Miami-Dade County Employee

Benefits

2016

Your 2016 Benefits at a Glance

Medical, Dental, Life and much more...

For additional information go to:
www.miamidade.gov/benefits

MIAMI-DADE COUNTY

Employee Benefits Resource Directory

Miami-Dade County Benefits Administration Unit

Telephone **Fax**	305-375-5633 or 305-375-4288 305-375-1368 or 305-375-1633
Web Site	www.miamidade.gov/benefits
DPR Contact Information	www.miamidade.gov/humanresources/benefits.asp (click DPR listing under Benefits)
On-Site Plan Representatives	Visit or call your on-site plan representative located in the Benefits Administration Unit, Stephen P. Clark Center, 111 NW 1st Street, Suite 2340, Miami, FL 33128

Medical Plans	**AvMed Health Plans**	Mon-Fri, 8:30a-5:00p	**(305) 375-5306**
457 Deferred Compensation Plans	ICMA-RC	Tues & Thurs, 9:00a - 4:00p	**(305) 375-4710**
	NRS	Mon & Wed, 9:00a - 4:00p	**(305) 375-4853**

Provider Addresses and Contact Information

MEDICAL

AvMed Health Plans
9400 S. Dadeland Blvd., Suite 420
Miami, FL 33156

Member Services 24/7
(800) 682-8633 or 800-68-AvMed
Fax (800) 926-4647
Nurse on Call 24/7
(888) 866-5432
TDD/TTY 711
www.avmed.org/mdc

DENTAL

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
(800) 471-1334
http://www.deltadentalins.com/mdc

Humana-OHS
5775 Blue Lagoon Drive, Suite 400
Miami, FL 33126
(800) 380-3187
www.humana.com/miami-dade-co-govt

MetLife DHMO
PO Box 3594
Laguna Hills, CA 38654-3594
(877) 638-2055
www.metlife.com/mybenefits

VISION

MetLife Vision Plan
PO Box 997565
Sacramento, CA 95899-7565
(877) 638-2055
www.metlife.com/mybenefits

OTHER

ARAG® Legal Insurance
400 Locust Street, Suite 480
Des Moines, IA 50393
(800) 667-4300
www.ARAGLegalCenter.com
Access Code: 10277mdc

ICMA-RC
777 North Capitol Street, NE
Washington, DC 20002-4240
Local Phone: (305) 375-4710
Fax: (305) 375-4711
Investor Services: (800) 669-7400
www.icmarc.org/miamidade

NACo/Nationwide Retirement Solutions
21707 Altamira Avenue
Boca Raton, FL 33433
Fax: (877) 677-4329
Account Info (866) 98Miami (866-986-4264)
www.miamidade457.com

MetLife Disability
MetLife Disability Unit
P.O. Box 14590
Lexington, KY 40511-4590
(888) 463-2023
Fax *(800) 230-9531 or (866) 690-1264
www.mybenefits.metlife.com

(overnight deliveries)

Metlife Disability c/o ACS
2025 Leestown Road, Suite A-2
Lexington, KY 40511
(859) 825-6486 (For delivery purposes)

Completed statements of health (evidence of insurability forms)/inquiries:
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
(800) 638-6420
FAX (859) 225-7909

Fringe Benefits Management Company, a division of WageWorks
P.O. Box 1878
Tallahassee, FL 32302-1878
FSA inquiries: (800) 342-8017
Interactive Benefits: 1-800-865-3262
Fax: (866) 440-7154
www.myFBMC.com

* When faxing information, include your name, SSN and/or claim # in the upper

Miami-Dade County Benefits Handbook

Table of Contents

Visit www.miamidade.gov/benefits for the current biweekly employee rates and monthly COBRA premiums.

This booklet is a summary of the Miami-Dade County Group Insurance Program and includes plan descriptions and provisions that govern the program. The plan year begins January 1 and ends December 31. The material contained in this Handbook does not constitute an insurance certificate or policy. The information provided 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 the certificates of insurance issued by the participating insurance companies. Employees receive benefit certificates for those benefits selected.

This guide does not change or replace the express written terms of any policy, plan, or coverage, which are subject to change at any time.

Web Access to Plan Information

Do you need a provider directory? Find a participating pharmacy, obtain a preferred drug formulary list? View your plan benefit summary or co-payments? Your health plan's Web site is a valuable resource for obtaining benefits information 24 hours a day, seven days a week. In addition to the "basics," here are the highlights of additional benefits available online:

For employees without computer access, please contact your departmental personnel representative.

AvMed (800) 682-8633 - www.avmed.org/mdc
View benefit summaries and co-payments for each plan, medication lists, forms, and details regarding provider and pharmacy networks. Print and request ID cards. Members can access medical and pharmacy claims history as well as other tools to keep you informed and proactive in making your health care decisions.

Delta Dental (800) 471-1334 - www.deltadentalins.com/mdc
Find preferred dental providers, print an ID card, view your plan benefits, download a dental claim form, or find articles on oral health and wellness.

Humana OHS Dental (800) 380-3187
www.humana.com/miami-dade-co-govt
Find a participating dentist, specialist, request an ID card, change providers and much more.

MetLife - Life: (800) 638-6420, Disability: (888) 463-2023
Dental HMO and Vision: (877) 638-2055, www.metlife.com/mybenefits
Disability - Initiate a new claim, view claim status.
Dental - Access co-pay schedules, provider lookup and ID card download.

ARAG - (800) 667-4300
www.ARAGLegalCenter.com (Access Code: 10277mdc):
Find a Network Attorney; view your benefit summary; learn how to best use your plan; download a claim form; use legal tools and resources, including the Law Guide, DIY Docs™, the Legal Risk Assessment™ and the Legal Cost Calculator; send e-mail inquiries to the ARAG Customer Care Center, and much more.

MDC Benefits Website - www.miamidade.gov/benefits
Benefit forms can be accessed through this website. For example, Flex Benefits Change In Status (CIS) & Plan Status change forms, dental claim form, Optix Vision claim form, FSA claim form, disability claim form, evidence of insurability form (SOH) and many more.

Quick Reference Guide

BENEFIT PLAN QUICK OVERVIEW

This chart is a quick overview of the insurance and other benefits offered by Miami-Dade County. Refer to the applicable sections of this handbook to find out how these plans work . Call the insurance company directly for plan information specific to your needs.

Benefit	Plan Options	Description & Cost Sharing	Resources
MEDICAL (Page 11)	**AvMed POS** Plan allows you to use both in and out of network providers	In-network: Plan pays 100% of covered charges, after applicable co-payments. 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.	www.avmed.org/mdc (800) 682-8633
	AvMed High Option HMO In-network benefits only	Plan pays 100% of covered charges, after applicable co-payments. Your up-front cost for dependent coverage is higher than the HMO Low Option, but co-payments (office visits, etc.) are lower when you use the plan.	www.avmed.org/mdc (800) 682-8633
	AvMed MDC Select Network HMO In-network benefits only	Non-bargaining and eligible bargaining unit employees in accordance with their CBA. Plan benefits mirror the High Option HMO, except for the Emergency room co-pay and out of pocket max.	www.avmed.org/mdc (800) 682-8633
	AvMed Low Option HMO In-network benefits only	This plan is only available to union employees that do not have tentative agreements with the County regarding healthcare redesign. Plan pays 100% for covered charges, after applicable co-payments. Your up-front cost for dependent coverage is lower than the HMO High Option, but co-payments (office visits, etc.) are higher when you use the plan.	www.avmed.org/mdc (800) 682-8633
	AvMed MDC Jackson First HMO	**New Plan for 2016!** 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 employees with finding a network provider, scheduling appointments and coordinating specialty and/or hospital care. Jackson First Concierge For appointments: (305) 585-2727 JacksonFirstConcierge@jhsmiami.org	www.avmed.org/med (800) 682-8633
DENTAL (Page 11)	**Delta Dental** Indemnity Plan with Standard or Enriched options	You have the option of using Delta PPO network or out of network providers. Benefits are payable at various coinsurance levels. A deductible is applied for services other than preventive and diagnostic. Annual maximum reimbursements are $1,000 per person for the Standard plan and $1,500 per person for the Enriched plan. The Enriched plan includes orthodontia.	www.deltadentalins.com/mdc (800) 471-1334
	Humana OHS Pre-paid Dental with Standard or Enriched options	Limited to participating dentists in the Humana-OHS network. Most preventive and diagnostic services 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.	www.humana.com/miami-dade-co-govt (800) 380-3187
	MetLife DHMO Pre-paid Dental with Standard or Enriched options	Limited to participating dentists in the DHMO network. Most preventive and diagnostic 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. The Enriched Prepaid Dental plan provides additional benefits and specialty coverage not covered under the Standard program.	www.metlife.com/mybenefits (877) 638-2055

Quick Reference Guide

Benefit	Plan Options	Description & Cost Sharing	Resources
VISION (Page 12)	**MetLife Vision Plan** Use in or out of network providers.	Use participating optometrists or ophthalmologists on the Optix Plan network to get the most savings. Participating providers file claims electronically; no forms for you to fill out. Using out-of-network providers will result in lower savings and you must pay for vision services up front, then file a claim to receive reimbursment.	www.metlife.com/mybenefits (877) 638-2055
GROUP LIFE (Page 48)	**Term Life Insurance** Basic Coverage	Coverage is equal to your annual adjusted base salary and provided by the County at no cost to you.	www.metlife.com/mybenefits (877) 638-4671
	Optional Life Insurance Supplemental Coverage	You may purchase Optional Life coverage equal to 1 to 5 times your annual adjusted salary. Rates are based on age and amount selected. Some coverage may be subject to a Statement of Health.	
DISABILITY PLANS (Page 30)	**MetLife Short-Term Disability** (STD) Low and High Options	STD insurance provides income protection while you are out of work due to a non-job related illness or injury and have exhausted all of your sick leave. Plan pays 60% of your adjusted weekly salary up to the maximum benefit for the option selected: Low Option benefit $500/week, High Option benefit $1,000/week.	www.metlife.com/mybenefits (888) 463-2023
	MetLife Long-Term Disability (LTD) Low and High Options	LTD insurance provides income protection while you are out of work for more than 26 weeks and have exhausted all of your sick leave. Plan pays 60% of your adjusted monthly salary up to the maximum benefit for the option selected: Low Option benefit $2,000/month, High Option benefit $4,000/month.	
	MetLife Premier Long-Term Disability	The Premier LTD Plan offers a monthly benefit of 66 2/3 % of your adjusted monthly salary up to a maximum of $7,000 per month. Enrollment in the Premier LTD cannot be combined with the regular STD and LTD plans because the plans are mutually exclusive due to overlapping waiting periods.	

Eligibility Requirements

Who is Eligible for Group Benefits?

- Any full-time regular Miami-Dade County employee who has completed 60 days of employment, is eligible. Coverage becomes effective the first of the month following or coincident to 60 days of employment, provided timely benefit elections are made online on the New Hire Benefits Enrollment, located on the eNet portal.
- Any part-time employee who consistently works at least 60 hours biweekly, and has completed 60 days of employment, is eligible. Coverage becomes effective the first of the month following or coincident to 60 days of employment provided timely election is made. The part-timer must continue to satisfy the minimum number of working hours requirement to remain eligible for benefits.
- Variable Hour Employees (VHE), as defined under the Affordable Care Act, are measured for twenty-six (26) pay periods to determine benefits eligibility. At the completion of the measurement period, if the total hours worked average 60 or more hours per pay period, the employee is eligible for benefits.
- Employees must be actively at work for disability and group life benefits to become effective.
- All employees are eligible to participate in the deferred compensation plan.
- Upon certain Qualifying Events, ex-spouses, children who cease to be dependents, employees going from full-time to part-time status and dependents of a deceased employee may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Contact your Department Personnel Representative for questions regarding your eligibility for group medical, dental, vision, life insurance, disability and group legal, or to participate in a flex spending account.

New Employees

New hires become eligible for benefits on the 1st of the month following or coincident to 60 days of employment. All new employees must enroll for benefits directly online, through the County's eNet portal New Hire Benefits Enrollment link. Only new employees meeting the benefits eligibility criteria can access the enrollment website. To access the website, go to http://enet.miamidade.gov logon, then select the New Hire Benefits Enrollment link. Once the online benefits enrollment is completed, the employee is directed back to the eNet to complete the Beneficiary Designation information for their life insurance coverage. The online enrollment must be completed **before** the employee's benefits eligibility date (eligibility date = the 1st of the month following or coinciding with sixty (60) days of employment). The enrollment window is from the date the employee is 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.

New Hires with a benefits eligibility date of October 1 or earlier, will enroll for their initial benefits through the online New Hire Benefits Enrollment link, but must use the online Open Enrollment website (also on eNet) to re-enroll for a spending account or modify their plan elections for the following plan year. New hires with a benefits eligibility date of November 1 or December 1, cannot enroll on the Open Enrollment website. You must submit your benefits selections online through the County's eNet portal New Hire Benefits Enrollment link. Your new hire plan selections for the current year will carryover into the next plan year. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of the current year and a separate amount for the next plan year.

Special Enrollment Rights Pertaining to Medical Benefits

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in the County's plan. Refer to sections related to Qualifying Events (QEs) and Special HIPAA Enrollment.

Defining "Variable Hour" Employees (VHE)

Under the Affordable Care Act (ACA), a "variable hour" employee is an employee who, at the start of employment, the employer cannot in good faith determine whether the individual is expected to average 30 hours of service per week during an initial measurement period. This applies to both new and ongoing employees.

If you are a variable hour employee hired prior to **October 13, 2014** and averaged at least 30 hours per week during the County's standard measurement period ending **October 11, 2015**, you may be eligible for medical coverage effective January 1, 2016.

Employees hired after the start of the County's standard measurement period indicated above, are subject to an individual measurement period of 26 pay periods from their hire date, to determine benefits eligibility.

Department Personnel Representatives (DPRs) are responsible for tracking the work hours of their employees during the established measurement period to determine if the employee meets the definition of "full time" as defined under the Affordable Care Act.

The DPR will also notify employees when they reach eligibility for benefits and provide instructions on how to enroll for health insurance coverage online. Follow-up with your DPR If you believe you have met the requirement and are not contacted.

Employees on Leave

If you participate in any of the benefits offered by Miami-Dade County and go on an approved leave of absence, or if you are in a "no-pay status" due to worker's compensation or suspension from work, it will affect your participation in the benefit plans. You are required to continue making payments to maintain insurance coverage. If you fail to submit payments, your coverage will be cancelled. Coverage may not be reinstated upon your return to work. Contact your Departmental Personnel Representative for detailed information. See the Leave of Absence Q&A section of this Benefits Handbook for further details.

Terminating Employees (Except Retirement)

All benefits end on the last day of the pay period in which the termination date falls and for which the employee experiences a regular insurance deduction or made a direct payment to the Benefits Administration Unit (if on an unpaid leave of absence).

