logging into your account on **www.AvMed.org/mdc**.

Lastly, look at the cost of the plans. When reviewing cost, you need to consider:

- The biweekly premium that will be deducted.
- The co-pays and associated co-insurance (out-of-pocket) costs.

All plans offered include annual out-of-pocket maximums to protect your financial security in the event of unexpected medical expenses. If you utilize out-of-network providers under the POS plan, you are responsible for the difference between the charges and plan-allowed amount, which is not considered in the out-of-pocket maximum.

After you have determined your needs, you should review the plans to look for the coverage and benefits that will best meet your needs. For more detailed information visit **www.AvMed.org/mdc.**

Dental Plan Highlights

A single dental provider, Delta Dental, offering both a DHMO and a DPPO plan each with a Standard and Enriched option.

Significant enhancements to the DeltaCare USA plan include:

- **NEW** Additional dental procedures covered with a copay;
- **NEW** Teeth Whitening;
- **NEW** Standard Option – See a specialist with a copay instead of a 25% discount off the charges;
- **NEW** under the DHMO standard – Orthodontic services offered with a copay instead of a 25% discount off the charges;

Significant enhancements to the DPPO plan include:

- **NEW** Additional dental procedures covered;
- **NEW** Coverage added for implants at the major restorative services level.
- **NEW** A Diagnostic and Preventative (D&P) Maximum Waiver. Helps with keeping your annual maximum dollars available for other types of covered services.
- **NEW** Enriched Option - Increase in the annual benefit maximum from $1,500 to $2,000 and the lifetime orthodontia maximum from $1,000 to $1,300.

Redesign Plans

AvMed POS / AvMed High Option HMO / AvMed MDC Select Network / AvMed MDC Jackson First HMO / AvMed MDC Jackson First "Pilot" HMO

Biweekly Medical Rates – Redesign Plans

TIER LEVEL	AvMed POS	AvMed HMO High Opt	AvMed MDC Select Network	AvMed MDC Jackson First/"Pilot" HMO*
EMPLOYEE ONLY	$100.00	$75.00	$0.00	$0.00*
EMPLOYEE + CHILD(REN)	$285.86	$180.17	$141.00	$112.02*
EMPLOYEE + SPOUSE	$344.54	$208.35	$166.00	$134.71*
EMPLOYEE + FAMILY	$595.59	$287.77	$236.00	$197.84*

***AvMed MDC Jackson First "Pilot" HMO availability is based on Bargaining Unit status.**

2018 Biweekly Rates – All Employees

PLAN	EMPLOYEE ONLY		EMPLOYEE + 1		EMPLOYEE + FAMILY	
	STD	ENR	STD	ENR	STD	ENR
DELTACARE USA	$0.00	$0.56	$3.03	$3.99	$7.11	$9.09
DELTA DENTAL DPPO	$0.00	$5.46	$13.11	$23.89	$29.33	$46.74

Other Plan Rates

METLIFE VISION	
EMPLOYEE ONLY	$1.91
EMPLOYEE + 1	$3.83
EMPLOYEE + FAMILY	$7.03

ARAG LEGAL PLAN	
EMPLOYEE ONLY	$7.29
EMPLOYEE + 1	$9.34
EMPLOYEE + FAMILY	$9.61

Other Plan Rates (continued)

FLEXIBLE SPENDING ACCOUNTS (FSA)		
	Contribution Limit	Administrative Fees Per Pay Period
Healthcare FSA Only	$2,650.00	$2.02
Dependent Care FSA Only	$5,000.00 *	$2.02
Both Health & Dependent Care		$2.02

* Maximum Dependent Care FSA annual deposit depends on participant's tax filing status:

- Married and filing separately $2,500.00
- Single and head of household $5,000.00
- Single and not head of household $2,500.00
- Married and filing jointly $5,000.00

METLIFE Short Term Disability (STD)	Premium Per $100 Weekly Benefit
Low Opt ($500 max weekly benefit)	$1.38
High Opt ($1,000 max weekly benefit)	$1.38

METLIFE Long Term Disability (LTD)	Premium Per $100 of Covered Monthly Payroll
Low Opt ($2,000 max monthly benefit)	$0.221
High Opt ($4,000 max monthly benefit)	$0.265
Premier ($7,000 max monthly benefit)	$0.368

Dependents Eligible for Coverage are:

Spouse, Domestic Partner (DP), Child, Child with a disability, Stepchild, Foster Child, Legal Guardianship, Grandchild, Over-age dependent. For a full list of limitations please refer to the Miami-Dade County Employee Benefit Handbook online at **www.miamidade.gov/openenrollment**.

Are You Adding a New Dependent?

If you are adding a dependent for the 2019 plan year, you must provide supporting documentation that the dependent meets the eligibility requirement for coverage under the Miami-Dade County insurance plans by no later than October 15. This is a mandatory requirement that applies to any dependent added now and in the future. Please be aware that failure to provide acceptable documentation will result in cancellation of the dependent's medical, dental and/or vision coverage (if enrolled), effectively as of January 1.

Acceptable Documents

Children
- Adoption Certificate
- Birth Certificate
- Official court documentation of legal and permanent custody
- Social Security Income Statement (disabled child)

Spouse
- Marriage Certificate (issued by government entity)
- Domestic Partnership Certificate

Over Age Dependent Children – New and Currently Enrolled
Once your dependent child reaches age 26, you are required to submit an Affidavit of Eligibility every year, no exceptions, to continue medical coverage. To download the form, go to **www. miamidade.gov/humanresources/benefits-forms.asp**. Failure to provide the documentation will result in cancellation of coverage and unpaid claims effectively as of January 1. To enroll a new dependent age 26+ in your 2018 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.

Please note: It is your responsibility to remove ineligible or overage dependents from your coverage for the upcoming benefit year. Failure to do so will result in your paying the premium for the existing level of coverage through the end of the plan year, unless you have a qualifying event.

Gather the required documentation listed above by October 15. Enter your name and employee ID on your dependent's document for easier identification. Please make sure the document is legible and retain proof of mailing, or fax transmittal for your records.

Fax Documents to
Benefits Administration Unit
Fax (305) 375-2964

Online Enrollment Overview

For the 2018 Open Enrollment, participation is very important. Please take this opportunity to review your current plan elections and decide if they still meet your needs. You may change your existing elections, add coverage or simply confirm that you wish to remain with the same plan. To use the online web enrollment, go to **www.miamidade.gov/openenrollment**. 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. No 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 elections, no problem. The website is secure and available 24/7 during the Open Enrollment period.

Ensure that your dependents still qualify for coverage. Use this guide and look on the Open Enrollment website. Once you have the answers you need, begin the enrollment process. The deadline to change your plan elections is November 15, 2017. Once the deadline expires, you are locked into the plan elections you make until the next Open Enrollment period. In addition, you will pay the premiums for these elections for the entire benefit year regardless of dependent eligibility, unless you have a qualifying event.

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 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, 8 a.m. to 5 p.m.

Find the regional meeting schedule at **www.miamidade.gov/openenrollment**.

Checklist For Online Enrollment

Obtain this information before you begin:

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

After Open Enrollment

If you do not submit your enrollment/changes online by the deadline (October 15), you will have to wait until the next Open Enrollment period. Employees are not permitted to switch plans during the year once Open Enrollment closes.

Declining Medical Coverage

You may opt-out of County-provided medical coverage during open enrollment. If you decline coverage, you cannot reapply until the next open enrollment, unless you experience a family status or HIPAA qualifying event. Should you decide to decline coverage during Open Enrollment, make sure you do so through the Open Enrollment website; otherwise, you will be required to complete and submit a paper Coverage Waiver Form.

The decision to waive coverage has consequences. Declining County medical coverage without enrolling in another group/marketplace health plan may result in a tax penalty. Go to **www.Healthcare.gov** for additional information regarding the Affordable Care Act's individual mandate.

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 Internal Revenue Code 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 Department Personnel Representative (DPR) in writing and will be processed prospectively (next pay period from date request is received).

