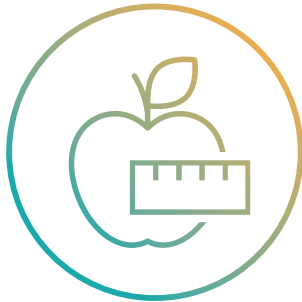


2020

YOUR BENEFITS

Miami-Dade County Employee Annual Benefits Enrollment Guide

BEHEALTHY



BEWELL



BEWISE



www.miamidade.gov/OpenEnrollment

OPEN ENROLLMENT OCT. 7-21, 2019

Open Enrollment Is Here

The annual Open Enrollment period for County employees will run from Monday, October 7, 2019 through Monday, October 21, 2019. During this period, benefits-eligible employees may elect or make changes in plans, levels of coverage and update beneficiary and dependent elections. All changes made become effective on January 1, 2020.

The plan benefits for the 2020 plan year will remain virtually unchanged from 2019. The County will continue to offer three self-insured HMO plans and one POS plan managed by AvMed. Please refer to the Medical Plans section on Page 4 to determine what plans you may be eligible to elect. **As a reminder, medical plan eligibility is based on several factors including, but not limited to, date of hire and bargaining unit.**

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



Assess your needs:

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

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

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

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

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

Update Your Beneficiary Designations!

- **Review and/or update** your beneficiary designations today by visiting the Minnesota Life LifeBenefits portal at <https://LifeBenefits.com>. User ID and Password are required.
- **Paper Beneficiary** designation forms are no longer being accepted.
- To update or make changes to your beneficiaries for your retirement plans, visit the websites below:
 - FRS: <https://www.rol.frs.state.fl.us/login.aspx> (Pension Plan) <https://myfrs.com/> (Investment Plan)
 - ICMA-RC: <https://www.icmarc.org/miami-dadecounty.html>
 - Nationwide Retirement: <https://www.miamidade457.com>
- **Update your beneficiaries now** - do not leave this important decision for later or the Florida Statute will apply!

Submit Your Dependent Documentation Before Open Enrollment Closes!

- Your **dependents will not be covered** unless your documentation is submitted by the Open Enrollment deadline.
- Once the deadline passes, you **will not be permitted to add** your dependents to your coverage until the next Open Enrollment period, unless you have a qualifying event.
- **Review** page 7 of this Guide or the Employee Benefits Handbook for a list of acceptable documentation to verify eligibility.
- **Failure to remove** ineligible dependents may affect your bi-weekly premiums for the remainder of the plan year.

Medical Plans

AvMed Advantage Plans*

First Choice Advantage HMO / Select Advantage HMO / HMO Advantage / POS Advantage

■ Applicable to Non-Bargaining, GSAF Professional and Supervisors, and IAFF HIRED PRIOR TO JANUARY 1, 2019.

First Choice Advantage HMO / Select Advantage HMO

■ Applicable to Non-Bargaining, GSAF Professional and Supervisors, and IAFF HIRED ON OR AFTER JANUARY 1, 2019.

Redesign Plans (2019/2020 Status Quo Plans)

Jackson First HMO / Select Network HMO / High Option HMO / POS

■ Applicable to AFSCME Aviation, AFSCME General, AFSCME Solid Waste, AFSCME Water & Sewer, Transit Workers Union (TWU), and PBA Rank/File and PBA Supervisory Employees**

TIER LEVEL	First Choice Advantage HMO/ Jackson First HMO	Select Advantage HMO/ Select Network HMO	HMO Advantage/ High Option HMO	POS Advantage/ POS Plan**
EMPLOYEE ONLY	\$0.00	\$0.00	\$75.00	\$100.00
EMPLOYEE + CHILD(REN)	\$112.02	\$141.00	\$180.17	\$285.86
EMPLOYEE + SPOUSE	\$134.71	\$166.00	\$208.35	\$344.54
EMPLOYEE + FAMILY	\$197.84	\$236.00	\$287.77	\$595.59

* Advantage Plans available to those Bargaining Units which have negotiated these plans as part of their collective bargaining agreements.

** POS Plan not available to PBA Rank/File and PBA Supervisory Employees hired January 1, 2019 or later.

HMO Advantage and POS Advantage is not available to employees hired on or after January 1, 2019.

Dental Plans

Delta Dental PPO/DeltaCare DHMO

Biweekly Dental Rates

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

Other Plan Rates

METLIFE VISION	
EMPLOYEE ONLY	\$2.30
EMPLOYEE + 1	\$4.61
EMPLOYEE + FAMILY	\$8.46

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

Other Plan Rates (continued)

FLEXIBLE SPENDING ACCOUNTS (FSA)		
	Contribution Limit	Administrative Fees Per Pay Period
Healthcare FSA Only	\$2,700	\$1.36
Dependent Care FSA Only	*\$5,000	\$1.36
Both Health & Dependent Care		\$1.36

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

- Married and filing separately \$2,500
- Single and head of household \$5,000
- Single and not head of household \$2,500
- Married and filing jointly \$5,000

METLIFE Short Term Disability (STD)	Premium Per \$100 Weekly Benefit
Low Opt (\$500 max weekly benefit)	\$1.46
High Opt (\$1,000 max weekly benefit)	\$1.46

METLIFE Long Term Disability (LTD)	Premium Per \$100 of Covered Monthly Payroll
Low Opt (\$2,000 max monthly benefit)	\$0.239
High Opt (\$4,000 max monthly benefit)	\$0.285
Premier (\$7,000 max monthly benefit)	\$0.397

Dependents Eligible for Coverage are:

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

Are You Adding a New Dependent?

If you are adding a dependent for the 2020 plan year, you must provide supporting documentation that the dependent meets the eligibility requirement for coverage under the Miami-Dade County insurance plans by the end of Open Enrollment. This is a mandatory requirement that applies to any dependent added now and in the future. Please be aware that failure to provide acceptable documentation will result in no coverage for the newly added dependent for plan year 2020.

Acceptable Documents

Children

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

Spouse

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

Over-Age Dependent Children – New and Currently Enrolled

Once your dependent child reaches age 26, you are required to submit an Affidavit of Eligibility every year, no exceptions, to continue medical coverage. To download the form, go to <https://www8.miamidade.gov/global/humanresources/benefits/benefits-forms.page>. Failure to provide the documentation will result in cancellation of coverage and unpaid claims effectively as of January 1, 2020. To enroll a new over-age dependent in your 2020 medical coverage, you must also provide proof the adult child was continuously covered by other creditable insurance, without a gap in coverage of more than 63 days.