- Health & Life Insurance - You will receive instructions by mail from the medical, dental and vision insurance carriers regarding continuation of existing coverage (COBRA). You have sixty (60) days to elect coverage continuation. Refer to COBRA section for additional nformation. Life insurance is not subject to COBRA, however, basic and\or optional life coverage may be converted to an individual policy at the prevailing rates. The life insurance information will be mailed to you. You have the later of, thirty (30) days from termination, or fifteen (15) days from notice, to elect the conversion policy. If you are a terminating employee, you can continue certain benefits by contacting the following providers within 60 days of your termination of employment:
- Contact FBMC Customer Care Center at 1-800-342-8017 to apply for continuation, on an after-tax basis, of your Healthcare FSA. If you elect to continue your Healthcare FSA through COBRA, you can be reimbursed for expenses incurred through the end of the plan year (December 31) or until you exhaust your account balance. If you choose not to continue your Healthcare FSA through COBRA, you can only be reimbursed for expenses incurred within your period of coverage. NOTE: Your employer's Healthcare FSA Plan is not subject to COBRA continuation beyond the end of the plan year in which a COBRA-qualifying event occurs. Dependent Care FSA cannot be continued.
- You may contact ARAG directly if interested in purchasing a group legal conversion policy. Note, the plan benefits and rates may differ under a conversion policy.

Dependent Eligibility

Who Are My Eligible Dependents?

If you enroll for medical, dental, vision, or group legal, you may also cover your eligible dependents by selecting dependent coverage under those options, when you enroll online. Outside of the open enrollment period, dependents may be added\cancelled only if you experience a mid-year qualifying event. Refer to page 41 for further information. Eligible dependents include:

- **Your spouse or domestic partner (DP)** (in accordance with County Ordinance 08-61)

  You cannot cover your spouse\DP as a dependent, if your spouse\DP is also a County or Public Health Trust employee eligible for their own medical and dental coverage.

- **Your child** – your biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.

- **Your child with a disability** – your covered child who is permanently, mentally or physically disabled. Your child may continue health insurance coverage after reaching age 26 (age 25 for dental), if you provide acceptable documentation validating disability upon request and the child was continuously covered in a County health plan prior to reaching the limiting age. The child must be unmarried, dependent on you for financial support, and has no dependents of his/her own.

- **Your stepchild** – the child of your spouse for as long as you remain legally married to the child's parent. The child of your domestic partner, as long as the domestic partnership continues to meet the requirements of Miami-Dade County Ordinance No. 08-61, Sec. 11a-72.

- **Your foster child** – a child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible to their age of maturity.

- **Legal guardianship** – a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible until his or her age of maturity.

- **Your grandchild** – a newborn dependent of your covered child. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered. After 18 months, the grandchild must meet the criteria of legal guardianship by the employee, spouse or domestic partner.

- **Your over-age dependent** – your child after the end of the calendar year in which he\she turned age 26, through the end of the calendar year the over-age child turned 30. Only medical coverage is extended beyond age 26.

Coverage Limiting Age for Dependent Children

Your dependent child's coverage ends on:

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

- **Dental & Vision** - December 31 of the calendar year child turns 26. There is no extension beyond the limiting age, unless the adult child is disabled.

Eligibility for Adult Children Age 26+ to 30

(Chapter 627.6562 Florida Statutes)

To be eligible, the adult child must be:

1) Unmarried without any dependents, and

2) A resident of the state of Florida, or a full-time\part-time student, and

3) Is not provided coverage or is a covered person under any other group health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

The extension appliesto medical coverage only. Coverage ends December 31 of the year dependent turns age 30, unless the adult child is disabled and enrolled prior to age 26.

Loss of Eligibility -Dependent Children Under Age 26

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

Imputed Income

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

Is Coverage Guaranteed?

During Open Enrollment eligible employees and their dependents are guaranteed enrollment in any of the County-sponsored medical plans. Eligible new hires and their dependents are also guaranteed coverage in any of the County-sponsored medical plans if they enroll during their initial eligibility period. Coverage is also guaranteed if you enroll yourself and/or your dependents within 45 days of a Change In Status (60 days for newborns, adoption\placement for adoption), or if you qualify under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). See the Changing Your Coverage section for more information on Changes In Status and HIPAA.

For additional information on medical plans, refer to your Benefit Comparison Chart included in this Benefits Handbook, visit the plans' website or contact the plans directly at the numbers provided for information specific to your needs.

Dependent Eligibility

IRS 1095-C Form – Employer Provided Health Insurance

You have probably heard of Health Care Reform and the Affordable Care Act (ACA), and one change that may impact you directly is IRS Form 1095-C. The County is required to report to the IRS on the health insurance offered to full-time employees. A full-time worker, according to the law, is someone who works at least 30 hours a week.

The Form 1095-C includes information about the health insurance coverage offered to you and, if applicable, your family. The IRS uses the information provided to verify which individuals have coverage through an employer and are therefore not subject to the individual mandate penalty tax. You may need to submit coverage information in 2016 as a part of your personal tax filing for 2015. Every employee of an ALE who is eligible for insurance coverage should receive a 1095-C. Eligible employees who decline to participate in their employer's health plan will still receive a 1095-C.

Dependent Eligibility Update

In preparation for the Form 1095-C filing and assure the County meets its reporting obligations, employees who covered family members on their medical plan at any time during 2015 were asked to validate their dependent's information. The purpose was to assure the dependent's Social Security number (SSN) and date of birth (DOB) are correct in our database. Dependents may include a spouse, domestic partner, or child. Employees viewed and validated their dependent's information online. The IRS will use the 1095-C data to reconcile with individual tax filings and to confirm taxpayers have met the individual mandate. That process will be hampered if the IRS cannot identify your dependents due to an invalid SSN. In addition to the validation process mentioned above, employees are required to submit evidence supporting their dependent's eligibility for coverage. This is a mandatory requirement that applies to currently enrolled dependents and any new dependent added 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).

Domestic Partners (DP)

County benefit plans that are otherwise available to an employee's spouse and dependent children (medical, dental, vision, and group legal plan) are available to domestic partners (DP) and their dependent children. This provision applies to both same sex and common law relationships. DP's and their children are not eligible for expense reimbursement through a healthcare or dependent care spending account.

To enroll a domestic partner (DP) in a County-sponsored benefit plan, the employee and DP must first file a declaration of domestic partnership with the Miami-Dade County Department of Regulatory and Economic Resources (RER). The employee may add the domestic partner (and/or children of the domestic partner) within 45 days of the qualifying event, using the Health Plan Status Change form; attach the domestic partnership certificate, plus the birth certificates of DP's dependent children to be enrolled. Once the eligibility period lapses, the employee will have to wait until the annual open enrollment to submit the benefit selections online. Refer to page 10 for dependent documentation requirements. The deadline to submit documentation for dependents enrolled during the open enrollment is December 1, to assure timely receipt of the insurance ID cards.

Mid-Year Status Changes

For mid-year family status changes, the date the partnership is registered or terminated with the MDC Consumer Services Department will be the start of the 45-day eligibility period. The benefits enrollment or deletion of dependents must be completed during the 45-day eligibility period. Refer to page 41 for information regarding mid-year status changes.

Dissolution of Domestic Partnership

Either partner of a registered Domestic Partnership may terminate such relationship by filing a notarized declaration with the Department of Regulatory and Economic Resources (RER), Consumer Services. The dissolution of the partnership is effective thirty (30) days from the date the certificate is issued by RER.

At this point the employee must drop the domestic partner and the partner's dependent children from the County's group insurance plans. To cancel coverage, present a copy of the certificate issued by RER along with the Change in Status forms, to the Benefits Administration Unit, within 45 days from the partnership dissolution effective date.

The premium change, if any, will be effective the 1st day of the pay period following receipt of the Change in Status form by the Benefits Administration Unit. Be aware that under the domestic partnership benefits ordinance, any employee who obtains or attempts to obtain benefits fraudulently under this provision (including continuing insurance coverage for ineligible individuals after the dissolution of a domestic partnership) shall be subject to discipline, up to and including termination.

Please note that under IRS rules, insurance premiums for a DP and/or DP's children must be deducted on a post-tax basis and subject to imputed income tax. The IRS rules prohibit changing premiums mid-year from pre-tax to post tax (as well as the reverse). An example of this would occur when an employee's enrollment level is "Employee + Child(ren)" covering his\her natural child (or children), then acquires a child of a domestic partner (DP) during the year. The entire dependent child premium would now become post-tax, due to the addition of the DP's child. However, since the IRS rules prohibit changing premiums mid-year from pre-tax to post-tax (and post to pre-tax), the employee would have to wait until the next open enrollment to add the DP's child.

Domestic Partner (DP) - Coverage Continuation

Coverage continuation under COBRA law is not available to Domestic Partners and their dependents. However, if the insured DP (and\or dependents) experience a qualifying event due to the employee's termination of employment or reduction of hours, continuation of group health, dental and/or vision coverage will be allowed for a period of up to 18 months. Continuation up to 36 months will be allowed for events such as death of the employee, the employee's entitlement to Medicare, dissolution of the domestic partnership registered with Miami-Dade County. Continuation depends on the timely payment of premiums. It is the responsibility of the employee or DP to notify the Benefits Administration Unit in writing within 45 days, of the loss of eligibility and to apply for continuation of benefits. Supporting documentation is required.

Dependent Eligibility

Dependent Documentation

New Dependent Documentation Requirement – During Open Enrollment, for all new dependents enrolled, employees must submit supporting evidence of their dependent's eligibility for coverage. Acceptable documents are listed below. Please be aware that failure to provide acceptable documentation will result in retroactive cancellation of the dependent's medical, dental and\or vision coverage (if enrolled). This process will help us ensure that ineligible dependents are not being covered, and costing the plan (and you) money. Refer to the section regarding adult dependent children for additional requirements.

It is your responsibility to provide the health plans with the required documentation by December 1. New employees enrolling for benefits during their initial eligibility must submit supporting documentation for all family members to be enrolled; the health plan must receive all dependent information by the employee's benefits effective date. Please obtain proof of mailing or fax sent to the plans. Also, remember the on-site representatives and your DPR will accept proof of dependent eligibility. Failure to provide the information will jeopardize the coverage of your dependent(s).

Type of Documentation Required by Dependent Type

Spouse
Copy of official certified or registered Marriage Certificate (religious certificates are not acceptable).

Domestic Partner
Copy of the domestic partnership certificate issued by the Department of Regulatory and Economic Resources (RER), Consumer Services.

Child(ren) of Domestic Partners
Copy of official Birth Certificate(s) showing employee's Domestic Partner as parent (birth cards are not acceptable) and copy of the domestic partnership certificate issued by the Department of Regulatory and Economic Resources (RER), Consumer Services.

Child(ren)
Copy of official Birth Certificate(s) showing employee as parent (birth cards are not acceptable).

Stepchildren
Copy of official Birth Certificate(s) AND copy of official State certified or registered Marriage Certificate.

Child(ren) Under Legal Guardianship, Custody or Foster Care
Copy of Legal Guardianship/Custody document from the Courts or copy of Foster Care documentation from Courts.

Child(ren) Adopted or Child(ren) in the Process of Adoption
Copy of Legal Adoption documentation showing relationship to employee and placement in employee's home or copy of Adoption Certificate issued through the Courts.

***Grandchild(ren) OR Other Child Not Related**
Copy of official Birth Certificate(s) of child(ren) AND copy of Legal Guardianship, Adoption or Foster Care document from the Courts.

*A dependent of a dependent (child born to an enrolled child dependent) may remain on the plan for up to 18 months from the date of birth. After 18 months, the grandchild must meet the criteria of legal guardianship by the employee, spouse or domestic partner.

Additional Documentation Required For All Adult Dependent Children Age 26 or Older

Mid-Year Status Changes
The following documentation is also required to add a new dependent adult child age 26 or older, or to continue coverage for an existing covered adult child beyond age 26. Employees are required to submit the documentation listed below every year, before the start of the plan year.

Required Documents
1) Affidavit of Eligibility and 2) Proof of Florida residency (e.g. child's driver's license, etc.), or proof of student status.

New Dependent(s) age 26+
Employees enrolling a new dependent age 26+ must also provide proof the adult child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

Limiting Age for Adult Children age 26+ to 30
Coverage ends December 31 of the year dependent turns age 30.

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)

Group Medical, Dental and Vision Plans

Period of Coverage

Your period of coverage is the same as the plan year, January 1 through December 31 unless you terminate employment, or no longer work the minimum number of hours required to be eligible for benefits.

Group Medical Coverage

Plan Definitions

A Point of Service (POS) plan allows you to receive services from a participating in-network provider or out-of-network provider of your choice. If you choose an out-of-network physician, your healthcare services will be subject to the plan deductible and co-insurance provisions.

A Health Maintenance Organization (HMO) provides a wide range of healthcare services to you on a prepaid basis. Under this plan, you receive medical services at no cost or for moderate co-payments without deductibles or claim forms.

As an eligible Miami-Dade County employee, you may choose from the following medical plan options:

AvMed Point of Service (POS)

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

AvMed Select Network HMO

Plan pays 100% of covered charges, after applicable co-payments. Plan benefits mirror the High Option HMO, except for the Emergency Room co-pay and out of pocket max. This plan is only available to non-bargaining employees,and eligible bargaining unit employee in accordance with their Collective Bargaining Agreement. This plan is not available to employees in bargaining units that do not have tentative agreements with the County with regards to healthcare redesign.

AvMed Low HMO

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

AvMed MDC Jackson First HMO

New Plan for 2016! 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 employees 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 employee in accordance with their Collective Bargaining Agreement.

Union Plan

Members of the DCFF fire union may be eligible for coverage in their Union-sponsored plan. Contact your Union office for further details.

Can Employees Decline of Medical Coverage?

Employees may opt-out of county-provided medical coverage during open enrollment. If you decline coverage, you cannot re-apply until the next open enrollment, unless you experience a family status or HIPAA qualifying event.

The decision to waive medical coverage has consequences. Declining County medical coverage without enrolling in another group or 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 Particiption After Open Enrollment

After open enrollment, you may cancel any post tax benefit plan (Group Legal, Short-Term, or Long-Term Disability Plans) without a penalty. If you cancel a pre-tax benefit plan subject to the IRC Section 125 salary reduction provisions, such as medical, dental and vision, you are still required to pay the employee premium (if any) for the remainder of the year. Submit your plan cancellation request to your DPR in writing for transmittal to the Human Resources Department, Benefits Administration Section.

Your request will be processed prospectively (next pay period from date request is received by Benefits Adminitration).

Group Dental Plan

You may enroll yourself and your eligible dependents for dental coverage, even if you don't elect medical coverage. You may choose the plan that best suits your needs:

- **Delta Dental** - Standard or Enriched Dental Indemnity plan
- **Humana OHS** - Standard or Enriched Dental Prepaid Plan
- **Metlife DHMO** - Standard or Enriched Dental Prepaid Plan

Indemnity

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 are: $1,000 per person for the Standard plan and $1,500 per person for the Enriched plan. The Enriched plan also includes orthodontia.

Prepaid

Standard or Enriched - Choose a plan 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 prepaid dental programs. The Enriched Prepaid Dental plan provides additional benefits and specialty coverage not covered under the Standard program. No referrals are required to receive covered dental services from participating specialists. **Services must be received by a participating provider within the plan's service area.**

Are Married Employees Permitted To Cover Each Other ?