Important Notes

1. Print and retain the online benefits confirmation notice after you make your elections for the 2018 plan year. The online benefits confirmation notice will be the required proof of your 2018 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, 2018. Employees are not permitted to switch plans during the year.

3. All Open Enrollment 2018 plan year benefit elections are in effect January 1, 2018 through December 31, 2018.

4. If you are a new hire with a benefits eligibility date of November 1 or December 1, 2017, you must submit your benefits selections online through the County's eNet portal New Hire Benefits Enrollment link. Your 2017 new hire plan selections will carry over into 2018. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of 2017 and a separate amount for the 2018 plan year.

5. Remove any ineligible or overage dependents from your coverage for the upcoming benefit year through the Open Enrollment website by the November 15, 2017 deadline. Failure to do so will result in your paying the premium for the existing level of coverage through the end of the plan year, unless you have a qualifying event.

Remember These Dates

	Benefit Fairs at Various County Facilities
	Online Enrollment Period (24 hour website closes at 12:00 a.m. on Nov 16)
	Deadline to Submit Dependent Documentation
	Deadline for Reporting System Errors in the Processing of Online Benefit Elections

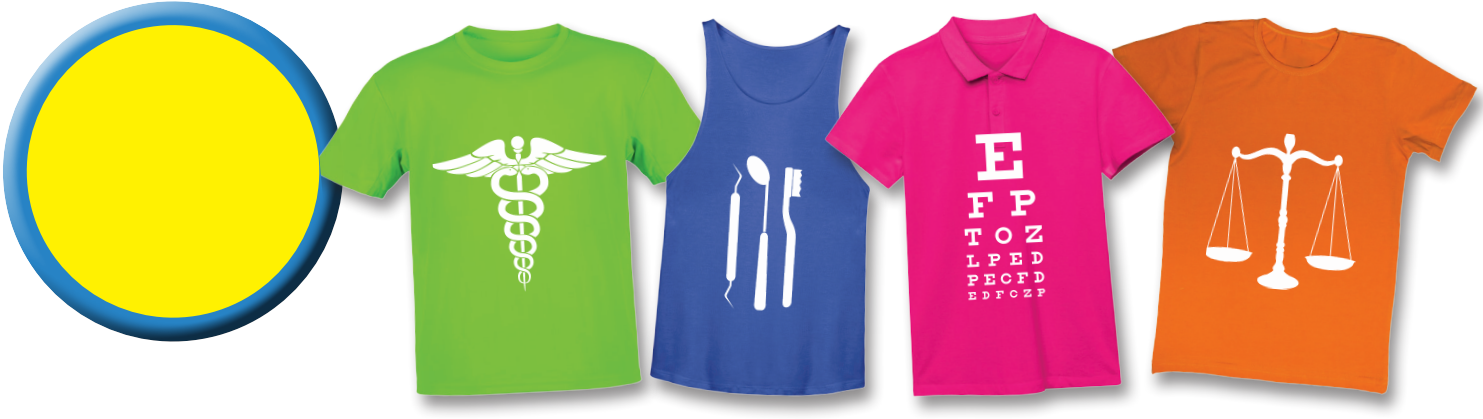
Contact Information

Open Enrollment website		www.miamidade.gov/openenrollment
Benefits Administration Unit (BAU)	(305) 375-4288 or 5633	www.miamidade.gov/humanresources/benefits.asp
Wellness Works		www.miamidade.gov/wellnessworks
MEDICAL PLANS		
AvMed Health Plans	(800) 682-8633	www.avmed.org/mdc
AvMed On site Representatives	(305) 375-5306	SPCC 23rd Floor Mon-Fri 8:30 a.m. - 5:00 p.m.
DENTAL & VISION PLANS		
Delta Dental	(800) 471-1334	www.deltadentalins.com/mdc
MetLife Vision	(877) 638-2055	www.metlife.com/mybenefits
OTHER		
ARAG Legal Plan	(800) 667-4300	www.ARAGLegalCenter.com code:**10277mdc**
WageWorks Flexible Spending Accounts	(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
Nationwide - 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)

Choose the Right **FIT!**



The following benefits comparison chart will give you an overview of the plan options. Use it to decide which plan is the right fit for you.

MEDICAL

SCHEDULE OF BENEFITS	AVMED POS PLAN In-Network	AvMed HMO HIGH In-Network Only	AvMed MDC Select HMO In-Network Only	AvMed MDC Jackson First Pilot HMO - In-Network Only
	COST TO MEMBER	COST TO MEMBER	COST TO MEMBER	COST TO MEMBER
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Co-Insurance Levels	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Calendar Year Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Out-Of-Pocket Maximum (Per Calendar Year) Individual/Dependent Maximum**	$3,000/$6,000	$3,000/$6,000	$2,500/$5,000	$2,500/$5,000
Physician Office Visits	$15 per visit	$15 per visit	$15 per visit	No Charge
Specialists Office Visits	$30 per visit	$30 per visit	$30 per visit	No Charge
Pediatrician	$15 per visit	$15 per visit	$15 per visit	No Charge
Chiropractic	$15 per visit	$15 per visit	$15 per visit	No charge
Preventive Care	No Charge	No Charge	No Charge	No Charge
Mammogram, PSA, Pap Smear	No Charge	No Charge	No Charge	No Charge
Inpatient Hospital Services*	$200 copay per admission	$200 copay per admission	No Charge	No Charge
Outpatient Facility Services*	$100 copay	$100 copay	No Charge	No Charge
Emergency Room (copay waived if admitted)	$100 copay	$100 copay	$50 copay	$50 copay
Urgent Care Facility or Outpatient Facility+	$50 per visit/$15 copay	$25 copay/$15 copay	$25 copay/$15 copay	$25 copay/$15 copay
Maternity Care Services				
Initial Visit	$30 per visit	$30 copay	$30 copay	No Charge
Subsequent Visits	No charge	No charge	No charge	No Charge
Prescription Medication Benefit — Retail, 30 Day Supply (Includes Contraceptives)				
Generic	$15	$15	$15	$15
Preferred Brand	$40	$40	$25	$25
Non-Preferred Brand	$55	$55	$35	$35
Specialty (30-Day Supply Through Specialty Pharmacy)	$100	$100	$15/$25/$35	$15/$25/$35
Prescription Medications - Mail-Order, 90 Day Supply (Includes Contraceptives)				
Generic	$30	$30	$30	$30
Preferred Brand	$80	$80	$50	$50
Non-Preferred Brand	$110	$110	$70	$70

* Copay waived at Jackson Health System Facility. ** Pharmacy copays will count towards the Out-of-Pocket maximum
***POS & High HMO Plans - Diagnostic Tests & Imaging (x-ray, blook work, CT, MRI, etc) will be subject to $100 copay, if test is performed at a hospital afflilated facility.
No charge if test performed at Jackson or non-hospital independnet facility. Copay not applicable to the Select Network HMO
**** MDC Jackson First Pilot HMO availability is based on Bargaining Unit Status
+ Urgent Care facility/visit at retail facility