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

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

Fax Documents to

Benefits Administration Unit
Fax (305) 375-2964

Online Enrollment Overview

Open Enrollment participation is very important. Please take this opportunity to review your current plan elections and decide if they still meet your needs. You may change your existing elections, add coverage or simply confirm that you wish to remain with the same plan. To use the online web enrollment, go to www.miamidade.gov/openenrollment. Contact your Department Personnel Representative (DPR) for assistance, if you do not have access to a computer.

Enrolling online is easy! No forms to fill out. No need to worry about paperwork getting misplaced. All you need is 10-15 minutes of uninterrupted time to make your elections. Then print your confirmation page for your records and you are finished! If you need to go back online and change your elections, no problem, the website is secure and available 24/7 during the Open Enrollment period.

Ensure that your dependents still qualify for coverage. Use this guide and look on the Open Enrollment website. Once you have the answers you need, begin the enrollment process. The deadline to change your plan elections is October 21, 2019. Once the deadline expires, you are locked into the plan elections you make until the next open enrollment period, unless you have a qualifying event.



Don't wait until the last minute! If you have questions regarding plan benefits attend an Open Enrollment regional meeting, review the online benefits information or contact the plan directly during business hours for specific plan benefits and limitations. The Help Desk (305-596-Help) will assist only with technical issues (web access, password reset, etc.) and is available Monday - Friday, 8 a.m. to 5 p.m.

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

Checklist For Online Enrollment

Obtain this information before you begin:

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



After Open Enrollment

If you do not submit your enrollment/changes online by the deadline of October 21, 2019, you will have to wait until the next Open Enrollment period. Employees are not permitted to switch plans during the year once Open Enrollment closes. If you do not make changes, your selection for 2020 will be defaulted to current selection.

Declining Medical Coverage

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

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

Cancelling Plan Participation After Open Enrollment

After Open Enrollment, you may cancel any post tax benefit plan (Group Legal, Short-Term, or Long-Term Disability Plans) without a penalty. If you cancel a pre-tax benefit plan subject to the Internal Revenue Code Section 125 salary reduction provisions, such as medical, dental and vision, you will still be required to pay the employee premium (if any) for the remainder of the year.

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



Important Notes

1. Print and retain the online benefits confirmation notice after you make your elections for the 2020 plan year. The online benefits confirmation notice will be the required proof of your 2020 benefit elections, in the event there are any discrepancies. Once the Open Enrollment deadline passes, the only plan election changes permitted will be those resulting from a processing error. A processing error is defined as the unlikely event of a computer system malfunction that failed to process the employee's elections, as recorded on the final confirmation notice submission.
2. Review your benefit plan options carefully, because once you submit your final selections online you are locked into these plan choices until December 31, 2020. Employees are not permitted to switch plans during the year.
3. All Open Enrollment 2020 plan year benefit elections are in effect January 1, 2020 through December 31, 2020.
4. If you are a new hire with a benefits eligibility date of November 1 or December 1, 2019, you must submit your benefits selections online through the County's eNet portal New Hire Benefits Enrollment link. Your 2019 new hire plan selections will carry over into 2020. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of 2019 and a separate amount for the 2020 plan year.
5. Remove any ineligible or overage dependents from your coverage for the upcoming benefit year through the Open Enrollment website by the October 21, 2019 deadline. Failure to remove ineligible dependents will result in your paying the premium for the existing level of coverage through the end of the plan year, unless you have a qualifying event. Failure to provide the appropriate documentation to verify your overage dependent as eligible will result in your overage dependent being removed from coverage effective January 1, 2020.

Remember These Dates

September 30 - October 16, 2019	Benefit Fairs at Various County Facilities
October 7 - October 21, 2019	Online Enrollment Period (24 hour website closes at 12:00 a.m. on Oct. 21)
October 21, 2019	Deadline to Submit Dependent Documentation
January 1, 2020	New Plan Year - Open Enrollment changes effective
January 12, 2020	Deadline for Reporting System Errors in the Processing of Online Benefit Elections

Miami-Dade County Employee Benefits



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

COMPARISONCHART

Medical

SCHEDULE OF BENEFITS	First Choice Advantage HMO In-Network Only	Select Advantage HMO In-Network Only	HMO Advantage In-Network Only	POS Advantage In-Network
	COST TO MEMBER	COST TO MEMBER	COST TO MEMBER	COST TO MEMBER
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Co-Insurance Levels	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Calendar Year Deductible	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Out-Of-Pocket Maximum (Per Calendar Year)** Individual/Dependent Maximum	\$2,500/\$5,000	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000
Physician Office Visits	\$10 per visit	\$15 per visit	\$15 per visit	\$15 per visit
Specialists Office Visits	\$30 per visit	\$30 per visit	\$40 per visit	\$40 per visit
Pediatrician	\$10 per visit	\$15 per visit	\$15 per visit	\$15 per visit
Chiropractic	\$15 per visit	\$15 per visit	\$15 per visit	\$15 per visit
Preventive Care	No Charge	No Charge	No Charge	No Charge
Mammogram, PSA, Pap Smear	No Charge	No Charge	No Charge	No Charge
Inpatient Hospital Services	\$100 copay per admission	\$100 copay per admission	\$200 copay per admission	\$200 copay per admission
Outpatient Facility Services includes diagnostic tests, blood work & imaging (x-rays, CTs, MRIs, etc.)	\$50 copay per admission	\$50 copay per admission	\$100 copay per admission	\$100 copay per admission
Emergency Room (copay waived if admitted)	\$100 copay	\$100 copay	\$150 copay	\$200 copay
Urgent Care Facility or Outpatient Facility***	\$25 copay/\$15 copay	\$25 copay/\$15 copay	\$25 copay/\$15 copay	\$50 copay/\$25 copay
Maternity Care Services				
Initial Visit	\$30 copay	\$30 copay	\$50 copay	\$50 copay
Subsequent Visits	No charge	No charge	No charge	No Charge
Prescription Medication Benefit — Retail, 30 Day Supply (Includes Contraceptives)				
Generic	\$15	\$15	\$15	\$15
Preferred Brand	\$25	\$25	\$40	\$40
Non-Preferred Brand	\$35	\$35	\$55	\$55
Specialty (30-Day Supply Through Specialty Pharmacy)	\$50	\$50	\$150	\$200
Prescription Medications - Mail-Order, 90 Day Supply (Includes Contraceptives)				
Generic	\$30	\$30	\$30	\$30
Preferred Brand	\$50	\$50	\$80	\$80
Non-Preferred Brand	\$70	\$70	\$110	\$110
** Pharmacy copays will count towards the Out-of-Pocket maximum. *** Urgent Care facility/visit at retail facility.				