You cannot cover your spouse\domestic partner (DP) as a dependent under your group medical or dental coverage, if your spouse\domestic partner is also a County employee and eligible for benefits. The only exception permitted is during an unpaid leave of absence; you may temporarily suspend coverage and transfer to your spouse's plan by filing a change in status request within 45 days of the event.

MetLife Vision Plan

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

VISION SERVICES	Out of Pocket Costs with MetLife Vision	*Out of Pocket Costs without Insurance
Eye Exam	No copayment	$140
Glasses	$10 copayment	N/A
Frame	$0	$130
Lenses (Single Vision)	$0	$84
Ultraviolet coating	$0	$23
Polycarbonate lenses	$0	$52
Annual Premium (single coverage)	$50	N/A
Total Cost of Services	$60	$429

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

Employees are eligible for vision coverage regardless of union affiliation.

What You Can Expect:

- Immediate savings
- Convenient locations
- Quality professional care and services
- No complicated forms to fill out
- No long waits for rebates
- Out-of-network benefits

For additional information on MetLife vision benefits, refer to the MetLife Plan literature, or contact the plan.

Union Plan

If you are enrolled in the DCFF Fire Union-sponsored health plan, you may elect coverage through the MetLife vision plan, but you cannot participate in any County-sponsored dental program. Contact the DCFF Union Office for health coverage information and dependent eligibility.

Is Coverage Guaranteed?

You are guaranteed group medical, dental and group vision coverages as long as you enroll during Open Enrollment, during your initial eligibility period, within 45 days of a Change In Status (60 days for newborns, adoptions\placement), or if you qualify under HIPAA.

For additional information on the dental plans, refer to the Benefit Comparison Chart included in this handbook or contact the plan.

Report Address Changes

The County's benefit providers experience an ongoing problem receiving numerous returned mail due to incorrect employee addresses. To guarantee that important information is properly delivered to you (such as the FRS Annual Member Statements, Medical Plan Claim Explanation of Benefits, insurance ID cards, summary plan descriptions, etc), please assure your address is updated in the County's payroll records. Remember to promptly advise your department personnel representative (DPR) of any change in your address so they may update the payroll records.

Insurance Rates

Visit www.miamidade.gov/benefits for current biweekly rates.

If you have medical, dental or vision coverage, your co-payments or uninsured out-of-pocket expenses may be eligible for reimbursement through your Healthcare FSA. See Page 29 for a partial list of eligible expenses or call FBMC Customer Care Service Center at 1-800-342-8017.

Leave Of Absence (LOA) Q&A

What is the cost to maintain group benefits while on an approved Leave of Absence (LOA) without pay?

The premium you are responsible for depends on the type of leave. If your leave is illness related (i.e. Family Medical Leave (FMLA), disability, worker's compensation, maternity etc.), you will only be responsible for paying the biweekly insurance contributions that are usually withheld from your paycheck. If your leave is other than illness related (i.e. educational, suspension, personal, etc.), you will be responsible for paying both the biweekly employee and County contributions. Your Department Personnel Representative (DPR) will provide you with an LOA information package, billing notice and remittance form. Contact your DPR for additional information related to military leave.

When are LOA payments due?

Your DPR will provide you with a leave of absence package which explains the process to maintain your insurance while on leave, if you so choose. It also includes instructions on where payments must be sent. The first payment is due within two weeks of your last payroll deduction for benefits. Thereafter, premium payments are due biweekly in advance of the pay period to be covered. If coverage is cancelled due to non-payment of premiums when due, you will only be allowed to re-enroll during the next annual open enrollment period. Please follow-up with your DPR to receive this information when on an approved LOA.

If dependent premiums become a financial hardship, may I delete my dependent(s) from my health insurance while on an approved leave without pay status?

Yes. You may delete your dependent(s) while on an approved leave without pay by submitting a completed Flexible Benefits Change in Status Form and Plan Status Change Form. You must submit these forms to your DPR within 45 days of being in a no-pay status.

May I temporarily cancel my health insurance while I am on an approved leave of absence?

You may submit a completed Flexible Benefits Change in Status Form and Insurance Status Change form within 45 days of being in a leave without pay status to temporarily cancel your health insurance coverage. Upon return to pay status (within 45 days), you must re-submit a completed Flexible Benefits Change in Status form and Insurance Status Change Form to your DPR to reinstate coverage.

What is the process to report a change in family status?

Contact your DPR to obtain the Flexible Benefits Change in Status Form and the Plan Status Change Form (or download from www.miamidade.gov/benefits), if you experience a family status change (adding newborn, divorce, etc.). Submit the forms to your DPR within 45 days of the event (60 days for newborns, adoption\placement for adoption). If the status change results in a premium adjustment, contact your DPR to determine the cost, or go to www.miamidade.gov/benefits for the current employee biweekly rates. Follow-up with your DPR if you don't receive a revised LOA billing notice. Don't delay the payment for this reason, otherwise you risk having your coverage cancelled for non-payment. It is the employee's responsibility to submit the insurance payments in a timely manner and for the correct amount.

If my insurance coverage is cancelled for non-payment of premiums, will it be reinstated when I return to work?

No, your coverage will not be automatically reinstated when you return to active status. You will have to wait until the next open enrollment. Optional life insurance and income protection (disability) coverage will be subject to medical review, when you re-apply during open enrollment.

Enrollment On The Web

Online Benefits Enrollment

Newly hired employees eligible for County health and flexible benefits must enroll directly online. The online process is simple. No long forms to fill out or need to worry about paperwork getting misplaced. No guessing what your payroll deductions will be. Rates will be automatically calculated for you online. All you need is 15 to 20 minutes of uninterrupted time to make your elections.

Enroll using the New Hire Benefits Enrollment link, located on the eNet portal. After submitting your benefit plan selections, you will be prompted to continue to the Online Beneficiary Designation in connection with your life insurance coverage. Enter your designated beneficiaries for your basic life insurance death benefits. If you elected optional life insurance coverage, enter your beneficiaries in the Optional Life section. Save each entry. Remember that your beneficiary information will not be saved and the document will not be registered, until you click on the "Submit All Changes" button. Print your life insurance beneficiary designation confirmation page and retain with your important documents.

The New Hire Benefits Enrollment website can be accessed from any computer 24/7, but only during your eligibility period. Enrollment Window–The enrollment window starts on the date you are active in the payroll system, to the day before your benefits eligibility date. Your benefits eligibility date = the 1st of the month following or coinciding with sixty (60) days of employment. Contact your Department Personnel Representative (DPR) if you have any questions regarding your benefits eligibility. The Online Beneficiary Designation link can be accessed 24/7 and you may change beneficiaries at any time during the year.

Before You Start

Make sure you thoroughly review your enrollment materials. Most of these documents are online. If, after reviewing the materials, you still have questions, contact the plan directly or your Department Personnel Representative (DPR). Make sure you have the following information handy:

Employee Identification Number (Miami-Dade eKey) - This 8-digit number can be found on the upper left corner of your pay stub or in most cases, your employee photo ID. You'll also need to know the last 4 digits of your social security number the first time you log on to eNet.

Primary Care Physician Number (for you and dependents) - Enter only if enrolling in the AvMed Low Option HMO Plans.

Participating Dentist Number - Enter only if electing the Met DHMO or Humana- OHS Dental Plans.

Dependent Information - This includes names and dates of birth for all eligible dependents to be enrolled. Also, indicate if dependent is covered by another group medical plan, for coordination of benefits (COB) purposes.

Spending Accounts - Annual amount you wish to contribute.

First time eNet users will be required to set-up an account and create a password. To begin, your Miami-Dade e-Key is the combination of the letter "e" and your employee payroll ID#. First time eNet users, your initial password will be "Pass" plus last 4 digits of your Social Security number (example Pass1234). Click the Login button. First time users, you will be required to change your initial password (to a different one. Follow the instructions on the screen to change password. Click "Change Password" and login to eNet using your newly created password.

Not a first time eNet user? Enter e-Key and your eNet password and click Login button. Forgot your password? Click "Forgot Password" and follow the instructions to reset it. Contact the Help Desk at 305-596-Help, if you experience technical difficulties.

If Your Benefits Eligibility Date is November 1 or December 1

New hires with a benefits eligibility date of November 1, or December 1, cannot enroll on the Open Enrollment website. You must submit your benefit selections online through the County's eNet portal New Hire Benefits Enrollment link. Your new hire plan selections for the current year will carry-over into the next plan year. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of the current year and a separate amount for the next plan year.

Enrollment On The Web

Logging On

Online enrollment is a simple process that must be completed in one session. If you log off before completing the final step, your plan elections will not be saved. Please be sure you have the 15 to 20 minutes it takes to complete all the steps.

1. Go directly to **http://enet.miamidade.gov** to logon.

2. On the next screen, click "New Hire Benefits Enrollment" link in the "Secure eNet Services" to begin the enrollment process.

3. Review the information on the screen, then click the "Begin Enrollment " button. Once you complete your plan selections, go to the bottom of the Benefit Elections Menu, check the "I read and accept" box, then click the "SAVE BENEFIT ELECTIONS" button. This will complete your enrollment, allow you to print an enrollment confirmation notice and take the survey. You can return to the enrollment website at any time to make changes prior to your benefits eligibility effective date.

4. You will then be prompted to the online Beneficiary Designation link. Enter the requested beneficiary information for your group life insurance. Save each beneficiary entry. Remember that the beneficiary information will not be saved and the document will not be registered, until you click the "Submit All Changes" button. Print your life insurance beneficiary designation confirmation page and retain with your important documents.

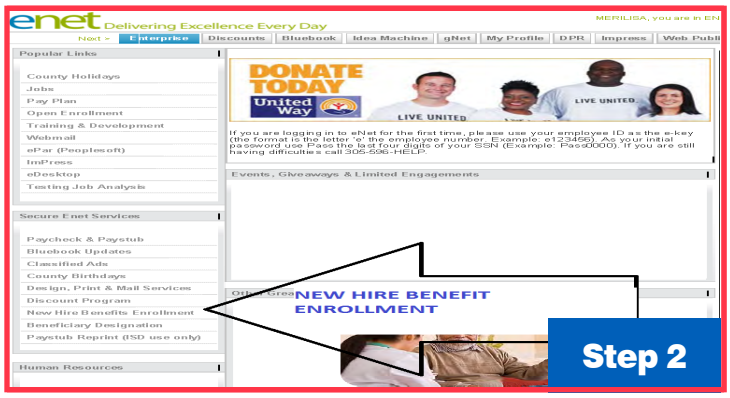
What's Online?

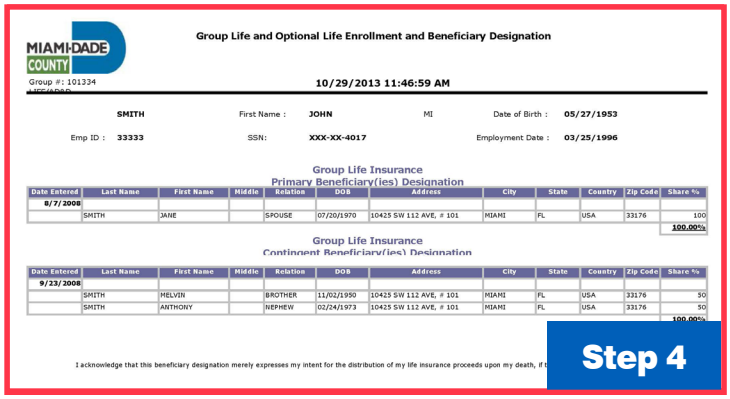
Everything you need for online benefits enrollment can be found on the New Hire Enrollment website, including:

- Benefits Handbook
- Links to provider Web sites
- Medical Plan Comparison
- Dental Plan Comparison
- Dependent Eligibility
- Department Personnel Representative Directory
- Frequently Asked Questions (FAQs)

Need Technical Assistance?

Call 305-596-HELP





AVMED POS PLAN

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

SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
LIFETIME MAXIMUM	Unlimited	Unlimited
CO-INSURANCE LEVELS	Not Applicable	Plan pays 70% of Maximum Allowable Payment (MAP); member pays 30% co-insurance after deductible
CALENDAR YEAR DEDUCTIBLE		
Individual (per contract year)	Not Applicable	$200
Dependent Coverage (per contract year)	Not Applicable	$500
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual Maximum	$3,000	$3,000
Dependent Coverage Maximum	$6,000	$6,000
PHYSICIAN SERVICES		
Services at Physician's offices include, but are not limited to:		
Primary Care Physician's Office Visit	$15 per visit	30% co-insurance after deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	$30 per visit	30% co-insurance after deductible
Allergy Injections	No charge	30% co-insurance after deductible
Allergy Skin Testing	$30 per visit	30% co-insurance after deductible
PREVENTIVE CARE		
Preventive Care (as required by the Patient Protection Affordable Care Act "PPACA")	No charge	30% co-insurance after deductible
MAMMOGRAM, PSA, PAP SMEAR		
Preventive care related services (i.e. "routine" services)	No charge	30% co-insurance after deductible
Diagnostic related services (i.e. "non-routine")	$100 copay/ tests at hospital based facility; no charge at Jackson Health Systems, or independent\ non-hospital based facility	30% co-insurance after deductible

2016 Medical Plan Summary - Redesign

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
INPATIENT HOSPITAL SERVICES		
Pre-Certification of Hospital Confinements	Handled by admitting physician	Pre-certification required
Hospital inpatient care includes: Room and board – unlimited days (semi-private)	$200 copay per admission (no charge at JHS facility)	30% co-insurance after deductible
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	No charge	30% co-insurance after deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	30% co-insurance after deductible
Inpatient/Outpatient Hospital Professional Services	No charge	30% co-insurance after deductible
OUTPATIENT FACILITY SERVICES		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	$100 copay\ no charge at Jackson Health Systems, or independent\ non-hospital based facility	30% co-insurance after deductible
EMERGENCY AND URGENT CARE SERVICES		
PCP's Office	$15 per visit	30% co-insurance after deductible
Specialist's Office	$30 per visit	30% co-insurance after deductible
Hospital Emergency Room	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)
Outpatient Professional Services (radiology, pathology, ER physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	$50 per visit	$50 per visit
DIAGNOSTIC\ LABORATORY AND RADIOLOGY SERVICES		
(includes pre-admission testing)		
Physician's office visit	No charge	30% co-insurance after deductible
Hospital facility	$100 copay (no charge at JHS facility)	30% co-insurance after deductible
Outpatient hospital facility	$100 copay (no charge at JHS facility)	30% co-insurance after deductible
Independent x-ray and/or laboratory facility	No charge at participating lab/ facility	30% co-insurance after deductible
ADVANCED RADIOLOGICAL IMAGING		
(i.e. MRI, MRA, CAT scan , PET scan, etc.) The scan copayment/deductible applies per type of scan per day		
Hospital Affiliated Facility	$100 copay (no charge at JHS facility)	30% co-insurance after deductible
Non-Hospital Affiliated Facility	No charge at participating facility	30% co-insurance after deductible
Physician's Office	No charge	30% co-insurance after deductible
OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES		
IN \OUT: Limited to 60 visits per calendar year: chiro services, rehab pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined; 36 visits per calendar year for cardiac rehab.		
Chiropractor	$15 per visit	30% co-insurance after deductible
Physical\ Speech\ Occupational Therapies, Pulmonary Rehab, Cognitive Therapy, Resp.Therapy	$30 per visit	30% co-insurance after deductible

2016 Medical Plan Summary - Redesign

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	**Out-of-Network***
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	30% co-insurance after deductible
All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee)	No charge	30% co-insurance after deductible
Delivery facility (inpatient hospital, birthing center)	$200 copay\per admission, no charge at Jackson Health Systems	30% co-insurance after deductible
DURABLE MEDICAL EQUIPMENT		
Contract Year Maximum: Unlimited	No charge/ device for DME and Orthotics. External prosthetic appliance in network: no charge after $200 contract year deductible.	Not Covered
ACUPUNCTURE	Out-of-network coverage only	30% co-insurance after deductible
MENTAL HEALTH		
Outpatient	$15 per visit	30% co-insurance after deductible
Inpatient	$200 copay\per admission, no charge at Jackson Health Systems	30% co-insurance after deductible
Intensive Outpatient	$15 per visit	30% co-insurance after deductible
SUBSTANCE ABUSE		
Outpatient	$15 per visit	30% co-insurance after deductible
Inpatient		30% co-insurance after deductible
Intensive Outpatient	$15 per visit	30% co-insurance after deductible
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER (See plan limitations)		
Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year.		
Applied Behavioral Analysis (ABA)	$15 per visit	30% co-insurance after deductible
Physical, Speech, Occupational Therapy	$15 per visit	30% co-insurance after deductible
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$15	30% of charges
Preferred Brand	$40	30% of charges
Non-Preferred Brand	$55	30% of charges
SPECIALTY (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY)		
Cost Sharing	$100.00	30% of charges
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$30	30% of charges
Preferred Brand	$80	30% of charges
Non-Preferred Brand	$110	30% of charges
Generic: medication on the Prescription medication list - **Preferred Brand:** medication designated as preferred on the prescription medication list with no Generic equivalent - **Non-Preferred Brand:** medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.		
* Member may be responsible for all Out-Of-Network charges in excess of the Maximum Allowable Payment (MAP). Charges in excess of MAP cannot be applied to out-of pocket maximum.		
**There is no copayment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).		