DENTAL

SCHEDULE OF BENEFITS	Delta Dental PPO - Standard	Delta Dental PPO - Enriched	DeltaCare DHMO - Standard	DeltaCare DHMO - Enriched
	Plan Pays	**Plan Pays**	***You Pay**	***You Pay**
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.		Limited to participating Dentists within the DeltaCare USA Network.	
Maximum Benefit / Deductible	$1,000 per year per person	$2,000 per year per person	No Maximum / No Deductible	
	$50 deduct. per yr per person	$50 deduct. per yr per person		
	$150 family maximum	$150 family maximum		
		$50 Lifetime deductible for orthodontics		
Type I			**General/Specialist**	
0150 Comp. Oral Evaluation -New Or Established	100%	100%	No charge/No charge	No charge
0120 Periodic Oral Exam	100%	100%	No charge/No charge	No charge
X-Rays				
1110/20 Prophylaxis	100% (2X calendar year)	100% (2X calendar year)	No charge/No charge	No charge
1206 Fluoride Treatment (Children Up To The Age 19)	100%, 2x per year	100%, 2x per year	No charge/No charge	No charge
1351 Sealant - Per Tooth	100% to age 16	100% to age 16	No charge/No charge	No charge
1510 Space Maintainers	100% to age 19	100% to age 19	No charge/No charge	$25
Type II Filings			**General/Specialist**	
2330 - One Surface	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP	$10/$28	No charge
2331 - Two Surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP	$18/$35	No charge
2390 - Resin Crown, Anterior	100% PDP/ 75% Non PDP	100% PDP/ 75% Non PDP	$30/$90	$30
2394 - Resin, Four Or More Surfaces	100% PDP/ 75% Non PDP	100% PDP/ 75% Non PDP	$65/$115	$65
Root Canals				
3310 – Anterior	75%	75%	$90/$110	$45
3330 – Molar	75%	75%	$200/$245	$145
Extractions				
7111 - Single Tooth	75%	75%	No charge/$45	No charge
4210 - Gingivectomy / Gingivoplasty-Per Quadrant	75%	75%	$120/$165	$90

DENTAL (continued)

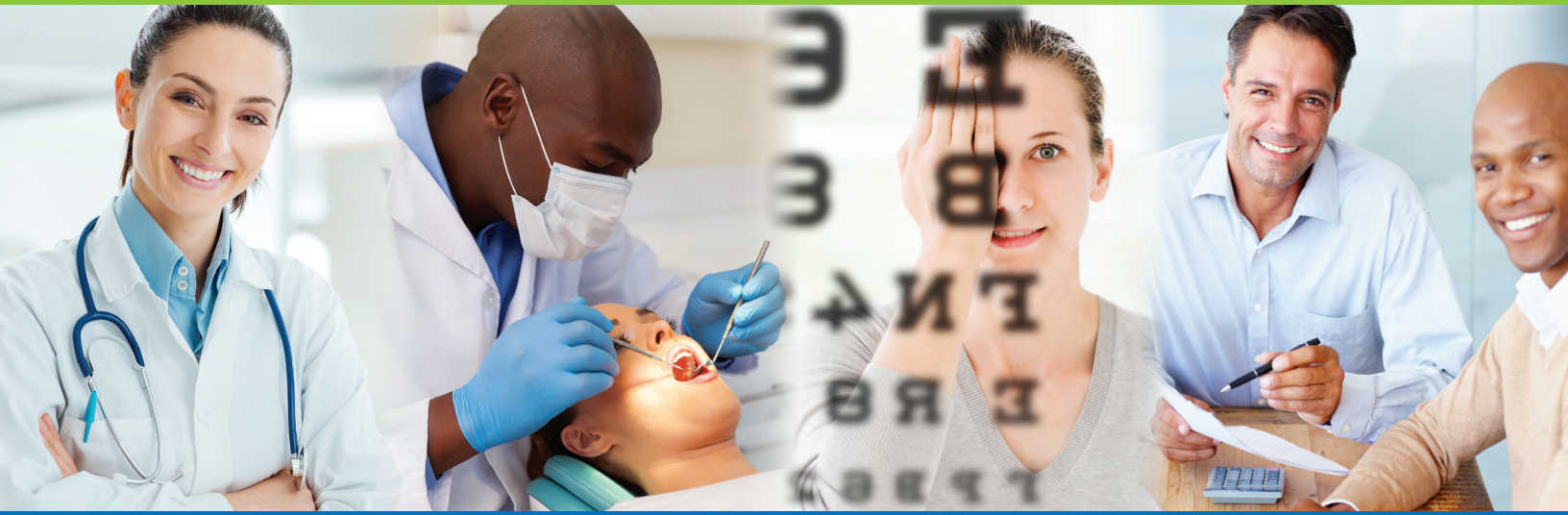
SCHEDULE OF BENEFITS	Delta Dental PPO - Standard	Delta Dental PPO - Enriched	DeltaCare DHMO - Standard	DeltaCare DHMO - Enriched
Type III Crown & Bridge			**General/Specialist**	
2930 - Prefabricated Stainless Steel Primary Tooth	50%	50%	$25/$35	No charge
2750 - Crown Porcelain Fused To High Noble Metal	50% (1 per tooth within a 5 year period)	50% (1 per tooth within a 5 year period)	$477.50/$485	$355
6750 - Crown Porc. 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+)	$477.50/$485	$355
Prosthodontics				
5110 - Complete Upper	50%	50%	$230/$510	$205
5120 - Complete Lower	50%	50%	$230/$510	$205
Orthodontia				
Consultation	Not Covered			
Evaluation	Not Covered			
Records	Not Covered	Adults & Children covered at 50% after one-time deductible of $50 per person.	Pre-treat. Records - $200 Post-treat. Records - $70 Child to age 19 - $2,100 Adults - $2,250	Pre-treat. Records - $200 Post-treat. Records - $70 Child to age 19 - $1,400 Adults - $1,950
8070/808 Comp. Treat. Child to Age 19 Normal	Not Covered			
Class II				
8090 Comp. Treat. Adult - Normal Class Ii	Not Covered			
8680 Retention	Not Covered	$1,300 Lifetime Maximum.	Retention - $300	Retention - $275
*All Type II and III charges subject to annual deductible. The above reimbursements are exclusive of gold. All services must be performed by a DeltaCare USA network provider. A referral is required to see a specialist.				

VISION

	Out-of-Pocket Costs with MetLife Vision		
Eye Exam	No copayment -every12 months		
Glasses	$10 copayment -every12 months		
Frame	160 Retail Allowance + 20% off balance		
Lenses (Single, bifocals, trifocals)	$10 copayment -every12 months		
Ultraviolet coating	$0		
Polycarbonate lenses	$0		
Elective Contacts (in lieu of frame & lenses)	160 Retail Allowance every 12 months		

2018 YourBeneFITS

MIAMI-DADE COUNTY EMPLOYEE BENEFITS



BENEFIT HIGHLIGHTS

MIAMI-DADE COUNTY

Benefit Highlights

Miami-Dade County provides a comprehensive and competitive benefits package that supports you and your family. This Benefit Highlights Guide provides an overview of your benefits, guidance for new hires and existing employees on enrolling and making benefit changes, and information on additional employee services and how to access them.

Eligibility

Employee Eligibility

Eligible employees include:

- Full-time employees
- Part-time employees who are scheduled to work 60 hours per pay period
- Variable Hour Employees (VHE), who average 60 or more hours worked per pay period measured over 26 pay periods, per ACA regulations

Dependent Eligibility

Eligible Dependents include:

- Spouse or Domestic Partner
- Disabled child*
- Legal Guardianship
- Adult dependent child*
- Child
- Stepchild
- Grandchild*

* Special conditions apply. For additional information on eligible dependents including documentation required for enrollment, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

You may cover your spouse/domestic partner and dependent children under your medical, dental, and vision plans. Refer to the Benefits Handbook for additional information regarding dependent eligibility document requirements and domestic partner benefits. Premiums for overage children, domestic partner and children of a domestic partner will be deducted post-tax and subject to imputed income tax.

Coverage for a spouse/domestic partner ends on the effective date of the divorce/dissolution of domestic partnership.

The limiting age for dependent children is the end of the calendar year that the child reaches age 26 for medical, dental and vision. Medical coverage may be extended to age 30, under the conditions listed below.

Adult Dependent Children Age 26+ to 30
Florida Statute (FSS 627.6562)

Medical coverage may be continued for adult children age 26+ through the end of the calendar year the child turns 30, if the child:

- Is not married and has no dependents (i.e. children, spouse/domestic partner), and
- Is not provided other major medical health insurance, and
- Is either a resident of Florida or is a student in another state.

To enroll a new dependent age 26+ to 29 (not currently enrolled in a County medical plan) proof of other continuous creditable coverage (without a gap of more than 63 days), must be submitted to the health plan.