Dental

SCHEDULE OF BENEFITS	Delta Dental PPO - Standard	Delta Dental PPO - Enriched	DeltaCare DHMO - Standard	DeltaCare DHMO - Enriched
	Plan Pays	Plan Pays	*You Pay	*You Pay
Choice Of Dentist	Choose any dentist you wish for services and receive applicable benefits. Save the most with a Delta Dental PPO network participating dentist. Percentages below are based on Delta's applicable allowances and not the dentist's actual charge. Payments to non-Delta Dental dentists are based on the PPO fee schedule.		Limited to participating Dentists within the DeltaCare USA Network.	
Maximum Benefit / Deductible	\$1,000 per year per person	\$2,000 per year per person	No Maximum / No Deductible	
	\$50 deduct. per yr per person	\$50 deduct. per yr per person		
	\$150 family maximum	\$150 family maximum		
		\$50 Lifetime deductible for orthodontics		
Type I			General/Specialist	
0150 Comp. Oral Evaluation -New Or Established	100%	100%	No charge/No charge	No charge
0120 Periodic Oral Exam	100%	100%	No charge/No charge	No charge
X-Rays				
1110/20 Prophylaxis	100% (2X calendar year)	100% (2X calendar year)	No charge/No charge	No charge
1206 Fluoride Treatment (Children Up To The Age 19)	100%, 2x per year	100%, 2x per year	No charge/No charge	No charge
1351 Sealant - Per Tooth	100% to age 16	100% to age 16	No charge/No charge	No charge
1510 Space Maintainers	100% to age 19	100% to age 19	No charge/No charge	\$25
Type II Filings			General/Specialist	
2330 - One Surface	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP	\$10/\$28	No charge
2331 - Two Surfaces	100% PDP/ 75% NON PDP	100% PDP/ 75% NON PDP	\$18/\$35	No charge
2390 - Resin Crown, Anterior	100% PDP/ 75% Non PDP	100% PDP/ 75% Non PDP	\$30/\$90	\$30
2394 - Resin, Four Or More Surfaces	100% PDP/ 75% Non PDP	100% PDP/ 75% Non PDP	\$65/\$115	\$65
Root Canals				
3310 - Anterior	75%	75%	\$90/\$110	\$45
3330 - Molar	75%	75%	\$200/\$245	\$145
Extractions				
7111 - Single Tooth	75%	75%	No charge/\$45	No charge
4210 - Gingivectomy / Gingivoplasty-Per Quadrant	75%	75%	\$120/\$165	\$90

Dental (continued)

SCHEDULE OF BENEFITS	Delta Dental PPO - Standard	Delta Dental PPO - Enriched	DeltaCare DHMO - Standard	DeltaCare DHMO - Enriched
Type III Crown & Bridge			General/Specialist	
2930 - Prefabricated Stainless Steel Primary Tooth	50%	50%	\$25/\$35	No charge
2750 - Crown Porcelain Fused To High Noble Metal	50% (1 per tooth within a 5 year period)	50% (1 per tooth within a 5 year period)	\$477.50/\$485	\$355
6750 - Crown Porc. Fused To High Noble Metal	50% (1 per tooth within a 5 year period age 16+)	50% (1 per tooth within a 5 year period - age 16+)	\$477.50/\$485	\$355
Prosthodontics				
5110 - Complete Upper	50%	50%	\$230/\$510	\$205
5120 - Complete Lower	50%	50%	\$230/\$510	\$205
Orthodontia				
Consultation	Not Covered			
Evaluation	Not Covered			
Records	Not Covered	Adults & Children covered at 50% after one-time deductible of \$50 per person.	Pre-treat. Records - \$200 Post-treat. Records - \$70 Child to age 19 - \$2,100 Adults - \$2,250	Pre-treat. Records - \$200 Post-treat. Records - \$70 Child to age 19 - \$1,400 Adults - \$1,950
8070/8080 Comp. Treat. Child to Age 19 Normal	Not Covered			
Class II				
8090 Comp. Treat. Adult - Normal Class II	Not Covered			
8680 Retention	Not Covered	\$1,300 Lifetime Maximum.	Retention - \$300	Retention - \$275
*All Type II and III charges subject to annual deductible. The above reimbursements are exclusive of gold. All services must be performed by a DeltaCare USA network provider. A referral is required to see a specialist.				

Vision

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

Contact Information

Open Enrollment website		www.miamidade.gov/openenrollment
Benefits Administration Unit (BAU)	(305) 375-4288 or 5633	www.miamidade.gov/humanresources/benefits.asp
Wellness Works		www.miamidade.gov/wellnessworks

MEDICAL PLANS

AvMed Health Plans	(800) 682-8633	www.avmed.org/mdc
AvMed On site Representatives	(305) 375-5306	SPCC 23rd Floor Mon-Fri 8:30 a.m. - 5:00 p.m.