Medical Plan Summary - Redesign

AVMED HMO PLANS		
This Schedule of Benefits reflects the higher provider and prescription copayments. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/mdc.		
SCHEDULE OF BENEFITS	**AVMED HMO HIGH**	**AvMed MDC Select & MDC Jackson First***
	COST TO MEMBER	**COST TO MEMBER**
LIFETIME MAXIMUM	Unlimited	Unlimited
CALENDAR YEAR DEDUCTIBLE		
Individual /Family	Not Applicable	Not Applicable
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual	$3,000	$2,500
Dependent coverage	$6,000	$5,000
PRIMARY CARE PHYSICIAN		
Office visits	$15 per visit	$15 per visit
Preventive care-routine physicals/pediatric well baby care (and other preventive services required by the Patient Protection Affordable Care Act "PPA-CA")	No Charge	No Charge
Pediatrician	$15 per visit	$15 per visit
SPECIALIST'S SERVICES	Open Access	Open Access
Office Visits	$30 per visit	$30 per visit
Annual gyn exam when performed by participating specialist	No Charge	No Charge
MATERNITY CARE SERVICES		
Initial visit	$30 copay	$30 copay
Subsequent visits	No charge	No charge
ALLERGY TREATMENTS		
Allergy Injections	$15 per visit	$15 per visit
Skin testing (per course of treatment)	$30 per visit	$30 per visit
HOSPITAL SERVICES - Inpatient care at participating hospitals includes:		
Room and board - unlimited days (semi-private)	$200 copay per admission (no charge at JHS facility)	No Charge
Physicians', specialists' and surgeons' svces	No charge	No Charge
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication	No charge	No Charge
Intensive care unit and other special units, general and special duty nursing	No charge	No Charge
Laboratory and diagnostic imaging	No charge if part of inpatient hospitalization	No Charge

* AvMed MDC Jackson First HMO – 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.

2016 Medical Plan Summary - Redesign

AVMED HMO PLANS		
SCHEDULE OF BENEFITS	**AVMED HMO HIGH**	**AvMed MDC Select & MDC Jackson First***
	COST TO MEMBER	COST TO MEMBER
CHIROPRACTIC	$15 per visit	$15 per visit
PODIATRY	$15 per visit	$15 per visit
OUTPATIENT SERVICES		
Outpatient surgeries, including cardiac catheterizations and angioplasty	$100 copay; no charge at Jackson Health System facility	No charge
OUTPATIENT DIAGNOSTIC TESTS		
Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)	$100 copay per test at hospital based facility; no charge at Jackson Health System or an independent/non-hospital based facility	No charge
Other diagnostic imaging tests and Laboratory		No charge
Mammogram	No charge	No charge
EMERGENCY SERVICES		
An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care.	Copay waived if admitted. Plan must be notified within 24 hours of emergency inpatient admission.	Copay waived if admitted. Plan notification required within 24 hours of emergency inpatient admission.
Emergency svces at participating hospitals	$100 copay	$50 copay
Emergency services - non-participating hospitals, facilities and/or physicians	$100 copay	$50 copay
URGENT /IMMEDIATE CARE		
Medical Services at a participating Urgent/Immediate Care facility or svces rendered after hours in your Primary Care Physician's office	$25 copay	$25 copay
Medical Services at a participating retail clinic	$15 copay	$15 copay
Medical Services at a non-participating Urgent/ Immediate Care facility or non-participating retail clinic	$25 copay	$25 copay
AMBULANCE		
When pre-authorized or in the case of emergency	No charge	No charge
DRUG & ALCOHOL REHABILITATION PROGRAMS		
Outpatient	$15 per visit	$15 per visit
Inpatient	$200 copay \admission; no charge at Jackson Health Systems	No charge
MENTAL / NERVOUS DISORDERS		
Outpatient	$15 per visit	$15 per visit
Inpatient	$200 copay \admission; no charge at Jackson Health Systems	No charge

* AvMed MDC Jackson First HMO – 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.

2016 Medical Plan Summary - Redesign

AVMED HMO PLANS		
SCHEDULE OF BENEFITS	**AVMED HMO HIGH**	**AvMed MDC Select & MDC Jackson First***
	COST TO MEMBER	COST TO MEMBER
PHYSICAL, SPEECH, RESPIRATORY & OCCUPATIONAL THERAPIES		
Short-term Physical, Speech, Respiratory and Occupational therapy for acute conditions. Coverage is limited to 60 visits combined per Calendar year	$30 per visit	$30 per visit
DURABLE MEDICAL EQUIPMENT Equipment includes but not limited to: Hospital beds, walkers, crutches,wheelchairs	$50 per episode of illness	$50 per episode of illness
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER		
Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year.		
Applied Behavioral Analysis (ABA)	$15 per visit	$15 per visit
Physical, Speech, Occupational Therapy	$15 per visit	$15 per visit
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$15 copay	$15 copay
Preferred Brand	$40 copay	$25 copay
Non-Preferred Brand	$55 copay	$35 copay
SPECIALTY DRUGS (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY) Retail		
Generic	$100 copay	$15 copay
Preferred Brand		$25 copay
Non-Preferred Brand		$35 copay
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$30 copay	$30 copay
Preferred Brand	$80 copay	$50 copay
Non-Preferred Brand	$110 copay	$70 copay

DEFINITIONS: Generic - medication on the Prescription medication list. Preferred Brand - medication designated as preferred on the prescription medication list with no Generic equivalent. Non-Preferred Brand - medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.

BRAND ADDITIONAL CHARGE - When Brand is requested and a generic equivalent is available: Member pays the difference between the cost of the Brand medication and Generic medication, plus the Brand or Non-Preferred Brand copayment.

*There is no copayment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).

PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO:

All Inpatient Services, Observation Services, Residential Treatment, Outpatient Surgery, Intensive Outpatient Programs, Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging), Non-Emergency Ambulance, Dialysis Services, Transplant Services, use of Non-Participating Providers, Certain Medications Including Injectables

BARIATRIC SERVICES - Effective January 1, 2016 - Bariatric surgery services performed at JHS Centers of Excellence will be covered under the offered MDC HMO plans. Previously, bariatric services were only covered under the POS plan. You must meet specific criteria to qualify. Please contact AvMed for the specific criteria and any further details.

* AvMed MDC Jackson First HMO – 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.

Medical Plan Summary - No Plan Redesign

AVMED POS PLAN		
This Schedule of Benefits reflects the higher provider and prescription copays. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed web-site at www.avmed.org/mdc.		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
LIFETIME MAXIMUM	Unlimited	Unlimited
CO-INSURANCE LEVELS	Not Applicable	Plan pays 70% of Maximum Allowable Payment (MAP); member pays 30% co-insurance after deductible
CALENDAR YEAR DEDUCTIBLE		
Individual (per contract year)	Not Applicable	$200
Dependent coverage (per contract year)	Not Applicable	$500
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual - Medical	$1,500	$1,500
Dependent Coverage - Medical	$4,500	
Individual - Pharmacy	$1,500	$1,500
Dependent Coverage - Pharmacy	$3,000	$3,000
PHYSICIAN SERVICES		
Services at Physician's offices include, but are not limited to:		
Primary Care Physician's Office Visit	$15 per visit	30% co-insurance after deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	$30 per visit	30% co-insurance after deductible
Allergy Injections	No charge	30% co-insurance after deductible
Allergy Skin Testing	$30 per visit	30% co-insurance after deductible
PREVENTIVE CARE		
Preventive Care (as required by the Patient Protection Affordable Care Act "PPACA")	No charge	30% co-insurance after deductible
MAMMOGRAM, PSA, PAP SMEAR		
Preventive care related services (i.e. "routine" services)	No charge	30% co-insurance after deductible
Diagnostic related services (i.e. "non-routine")	Subject to the plan's x-ray and laboratory benefit, based on place of service	Subject to the plan's x-ray and laboratory benefit, based on place of service

2016 Medical Plan Summary - No Plan Redesign

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

2016 Medical Plan Summary - No Plan Redesign

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

Medical Plan Summary - No Plan Redesign

AVMED HMO PLANS		
This Schedule of Benefits reflects the higher provider and prescription copays. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/go/mdpht.		
SCHEDULE OF BENEFITS	**AVMED HMO HIGH**	**AVMED HMO LOW**
	COST TO MEMBER	**COST TO MEMBER**
LIFETIME MAXIMUM	Unlimited	Unlimited
CALENDAR YEAR DEDUCTIBLE		
Individual /Family	Not Applicable	Not Applicable
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual - Medical	$1,500	$6,350
Dependent Coverage - Medical	$3,000	$12,700
Individual - Pharmacy	$1,500	Combined with medical above
Dependent Coverage - Pharmacy	$3,000	Combined with medical above
PRIMARY CARE PHYSICIAN		
Office visits	$15 per visit	$30 per visit
Preventive care-routine physicals/pediatric well baby care (and other preventive services required by the Patient Protection Affordable Care Act "PPACA")	No Charge	No Charge
Pediatrician	$15 per visit	$30 per visit
SPECIALIST'S SERVICES	Open Access	Referral required for services
Office Visits	$30 per visit	$45 per visit
Annual gyn exam when performed by participating specialist	No Charge	No Charge
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	$45 per visit
Subsequent visits	No charge	No charge
ALLERGY TREATMENTS		
Allergy Injections	$15 per visit	$30 per visit
Skin testing (per course of treatment)	$30 per visit	$45 per visit
HOSPITAL SERVICES - Inpatient care at participating hospitals includes:		
Room and board - unlimited days (semi-private)	No charge	$150 per day for the first 3 days, per admission. No charge thereafter.
Physicians', specialists' and surgeons' svces	No charge	
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication	No charge	
Intensive care unit and other special units, general and special duty nursing	No charge	
Laboratory and diagnostic imaging	No charge	

2016 Medical Plan Summary - No Plan Redesign

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

2016 Medical Plan Summary - No Plan Redesign

AVMED HMO PLANS		
SCHEDULE OF BENEFITS	**AVMED HMO HIGH**	**AVMED HMO LOW**
	COST TO MEMBER	COST TO MEMBER
PHYSICAL, SPEECH, RESPIRATORY & OCCUPATIONAL THERAPIES		
Short-term Physical, Speech, Respiratory and Occupational therapy for acute conditions. Coverage is limited to 60 visits combined per Calendar year	$30 per visit	$45 per visit
DURABLE MEDICAL EQUIPMENT Equipment includes but not limited to: Hospital beds, walkers, crutches,wheelchairs	$50 per episode of illness	$50 per episode of illness
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER		
Habilitative physical, occupational, & speech therapy services, are covered to a combined maximum of 100 visits per calendar year.		
Applied Behavioral Analysis (ABA)	$15 per visit	$30 per visit
Physical, Speech, Occupational Therapy	$15 per visit	$30 per visit
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$15 copay	$20 copay
Preferred Brand	$25 copay	$35 copay
Non-Preferred Brand	$35 copay	$55 copay
SPECIALTY (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY)		
Generic	$15 copay	$20 copay
Preferred Brand	$25 copay	$35 copay
Non-Preferred Brand	$35 copay	$55 copay
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$30 copay	$40 copay
Preferred Brand	$50 copay	$70 copay
Non-Preferred Brand	$70 copay	$110 copay

DEFINITIONS: Generic - medication on the Prescription medication list. Preferred Brand - medication designated as preferred on the prescription medication list with no Generic equivalent. Non-Preferred Brand - medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.

BRAND ADDITIONAL CHARGE - When Brand is requested and a generic equivalent is available: Member pays the difference between the cost of the Brand medication and Generic medication, plus the Non-Preferred Brand copay.

* There is no copay for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).

PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIMITED TO:

All Inpatient Services, Observation Services, Residential Treatment, Outpatient Surgery, Intensive Outpatient Programs, Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging), Non-Emergency Ambulance, Dialysis Services, Transplant Services, use of Non-Participating Providers, Certain Medications Including Injectables

BARIATRIC SERVICES - Effective January 1, 2016 - Bariatric surgery services performed at JHS Centers of Excellence will be covered under the offered MDC HMO plans. Previously, bariatric services were only covered under the POS plan. You must meet specific criteria to qualify. Please contact AvMed for the specific criteria and any further details.

2016 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.