Dependent children who are incapable of sustaining employment because of mental or physical disability, and are dependent upon the employee for support, may continue to be covered beyond the limiting age, if enrolled prior to age 26. Proof of disability must be submitted to the plan within 31 days of the end of the calendar year of the child's 26th birthday and subsequently as may be required.

Dependents who become County employees must enroll in their own County benefits.

Dependent Eligibility Verification

Miami-Dade County is committed to offering a comprehensive benefit package to you and your family, but also realizes many dependents may no longer be eligible for coverage due to life status changes. Miami-Dade County will continue to conduct Dependent Eligibility Audits to verify the eligibility of covered family members. You will be required to provide documentation, such as birth or marriage certificates, for any dependents enrolled for healthcare benefits.

Timely Notification of Ineligible Dependents

It is your responsibility to contact the Benefits Administration Unit or Human Resources office when one of your enrolled dependents becomes ineligible for benefits coverage. Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action, and repayment of claims. In addition, failure to notify the Benefits Administration Unit or Human Resources office of your ineligible dependent within either the designated Open Enrollment period or the 45-day Change In Status period will result in (1) cancellation of the ineligible dependent as of the date the dependent became ineligible and (2) continuation of the existing coverage level and respective premium through the end of the plan year. Dependents may be eligible to continue their medical, dental and vision coverage through COBRA (continuation coverage) if you notify the Benefits Administration Unit or Human Resources office within 60 days of a qualifying event.

New Hire Enrollment

You may use the Benefits Enrollment link on eNet (**https://enet.miamidade.gov**) to enroll in benefits. Benefits are effective 1st of the month following (or coincident to) 60 days of employment.

Before you begin the online enrollment process, be sure to review the reference materials and online enrollment steps available online. Once you have the answers you need, begin the enrollment process. Don't wait until the last minute! If you have questions regarding plan benefits 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.).

The online enrollment must be completed before your benefits eligibility date. The enrollment window is from the date you are added to the payroll system to the day before the benefits eligibility date. The Benefits Enrollment website is accessible from any computer 24/7.

If you do not submit your benefit elections during your initial eligibility period, you will not have another opportunity until the next open enrollment. At that time, life insurance and disability coverage will be subject to evidence of insurability and approval is not guaranteed.

Change In Status (CIS)

Once the Open Enrollment period closes, you may add or delete dependents to your health plan only under limited circumstances such as a Qualifying Event (QE). Changes must be reported within 45 days of a QE (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.

For additional information and Internal Revenue Code (IRC) Section 125 QEs, go to **www.miamidade.gov/humanresources/benefits.asp** to access the online Benefits Handbook. You may also download the CIS and Benefit Election Change forms from this website.

Your change request must include documentation supporting the loss or gain of insurance coverage. Do not delay submission of your CIS and Benefit Election Change forms while you gather your documentation. Ensure your CIS and Benefit Election Change forms are submitted within the 45-day deadline. Simply forward the forms to your Departmental Personnel Representative and then present your supporting 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, 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 will process a change in premium as of 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.

For additional information on eligibility and enrollment, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Medical and Prescription Drugs

As an eligible Miami-Dade County employee, you may enroll yourself and eligible dependents for coverage in one of the offered medical plans.

The available medical plans are:

AvMed POS

In-Network: Plan pays 100% for covered charges, after applicable copayments.

Out-of-Network: Plan pays 70% of Maximum Allowable Payment (MAP); you pay 30% co-insurance after deductible. You will be responsible for all Out-of-Network charges in excess of the Maximum Allowable Payment. AvMed encourages but does not require the selection of a primary care physician (PCP). No referrals are required to receive covered medical services from participating specialists.

AvMed High Option HMO

Plan pays 100% for covered charges, after applicable co-payments. AvMed encourages but does not require the selection of a primary care physician (PCP). No referrals are required to receive covered medical services from participating specialists.

AvMed Low Option HMO

Plan pays 100% of covered charges, after applicable co-payments. You are required to select a PCP for each person enrolled. Referrals from the PCP are required to receive covered medical services from participating specialists. This plan is not available to Non-bargaining employees or Bargaining Unit employees that accepted the plan redesign in their Collective Bargaining Agreements.

AvMed Select Network HMO

Plan pays 100% of covered charges, after applicable co-payments. This plan is only available to Non-Bargaining employees and eligible Bargaining Unit employee in accordance with their Collective Bargaining Agreement.

AvMed Jackson First HMO

A more affordable healthcare option with a network limited to only Jackson Health System (JHS)/University of Miami Health System (UMHS) facilities. AvMed contracted providers with privileges at the JHS and UMHS facilities are included. One exclusive feature is a Healthcare Concierge Service (“Fast Track”). The Concierge team will have the ability to assist you with finding a network provider, scheduling appointments and coordinating specialty and/or hospital care. This plan is only available to Non-bargaining employees and eligible Bargaining Unit employees in accordance with their Collective Bargaining Agreement.

Detailed coverage information on each plan may be found at **https://www.avmed.org/mdc**.

Making the Most of Your Medical Coverage

SmartShopper

AvMed offers SmartShopper, giving you a chance to earn cash back while saving on healthcare costs. Medical procedures or diagnostic tests can qualify you or your dependents for CASH BACK when you choose a cost-effective location! This service is available to members in the MDC Select HMO, High and Low option HMOs, and POS plans*.

Here's how SmartShopper works:

Your doctor recommends a qualifying procedure. You then call SmartShopper and a Health Cost Adviser will provide information on cost-effective locations in your area for the service your doctor has recommended. You will need to have your Member ID for verification. You can also shop online at AvMed.VitalsSmartShopper.com. Then, contact your doctor to schedule the service.

Please note: In order to qualify for incentives, you must contact AvMed SmartShopper AT LEAST 24 hours before the procedure. If you choose to use a cost-effective location, as identified by AvMed SmartShopper, you will receive an incentive check in the mail no later than 60 days after your claim has been paid.

To access SmartShopper, go to **AvMed.VitalsSmartShopper.com** or call 1-855-869-2133, Monday-Thursday from 8:30 am-8 pm, Friday from 8:30 am-5 pm, and easily shop healthcare services in your area.

*SmartShopper is not offered to Jackson First HMO Members

Virtual Visits

AvMed Virtual Visits, powered by MDLIVE, provides anytime remote access to board-certified doctors from your home, your office, or on the go. Just 15 minutes after a simple sign-up, members can speak with a doctor about non-emergency medical issues by phone or by secure video using a computer, tablet, or smartphone, for the cost of a PCP visit. It's healthcare that works for AvMed Members, wherever and whenever you need it. Enrolling all of your covered family members in advance will save you time when you need the service.

Below are just some of the medical issues a doctor can assist you with:

Acne	Fever	Respiratory problems
Allergies	Headache	Sore throats
Constipation	Insect Bites	Urinary problems/ UTI
Cold/Flu	Nausea	Vaginitis
Diarrhea	Pink eye	Vomiting
Ear Problems	Rash	

To sign up for Virtual Visits, register online at **mdlive.com/AvMed**, by phone at 1-888-632-2738, or by downloading the "MDLIVE" app.

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**. On the left hand side list of quick links, click on your plan's network: "MDC Select Network" or "Elite Network", then click on "Urgent Care Search" on the left hand side.

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.

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		

Disease Management

Receive support managing your condition with the Disease Management Program. This service is free with your AvMed plans. You will learn how to manage your condition, lower your risks for new conditions, work better with your doctor, take your medicine safely and also receive education and resources specific to your condition. If you have a condition and or think you're at risk contact AvMed/Optum (855) 81-AVMED (28633) for more information about the program.

Lifestyle Coaching

Eligible employees who meet certain criteria may be referred to Lifestyle Coaching by an AvMed Health Coach who can help employees manage a lifestyle change or condition.

Generic Medications Cost Less

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.


WELCOME
TO YOUR
NEIGHBORHOOD
URGENT CARE
CENTER
THE DOCTOR WILL
SEE YOU NOW

At UHealth Jackson Urgent Care, we treat common conditions with uncommon convenience. With board-certified physicians from the University of Miami Health System on site seven days a week, you'll get the treatment you need — so you can get back to being you again.