DENTAL & VISION PLANS

Delta Dental	(800) 471-1334	www.deltadentalins.com/mdc
MetLife Vision	(877) 638-2055	www.metlife.com/mybenefits

OTHER

ARAG Legal Plan	(800) 667-4300	www.ARAGLegalCenter.com code: 10277mdc
Flexible Spending Accounts	(844) 774-0469	https://portal.myaxisplus.com
MetLife Disability Plans	(888) 463-2023	www.metlife.com/mybenefits
ICMA-RC - Deferred Comp.	(800) 669-7400	https://www.icmarc.org/miami-dadecounty.html
Nationwide - Deferred Comp.	(866) 986-4264	www.miamidade457.com
Minnesota Life	(866) 293-6047	www.lifebenefits.com

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

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (Section 817.234 (1) (b) Florida Statutes)

2020

YOUR BENEFITS

Miami-Dade County Employee Benefits



www.miamidade.gov/humanresources/benefits.asp

BENEFITHIGHLIGHTS

Benefit Highlights

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

Eligibility

Employee Eligibility

Eligible employees include:

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

Dependent Eligibility

Eligible Dependents include:

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

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

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

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

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



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

Medical coverage may be continued for adult children age 26 through the end of the calendar year the child turns 30, if all criteria below are met:

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

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

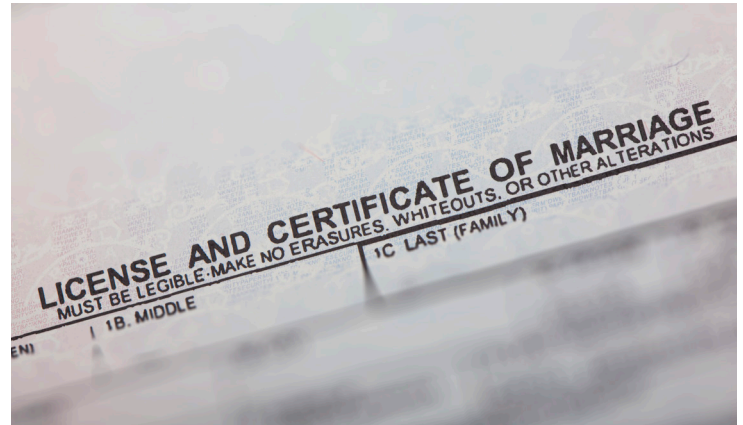
Dependent children who are incapable of sustaining employment because of mental or physical disability, and are dependent upon the employee for support, may continue to be covered beyond the limiting age, if enrolled prior to age 26. Proof of disability must be submitted to the plan within 31 days of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

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

Submission of Dependent Documents upon Enrollment

When adding dependents to your coverage at new hire enrollment or during Open Enrollment, it is your responsibility to submit proof of eligibility, such as birth or marriage certificates, for any dependents you wish to enroll for healthcare benefits. Your dependents will not be covered unless your documentation is provided by the new hire enrollment deadline or Open Enrollment deadline. Following a change in status event, it is your responsibility to submit proof of eligibility for your dependents by the change in status deadline. Failure to submit the required documents in a timely way will result in:

1. cancellation of your dependent's coverage
2. continuation of the existing coverage level premium through the end of the plan year, with no premium refunds issued.





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SmartShopper today!

Your SmartShopper Personal Assistant can help you set up your SmartShopper account, shop for your options for medical care and even schedule your appointment.

How it works



1. SHOP
by phone or online

With SmartShopper, you earn cash when you shop for medical procedures. Call your Personal Assistant today!

"SmartShopper saves money and puts money back in my pocket." - Carol, SmartShopper Member



2. GO

to a cost effective location



3. EARN

up to \$500 in cash back

Don't miss out on this great program you already have.

Call your Personal Assistant at **1-866-285-7453**
or log in to **AvMed.org/SmartShopper-MDC.**

The Personal Assistant Team is available M-Th 8am-8pm and F 8am-6pm

Made available by:



The SmartShopper program is offered by Vitals, an independent company. Incentives available for select procedures only. Payments are a taxable form of income. Rewards may be delivered by check or an alternative form of payment. Members with coverage under Medicaid or Medicare (including as secondary payer) are not eligible to receive incentive rewards under the SmartShopper program.

Your health plan benefit coverage conditions apply. Some limitations and exclusions for the SmartShopper program may apply.
Vitals does not offer Blue Cross or Blue Shield products

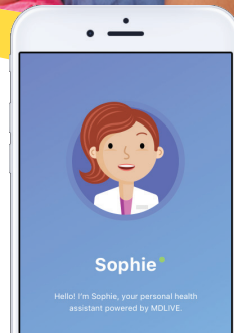
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Avoid the wait.
Your life is 24/7.
Now your doctor is too.

It's midnight, and someone in your house has awakened feeling awful. But the emergency room might mean an all-night wait – not to mention an expensive bill. Schedule a virtual visit with a caring AvMed Virtual Visits doctor. We can treat non-emergency symptoms from the comfort of your own home, without the wait. Doesn't that feel better already?



What you get with AvMed Virtual Visits.



See a doctor
by video or phone
24/7/365.



Board-certified and
licensed doctors with an
average of 15 years of
experience.



Doctors can send
prescriptions
right to the nearest
pharmacy.

Why use AvMed Virtual Visits?



The nation's
largest telehealth
network.



Quality care
on your
schedule.



Private
and secure
consultations.



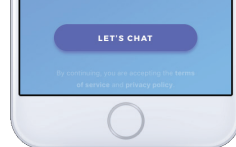
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you and your
family.

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800-400-MDLIVE

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Text AVMED To 635-483



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Timely Notification of Ineligible Dependents

It is your responsibility to contact your Benefits Specialist or Human Resources office when one of your enrolled dependents becomes ineligible for benefits coverage. Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action, and repayment of claims. In addition, failure to notify your Benefits Specialist or Human Resources office of your ineligible dependent within the 45-day change in status period will result in:

- 1. cancellation of the ineligible dependent’s coverage as of the date the dependent became ineligible
- 2. continuation of the existing coverage level premium through the end of the plan year, with no premium refunds issued.

Dependents may be eligible to continue their medical, dental and vision coverage through COBRA (continuation coverage) if you notify your Benefits Specialist or Human Resources office within 60 days of a qualifying event.

Medical Plan Eligibility By Date of Hire & Bargaining Unit

Date of Hire	ADVANTAGE PLANS		REDESIGN PLANS (STATUS QUO)			
	First Choice Advantage & Select Advantage	HMO Advantage & POS Advantage	Jackson First HMO	Select HMO	High Option HMO	POS
Prior to 1-1-2019	Non-bargaining, GSAF, IAFF	Non-bargaining, GSAF, IAFF	All AFSCME, PBA, TWU	All AFSCME, PBA, TWU	All AFSCME, PBA, TWU	All AFSCME, PBA, TWU
On or After 1-1-2019	Non-bargaining, GSAF, IAFF		All AFSCME, PBA, TWU	All AFSCME, PBA, TWU	All AFSCME, PBA, TWU	All AFSCME, TWU

Dependent Eligibility Audit

Miami-Dade County is committed to offering a comprehensive benefit package to you and your family, but also realizes many dependents may no longer be eligible for coverage due to life status changes. Miami-Dade County will continue to conduct a Dependent Eligibility Audit to verify the eligibility of covered family members. Employees will be required to provide documentation, such as birth or marriage certificates (birth cards not acceptable), for any dependents enrolled for healthcare benefits. Failure to submit the required documents will result in:

- 1. cancellation of your dependent’s coverage as of the date the coverage began
- 2. continuation of the existing coverage level premium through the end of the plan year, with no premium refunds issued.