2016 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 Estab.	No Charge	No Charge	No Charge	No Charge
0120 Periodic Oral Exam	No Charge	No Charge	No Charge	No Charge
X-rays	No Charge	No Charge	No Charge	No Charge
1110/20 Prophylaxis	No Charge (2/12mo) $15 ea. (2 add'l/12 mo)	No Charge (2/12 mo) $14ea. (2 add'l/12 mo)	No Charge (1/6 mo.)	No Charge (1/6 mo.)
1203 Fluoride Treatment (children to age 19)	No Charge	No Charge	No Charge	No Charge
1351 Sealant - per tooth	No Charge	No Charge	$ 6.00	No Charge
1510 Space Maintainers	$25.00	No Charge	$40.00	No Charge
TYPE II				
Fillings: (silver)				
2330 - One Surface	$10.00	No Charge	$10.00	No Charge
2331 - Two Surfaces	$18.00	No Charge	$18.00	No Charge
2332 - Three Surfaces	$23.00	No Charge	$23.00	No Charge
2335 - Four Surfaces	$25.00	No Charge	$60.00	$60.00
2390 - Resin Crown, Anterior	$30.00	$30.00	$90.00	$90.00
2394 - Resin, Four Or More Surfaces, Posterior	$65.00	$65.00	$130.00	$130.00
Root Canals:				
3310 - Anterior	$90.00	$45.00	$90.00	$45.00
3320 - Bicuspid	$155.00	$90.00	$155.00	$90.00
3330 - Molar	$200.00	$145.00	$200.00	$145.00
3410 - Apicoectomy	$75.00	$65.00	$75.00	$65.00
Extractions:				
7111 - Single Tooth	No Charge	No Charge	No Charge	No Charge
7140 - Extraction, erupted tooth or exposed tooth	No Charge	No Charge	No Charge	No Charge
7210 - Surgical Extraction of erupted tooth	$15.00	No Charge	$15.00	No Charge
Periodontics: (gum treatment)				
4341 - Periodontal Scaling & Root Planning - per quadrant	$40.00	$40.00	$40.00	$40.00
4210 - Gingivectomy / Gingivoplasty - per quadrant	$120.00	$90.00	$120.00	$90.00
4910 - Periodontal Maintenance Procedures	$25.00//ea (2/12 mo)	$25.00	$25.00	25% Discount
TYPE III				
Crown & Bridge				
2930 - Prefabricated Stainless Steel Primary Tooth	$25.00	No Charge	$25.00	No Charge
2791 - Crown Full Cast Predominately Base Metal	$210.00	$175.00	$210.00*	$175.00*
2750 - Crown Porcelain Fused to High Noble Metal	$290.00	$290.00	$275.00 + Lab Fees	$275.00 + Lab Fees
2751 - Crown Porcelain Fused to Base Metal	$210.00	$175.00	$210.00	$175.00
Pontics:				
6210 - Full Cast	25% Discount	25% Discount	25% Discount*	25% Discount
6240 - Porcelain Fused to Metal	25% Discount	25% Discount	25% Discount*	25% Discount
6750 - Crown Porcelain Fused to High Noble Metal	$290.00	$290.00	$275.00 + Lab Fees	$275.00 + Lab Fees
Prosthodontics:				
5110 - Complete Upper	$230.00	$205.00	$230.00	$205.00
5120 - Complete Lower	$230.00	$205.00	$230.00	$205.00
5213/14 - Partial Upper/ or Lower - Cast Metal Base	$245.00	$240.00	$275.00	$240.00
ORTHODONTIA				
Consultation	25% Discount	No Charge	25% Discount	No Charge
Evaluation	25% Discount	No Charge, (D8660)	25% Discount	$25.00
Records	25% Discount	$250.00	25% Discount	$200.00
Children - Normal Class II	25% Discount	$1400.00	25% Discount	$1400.00
Adult - Normal Class II	25% Discount	$1950.00	25% Discount	$1950.00
Retention	25% Discount	$300.00 (D8680)	25% Discount	25% Discount
	Additional Costs: High Noble Metal fees capped at $150 per crown. Porcelain fees capped at $75 per crown.		Cost of High Noble Metal additional.	
	Self Referral Plan: The following copayments 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 copayment 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 preauthorization from SafeGuard is required	Humana OHS does not require prior authorization or referrals to seek treatment with a participating Humana OHS Specialist.	

Disability Income Protection Plans

Disability insurance protects one of your most valuable assets, the ability to work. Chances are that you do not have enough money in your personal or other long-term savings accounts that would allow you to miss more than two months of work without suffering financial consequences.

What is the difference between Short Term and Long Term Disability insurance? Short Term Disability (STD) insurance can help you replace a portion of your income during the initial weeks of a disability and pays a weekly benefit. Long Term Disability (LTD) insurance helps replace a portion of your income for an extended period of time and pays a monthly benefit.

You may choose from the following Disability Income Protection Insurance plans:

Short-Term Disability (STD) Plan (Low or High Option)

Long-Term Disability (LTD) Plan (Low or High Option)

Premier Long-Term Disability Plan

You may enroll in the regular MetLife STD Plan with or without the regular LTD Plan, or the Premier LTD Plan alone. Enrollment in the Premier LTD cannot be combined with the regular STD and LTD plans. The plans are mutually exclusive because of the overlap in the elimination periods. To enroll or upgrade to a higher benefit disability plan during the Open Enrollment period, a Statement of Health is required.

An employee must be actively at work for coverage to begin. Minimum requirement for active employment is 60 hours biweekly.

Short-Term Disability (STD) Income Protection Highlights

- The Short-Term Disability (STD) Insurance plan provides up to 60% of your weekly salary, with a maximum weekly benefit of $500 for the STD Low Option Plan, or $1,000 for the STD High Option Plan.
- STD benefits start to accrue after you meet the definition of disability as defined in the policy and satisfy a 14-consecutive day waiting period, or the expiration of all sick leave, whichever is later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you
- Short-term disability benefit payments are issued in arrears on a weekly basis, and benefits can continue for each period of disability, but not beyond the maximum benefit period of 26 weeks.
- Pregnancy/childbirth is considered a disability just like any other illness or injury that may occur while covered under this plan. For a normal childbirth, disability typically covers you up to a total of six weeks. (Example, if you have two weeks of sick leave, your MetLife benefits would be payable for four weeks.)
- To receive benefits, you must be unable to earn more than 80% of pre disability earnings at your own occupation as a result of sickness or injury.
- No pre-existing limitation clause applies.
- There is no waiver of premium if approved for benefits.

What's Not Covered?

Sickness or injuries not covered are those resulting from:

- War, declared or undeclared, or acts of war, insurrection, rebellion, or terrorist act
- Active participation in a riot
- Committing or attempting to commit a felony or assault
- Intentionally self-inflicted injuries
- Attempted Suicide
- Work related injury or sickness.

Long-Term Disability (LTD) Income Protection Highlights

- The Long-Term Disability (LTD) Insurance plan can provide up to 60% of your monthly salary, with a maximum monthly benefit of $2,000 for the LTD Low Option Plan, or $4,000 for the LTD High Option Plan.
- LTD benefits start to accrue after you meet the definition of disability as defined in the policy and satisfy the waiting period of 180 days. Before LTD benefits will begin, an employee must exhaust any short-term disability or the expiration of all sick leave, whichever occurs later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you.
- The Maximum Benefit Period is the later of, your normal retirement age or the period shown in the chart below.
- Pre-existing limitation clause applies.
- The minimum monthly benefit is the greater of $100, or 10 percent of the monthly benefit before reductions for other income benefits.
- As long as you are receiving disability benefits from MetLife, your LTD premiums are waived.

Premier (LTD) Income Protection Highlights

- The Premier Long-Term Disability (LTD) Insurance plan provides up to 66 2/3 % of your monthly salary, with a maximum benefit of $7,000 per month.
- LTD benefits start to accrue after you meet the definition of disability as defined in the policy and satisfy the 90-day waiting period, or exhaust all sick leave, whichever occurs later.
- Pre-existing limitation clause applies.
- The minimum monthly benefit is the greater of $100, or 10 percent of the monthly benefit before reductions for other income benefits.
- As long as you are receiving disability benefits from MetLife, your LTD premiums are waived.
- The Maximum Benefit Period is the later of, your normal retirement age or the period shown in the chart below.

Age On Date Of Disability	Benefit Period
Under 60	To age 65,
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and above	12 months

Disability Income Protection Plans

Definition of Long-Term Disability

You are disabled when MetLife determines that:

1. Due to Sickness, or as a direct result of accidental injury, you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
2. You are unable to earn more than 80% of your pre-disability earnings at your own occupation for any employer in your local economy.

After 24 mos. of payments, you are disabled when MetLife determines that:

1. Due to Sickness, or as a direct result of accidental injury, you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
2. You are unable to earn more than 80% of your pre disability earnings from any employer in your local economy at any gainful occupation for which they are reasonably qualified taking into account their training, prior education and experience.

Rehabilitation & Return To Work Assistance

Vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help them return to productive, independent lifestyles.

What's Not Covered?

Sickness or injuries not covered are those resulting from:

- War, declared or undeclared, or acts of war, insurrection, rebellion, or terrorist act.
- Active participation in a riot.
- Committing or attempting to commit a felony or assault.
- Intentionally self-inflicted injuries.
- Attempted Suicide.

Annual Leave and Your Disability Benefits

If you are on sick leave and your sick leave runs out, the County automatically uses any accrued annual leave. However, if you purchase short-term or long-term disability insurance, you can choose not to be paid for your annual leave even if you exhaust your sick leave. Contact your Departmental Personnel Representative and request in writing that your annual leave not be paid to you during your absence from work due to illness or injury.

What If I Receive Benefits From Another Group Disability Plan, Social Security Or the Florida Retirement System?

Both the short-term and long-term disability plans coordinate with benefits payable under any statutory disability law, the Federal Social Security Act and any other federal, state, county or municipal retirement acts or laws. These benefits also coordinate with any other group policies you may have that provide disability benefits. Any employer-sponsored salary continuation or retirement program benefits are coordinated as well.

Coordination of disability benefits means the disability payments you receive are offset by the amount you receive from other sources of income as defined in the policy.

Termination of Coverage

Your coverage under the policy ends on the earliest of the following:

- The date the group policy or plan is cancelled. Employees may cancel coverage within 45 days of going on no-pay status or obtaining disability coverage through another group plan.
- The date you are no longer in an eligible group.
- The date your eligible group is no longer covered.
- The last day of the period for which you made any required contributions, or
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

MetLife will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

Delayed Effective Date

This insurance coverage will be delayed if you are not in active employment status because of injury, sickness, temporary layoff or leave of absence on the date that this insurance would otherwise become effective.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to the Policy.

Policy Provider

Metropolitan Life Insurance Company underwrites these plans.
MetLife Disability (888) 463-2023 - www.metlife.com/mybenefits
File a disability claim online, check the status and details of your claim.

Biweekly Premiums

Short Term (Low Option and High Option plans):
$1.20 per $100 of Weekly Benefit

Long Term (Low Option plan): $0.192 per $100 of Covered Payroll
Long Term (High Option plan):$0.230 per $100 of Covered Payroll

Premier Long Term: $0.320 per $100 of Covered Payroll

DISABILITY CALCULATOR

STD Low Option Biweekly Premium =
Adj. Biweekly Salary (capped at $1,666.67) ÷ 2 x 0.60 x 0.0120

STD High Option Biweekly Premium =
Adj. Biweekly Salary (capped at $3,333.34) ÷2 x 0.60 x 0.0120

LTD Low Option Biweekly Premium =
Adj. Biweekly Salary (capped at $1,538.76) x 26 ÷12 x 0.00192

LTD High Option Biweekly Premium =
Adj. Biweekly Salary (capped at $3,077.52) x 26 ÷12 x 0.00230

Premier LTD Biweekly Premium =
Adj. Biweekly Salary (capped at $4,846.16) x 26 ÷12 x 0.00320

Online Disability Calculator

Go to http://www.miamidade.gov/humanresources/supplemental-benefits.asp and click on the Calculator link listed under Short and Long-Term Disability.

FBMC - Flexible Spending Accounts (FSA)

FBMC's Web site provides information regarding your benefits and comprehensive details on your Flexible Spending Account(s). By entering www.myFBMC.com into your Internet browser, you will open FBMC's home page. Answers to many of your Flexible Spending Accounts questions can be obtained by using the following navigational tabs located along the top portion of the home page.

Account Information
If you previously registered an e-mail address and password on FBMC's Web site, you may continue using this information. If you haven't registered, log in to the site as a first time user. Follow the link on the login page and register. After this login, the following menu items will be available to you.

- My Benefits- includes information on current benefits, such as effective date, number of deductions and pre-tax annual contribution
- My Account - allows review of transactions from your current and previous plan years, including run-out period information, payment status, claims and account availability
- My Profile - helps you keep your personal information current, as well as manage your password and e-mail address
- My Resources - gives you access to downloadable forms, such as FSA claim form and Direct Deposit forms, and FAQs.

Downloading Forms
When you select the 'My Account' tab, a choice of forms, including a Letter of Medical Need, FSA claim form and Direct Deposit Form, are posted for your convenience.

Frequently Asked Questions
The 'Frequently Asked Questions' tab provides answers to many of your general questions regarding Flexible Spending Accounts and enrollment information.

FBMC Customer Care Center
Clicking on the "Contact" tab gives you a direct link to the FBMC Customer Care Center.

FBMC Interactive Benefits
FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA claim form
- Change Your PIN

Personal Identification Number (PIN)
To access Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero. If you forget your PIN, call FBMC Customer Care at 1-800-342-8017.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

What Is A Flexible Spending Account (FSA)?

FBMC Benefits Management, Inc provides you with IRS tax-favored FSAs to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary and
- savings on income and Social Security taxes.

Is An FSA Right For Me?

If you spend $260 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis at www myFBMC.com.

Enrollment

Flexible Spending Accounts (FSA) do not carryover from one year to the next. If you wish to participate during the next plan year, you must enroll \re-enroll during the online open enrollment.

What Is My FSA Period of Coverage?

Your period of coverage for FSAs is January 1- December 31, unless you make a permitted mid-plan year election change, terminate employment or lose eligibility for group coverage. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage.

Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

Is There a Cap on the Contribution Level?

Healthcare FSA

Minimum Deposit: $10 per pay period, or $260 year
Maximum Deposit: $ 98.08 per pay period, or $2,550 per year

Dependent Care FSA

Minimum Deposit: $10 per pay period , or $260 year
Maximum Deposit: $192.31 per pay period, or $5,000 year

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

If married and filing separately, the maximum annual deposit is $2,500.

If single and head of household, the maximum annual deposit is $5,000.

If you are single and not head of household, your maximum annual deposit is $2,500.

If married and filing jointly, the maximum annual deposit is $5,000.

What Are The Administrative Fees?

Healthcare FSA Only..... $2.02 Biweekly, or $52.52 Annually
Dependent Care FSA Only.....$2.02 Biweekly, or $52.52 Annually

If enrolled in both Healthcare and Dependent Care FSAs, the total combined fee is:..... $2.02 Biweekly, or $52.52 Annually

Annual deposit amounts above include the admin fee. The net annual deposit for Health FSA is: $2,497.48 and for Dependent Care: $4,947.48

What Types Of FSAs Are Available?

Your employer offers you a Healthcare FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Healthcare FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Healthcare FSA, including:

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items (with prescription). See myFBMC.com for quarterly updates.

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- day care services
- elder care services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the Healthcare FSA and Dependent Care FSA sections of this Reference Guide for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time we receive your properly completed and signed FSA claim form.

To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

To apply, complete the Direct Deposit Enrollment Form available from www.myFBMC.com or call FBMC Customer Care Center at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where Can I Get Information About FSAs?

If you have specific questions about FSAs, contact the Customer Care Center.

- Visit www.myFBMC.com.
- Call 1-800-342-8017 (Monday-Friday, 7 a.m.-10 p.m. ET).