UHealth Jackson
UNIVERSITY OF MIAMI HEALTH SYSTEM HEALTH SYSTEM

Urgent Care

Open Every Day, 8 a.m. to 8 p.m.

JacksonUrgentCare.com

Country Walk
13707 S.W. 152nd Street
Miami, FL 33177
305-585-9200

Keystone Point
13120 Biscayne Boulevard
North Miami, FL 33181
305-585-9210

Cutler Bay
18910 South Dixie Highway
Cutler Bay, FL 33157
305-585-9230

Our charges for medical services are less than the charges for comparable medical services at Jackson Memorial Hospital.

Mail Order Prescriptions

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

Prescription for Healthy Living

If you agree to participate in this program, the co-pays for your diabetes, cholesterol and high blood pressure medications will be reduced to zero for any generic medication and $5 for any second and third tier medication. Contact AvMed to opt-in. Additional requirements apply.

Imputed Income

The Internal Revenue Service (IRS) allows "tax free" health insurance subsidies for you and your eligible dependents, 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 your income, referred to as "imputed income" and this imputed income will be taxed accordingly. Go to **www.miamidade.gov/humanresources/benefits.asp** for additional information regarding imputed income tax. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

IRS 1095-C Form Employer-Provided Health Insurance

When filing 2017 taxes, you will need to show whether you had minimum essential coverage, as defined and required by the Affordable Care Act (ACA). To provide the information needed for tax filing, employers who sponsor self-funded health plans generally must provide a Form 1095-C by January 31, 2018. The 1095-C demonstrates that you were given the opportunity to enroll in ACA-compliant coverage and, if applicable, you enrolled in it.

For more information, go to:
www.miamidade.gov/humanresources/library/benefit-change-advisory-health-care-information.pdf
or contact:
Benefits Administration Unit: (305) 375-5632

Access your Medical benefits and coverage information online!

If you are currently enrolled, you may view information on your enrollment, benefits claims, and find participating providers at **https://www.avmed.org/web/mdc.**

For additional information on the County's Medical plans, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Dental

You may enroll yourself and your eligible dependents for dental coverage even if you decline the medical coverage. There are two dental plans available, each with a Standard and Enriched option:

Delta Dental PPO Standard or Enriched

Select the dentist of your choice. Benefits are payable at various coinsurance levels. A deductible is applied for services other than preventive and diagnostic. Annual maximum reimbursements apply. The Enriched plan also includes orthodontia.

DeltaCare USA DHMO Standard or Enriched

Choose a dentist from a list of participating dentists and receive coverage for a variety of services. Participating dentists are primarily in the South Florida Tri-County area. Most preventive, diagnostic and many other services are provided at no additional cost to members. Some services have fixed co-payments. There are no claim forms, no deductibles and no annual dollar maximum under the DHMO dental programs. The Enriched DHMO Dental plan provides additional benefits and specialty coverage not covered under the Standard program. Services must be received by a participating provider within the plan's service area.

Detailed coverage information on each plan may be found at **www.miamidade.gov/humanresources/benefits-forms.asp**.

Planning for major dental work? Consider a Pre-treatment Estimate!

If you know you'll need major dental work, Delta Dental can tell you exactly what your share of the cost will be before you receive treatment.

Minimize your out-of pocket expense for dental care by asking your dentist for a pre-treatment estimate from Delta Dental before you agree to receive any prescribed, major treatment. This lets you know up front what the plan will pay, and the difference you will be responsible for. Your dentist may be able to present alternative treatment options that will lower your share of the bill, while still meeting your basic dental care needs. (This service is not available to DeltaCare® USA enrollees.)

A pre-treatment estimate is particularly useful for more costly procedures such as crowns, wisdom tooth extractions, bridges, dentures or periodontal surgery. When your dentist submits a pre-treatment estimate to Delta Dental, Delta Dental will send an estimate of your share of the cost and how much Delta Dental will pay.

For more information, contact a Delta Dental representative at 1-800-471-1334.

Dental Emergencies

Here is what you need to know if you or a family member needs after-hours or urgent care:

- Before an emergency arises, find out how to contact your dentist if you need urgent care treatment or treatment after normal office hours. Typically, dentists have a plan for how they can be reached in case of emergency, or will make prior arrangements with other dentists if they are unavailable to provide care to you in case you need treatment immediately or urgently.
- You may also call the local dental society (listed in your telephone directory) if your dentist is not available to refer you to another dentist for urgent, emergency or after-hours care.
- All plans have provisions for after-hours or urgent care. (Check your Contract or Evidence of Coverage to learn more about your after-hours and urgent care coverage.)
- If you or a family member has special needs, you should ask your dentist about accessibility to their office or clinic at the time you call for an appointment. Your dentist will be able to tell you if their office is accessible, taking into consideration your specific needs.

For Delta Dental PPO enrollees

- You can obtain routine or urgent care from any licensed dentist during normal office hours.
- You may seek treatment for urgent or emergency care after normal office hours from any licensed dentist without preauthorization.
- Your out-of-pocket costs are likely to be lower if you get emergency care from a dentist who is in your network.

For DeltaCare USA enrollees

- Always try to contact your assigned network dentist first for urgent or emergency care.
- Your network dentist may treat you or provide an authorized referral to another dentist.
- If your assigned network dentist is not available, DeltaCare USA's Customer Service staff can provide an authorized referral for immediate treatment. Call (800) 422-4234.
- If you cannot reach your network dentist or DeltaCare USA for a referral, you may use your out-of-area emergency benefit (typically limited to $100 per emergency, subject to standard plan limitations and exclusions; copayments may apply).

Access your Dental benefits and coverage information online!

If you are currently enrolled, you may view information on your enrollment, benefits claims, and find participating providers at **https://www.deltadentalins.com**.

For additional information on the County's Dental plan, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Vision

The MetLife Vision Plan is available to all employees eligible for medical and dental coverage, regardless of union affiliation. You pay the full cost of the program. The plan offers you and your enrolled dependents an annual comprehensive eye exam at no charge with a participating optometrist or ophthalmologist. Members may also receive a pair of glasses every year, with a $10 copay from a special selection of frames available at participating providers. Contact lenses or other frames are available as alternate benefits.

This program allows you to use non-participating providers and be reimbursed according to the nonparticipating benefit schedule.

Employees interesting in learning more about the plan may view the MetLife plan literature at **http://www.miamidade.gov/humanresources/library/metlife-vision-benefits.pdf** or call MetLife toll-free at 1-877-638-2055.

Detailed coverage information on the Vision Plan may be found at www.miamidade.gov/humanresources/benefits.asp.

Access your Vision benefits and coverage information online!

If you are currently enrolled, you may view information on your enrollment, benefits, claims, and find participating providers at https://metlife.com/mybenefits.

For additional information on the County's Vision Plan, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Legal Plan

The Pre-paid Legal Plan offers affordable and unlimited access to professional attorneys for a wide array of legal needs. You pay the full cost of the program. To locate a participating attorney, call the ARAG Customer Care Center at (800) 667-4300 or visit **www.ARAGLegalCenter.com** and enter Access Code: 10277mdc.

For additional information on the County's Legal plan, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Flexible Spending Account (FSA)

FSAs are IRS tax-favored accounts that can be used to pay eligible expenses. These funds are deducted from your salary before taxes are withheld, allowing you to pay your eligible expenses tax-free. A Healthcare FSA (HFSA) allows you to pay for eligible medical, dental or vision care expenses not covered by your insurance or any other plan. Dependent Care FSA funds can be used to pay eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working.

FSA Limits

Health Care FSA Maximum Annual Deposit:
$2,650 (less a $52.52 annual administrative fee)

Dependent Care FSA Maximum Annual deposit:
$5,000 (less a $52.52 annual administrative fee)

Don't forfeit your FSA Funds!