New Hire Enrollment

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

Be sure to review the reference materials and online enrollment steps available before you begin the online enrollment process. Once you have the answers you need, begin the enrollment process. Don't wait until the last minute! If you have questions regarding plan benefits contact the plan directly during business hours for specific plan benefits and limitations. The Help Desk (305-596-Help) will assist only with technical issues (web access, password reset, etc.).

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

When adding dependents to your coverage at new hire enrollment, it is your responsibility to submit proof of eligibility, such as birth or marriage certificates, for any dependents whom you wish to enroll or healthcare benefits. Your dependents will not be covered unless your documentation is provided by the new hire enrollment deadline. Once the new hire enrollment deadline passes, you will not be permitted to add your family members onto your coverage until the next Open Enrollment period, unless you have qualifying event.

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.

Qualifying Change In Status (CIS)

Once the Open Enrollment period closes, you may add or delete dependents to your health plan only under limited circumstances such as a Qualifying Event (QE). Changes must be reported within 45 days of a QE (60 days to add newborns/ adoption, or placement for adoption). Complete and submit a Change in Status (CIS) form and Benefit Election Change form to the Benefits Administration Unit. Election changes must be consistent with the event and result in the loss or gain of insurance coverage. Mid-year changes from one health plan to another are not permitted.

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

Your change request must include documentation supporting the loss or gain of insurance coverage. Do not delay submission of your CIS and Benefit Election Change forms while you gather your documentation. Ensure your CIS and Benefit Election Change forms are submitted within the 45-day deadline. Simply forward the forms to your Departmental Personnel Representative and then present your supporting documentation as soon as it becomes available. Your existing elections will be stopped or modified (as appropriate) upon approval of your

election change request. Generally, mid-year pre-tax election changes are made prospectively. That is, no earlier than the beginning of the pay period following receipt by the Benefits Administration Unit, unless otherwise provided by law. Qualifying changes to add dependents become effective the first pay period following receipt of a timely request, except as indicated below:

- Newly Acquired Spouse/Domestic Partner/Dependent Child – Coverage effective as of first of the month following receipt of documentation.
- Newborn Child(ren) – Coverage is effective as of the date of birth.
- Adopted Child – Coverage is effective on the date of adoption, or the date child is placed in the home, whichever is earlier.
- Dependents who are losing other coverage – If documentation is received prior to the end of the coverage, then coverage will be effective the day following the end of coverage. Regardless of where the effective date falls in the pay cycle, there will be no prorating of premiums.

CIS Premium Changes

The Benefits Administration Unit (BAU) will process a change in premium effective the later of (1) the beginning of the pay period in which coverage effective date falls or (2) the beginning of the pay period following timely receipt of your CIS request. The full premium is charged for the affected pay period, regardless of the number of days you (or dependent) had coverage. The payroll deduction will not be prorated based on the number of days coverage was active in the affected pay period. Refer to the Benefits Handbook for additional information. If a request to delete an ineligible dependent is received after the 45-day deadline, the dependent's coverage will be cancelled, but the dependent premium payroll deduction will continue through the end of the plan year with no premium refunds issued.

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

Medical and Prescription Drugs

As an eligible Miami-Dade County employee, the medical plans available to you are based on your Bargaining Unit's collective bargaining agreement. As such, not all medical plans may be available to you. Below is an overview of each of the medical plans offered by Miami-Dade County. Visit <https://www.avmed.org/web/mdc/mdc-2019-plans> to view the detailed Summary of Benefits and Coverage for each plan.

The available medical plans are:

POS Advantage

POS

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

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

HMO Advantage

High Option HMO

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

Select Advantage HMO Select Network HMO

Plan pays 100% of covered charges, after applicable co-payments.

First Choice Advantage HMO Jackson First HMO

This plan offers more affordable healthcare option with a network limited to only Jackson Health System (JHS)/University of Miami Health System (UMHS) facilities. AvMed contracted providers with privileges at the JHS and UMHS facilities are included. One exclusive feature is a Healthcare Concierge Service ("Fast Track"). The Concierge team will have the ability to assist you with finding a network provider, scheduling appointments and coordinating specialty and/or hospital care.

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

Making the Most of Your Medical Coverage

SmartShopper™

AvMed offers SmartShopper™, giving you a chance to earn cash back while saving on healthcare costs. Medical procedures or diagnostic tests can qualify you or your dependents for CASH BACK when you choose a cost-effective location. This service is available to members in the MDC Select HMO, High HMO, and POS plans. SmartShopper™ is not offered to AvMed Jackson First HMO members.

Here's how SmartShopper™ works:

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

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

To access SmartShopper™, go to [AvMed.VitalsSmartShopper.com](https://www.AvMed.VitalsSmartShopper.com) or call 1-855-869-2133, Monday-Thursday from 8:30 a.m.- 8 p.m., Friday from 8:30 a.m.- 5 p.m., and easily shop healthcare services in your area.

Best Doctors

When you need answers, Best Doctors can help. Get an Expert Medical Opinion from one of the world-renowned specialists so you can have the answers and confidence to make informed decisions about your health. Call **1-866-904-0910**.

Miami-Dade County
Members on
Advantage Plans

Changes for Your Maintenance Medications



If you're on long term treatment, such as medications for high blood pressure or high cholesterol, after filling up to three times at any network pharmacy, you must switch your pharmacy and re-fill your 90-day prescription for medications (and only pay 2 co-pays) at the following **CVS Maintenance Choice** pharmacies:

CVS Mail Order Pharmacy program
CVS stores

Target stores
Navarro

To transfer your prescriptions, registered Members can login to their AvMed Member portal account and select the Caremark link.

In addition, Members can register on Caremark.com (if not already registered) and navigate to **View/Refill All Prescriptions** and select **Refill Options** to transfer their non-CVS prescriptions to a CVS retail of your choice. It's that easy.