Please note that your account information will not be discussed with others without your verbal or written authorization.

FSA Savings Example

With FSA		Without FSA
$31,000.00	Annual Gross Income	$31,000.00
- $2,550.00	FSA Deposit for Recurring Expenses	- $0.00
$28,450.00	Taxable Gross Income	$31,000.00
-$6,444.00	Federal, Social Security Taxes	-$7,022.00
$22,006.00	Annual Net Income	$23,979.00
-$0.00	Cost of Recurring Expenses	-$2,550.00
$22,006.00	Spendable Income	$21,479.00

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of **$578 !**

*Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Flexible Spending Accounts

FSA Guidelines

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA. Refer to the "Written Certification" portion of the Beyond Your Benefits section of this Benefits Handbook for more specifics.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Healthcare FSA or vice versa.
3. You have a grace period of two months and 15 days following the end of your Plan Year (December 31) for a Healthcare FSA. This grace period ends on March 15. During the grace period, you may incur expenses and submit claims for these expenses. Funds will be automatically deducted from any remaining dollars in your Healthcare FSA balance.
4. You have a 120-day run-out period (until April 30) following the end of the plan year, for reimbursement of eligible FSA expenses incurred during your period of coverage.
5. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
6. You cannot deduct reimbursed expenses for income tax purposes.
7. You may not be reimbursed for a service that you have not yet received.
8. Be conservative when estimating your medical and/or dependent care expenses for the Plan Year. IRS regulations state that any unused funds which remain in your FSA after a plan year and grace period ends (and all reimbursable requests have been submitted and processed) cannot be returned to you nor carried forward to the next plan year.

Termination or Leave

If you terminate employment or go on unpaid leave, your eligibility for either or both FSAs may change.

Healthcare FSAs

If you experience an event permitting a mid-plan year FSA election change such as termination of employment or unpaid leave, you can continue to contribute to your Healthcare FSA on an after-tax basis by calling the Customer Care Center at 1-800-342-8017 within 45 days (60 days for newborns\adoption or placement).

As long as you make full after-tax contributions to your Healthcare FSA, you can receive reimbursements on eligible healthcare expenses incurred during your period of coverage.

You have a 120-day run-out period (until April 30) after the plan year ends to submit claims for reimbursement of eligible FSA expenses which you incurred during your period of coverage (normally Jan 1-Dec 31). However, should you terminate employment prior to Dec. 31, your FSA will cease at the end of the month of termination). Your Healthcare FSA coverage will not be continued beyond the plan year in which the COBRA-qualifying event occurred.

Specific guidelines about termination and leave policies can be obtained from your DPR. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your DPR for further information and to obtain any paperwork necessary to complete.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage when on leave. Please contact your DPR for further information.

Dependent Care FSAs

You cannot continue contributing to your Dependent Care FSA. You can, however, continue to request reimbursement for eligible expenses incurred while employed until you exhaust your account balance or the plan year ends.

What Documentation Of Expenses Do I Need To Keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

How Do I Get the Forms I Need?

To obtain forms you will need after enrolling in either a Healthcare or Dependent Care FSA, such as an FSA claim form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, or call the Customer Care Center at 1-800-342-8017. For more information, refer to the Getting Answers section of this book.

Will Contributions Affect My Income Taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Patriot Act

In June 2008, President Bush signed a law that allows military personnel called to duty for a minimum of 180 days to receive taxable distribution of unused medical Flexible Spending Account (FSA) funds. Some of the changes made by the Act are permissive while others mandatory.

The bill defines "qualified reservist distribution" as any distribution to an individual of all or a portion of the balance in the employee's medical FSA account under such arrangement if:

- The individual is a member of a "reserve component" as defined in section 101 of title 37 of the United States Code
- The distribution is made only to a member that has been ordered or called to active duty for 180 days or more or for an indefinite period
- The distribution is made during the period beginning on the date the member is ordered or called and ending on the last date that reimbursements could otherwise be made under such arrangement for the plan year that includes the date of order or call.

Flexible Spending Accounts

Healthcare FSA Minimum Annual Deposit:

$260 per year ($10 per pay period)

Maximum Annual Deposit: $2,550

Includes a $52.52 annual administrative fee. The net maximum deposit for a Healthcare FSA is $2,497.48 per year

What Is A Healthcare FSA?

A Healthcare FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found in this section.

Whose Expenses Are Eligible?

Your Healthcare FSA may be used to reimburse eligible expenses incurred by:

- Yourself
- Your spouse
- Qualifying child or
- Your qualifying relative.

An individual is a qualifying child if they have not attained age 26.
An individual is a qualifying relative if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- Have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year or
- If no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if he/she is physically and/or mentally incapable of self care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Healthcare FSA.

When Are My Funds Available?

Once you sign up for a Healthcare FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.
Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of the plan year.

Are Prescriptions Eligible for Reimbursement?

Yes, most filled prescriptions are eligible for Healthcare FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy receipts (including prescription name, date(s) of service, and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Can Travel Expenses For Medical Care Be Reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Healthcare FSA. With proper substantiation, eligible expenses can include:

- Actual round-trip mileage
- Parking fees
- Tolls and
- Transportation to another city.

Is Orthodontic Treatment Reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA claim form each plan year:

- A written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service and the cost for the service and
- A copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call the Customer Care Center at 1-800-342-8017.

Should I Claim My Expenses On IRS Form 1040 ?

With a Healthcare FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Healthcare FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are Some Expenses Ineligible?

Expenses not eligible for reimbursement through your Healthcare FSA include:

- Insurance premiums
- Vision warranties and service contracts and
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Complete information on ineligible expense can be found in IRS Publication 502 at www.irs.gov.

When Do I Request Reimbursement?

You may use your Healthcare FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How Do I Request Reimbursement?

Requesting reimbursement from your Healthcare FSA is easy. Simply mail or fax a correctly completed FSA claim form along with the following:

- A receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- An Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- A written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

Mail to: Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 866-440-7154

*EOBs are not required if your coverage is through an HMO.

Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your receipts for a minimum of one year and submit to us upon request.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Breast pumps, or Lactation Devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
Injections and vaccinations
In vitro fertilization
Lasik
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items (RX is required)
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Healthcare FSA funds is available for services that do not occur within your plan year or grace period.

*IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

What Is The myFBMC Card®?

The myFBMC Card® is a convenient Healthcare Flexible Spending Account (HFSA) reimbursement option that allows FBMC to electronically reimburse eligible expenses under Miami-Dade County's plan and IRS guidelines. When you swipe the myFBMC Card® to pay for eligible expenses, funds are electronically deducted from your HFSA account. The myFBMC Card® cannot be used for reimbursement of Dependent Care expenses.

If you are not enrolled in a Miami-Dade County health plan the myFBMC Card® may be of limited use, because the copay structure loaded into the card's database is limited to County plans. If you are enrolled in a non-County plan you will have to pay upfront then file a claim to obtain reimbursement of your eligible healthcare expenses.

What Are The myFBMC Card® Advantages?

You can use the myFBMC Card® for certain eligible Over-the-Counter (OTC) expenses (ex: band-aids) at drugstores. Other advantages include:

- Instant reimbursements for health care expenses, including prescriptions, co-payments and mail-order prescription services.
- Instant approval of known co-payments for medical and prescription drug coverage.
- Convenient, cash-less card payment for authorized co-payments and purchases

If I Enroll In An HFSA, Will I Receive The myFBMC Card®?

Yes. Prior to January 1, two cards will be sent to you in the mail (in a plain envelope); one for you and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date.

Remember, you can go to www.myFBMC.com to see your account information and check for any outstanding Card transactions.

How Can I Activate The myFBMC Card®?

To activate your myFBMC Card® anytime visit www.myFBMC.com. You may also call 1-888-514-6845.

How Do I Use The myFBMC Card®?

After activating your card, for eligible expenses, simply swipe the myFBMC Card®. Whether at your health care provider or drugstore, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Prescription and certain OTC purchases with the card are only accepted at registered merchants (i.e. stores like Publix, Wal-Mart, Target and CVS). For all other qualified expenses, such as medical co-payments, the myFBMC Card® will function normally. To find out if a pharmacy near you accepts the card, please refer to the **IIAS Store List and the Merchants Registered under the IRS 90% Rules List at www.myFBMC.com.**

A complete list of Frequently Asked Questions about FSAs and the myFBMC Card® are also available at www.myFBMC.com. If you have further questions, contact FBMC Customer Care at 1-800-342-8017 (Monday - Friday, 7 a.m. - 10 p.m. ET).

What Happens If I Fail To Submit Any Necessary Documentation?

If you fail to send in the requested documentation for a myFBMC Card® expense, you will be subject to:

- Withholding of payment for an eligible paper claim to offset any outstanding myFBMC Card® transaction
- Suspension of your myFBMC Card® privileges
- The reporting of any outstanding myFBMC Card® transaction amounts as income on your W-2 at the end of the tax year.

Make sure you review your account statements and take immediate action if there are any items flagged as requiring supporting documentation.

Types of services that would not require documentation:

- Co-payments under the Miami-Dade County health plan
- Mail-order prescriptions purchased through your health plan's mail order pharmacy.
- Multiple co-payments
- Prescription & certain OTC* items purchased at IIAS certified merchants

Types of services that would require documentation:

- Co-payments under a spouse's Medical Plan or Prescription Drug plan
- Dental expenses
- Prescription & certain OTC* items purchased at 90% merchants
- Durable medical equipment
- Eyeglasses, contacts lenses or Lasik surgery

***Note:** Over-the-Counter (OTC) drugs and medicines require a prescription to qualify for FSA reimbursement and myFBMC Card use.

Dependent Care FSA

Minimum Annual Deposit:
$260 per year ($10 per pay period)

Maximum Annual Deposit: $5,000, but depends on your tax filing status, as the list to the right indicates.

Includes a $52.52 annual administrative fee. The net maximum deposit for Dependent Care FSA is $4,947.48 per year.

Partial List of Eligible Expenses*

After School Care
Baby-sitting Fees
Day Care Services
Elder Care Services
In-home Care / Au pair Services
Nursery and Preschool
Summer Day Camps

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

*IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

What Is A Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose Expenses Are Eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a qualifying child, if they:
- Are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- Have a specified family-type relationship to you
- Live in your household for more than half of the taxable year
- Are 12 years old or younger and
- Have not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your spouse, if they:
- are physically and/or mentally incapable of self care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your qualifying relative, if they:
- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home
- receive more than one-half of their support from you during the taxable year.

Note: If you are the tax dependent of another person, you cannot claim qualifying individuals for yourself. You cannot claim a qualifying individual if they file a joint tax return with their spouse. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

What Is My Maximum Annual Deposit?

- If you are married and filing separately, your maximum annual deposit is $2,500
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When Are My Funds Available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Healthcare FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I Claim Tax Credits or Exclusions?

Since money set aside in your Dependent Care FSA is always tax free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit www.myFBMC.com to complete a Tax Savings Analysis.

Are Some Expenses Ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- Books and supplies
- Child support payments or child care if you are a non-custodial parent
- Health care or educational tuition costs and
- Services provided by your dependent, your spouse's dependent or your child who is under age 19.

Will I Need To Keep Any Additional Documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

How Do I Request Reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA claim form along with documentation showing the following:

- The name, age and grade of the dependent receiving the service
- The cost of the service
- The name and address of the provider and
- The beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to:

FBMC Benefits Management, Inc.
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 866-440-7154

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Appeals Process For Denied FSA Claims

If you have a request for an FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request to FBMC for review within 30 days of the denial.

Your appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- The denial letter you received
- Why you think your request should not have been denied and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt of it and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Healthcare FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES	
HEALTH INSURANCE DEDUCTIBLES	$
CO-INSURANCE OR CO-PAYMENTS	$
VISION CARE	$
DENTAL CARE	$
PRESCRIPTION DRUGS	$
TRAVEL COSTS FOR MEDICAL CARE	$
OTHER ELIGIBLE EXPENSES	$
TOTAL Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed $2,497.48.	$
DIVIDE by the number of paychecks you will receive during the plan year (26).*	$
This is your pay period contribution:	$

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary.

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES	
DAY CARE SERVICE	$
IN-HOME CARE / AU PAIR SERVICES	$
NURSERY AND PRESCHOOL	$
AFTER SCHOOL CARE	$
SUMMER DAY CAMPS	$
ELDER CARE EXPENSES	$
DAY CARE CENTER	$
IN-HOME CARE	$
TOTAL Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed $4,947.48.	$
DIVIDE by the number of paychecks you will receive during the plan year (26).*	$
This is your pay period contribution:	$

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary.

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Annual FSA Administrative Fee

Your annual FSA administrative fee is $52.52, regardless of which type of account you select. However, even if you select both accounts, your total fee will not exceed $52.52.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Am I Permitted To Make Mid-Year Election Changes?

A partial list of permitted changes appear on the following page. Election changes must be consistent with the event. Mid-year changes from one health plan to another, are not permitted.

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-year election change or vary a salary reduction amount, depending on the qualifying event (QE) and requested change. The benefit addition or deletion must have a direct relationship to the QE. For example, if your spouse and child were covered for medical and dental coverage only, through your spouse's employer, and your spouse terminated employment (therefore losing eligibility for continued group coverage), you may add your spouse and/or child to the County's medical and/or dental plan within 45 days of the loss of health insurance eligibility. However, you cannot enroll in or increase your healthcare or dependent care spending account, since your spouse was not enrolled for such benefits through the former employer at the time of termination.

How Do I Make A Change To My Health Plan Mid-Year?

To make a change, complete and submit the **Flexible Benefits Change in Status (CIS) and Health Plan Status Change** forms to your Department Personnel Representative (DPR) within 45 days (60 days to add newborns) of a qualifying event (QE). These forms may be obtained online at www.miamidade.gov/benefits. Documentation supporting the loss or gain of insurance coverage is required. Do not delay submission of the forms while you gather your documentation. Simply forward the forms to your DPR and present your documentation as soon as it becomes available.

Upon the approval and processing of your election change request, your existing elections will be stopped or modified (as appropriate). Generally, mid-year pre-tax election changes can only be made prospectively, no earlier than the beginning of the pay period after your election change request was received by the Benefits Administration Unit (BAU), unless otherwise provided by law. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption or placement for adoption which become effective as of birth or the earlier of: a) adoption or b) placement for adoption. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the CIS form is received by BAU within the 31 days from birth, the premium is waived for the first 31 days. If the CIS form is received after the first 31 days, but within 60 days of the qualifying event (birth, adoption\placement for adoption), the new premium will be charged retroactive to the qualifying event.

Status changes to delete a dependent, other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the Benefits Administration Unit. The exception is divorce\dissolution of domestic partnership. In these cases, dependents coverage is terminated retroactive to the date of divorce, or date of dissolution of domestic partnership.

CIS Premium Changes

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

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.

Opt-Out of Medical Coverage

In 2015 employees may opt-out of County-provided medical coverage during open enrollment. If you decline coverage, you cannot re-apply until the next open enrollment, unless you experience a family status or HIPAA qualifying event.

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 (IRC) Section 125 salary reduction provisions, such as medical, dental and vision, you will still be required to pay the employee premium (if any) for the remainder of the year. Also, cancelling your medical plan will not eliminate the required base salary contribution towards the County's cost of healthcare.