To ensure you don't lose your 2018 Healthcare FSA funds, you will need to spend that money by March 15, 2019 and submit your reimbursement for Healthcare FSA request(s) before April 30, 2019. For your Dependent Care FSA funds, you will need to spend that money by December 31, 2018 and submit your reimbursement for Dependent Care FSA request(s) before April 30, 2019. Miss these deadlines and that money – YOUR money – will sadly be forfeited. So please, plan carefully and be sure to spend the money you set aside.

Certain FSA Card Purchases Require Documentation

The Benefits Administration Unit provides to WageWorks (FBMC), on an annual basis, the co-payment amounts under the County's medical, prescription, dental and vision plans. As such, the co-payments that you pay using your FSA card will generally not be subject to verification. However, certain eligible expenses that you pay for with your FSA card will require documentation so that WageWorks (FBMC) can verify that you are not using your FSA card to pay for an expense that is covered under your insurance. Examples of services that would require documentation include:

- Co-payments under a spouse's Medical Plan or Prescription Drug Plan
- Medical & Dental deductible and co-insurance payments
- Some prescriptions & certain OTC* items
- Durable medical equipment
- Eyeglasses, contacts lenses or Lasik surgery
- Other eligible expenses that are not covered under your insurance

*Over-the-Counter (OTC) drugs and medicines require a prescription to qualify for FSA reimbursement and your FSA card use.

For expenses requiring documentation, the Explanation of Benefits (EOB) provided by the insurance carrier (if applicable) and the merchant's receipt or provider's statement is acceptable. EOBs for claims under the County's medical and dental plans can be obtained through the vendor's website.

If you fail to send in the requested documentation for an FSA Card expense, you will be subject to:

- Withholding of payment for an eligible paper claim to offset any outstanding FSA Card transaction
- Suspension of your FSA Card privileges
- The reporting of any outstanding FSA card transaction amounts as taxable income, and applicable taxes will be withheld.

Access your FSA balance and claim information online!

Need to check how much money you have left in your FSA Health Care or Dependent Care account? Visit www.myfbmc.com.

For additional information on the County's FSA plan, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Life Insurance

Basic Life

Basic Life insurance is provided at your annual adjusted base salary. Premiums for this coverage are paid by Miami-Dade County, meaning no cost to you. During the initial benefits eligibility period, new employees will be automatically enrolled in the County-paid basic life insurance coverage, upon enrolling for health or optional benefits using the online New Hire Benefits Enrollment website. You must be actively at work for coverage to start. Life insurance amounts in excess of $50,000 may be taxable and may be included as taxable income on your W-2 form.

Optional Life

Optional Life insurance is available in increments of 1x to 5x employee's annual adjusted base salary, to a maximum of $2 million. Premiums are age-based and depend on the amount of coverage purchased. You pay the full cost of this coverage. A Statement of Health may be required. Newly hired employees may elect coverage from 1x to 3x annual salary without completing a Statement of Health form.

Optional Life Open Enrollment

Open Enrollment for Optional Life is held annually, in early April. You may view your current election, increase your coverage or enroll for the first time. You may elect coverage in increments of 1x to 5x your base annual salary, to a maximum of $2 million. A Statement of Health may be required.

Visit **www.Metlife.com/MyBenefits** during the open enrollment period to make coverage elections.

Update Your Life Insurance Beneficiary Designation!

If you need peace of mind on your family's future, take time to update your beneficiary designation on your basic or optional life insurance on eNet. The process is easy, secure and will only take a few minutes. Do not leave this important decision for later. You can designate or update your beneficiaries online at **https://secure.miamidade.gov/enet/wps/portal**. For more information, visit **www.miamidade.gov/humanresources/benefits.asp**.

County Death Benefits

Miami-Dade County Death Benefit Resolution No. 81-02 provides for the following death benefit: When a permanent status and career exempt employee dies and it has been determined that his/her survivors are not entitled to County provided job related death benefits, the County will pay to the employee's beneficiary(ies) a death benefit amount determined by the employee's years of continuous County service. In addition, the beneficiary(ies) is/are eligible to continue the medical and dental coverage for either one or two pay periods based on the employee's longevity.

Update Your County Death Benefit Beneficiary Designation!

To update your Beneficiary Designation for the County Death Benefit, go to the Benefits web page under Forms and click on the County Death Benefit Beneficiary Designation under Beneficiary Change Forms, or contact your Departmental Personnel Representative (DPR) or the Benefits Administration Unit at 305-375-4288 for the required form. Please note that any paper beneficiary forms that are submitted must be notarized.

For additional information on the County's Life Insurance benefits, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Disability

Short Term Disability

Short Term Disability (STD) insurance is a voluntary benefit which helps you replace a portion of your income should you be absent from work due to your own medical condition for a period greater than 14 consecutive calendar days. **Employees going out on STD should apply for STD to begin as of the first day of medical absence, regardless of how much sick leave they have accrued.** There is a 14 calendar day elimination period before STD benefits can be paid. During this elimination period, you must exhaust all accrued sick leave. Any accrued sick leave remaining after the elimination period must also be exhausted before STD benefits are paid (annual leave will be exhausted as well, unless the employee actively requests that it not be used). STD benefits are paid at 60% of the employee's base annual salary to a maximum amount based on the plan option elected. Employees may elect the STD Low Option plan (maximum weekly benefit of $500 per week) or the STD High Option plan (maximum weekly benefit of $1,000 per week). You pay the full cost of STD coverage, through post-tax payroll deductions.

Long Term Disability

Long Term Disability (LTD) insurance is a voluntary benefit which helps you replace a portion of your income should you be absent from work due to your own medical condition for a period greater than 180 consecutive calendar days. LTD benefits are paid at 60% of your base annual salary to a maximum amount based on the plan option elected. You may elect the LTD Low Option plan (maximum monthly benefit of $2,000 per month) or the LTD High Option plan (maximum monthly benefit of $4,000 per month).

You may also elect the LTD Premier plan, which provides income replacement at 66 2/3% of your base salary to a maximum of $7,000, should you be absent from work due to your own medical condition for a period greater than 90 consecutive calendar days. An employee electing either of the STD plans may not elect the LTD Premier plan, because the 90-day elimination period under the LTD Premier plan overlaps the STD period of 180 days. You pay the full cost of LTD coverage, through post-tax payroll deductions.

Payment of disability benefits under all plan options are subject to medical review and approval by the disability insurance carrier.

For more information on the County's Disability plans, please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp**.

Leave Benefits

Leave Time

Accrued Annual leave, Sick leave, Birthday Holiday, Floating Holiday and eleven (11) paid County observed holidays.

- You accrue 80 hours Annual Leave (10 days) for one (1) year of continuous full-time service.
- You accrue 96 hours Sick Leave (12 days) for one year (1) of continuous full-time service.
  - —Any unused portion of the first 48 hours of Sick Leave accrued during the year is converted to Annual Leave on the employee's Leave Anniversary Date.

Longevity Annual Leave

After five years of service, you are granted an additional eight hours of annual leave on their leave anniversary date to a maximum of 80 hours/96 hours depending on the employee's regular work schedule.

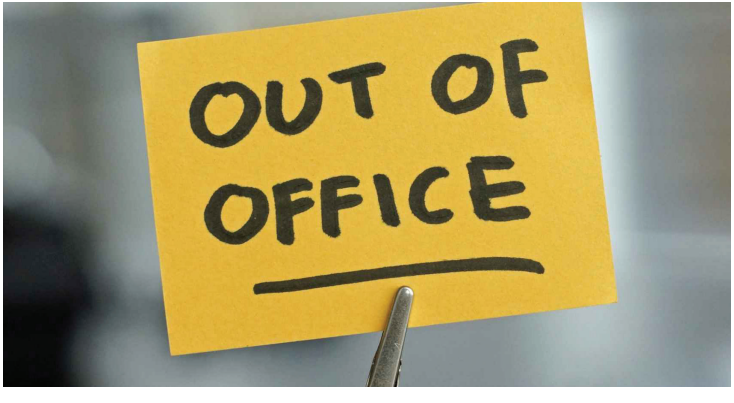
Longevity Bonus Award

The Miami-Dade County Pay Plan provides for longevity bonuses for employees who complete a minimum of 15 years of continuous service. These bonuses are calculated on a sliding scale of 1.5% to 3% depending ion years of continuous service.