Miami-Dade County Members can receive a three-month supply of maintenance medications for just two copays.

Check your plan documents, go to **www.AvMed.org/MDC**, or call AvMed's Miami-Dade County's dedicated Member Engagement Center at **800-682-8633** to learn more about your pharmacy benefits and related costs.



Embrace better health.®



WELCOME TO YOUR
NEIGHBORHOOD
URGENT CARE
CENTER

THE DOCTOR WILL
SEE YOU NOW

 **UHealth** Jackson
UNIVERSITY OF MIAMI HEALTH SYSTEM HEALTH SYSTEM
Urgent Care

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

Now Open!

Country Walk

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

Keystone Point

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

Cutler Bay

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

Doral

7400 N.W. 104th Avenue
Doral, FL 33178
305-585-9250

Coming Soon!

North Dade

16555 N.W. 25th Avenue
Opa-locka, FL 33054

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

JacksonUrgentCare.com



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

Virtual Visits

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

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

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

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

Urgent Care or the ER?

If you or a family member has a non-emergency illness or injury like a sprain, earache, flu-like symptoms or a sore throat, Urgent Care Centers can provide you with the medical attention you need—while saving you time and money. To find the Urgent Care Center nearest you, go to www.avmed.org/mdc. On the left hand side list of quick links, click on your plan’s network: “MDC Select Network” or “Elite Network”, then click on “Urgent Care Search” on the left hand side.

If you are not sure whether it’s an emergency, AvMed’s Nurse On Call is ready to help 24 hours a day, 7 days a week. Just dial the toll-free number: 1-888-866-5432 (TTY 711). Their experts are always available to answer your questions or help with triage conditions.

BEST USE OF URGENT CARE CENTERS		
Urgent Care Center	Emergency Room	Ambulance
Know where they are	Know How to get there fast	Call 9-1-1
Ear Infections	Sudden, Sharp Abdominal Pain	Chest Pain
Bronchitis\Pharyngitis	Uncontrolled Bleeding	Difficulty Breathing
Fever		Unconsciousness

Disease Management

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

Lifestyle Coaching

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

Generic Medications Cost Less

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

Mail Order Prescriptions

Maintenance medications can be filled at a retail pharmacy up to a maximum of 3 times. Subsequent refills are required to be filled


via CVS Mail Order or Maintenance Choice limited retail pharmacy network (CVS Mail Order, CVS, Target & Navarro pharmacies). A 3-month supply of your maintenance medications will be filled for only two co-payments! Existing prescriptions will be honored and can be transferred. Go to [Caremark.com/MoveMyMeds](https://www.caremark.com/MoveMyMeds) to transfer your existing prescriptions to CVS Mail Order or to one of the Maintenance Choice retail pharmacies.

Prescription for Healthy Living

For employees or covered family members selected by AvMed to participate in this program, the co-pays for your diabetes, cholesterol and high blood pressure medications will be reduced to zero for any generic medication and \$5 for any second and third tier medication. Program participants who are enrolled in one of the Advantage medical plans and are taking maintenance medications for one of the above named conditions may receive a 3-month supply of your maintenance medications for only two co-payments, at this reduced co-payment rate! Additional requirements apply.

Imputed Income

The Internal Revenue Service (IRS) allows "tax free" health insurance subsidies for you and your eligible dependents, but excludes amounts attributable to coverage of adult children above age 26, a domestic partner (DP), and dependents of a domestic partner. The County must include the fair market value of this coverage in your income, referred to as "imputed income" and this imputed income will be taxed accordingly. Go to www.miamidade.gov/humanresources/benefits.asp for additional information regarding imputed income tax. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

A photograph of a doctor with a beard, wearing a white lab coat, handing a small white box to an older male patient. The patient is wearing a light blue sweater and is looking down at the box. The background is a bright, out-of-focus clinical setting.

Are you a diabetic who is ready to live a healthier life?

**AvMed's Prescriptions for
Healthy Living Program
may be the answer.**

Prescriptions for Healthy Living is a program offered to Miami-Dade County employees and their eligible dependents who have either Type 1 or Type 2 diabetes.

As a participating member, you will pay \$0 for generic and \$5 for second and third-tiered brand qualified diabetes, cholesterol and hypertension prescriptions. Co-payments for these medications will be capped at a maximum out-of-pocket cost of \$30 per month.

If you qualify for this program, you will receive an invitation with plan materials by mail providing instructions on how to sign up. Any questions, please call us at the phone number on the back of your card.

To remain eligible, you will need to:

- Follow your doctor's orders and the American Diabetes Association guidelines on comprehensive diabetes care
- Take your medications as prescribed
- Get the tests your doctor orders such as an annual dilated or retinal eye exam and have your blood pressure monitored

Protect your wellness (and your wallet) through this free program, available to you as an AvMed Miami-Dade County Member. If you qualify, an invitation will be sent to you by mail asking you to participate and opt-in to the program.

Have questions? Please contact your Miami-Dade County dedicated Member Engagement Center at **1-800-682-8633**.

SF-3711 (08/18)



Embrace better health.®

Estimate Your Costs



Looking to budget your dental costs? Try the Cost Estimator. This feature of Delta Dental's online account gives you a personalized estimate of how much you'll pay for your next dentist visit.

Whether you're getting braces or need a cavity filled, you'll choose from the top reasons for visiting the dentist, written in everyday language. The Cost Estimator organizes information logically, so you don't need to be concerned whether the service involves multiple procedure codes or visits.

Advantages

- **Easy to use.** Questions guide you through the process, letting you add services to your visit, like getting x-rays or a cleaning alongside your dental exam.
- **Based on real data.** Your cost estimate is calculated from actual claims Delta Dental has processed, updated daily.
- **Personalized.** You'll get a customized cost based on your actual benefits, taking into account any maximums and remaining deductible.
- **Available on desktop and mobile.** Get an estimate on your computer, tablet or phone.

Features

- **Change your dentist.** Want to know if you'd save by switching to another dentist? Test it out by comparing up to five dentists.
- **Personalize your procedure.** Specify which tooth is being treated, the type of filling you need or whether you're going to a specialist. The price will be calculated accordingly.
- **Keep track of your benefits.** A handy sidebar shows the current status of any deductibles and annual and lifetime maximums.