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

How Do I Make An FSA change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances. A partial lists of permitted qualifying events appear on the following page. For example: if you get divorced, an IRS special consistency rule allows you to lower or cancel your Healthcare FSA coverage for the individual involved. The Benefits Administration Unit (BAU) of the Internal Services Department will review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility** - If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan** - If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses** - You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Appeals Process for Denied Change in Status Requests

If you have a request for a Change in Status denied, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to BAU. Your appeal must include:

1) A copy of the denied request, 2) The denial letter you received, 3) Why you think your request should not have been denied and 4) Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed and you will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within the employer's, insurance provider's and IRS regulations governing the plan.

Changing Your Coverage (Qualifying Events)

Mid-Year Permitted Changes In Status

MARITAL STATUS	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
CHANGE IN NUMBER OF DEPENDENTS	A change in the number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled if the dependent gains eligibility as a result of a valid CIS event. The gain\loss must have a direct relationship to the qualifying event.
CHANGE IN STATUS OF EMPLOYMENT AFFECTING COVERAGE ELIGIBILITY	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
GAIN OR LOSS OF DEPENDENTS' ELIGIBILITY STATUS	An event that causes an employee's dependent to satisfy, or cease to satisfy, coverage requirements under an employer's plan. This may include change in age, employment or tax status.
CHANGE IN RESIDENCE*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.
COVERAGE AND COST CHANGES*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
OPEN ENROLLMENT UNDER OTHER EMPLOYER'S PLAN*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • The other employer's plan has a different period of coverage (usually a plan year) or • The other employer's plan permits mid-plan year election changes under this event.
JUDGMENT/DECREE/ORDER†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
MEDICARE/MEDICAID†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 45 days (60 days to add newborns) of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE OF ABSENCE	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.
UNPAID LEAVE OF ABSENCE	You may submit a completed Flexible Benefits Change in Status Form and Insurance Status Change form within 45 days of being in a leave without pay status to temporarily cancel your health insurance coverage. Upon return to pay status (within 45 days), you must re-submit a completed Flexible Benefits Change in Status form and Insurance Status Change Form to your DPR to reinstate coverage.

ARAG® Legal Insurance

Legal Plan Coverage

When employees face a legal matter on their own, it can be confusing, time-consuming and expensive. In fact, without a legal plan, attorney services can average $323 per hour.* That's why we want to give you easy and affordable access to professional attorneys for a wide array of legal needs.

In-Office Legal Representation

When you are in need of legal representation, you can meet with an attorney in their office to get the legal help and protection necessary. Attorney fees for most covered matters are 100% paid-in-full when you work with a Network Attorney. Network Attorneys provide legal advice and representation, including review and document preparation for covered legal matters. Refer to page 44 for a list of covered services.

Telephone Legal Advice and Consultation

Attorneys can easily handle certain issues over the phone. You can consult with a Network Attorney over the phone as often as necessary and as long as necessary for any of the following legal needs:

- General Advice and Consultation
- Standard Will Preparation
- Living Will and Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up Calls and Letters
- Specific Document Preparation; Document Review

Identity Theft Services

As a member, you have toll-free access to Certified Identity Theft Case Managers to help you get your life back in order and repair any damage done to your identity. The case manager will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverage
- Provide identity theft tools and resources
- Monitor the resolution of the situation

Immigration Assistance

A service that gives you toll-free access to Telephone Network Attorneys for legal advice and consultation on:

- Immigration processes and guidelines
- Filing and processing applications or petitions
- Laws and regulations governing various types of immigration benefits, including asylum, adjustment of status, business visas and employment authorizations
- Deportation and removal proceedings

Online Legal Tools and Resources

Your path to legal protection starts with easy-to-use online resources via the ARAG Legal Center (ARAGLegalCenter.com, access code 10277mdc). There you can get help in handling legal issues on your own and take your first steps towards protection. Online resources include:

- The Education Center which contains Guidebooks, hundreds of articles, newsletters and more to help you understand everyday legal issues.
- DIY Docs® offer the convenience and control of creating your own state-specific, legally-valid documents online. Do you want to research a certain legal topic in the comfort of your own home? Just log on to the ARAG Legal Center (Access Code: 10277mdc for non- plan members) to learn more.

Who are my eligible dependents?

- Your spouse or domestic partner
- All unmarried dependent children, or children of a domestic partner, to the end of the calendar year the dependent turns age 26. The unmarried dependent child must reside in the employee's household, or is a full-time or part-time student.

To locate a network attorney visit www.ARAGLegalCenter.com and enter Access Code: 10277mdc, or call the ARAG Customer Care Center at (800) 667-4300.

Your After-Tax Rate Biweekly Premium:	
Employee Only:	$7.29
Employee +1:	$9.34
Employee +Family:	$9.61

*Average attorney rates in the United States of $323 per hour for attorneys with 11 to 15 years of experience, Survey of Law Firm Economics, The National Law Journal and ALM Legal Intelligence.

ARAG® Legal Insurance

Plan Provider

ARAG is a global leader of legal insurance. ARAG Insurance Company is rated A (Excellent) by A.M. Best Company. This material is for illustrative purposes only and is not a contract. For terms, benefits and exclusions, call ARAG toll free at (800) 667-4300.

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC.

Important Note

If you elect coverage for yourself and one dependent, the first dependent for whom you file a claim will be considered the only dependent covered under this plan. Changes to the plan, outside of the annual open enrollment period, are allowed only if a corresponding qualifying event is experienced and a timely request is made. Terminated employees may purchase a conversion policy by directly contacting ARAG at (800) 667-4300

BENEFITS		Network Attorney	Non-Network Attorney (Indemnity Benefit)
SMALL CLAIMS COURT (NEW FOR 2016!)	Legal services for an insured to obtain advice and counseling to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction). Legal services for an insured to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law. Exclusion #3 as it relates specifically to small claims matters does not apply to this benefit.	Paid-in-full Paid-in-full	$120* $240*
CONSUMER PROTECTION	Legal services for an insured as a plaintiff or defendant regarding written, verbal or implied contracts or warranties relating to consumer goods or services and/or residential contractor disputes. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,800** $100,000***
DEFENSE OF DEBT COLLECTION	Legal services for an insured as the defendant in a legal action related to consumer goods or services. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,800** $100,000***
FORECLOSURE	Legal services for an insured regarding foreclosure matters related to your primary residence. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,800** $100,000***
DEFENSE OF GARNISHMENT	Legal services for an insured in a legal action for a garnishment against you to collect a judgment related to goods or services. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,800** $100,000***
BANKRUPTCY	Legal services up to and including filing of a Chapter 7 bankruptcy final report or confirmation of a Chapter 13 bankruptcy and including post-confirmation amendments. Chapter 7 Chapter 13	Paid-in-full Paid-in-full	$780* $1020*
DEFENSE OF CIVIL DAMAGE CLAIMS (NEW FOR 2016!)	Legal services for an insured in defense against civil damage(s) claims, except claims involving the ownership or use of a motorized vehicle or claims which are covered by other insurance. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,800** $100,000***
COURT ADOPTION PROCEEDINGS	Legal services to become adoptive parents, and/or for international adoptions, where a foreign attorney is necessary, you are eligible to receive indemnity reimbursement in addition to the benefits available in the United States. Uncontested Proceedings Contested Proceedings- Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full Paid-in-full	$300* $1500** $100,000***

* Non-Network At attorney coverage is $60 per hour up to the stated amount

** Trial Indemnity y Benefits of $1,200 for up to three days of trial time are included in this amount ($200 per 1/2 day for trial time)

*** Trial starting on day four (4) until completion ($400 per 1/2 day of trial time)

ARAG® Legal Insurance

BENEFITS		Network Attorney	Non-Network Attorney (Indemnity Benefit)
GUARDIANSHIP/ CONSERVATORSHIP	Legal services rendered to you in court proceedings to appoint or to be appointed as a guardian or conservator. Uncontested Proceedings Contested Proceedings (NEW FOR 2016!) Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full Paid-in-full	 $300* $1740** $100,000***
MENTAL INCOMPETENCY OR INFIRMITY PROCEEDINGS	Legal services in the defense of mental incompetency or infirmity proceedings. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,800** $100,000***
NAME CHANGE	Legal services for a member to legally change his/her name.	Paid-in-full	$240*
JUVENILE COURT	Legal services for an insured child charged with a crime (except those involving traffic matters) when the court proceedings are held in juvenile court. If the matter is removed from juvenile court, coverage under this benefit will cease as of the date of the removal. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,800** $100,000***
PARENTAL RESPONSIBILITIES (NEW FOR 2016!)	Legal services for an insured in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding your parental responsibilities for an insured child. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,680** $100,000***
HABEAS CORPUS PROCEEDINGS	Legal services for an insured in habeas corpus proceedings. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,680** $100,000***
WILLS	Individual or husband and wife will(s). Does not include any tax planning services done in connection with the will.	Paid-in-full	$150
CODICIL	Codicil – amendment to a will	Paid-in-full	$40 single document $60 spousal documents
LIVING WILL	Living Will/Health Care Power of Attorney	Paid-in-full	$35 single document $50 spousal documents
DURABLE POWER OF ATTORNEY	Durable Power Of Attorney/Financial Power of Attorney	Paid-in-full	$35 single document $50 spousal documents
SOCIAL SECURITY / MEDICARE/ VETERANS	Legal services for an insured in an administrative proceeding arising out of Social Security, Veterans, Medicare or Medicaid benefits. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full	$5,000***
BUILDING CODES	Legal services for an insured in an administrative action for permit or code violations relating to the renovation and/or improvement of your existing primary residence. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,560** $100,000***

ARAG® Legal Insurance

BENEFITS		Network Attorney	Non-Network Attorney (Indemnity Benefit)
ZONING AND VARIANCES	Legal services for an insured in an administrative action related to a zoning change, variance, or an eminent domain proceeding involving your primary residence. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,560** $100,000***
EASEMENTS	Legal services for an insured in an administrative action regarding an easement on your primary residence Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,560** $100,000***
DOCUMENT PREPRATION AND REVIEW (NEW FOR 2016!)	Legal services for an insured for the preparation and review of Deeds, Mortgages, Promissory Notes, Affidavits, Lease Contracts, Demand Letters, and Installment Contracts.	Paid-in-full	$50 per document
PURCHASE / SALE OF REAL ESTATE	Legal services for an insured for the sale of your primary or secondary residence (NEW FOR 2016!) for the review and preparation of documents including the contract for sale and attendance at closing. Legal services for an insured for the purchase of your primary or secondary residence (NEW FOR 2016!) for the review and preparation of documents including contract for purchase and attendance at closing.	 Paid-in-full Paid-in-full	 $360* $360*
REFINANCING	Advice and review of relevant documents regarding refinancing of the named insured's primary residence.	Paid-in-full	$120*
NEIGHBOR DISPUTES (NEW FOR 2016!)	Legal services for an insured with a neighbor as a plaintiff or defendant in a dispute related to your primary or secondary residence, including boundary or property title disputes. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,800** $100,000***
REAL ESTATE DISPUTES (NEW FOR 2016!)	Legal services for an insured as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase, or sale of your primary or secondary residence. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,800** $100,000***
TENANT MATTERS (NEW FOR 2016!)	Legal services for an insured as a plaintiff or defendant with your landlord as tenant of your primary residence, including but not limited to, eviction and security deposit disputes. Pretrial and 3 days of trial Trial starting on the 4th day	 Paid-in-full Paid-in-full	 $1,440** $100,000***

* Non-Network At attorney coverage is $60 per hour up to the stated amount
** Trial Indemnity y Benefits of $1,200 for up to three days of trial time are included in this amount ($200 per 1/2 day for trial time)
*** Trial starting on day four (4) until completion ($400 per 1/2 day of trial time)

ARAG® Legal Insurance

BENEFITS		Network Attorney	Non-Network Attorney (Indemnity Benefit)
PRENUPTIAL AGREEMENT (NEW FOR 2016!)	Legal services for an insured for the preparation of a premarital agreement.	Paid-in-full	$300*
PROTECTION FROM DOMESTIC VIOLENCE (NEW FOR 2016!)	Legal services for the named insured to obtain a protective order related to domestic violence. Legal services for an insured to obtain a protective order related to domestic violence when the opposing party is not an insured under the same Certificate.	Paid-in-full Paid-in-full	$300* $300*
DISSOLUTION OF MARRIAGE	Legal services rendered to the named insured in a divorce, legal separation, and/or annulment of marriage. Uncontested Contested	Paid-in-full 15 hrs Paid-in-full	$480* $840*
POST DECREE DEFENSE	Legal services for an insured for a motion brought against you to modify a final decree for child support, child custody, child visitation, or alimony.	8 hrs Paid-in-full	$1,680** $100,000***
IRS AUDIT PROTECTION	Legal services for an insured involving Internal Revenue Service (IRS) audits related to your personal tax return where the initial written notice is received after your effective date and while your Certificate is in effect. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,680** $100,000***
IRS COLLECTION DEFENSE	Legal services for an insured in defense against collection actions by the Internal Revenue Service (IRS) related to errors on your personal tax return where the initial written notice is received after your effective date and while your Certificate is in effect. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,680** $100,000***
ESTATE ADMINISTRATION & CLOSING	Legal services for an insured in administering an estate where you have been named the executor.	9 hrs Paid-in-full	$540*
MINOR TRAFFIC OFFENSES (NEW FOR 2016!)	Legal services for an insured in the defense of a traffic offense, the conviction of which would not result in suspension or revocation of your driving privilege. (Does not include driving while impaired or under the influence of drugs or alcohol, parking, and any non-moving offense.).	Paid-in-full	$180*
DRIVING PRIVILEGE PROTECTION	Legal services for an insured in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of your driving privileges. Pretrial and 3 days of trial Trial starting on the 4th day	Paid-in-full Paid-in-full	$1,560** $100,000***
DRIVING PRIVILEGE RESTORATION (NEW FOR 2016!)	Legal services for an insured in an administrative proceeding for the restoration of suspended or revoked driving privileges of an insured.	Paid-in-full	$240*
GENERAL IN-OFFICE SERVICES	Legal advice, negotiation, document preparation, and review (except those legal matters which are specifically excluded or otherwise covered.) This benefit is limited to 4 hours per family per calendar year.	4 hrs Paid-in-full	$240*

* Non-Network At attorney coverage is $60 per hour up to the stated amount
** Trial Indemnity y Benefits of $1,200 for up to three days of trial time are included in this amount ($200 per 1/2 day for trial time)
*** Trial starting on day four (4) until completion ($400 per 1/2 day of trial time)

What's Not Covered?

Consult with ARAG or review the certificate of coverage for other exclusions and limitations:

1. Matters against us, the policyholder or an insured against the interests of the named insured under the same Certificate.

2. Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director or an organization, and patents or copyrights.

3. Legal services in class actions, post judgments, punitive damages, malpractice, appeals, small claims court or equivalent court in your state.

4. Legal services deemed by us to be frivolous or lacking merit or, in actions where you are the plaintiff and the amount we pay for your legal services exceed the amount in dispute, or in our reasonable belief you are not actively and reasonably pursuing resolution in your case.