For details on the longevity bonus award calculation and eligibility, visit **http://www.miamidade.gov/humanresources/library/personnel-payroll-reference.pdf**.

Annual and Sick Leave Payments at Time of Separation

- Maximum accumulation and payout for annual leave for 40/48 hour workweek employees is 500 hours.
- Sick Leave accumulates without limit. Depending on years of continuous service and upon separation, you may be eligible to cash out, on a sliding scale of 25 percent to 100 percent, up to 1,000 hours of Sick Leave.



Leave of Absence

A Leave of Absence (LOA) is an approved absence without pay for a maximum period of one year. Your department manages your requests for LOA, and approvals must be in accordance with the Leave Manual.

For Family & Medical Leave (FMLA) requests, you must submit the FMLA request form and the completed certification by the health care provider in advance of the date of leave.

You are responsible for paying the premiums for your group benefits. HR\Benefits Administration oversees the premium collection during unpaid LOA. The premium you are responsible for depends on the type of leave. If you are out on approved FMLA Leave, you are responsible for only the employee's portion of the premium. All other leave types require both the employee cost/county's portion of the premium:

A LOA Package, explaining benefit costs and where to send payment, will be provided to you by your department.

LOA premiums are due the 1st day of each pay period. A warning notice is sent to you after the 2nd pay period of non-payment. Coverage will be cancelled at the 3rd pay period of non-payment, and a notice of cancellation will be sent to you. If coverage is cancelled for non-payment, you must wait until the next Open Enrollment to re-apply for insurance coverage. A Statement of Health will be required if you re-enroll in Optional Life, Short Term Disability, and Long Term Disability.

For more information about Leave of Absence, please refer to the Benefits Handbook, located on the MDC Human Resources web site under Benefits. For additional information on leave eligibility, leave accrual and usage, or leave payout benefits, refer to the Leave Manual at **http://www.miamidade.gov/humanresources/library/compensation-leave.pdf**.

Paid Parental Leave

Paid Parental leave provides you leave with pay for the purpose of caring for your newborn, newly-adopted child, or newly-placed foster child or children. You are eligible for paid parental leave if you are an exempt/non-bargaining employee or any other employee covered by collective bargaining agreements whose agreement explicitly provide for this benefit. You may be granted paid parental leave if you have worked for Miami-Dade County for a minimum of one year.

Paid parental leave shall be up to six weeks long, and may be taken by day or week during the first year after the birth, adoption, or foster care intake of the child or children. The leave period is fixed regardless of the number of children born, adopted, or permanently placed in your home through foster care.

During the leave period, you shall be paid 100 percent of your base wages for the first two weeks, 75 percent of your base wages for the following two weeks, and 50 percent of your base wages for the remaining two weeks. You may be eligible to use any accrued leave in order to receive compensation up to 100 percent of base pay during the weeks reimbursed at the rates of 75 percent and 50 percent.

For additional information on Paid Parental Leave, refer to the Leave Manual at **http://www.miamidade.gov/humanresources/library/compensation-leave.pdf**.

COBRA

If you are a separated employee losing coverage, you may continue medical, dental and vision coverage for yourself and/or covered family members. You are eligible for up to 18 months of COBRA coverage. Dependents are eligible for up to 18 months of COBRA coverage, or 36 months if loss of coverage is due to your divorce, death, or child reaching the age limit. You may also continue the Flexible Spending Account (FSA) under COBRA through the end of year in which employment ends. Benefits end the last day of the pay period in which termination date falls and premiums were payroll deducted or direct payments made. This includes life, Medical, Dental, Vision, FSA, LTD, STD, Legal, and Optional Life.

COBRA Election forms will be mailed to you by the COBRA administrator, 7 - 10 business days after the termination pay period. You have 60 days to make an election. If elected, coverage is effective retroactive to the first date after active coverage ended. You have 45 days from the date of making a COBRA election to submit the initial premium payment.

Saving for Your Retirement

Florida Retirement System (FRS)

Miami-Dade County provides retirement benefits for eligible employees through the Florida Retirement System (FRS). Enrollment is automatic for full-time and part-time employees.

The FRS is qualified under Section 401(a) of the Internal Revenue Code and provides a defined benefit (FRS Pension Plan) and a defined contribution plan (FRS Investment Plan) option. Under the defined benefit plan, for every month you receive a paycheck, you receive one month of service credit; if you participate in the defined contribution plan, a contribution is made to your account and you are responsible for managing your investments. You must make your Florida Retirement System (FRS) plan election within the first 5 months of your employment by visiting **https://www.myfrs.com/** or you will be defaulted to the Investment Plan (except special risk employees).

Plan Features

In order to qualify for the pension benefit, you must be vested. Under the defined benefit plan, you must have at least 6 years of creditable service if enrolled in the FRS prior to July 1, 2011, and 8 years of creditable service if enrolled in the FRS on or after 7/1/2011.

Under the defined contribution plan, you need only have one year of creditable service to be vested.

As an FRS member, you must contribute 3% of your salary towards your retirement benefit, on a pre-tax basis (contributions are taken from your gross salary before Federal Withholding taxes are calculated). The remainder is paid by the Employer.

Members participating in the Deferred Retirement Option Program (DROP) and re-employed retirees who do not qualify for renewed membership are not required to make the 3% contribution.
For more information on the FRS, visit **https://www.myfrs.com**.

FRS Reemployment After Retirement

If a retiree returns to employment with an FRS employer during the first 12 months after retirement in any position, the following provisions will apply:

- If the reemployment occurs during the first 6 calendar months after the retirement, the employee will not be considered to have retired. The member's retirement will be canceled and they will be required to repay all retirement benefits received. Additionally, the department is responsible for repaying any retroactive contributions due on the service.
- If the reemployment occurs during the 7th through the 12th month after the date of retirement, payments of retirement benefits will be suspended for any months the retiree is employed during this 6 month period. Benefits that would otherwise have been paid during the period of suspension are forfeited. The retiree must repay any benefits received while working during the 7th through the 12th month after retirement.
- Effective July 1, 2017, reemployed retirees from the Investment Plan are eligible for renewed membership in FRS and will be required to make the 3% employee contribution.

Deferred Compensation

When you retire, you'll want to maintain the lifestyle you currently have. The Deferred Compensation Plan is a tax deferred savings plan governed by Section 457 Internal Revenue Code, and can be used at retirement to supplement your Florida Retirement System and Social Security benefits.

All Miami-Dade County employees are eligible to participate in this plan. There is no waiting period or minimum number of hours you must work bi-weekly.

Plan Features

Contributions are taken from your gross salary before Federal Withholding taxes are calculated.

You don't pay Federal Withholding Income taxes on your investment contributions or earnings until you receive the money (Social Security taxes on contribution amounts continue to be deducted from your gross salary).

Minimum Contribution: $10 per pay period; Maximum Contribution: 100% of your gross taxable salary or $18,000 (whichever is less) as of January 1, 2017.

Your contributions may be invested into ICMA-RC or Nationwide investments accounts. Each provider offers a number of investment options, including fixed funds, stock funds, bond funds, mutual funds and others.

NEW! 457 Roth Funding Option

In 2017 the Benefits Division introduced a new funding option for the 457 Plan called the Roth Funding Option. This feature allows employees to contribute to the deferred compensation program on a post-tax basis. One of the major benefits of the Roth Funding Option is that if certain conditions are met, the earnings and contributions when paid to you will be tax-free. Contact your local deferred compensation representative to determine if this feature can benefit you.