We keep you smiling®
deltadentalins.com/enrollees

Click on [I need](#) to go back to the full list of procedures.

Looking for a procedure not listed? Scroll to the bottom of the page for a link to a longer list.

Can't find what you're looking for?
Try the [Delta Dental Plans Association Cost Estimator](#) to find more procedures.
Although you won't be able to find your specific costs based on your level of benefits, you will be able to find the average dentists fees for that procedure in your area.

Clicking on [Explain cost details](#) will expand the breakdown of how your estimate was calculated.

To change the dentists shown, click on [Change compared dentists](#). Select your options, then click on [Show cost](#).

[I need](#) a filling

on **October 24, 2016**

for **John Smith**

Delta Dental PPO

Typical cost of a filling at your dentist
Last visited on 10/20/2016

\$17.80 out-of-pocket

[Explain cost details](#)

Mike Jones
General Dentist Out-of-Network
Mike Jones DDS Inc
100 Montgomery St
San Francisco, CA 94105

Current Benefits

Calendar Individual Maximum
\$1639.10 of \$2000.00 available

[\(details\)](#)

Lifetime Individual Maximum
\$1800.00 of \$1800.00 available

[\(details\)](#)

The benefits sidebar will show the current status of your maximums and deductibles, if applicable.

Typical cost of a filling at nearby dentists in your network

\$7.50 out-of-pocket

[Hide cost details](#)

Jane Smith
General Dentist In-Network
JaneSmith DDS Inc
100 Sutter St
San Francisco, CA 94105
(415) 555-1234

About This Visit

Includes a typical silver-colored filling for a back tooth. Consult your dentist for actual treatment and diagnosis.

[\(details\)](#)

This section summarizes the type of visit or procedure selected.

\$285.00	Typical Submitted Fees*
-\$210.00	Network Savings
-\$67.50	Delta Dental Pays
= \$7.50	You Pay

Try it out

Ready to get an estimate?

1. Log in to your account at **deltadentalins.com**.
(If you don't have one yet, click on **Register**.)
2. Click on the **Cost Estimator** link by your name.

How to navigate

Start by selecting the service you need.

As you explore, you can answer additional questions (like “Which tooth?” or “Are you a new patient?”) to further customize your results. If you've been using your dental benefits, your current dentist will show up by default, but if you want to see other options, just click on **Select dentists to compare**. Whenever you're ready, click **See cost**.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

Delta Dental PPO™ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA — Delta Dental of California; PA, MD — Delta Dental of Pennsylvania; NY — Delta Dental of New York, Inc.; DE — Delta Dental of Delaware, Inc.; WV — Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.



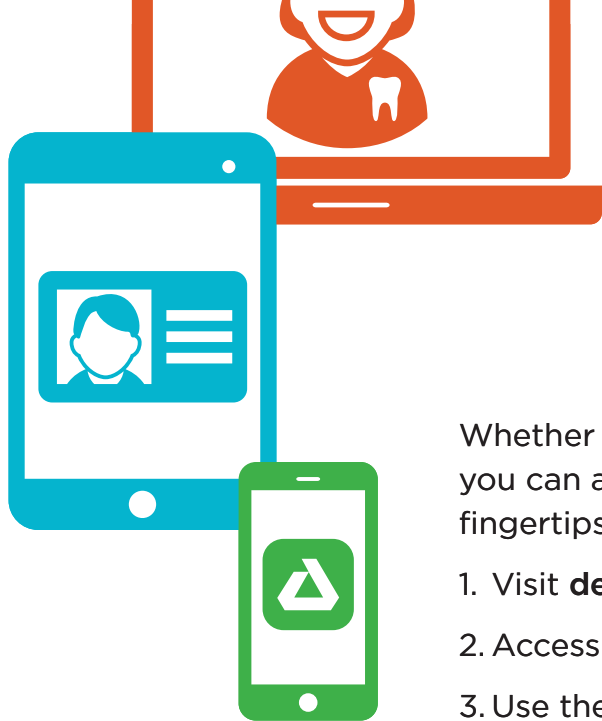
Stay Connected



Want information about your dental plan? Take advantage of our web and mobile resources to:

- **check your eligibility**





- look up coverage details
- check claims
- find a network dentist
- improve your oral wellness
- and more

Whether you're on a computer, tablet or smartphone, you can access all the information you need at your fingertips.

1. Visit **deltadentalins.com**
2. Access the **mobile-optimized site**
3. Use the **free Delta Dental app**



We keep you smiling®
deltadentalins.com/enrollees

IRS 1095-C Form

Employer-Provided Health Insurance

When filing 2019 taxes, you will need to show whether you had minimum essential coverage, as defined and required by the Affordable Care Act (ACA). To provide the information needed for tax filing, employers who sponsor self-funded health plans generally must provide a Form 1095-C by January 31, 2020. The 1095-C demonstrates that you were given the opportunity to enroll in ACA-compliant coverage and, if applicable, you enrolled in it.

For more information, go to:

www.miamidade.gov/humanresources/library/benefit-change-advisory-health-care-information.pdf

or contact:

Benefits Administration Unit: (305) 375-5632

Access your Medical benefits and coverage information online!

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

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

Dental

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

Delta Dental PPO Standard or Enriched

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

DeltaCare USA DHMO Standard or Enriched

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

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

Planning for major dental work?

Consider a Pre-treatment Estimate!

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

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

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

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

Dental Emergencies

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

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

For Delta Dental PPO enrollees

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

For DeltaCare USA enrollees

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

Access your Dental benefits and coverage information online!

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

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

Vision

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

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

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

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

Access your Vision benefits and coverage information online!

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

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

Legal Plan

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

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

Flexible Spending Account (FSA)

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

FSA Limits

Health care FSA Maximum Annual Deposit:
\$2,700

Dependent Care FSA Maximum Annual deposit:
\$5,000

Don't forfeit your FSA Funds!

To ensure you don't lose your 2020 Healthcare FSA funds, you will need to spend that money by March 15, 2021 and submit your reimbursement for Healthcare FSA request(s) before April 30, 2021. For your Dependent Care FSA funds, you will need to spend that money by December 31, 2020 and submit your reimbursement for Dependent Care FSA request(s) before April 30, 2021. Miss these deadlines and that money – YOUR money – will sadly be forfeited. So please, plan carefully and be sure to spend the money you set aside.