Deferred Compensation Plan

When you retire, you'll want to maintain the lifestyle you currently have. Social Security and the Florida Retirement System are not intended to replace all of your income at retirement. It is wise to start a savings plan now. The Deferred Compensation Plan is a tax-deferred savings plan that can be used at retirement to supplement your Florida Retirement System and Social Security benefits.

Eligibility

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 biweekly.

Plan Features

- Contributions are made to your deferred compensation account through payroll deductions. Note, the contribution limits are based on IRS allowances as of the printing of this book. Visit the benefits website for updates.
- Contributions are taken from your gross salary before Federal Withholding taxes are calculated.
- Your contributions are invested in the investment options of your choice.
- 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.
- This plan is governed by Section 457 Internal Revenue Code.

What Happens To The Money I Contribute?

You choose between two providers, ICMA-RC or National Association of Counties (NACo), administered by Nationwide Retirement Solutions (NRS). You may contribute to both providers if you wish, as long as you do not exceed the total maximum annual contribution.

Each provider offers a number of investment options, including fixed funds, stock funds, bond funds, mutual funds and others. You may wish to seek the advice of an accountant or other professional for investment assistance.

Both ICMA-RC and NRS have representatives available to meet with plan participants one-on-one to discuss your financial objectives. Contact your DPR for the name and telephone number of the plan representative(s) assigned to your department. In addition, on-site representatives are available in the Benefits Administration Unit. Please see page 2 of this Handbook for times and contact information.

Payouts

- Once you retire or separate employment, you become eligible for payments from your account. There is neither a minimum age requirement nor a waiting period for you to begin receiving payments.
- You are not required to select a payout commencement date. At the time you are ready to begin receiving your payout, simply contact your plan provider.
- Once you are eligible to receive payments, you may select from a variety of payment options. You may receive a lump sum, installment payments, irregular payments or an annuity.
- You may rollover funds from another eligible retirement plan, your FRS DROP account, or IRA into the 457 plan. You may also rollover your 457 funds into another eligible retirement plan or to an IRA. Please consult with your tax professional for guidance.

"Catch-up" Provision

If you are within three years prior to the year you designate for normal retirement, you may be eligible to take advantage of a special "catch-up" provision which may allow you to contribute up to $36,000. You may not participate in the "catch-up provision" beyond age 70½. Additionally, there is a provision that permits employees age 50 or older to contribute an extra $6,000 per year, for a total of $24,000. You may take advantage of this in the year that you turn 50 years old and beyond. You may not utilize both "catch-up" provisions simultaneously. Contact the Benefits Administration Unit at 305-375-5633 or 305-375-4288 or the on site deferred compensation plan representative for more information.

Unforeseeable Emergency Withdrawal

You may be able to withdraw money from your account while you are still working if you have an unforeseeable emergency. An unforeseeable emergency is a severe financial hardship to the participant resulting from a sudden and unexpected illness or accident of the participant or of a dependent of the participant, loss of the participant's property due to casualty or other similar extraordinary circumstances arising as a result of events beyond the control of the participant. The amount of money you could receive is limited to the amount necessary to relieve the hardship.

An Unforeseeable Emergency withdrawal is very difficult to receive, and you should not depend on the availability of your funds. Some examples of an Unforeseeable Emergency are health care and property losses due to theft or fire, which are not covered by insurance.

Employees can contact their provider directly to request an emergency withdrawal packet.

Loan Provision

The deferred compensation plan allows participants to borrow up to 50% of their plan balance, not to exceed $50,000. Employees can take one of two types of loans: 1) To purchase a primary residence, or 2) A general purpose loan. The maximum repayment term for a primary residence loan is 15 years and for a general purpose loan, it's 5 years. For employees participating in both plans, the $50,000 limit is the combined maximum. For additional information, contact your plan provider directly.

Benefit Available To Eligible Retired Public Safety Officers

One of the provisions of the Pension Protection Act of 2006 permits 457(b) plans to provide up to $3,000 in tax free insurance premium payments that are deducted from the retired public safety officer's 457(b) account and paid directly to the insurance provider. Upon retirement, please contact the deferred compensation provider for further information. If you are like most people, you want to make sure that your loved ones are adequately provided for should something happen to you.

2016 Plan Year

Biweekly Minimum Contribution: $10 per pay period

Annual Maximum Contribution: 100% of your gross taxable salary or $18,000 (whichever is less)

Group Term Life Insurance

Basic Life

The County provides you with group term life insurance equal to your annual adjusted base salary.

Plan Features

- Benefits are payable for death from any cause to the beneficiaries you name.
- Beneficiary designations may be updated at any time.
- If death results from accidental injuries, your beneficiary may be eligible to receive Group Accidental Death and Dismemberment Insurance (AD&D) equal to your annual base salary.
- Dismemberment benefits, up to the same amount as your group term basic life coverage, are payable for loss of hand, foot or sight of eye resulting from an accident. See your policy for plan provisions.

**In 2011, a new feature of the AD&D benefit is Identity Theft Protection. MetLife's partnership with AXA Assistance USA gives employees access to free credit reports, assistance with placing fraud alerts with the credit bureaus and filing a police report.*

- Employee 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. See the Beyond Your Benefits section for further details.

How To Enroll For Basic Life Coverage

New employees will be automatically enrolled for the County-paid basic life insurance upon enrolling for health or flex benefits online at http://enet.miamidade.gov, during their initial eligibility period. Select the New Hire Benefits Enrollment link to enroll for desired benefits and then go to the Beneficiary Designation link to list your beneficiaries for life insurance death benefits. The link is accessible 24\7 from any computer. You can also change your beneficiaries anytime using the eNet Beneficiary Designation link.

Employees who currently do not have life insurance coverage (either failed to apply during their initial eligibility period, or lost the coverage due to non-payment of premiums during an unpaid leave of absence), will not be able to enroll online. Contact your Department Personnel Representative for information regarding the evidence of insurability process and complete the MetLife Statement of Health (SOH) form for basic life insurance coverage. The application is subject to medical approval and may be denied. If approved, you must be actively at work for the coverage to be effective.

DCFF Fire Union-sponsored plan enrollees who change to a County sponsored medical/dental plan during the open enrollment period must complete a MetLife Life Insurance medical statement of health (SOH) to be considered for life insurance. Life insurance is subject to medical approval and may be denied. Basic Life Insurance through the DCFF plan will cease as of the open enrollment effective date.

Group Term Optional Life Insurance

Although the County assumes the full cost for your basic life insurance with MetLife, you may purchase additional coverage or, "Optional Life Insurance." Employees applying within their eligibility period, or 30 day grace period, may enroll for up to three times annual adjusted salary without evidence of insurability. All other amounts are subject to evidence of insurability.

Plan Features

- If interested, you should elect coverage at the time you sign up for group medical, dental, vision and/or basic life benefits.
- You may apply for coverage up to five times your annual adjusted base salary. Amounts above three times salary may be subject to Statement of Health.
- Premiums are age-based and depend on the amount of coverage purchased. Contact your Departmental Personnel Representative or the Benefits Administration Unit at 305-375-5633 or 305-375-4288 for further details. Visit the online premium calculator at http://www.miamidade.gov/benefits and check on left navigation link for Calculator.
- You may reduce the level of coverage or cancel coverage at any time. However, if you wish to re-enroll for coverage or increase the level of coverage, you must submit an application during the annual Optional Life Open Enrollment. Coverage is subject to medical approval.
- Will preparation services at no cost are offered by Hyatt Legal Plans, a MetLife company. Another benefit is Estate Resolution Services! Beneficiaries can work with a Hyatt Legal attorney for assistance with probate-related items such as document preparation and related tax items. For further assistance, contact Hyatt Legal Plans at 1-800-821-6400, provide them with the Miami-Dade County Group Number 25800 and your social security number.
- An employee must be actively at work for coverage to begin. This also applies to increases in coverage.

How To Enroll For Group Term Optional Life Coverage

When first eligible, new employees may apply for optional life coverage using the County's eNet portal at **http://enet.miamidade.gov**. Select the New Hire Benefits Enrollment link to enroll, and then go to the Beneficiary Designation link to list your beneficiaries for life insurance death benefits. The link is accessible 24\7 from any computer. You can also change your beneficiaries anytime using the eNet Beneficiary Designation link. If you don't enroll during your initial eligibility period, an Optional Life annual open enrollment is held once a year in the spring at http://metlife.com/mybenefits. You may submit an online application during this period, but it will be subject to medical approval. You must be actively at work for coverage to be effective.

Other Benefits Provided By Miami-Dade County

In addition to the group medical, dental and vision plans, Flexible Benefits Plan, and Group Legal Services, your benefits package also includes:

- Paid annual and sick leave
- 13 paid holidays
- Membership in either of the Florida Retirement System (FRS) plans
- Workers' Compensation
- Unemployment Compensation
- Social Security
- Employee Discount Program
- Tuition Refund and
- County Death Benefit.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What Is Continuation Coverage?

Federal law requires that most group health plans, including Healthcare Flexible Spending Accounts (Healthcare FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from your health plan or FBMC. Domestic partners and their dependents are not eligible for coverage continuation under COBRA law. Refer to page 8 for information regarding continuation of coverage for domestic partner dependents.

COBRA information packets are sent by the insurance carriers to terminating employees within fourteen (14) days of notification of termination from County service. The County's notification to the plans is through a biweekly listing issued after the employee's department processes the termination through the payroll system. Group medical, dental, vision and basic\optional life insurance coverage (if enrolled) ceases the last day of the pay period in which the termination date falls and for which the employee experiences a regular insurance deduction or made direct payments to the Benefits Administration Unit (if on an unpaid leave of absence). If you exercise your rights under COBRA, upon receipt of your initial premium the insurance plan will reinstate your coverage retroactive to the group benefits termination date (without a gap). The HIPAA certificates will be issued by your medical insurance carrier, at the same time the COBRA notice is issued. For more information, please contact the insurance carrier. The employee or a family member has the responsibility of directly informing the Benefits Administration Unit of a divorce, or a child losing dependent status. Requests must be made on a timely basis (no later than 45 days from the qualifying event).

Basic\optional life insurance coverage is not subject to COBRA. If covered under the basic or optional life plan, the terminating employee will have the opportunity to convert to a private policy without being subject to evidence of insurability and will receive a conversion notice by mail. Employees may convert up to the volume of life insurance in force at the termination of employment, or convert amounts as determined by the Metropolitan Life Insurance Company. To obtain the life insurance conversion rates, contact the insurance carrier at the phone number listed on the conversion notice.

How Long Will Continuation Coverage Last ?

FSAs -If you fund your Healthcare FSA entirely, you may continue your Healthcare FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Healthcare FSA for the year. For example, if you elected a maximum Healthcare FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Healthcare FSA for the remainder of the plan year or until such time that you receive the maximum Healthcare FSA benefit of $1,000. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time.

If your employer funds all or any portion of your Healthcare FSA, you may be eligible to continue your Healthcare FSA beyond the plan year in which the qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special contribution rules for employer-funded Healthcare FSAs. If you have questions about your employer-funded Healthcare FSA, call FBMC at 1-800-342-8017.

Health Plans

You will be able to continue medical, dental and vision for up to 18 months if you lose group coverage due to termination of employment or reduction in hours. If your covered dependent(s) lost group coverage (for example, due to divorce, your death or child reaching the limiting age), coverage may be continued for up to 36 months from the qualifying event. See your Summary Plan Description (SPD) or certificate of coverage for other COBRA-qualifying events and explanation of your COBRA rights.

How Can You Elect Continuation Coverage?

Each qualified beneficiary has an independent right to elect continuation coverage the latter of 60 days from the date of COBRA notice or qualifying event. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. Additionally, payment must be received within 45 days of COBRA election. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Terms And Conditions

Taxable Benefits and the IRS

Disability Income Protection - Disability benefits may be taxed when an employee becomes disabled depending on how the premiums were paid during the year of the disabling event. For example, if you purchased disability coverage with pre-tax premiums and/or nontaxable employer credits, any disability payments received under the plan will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any disability payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax advisor for additional information.

FICA taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums tax free on your first $50,000 of life insurance. You must pay tax on premiums for coverage exceeding $50,000. The first $50,000 limit includes any life insurance provided to employees by Miami-Dade County. Premiums for additional life insurance exceeding the IRS $50,000 maximum must be paid for with after-tax money.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Policies of the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies, and procedures from time to time adopted.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time. However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction.

FBMC Privacy Notice

This notice applies to products administered by FBMC Benefits Management Inc. and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal-and sometimes, sensitive-information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Care Center at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises Flexible Spending Account participants of the identity and relationship between Miami-Dade County and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Reimbursement Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Disclosure Notices

Social Security Number Disclosure Notice

The Benefits Administration Unit, Internal Services Department 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, Internal Services Department 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

Women's Health & 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're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www. healthcare.gov.

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

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

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

For further information on eligibility in Florida:

FLORIDA – Medicaid & KidCare

Website: http://www.floridakidcare.org/

Phone: 1-888-540-5437

Prescription Coverage & Medicare

2016 Important Notice About Your Prescription Drug Coverage and Medicare From Miami-Dade County To Active Employees & Dependents Participating in the Following County-Sponsored Health Plans

AvMed POS • AvMed High Option HMO • AvMed MDC Select Network HMO • AvMed Low Option HMO • AvMed MDC Jackson First HMO

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 you 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 Unit
Address: 111 NW 1st Street, Suite 2340
Phone Number: (305) 375-4288, (305) 375-5633

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 Unit
111 NW 1st Street, Suite 2340
Miami, FL 33128
(305) 37-4288, (305) 375-5633

HIPAA 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 Business 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 2014

New Health Insurance Marketplace Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace 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 right away. Open enrollment for health insurance Coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources Department\ Benefits Administration. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application. Here is some basic information about health coverage offered by this employer:

3. Employer Name: **Miami Dade County**	4. Employer Identification Number: (EIN) **59-6000573**		
5. Employer Address: **111 NW 1st Street**	6. Employer Phone Number: **305-375-4288**		
7. City: **Miami**	8. State: **FL**	9. Zip Code: **33128**	
10. Who can we contact about employee health coverage at this job? **Miami-Dade County Human Resources – Benefits Administration**			
11. Phone Number (if different from above)	12. Email Address:		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

[X] All employees. Eligible employees are: All full-time and part-time employees who work at least 60 hours each pay period consistently. Variable hour employees, as defined by the Affordable Care Act, who average at least 30 hours per week at the end of their measurement period.

- With respect to dependents:

[X] We do offer coverage. Eligible dependents are: Spouses\Domestic Partners; and dependent children of employees and domestic partners up to age 26; and adult children age 26+ in accordance with the guidelines of Florida State Statutes (FSS 627.6562).

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes . * An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

15. What is the premium for the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans): The biweekly premium for the lowest cost health plan Employee-only coverage is $0.00. Discounts for tobacco cessation and wellness program are not applicable.

Benefits Handbook

http://enet.miamidade.gov
www.miamidade.gov/benefits

Information contained herein does not constitute an insurance certificate or policy.
Certificates will be provided to participants following the start of the plan year, if applicable.