For more information on the Deferred Compensation plan, please visit **http://www.miamidade.gov/humanresources/deferred-compensation.asp.**

Wellness (in Partnership with AvMed)

The Wellness Works program provides a suite of personalized tools and support, to encourage healthier living. Miami Dade County employees, dependents and retirees covered by the AvMed insurance plan have access to the following free services:

GUIDANCE & COUNSELING
- Health coaching
- Nutritional consultations
- Health education courses
- Bi-annual Health Fairs

CHALLENGES
- Wellness challenges
- Other events to promote physical activity, weight loss, general health, and prevention

SUPPORT TOOLS
- Gym discounts
- Smoking cessation
- Wellness Watch Newsletter
- Weight Watchers

ONLINE SERVICES
- Personal Health Assessments
- Wellness Portal
- Wellness Watch Newsletter

Active County employees can also earn **Wellness Rewards** by participating in the Wellness Works program and earning points.

Earn 75 points in a quarter and you will be entered into a drawing for up to $250!

Participate throughout the year and earn 300 points and you will be to be entered into the annual drawing for $500!

Earn $40 every year by completing the online personal health assessment and the biometric screening at the health fair!

Are you ready to take the next step towards wellness? To learn more about the Wellness Works Program visit: **http://www.miamidade.gov/wellnessworks/.** Register for the Wellness Works program at www.healthyroads.com. To reach a member of the wellness team or schedule an appointment email: wellnessworks@miamidade.gov.

WELLNESSWORKS MIAMI-DADE COUNTY

AvMed

All reward money is subject to applicable payroll taxes. Reward amounts are subject to change.

Employee Assistance Program

What is the purpose of the Miami-Dade Employee Assistance Program (EAP)?

The Miami-Dade Employee Assistance Program (EAP) is a benefit designed to provide a confidential service to employees whose personal problems are affecting their ability to function on the job, at home, or in society.

Professional counselors at EAP can help you sort out the problems and choose the appropriate and workable solutions for you and your family. For more details, see the EAP guide, "Providing Employee Support in the Workplace", located at **http://www.miamidade.gov/humanresources/library/compensation-employee-support-manual.pdf**.

Who can use EAP?

Employee Assistance Program services are available to all Miami-Dade employees and your eligible dependent family members.

What kinds of problems can we help with?

Some of the major problem areas with which EAP can help are:

- Family/Marital Problems
  Family problems can be devastating. EAP can offer guidance in obtaining effective professional help.

- Stress/Anxiety/Emotional Problems
  The majority of us, at one time or another, experience mild anxiety or depression. Occasionally, however, these problems can be quite severe. EAP can assist you in obtaining appropriate professional help.

- Alcoholism and Drug-Related Problems
  Alcoholism is the nation's number one addiction problem. Miami-Dade recognizes addiction as a treatable illness. There has been an epidemic incidence of addiction to one or more of a variety of opioid based prescription medicine and other hard drugs like heroin. Problems persist with addiction to new synthetic drugs, cocaine, and other prescribed medicine such as sleeping pills. Whether your concern is for yourself or a family member, EAP can be an initial source of help.

- Financial Problems
  EAP will help you in finding a financial counselor to help resolve your financial problems.

Are our services confidential?

EAP is designed to ensure confidentiality. Persons who enter EAP on a voluntary basis will have information released only to those individuals authorized by the employee. Only the staff of the program will have access to information on any employee who utilizes the service of EAP in accordance with Federal and State regulations governing private health information.

How does EAP work?

You may self-refer for a consultation in any of the problem areas outlined above (financial, stress, family, and substance abuse).

Your supervisor can also make a mandatory referral in cases of identified substance abuse. Additionally, the supervisor can recommend consultation with EAP if family troubles are identified as adversely affecting the your performance.

Call 305-375-3293 to schedule an appointment. A consultation with EAP will take place 24 hours after your call. Emergency walk-ins are also accepted.

After the initial consultation EAP can suggest, or provide you referrals for resources such as therapy, legal aid, a lawyer, a health care facility, rehabilitation center, etc.

Job security or promotional opportunities will not be affected or jeopardized by requests for assistance or involvement in EAP.

What is the cost to you?

The initial EAP interview is free. Community-based referrals are covered by the various health plans offered by Miami-Dade County. You may be required to pay the co-payments charged for routine doctor office visits.

Employee Recognition

Miami-Dade County's Employee Recognition Programs are designed to recognize employees who demonstrate exceptional service and achievements in their public duties.

Employee Recognition Program

To recognize employees who demonstrate exceptional service and achievements in the performance of their public duties, Miami-Dade County has created a policy for the Countywide Employee of the Year process and authorized development of Departmental Employee Recognition Award (DERA) Programs in County departments. The Human Resources Department – Benefits Division oversees the Employee Recognition Programs. Refer to Administrative Order 7-30, located on the Human Resources website under Benefits – Employee Recognition, or contact the Employee Engagement Coordinator at 305-375-1389 for assistance creating a new program.

IDEA Rewards/ Employee Suggestion Program

Employees can submit a written description of their idea and the benefits that would result from its implementation with personal contact informa¬tion in the IDEA Machine on eNet (hyperlink). Submittals are posted once assigned for review by the appropriate County Department. Those submittals tested and implemented that meet the criteria for the IDEA Rewards Program filter through for further review and rec¬ognition through that program. The award maximum through this Program is $5,000. Refer to Administrative Order 7-8, located on the Human Resources website under Benefits – Employee Recognition, for more details.

Service Awards

County employees are recognized for achieving years of service milestones every five years. A list of the award items presented can be found at **http://www.miamidade.gov/humanresources/divisions-employee-mementos.asp**. With 30 years of service the awards are presented at the start of Board of County Commission committee meetings.

Employee Discount Program

The County offers a program of discounts on various products and services to all retired and current employees. You receive discounts by showing a County I.D., or utilizing coupons provided by the merchants. Access to the discount information is available at **enet.miamidade.gov** under Discounts. Events are also hosted where the merchants will interface with you at your worksite.

Disclosure Notices

Please refer to the Benefits Handbook at **www.miamidade.gov/humanresources/benefits.asp** 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

Additional Benefits

On-Site Child Care

Child care is available in the Downtown area at the Government Center. Services are fee based.

Tuition Reimbursement

If you are enrolled in an accredited educational institution, you may be reimbursed for 50% of tuition costs, for approved coursework which will enable you to improve your performance in your current positions and prepare you for increased responsibilities.

For additional information, including information on employee and course eligibility, visit **http://www.miamidade.gov/humanresources/training-tuition-refund.asp**.

Public Transportation Benefits

It's easy and affordable for County employees to use public transportation. The Monthly Pass Payroll Deduction program lets you take advantage of discounted monthly transit and pre-tax savings. Your monthly transit expenses will be deducted from your paycheck before taxes, and your EASY Card will be automatically reloaded every month as long as you remain in the program. If you pay for Metrorail parking as part of your monthly deduction, your parking decal will be mailed to you every month.

For additional information, including County employee discounts fees, visit **www.miamidade.gov/transit/county-employee-discount.asp**.

Benefit Reminders

- Use your enrollment period to preview your benefit choices before enrollment deadlines by logging in. Visit **www.miamidade.gov/openenrollment** for all benefits eligibility deadlines
- New hires and newly benefit eligible employees must enroll/decline benefits coverage before the completion of the 60th day of eligible employment.
- Add/Remove dependents and submit required dependent eligibility proof documents for enrolled dependents to avoid cancellation of dependent coverage
- Submit Affidavit of Eligibility every year for overage dependent children who have reached age 26 through age 30
- Verify SSN or ITIN for all covered dependents on eNet.
- Verify Personal information (address, email address, telephone number) on blue book with your DPR to ensure your receive applicable benefits notices.
- Designate and or/update beneficiaries (e.g. County Death Benefit, Basic Life, Supplemental Life, and Retirement Plans, if applicable)
- Enroll for your Florida Retirement System (FRS) plan election within the first 8 months of your employment by visiting **https:// www.myfrs.com** or you will be defaulted to the Investment Plan (except Special Risk).
- Enroll in and submit an annual contribution for your Flexible Spending Account (FSA)