Certain FSA Card Purchases Require Documentation

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

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

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

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

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

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

Access your FSA balance and claim information online!

Need to check how much money you have left in your FSA Health Care or Dependent Care account? Visit the FSA Administrator's website.

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

Life Insurance

Basic Life

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

Optional Life

Employee Optional Life insurance is available in increments of 1x to 8x employee's annual adjusted base salary, to a maximum of \$2 million. Premiums are age-based and depend on the amount of coverage purchased. You pay the full cost of this coverage. A Statement of Health may be required. Newly hired employees may elect coverage from 1x to 3x annual salary without completing a Statement of Health form. During Open Enrollment, all first-time elections or increases in coverage will be subject to Evidence of Insurability.

Spouse/Domestic Partner Optional Life insurance is available in the amount of \$10,000. You pay one flat premium for this coverage. Evidence of Insurability (EOI) is never required.

Child Optional Life insurance is available in the amount of \$10,000 for each covered child. You pay one flat premium for this coverage. Evidence of Insurability (EOI) is never required.

You must be enrolled in Employee Optional Life coverage in order to elect Spouse/Domestic Partner or Child Optional Life coverage.

County Death Benefits

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

Update Your County Death Benefit Beneficiary Designation!

Making provisions for your family in case of an unexpected loss is a critical component of planning your financial future. That's why it is so important that you take time to review and update your beneficiary designations today.

You may select, update or change your beneficiary designations by logging into the Minnesota Life LifeBenefits Portal at <https://LifeBenefits.com>, then selecting Beneficiary Designation. The process is easy, secure and will only take a few minutes. Do not leave this important decision for later!

Paper Beneficiary designation forms are no longer accepted. Any paper beneficiary forms that are currently on file will remain valid, but those designations could be outdated and may not reflect your current intentions. So you should access the portal immediately and update all of your beneficiary designations, to ensure that your selections are current and up-to-date. Once you submit your beneficiary designation online, it will revoke any previous primary or contingent beneficiary designation.

It is your responsibility to update your beneficiary designation on time. You do not need the beneficiary's consent to make a change to your beneficiary designation.

The beneficiary designations you select on this portal do not apply to your FRS, Nationwide or ICMA-RC retirement plans. The links to make changes to your beneficiary designations for each of these plans are also available on the beneficiary designation portal.

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

Disability

Short Term Disability

Short Term Disability (STD) insurance is a voluntary benefit which helps you replace a portion of your income should you be absent from work due to your own medical condition for a period greater than 14 consecutive calendar days. **Employees going out on STD should apply for STD to begin as of the first day of medical absence, regardless of how much sick leave they have accrued.**

There is a 14 calendar day elimination period before STD benefits can be paid. During this elimination period, you must exhaust all accrued sick leave. Any accrued sick leave remaining after the elimination period must also be exhausted before STD benefits are paid (annual leave will be exhausted as well, unless the employee actively requests that it not be used). STD benefits are paid at 60% of the employee's base annual salary to a maximum amount based on the plan option elected. Employees may elect the STD Low Option plan (maximum weekly benefit of \$500 per week) or the STD High Option plan (maximum weekly benefit of \$1,000 per week). You pay the full cost of STD coverage, through post-tax payroll deductions.

Long Term Disability

Long Term Disability (LTD) insurance is a voluntary benefit which helps you replace a portion of your income should you be absent from work due to your own medical condition for a period greater than 180 consecutive calendar days. LTD benefits are paid at 60% of your base annual salary to a maximum amount based on the plan

option elected. You may elect the LTD Low Option plan (maximum monthly benefit of \$2,000 per month) or the LTD High Option plan (maximum monthly benefit of \$4,000 per month).

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

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

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

Leave Benefits

Leave Time

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

- You accrue 80 hours Annual Leave (10 days) for one (1) year of continuous full-time service.
- You accrue 96 hours Sick Leave (12 days) for one (1) year of continuous full-time service.

Any unused portion of the first 48 hours of Sick Leave accrued during the year is converted to Annual Leave on the employee's Leave Anniversary Date.

Longevity Annual Leave

After five (5) years of service, you are granted an additional eight (8) hours of Annual Leave on your Leave Anniversary date to a maximum of 80 hours/96 hours depending on your regular work schedule.

Longevity Bonus Award

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

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

Annual and Sick Leave Payments at Time of Separation

Maximum accumulation and payout for annual leave for 40/48 hour workweek employees is 500 hours or 750 hours, based on your Bargaining Unit's Collective Bargaining Agreement.

Sick Leave accumulates without limit. Depending on years of continuous service and upon separation, you may be eligible to cash out, on a sliding scale of 25 percent to 100 percent, up to 1,000 hours of Sick Leave.

Leave of Absence

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

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

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

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

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

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

Paid Parental Leave

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

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

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

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

COBRA

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

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

Saving for Your Retirement

Florida Retirement System (FRS)

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

The FRS is qualified under Section 401(a) of the Internal Revenue Code and provides a defined benefit (FRS Pension Plan) and a defined contribution plan (FRS Investment Plan) option. Under the defined benefit plan, for every month you receive a paycheck, you receive one month of service credit, if you participate in the defined contribution plan, a contribution is made to your account and you are responsible for managing your investments. You must make your Florida Retirement System (FRS) plan election within the first eight (8) months of your employment by visiting <https://www.myfrs.com/> or you will be defaulted to the Investment Plan (except special risk employees).

Plan Features

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

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

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

Members participating in the Deferred Retirement Option Program (DROP) and re-employed retirees who do not qualify for renewed membership are not required to make the 3% contribution.

For more information on the FRS, visit <https://www.myfrs.com>.

FRS Reemployment After Retirement

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

- If the reemployment occurs during the first 6 calendar months after the retirement, the employee will not be considered to have retired. The member's retirement will be canceled and they will be required to repay all retirement benefits received. Additionally, the department is responsible for repaying any retroactive contributions due on the service.
- If the reemployment occurs during the 7th through the 12th month after the date of retirement, payments of retirement benefits will be suspended for any months the retiree is employed during this 6 month period. Benefits that would otherwise have been paid during the period of suspension are forfeited. The retiree must repay any benefits received while working during the 7th through the 12th month after retirement.

- Effective July 1, 2017, reemployed retirees from the Investment Plan are eligible for renewed membership in FRS and will be required to make the 3% employee contribution.

Deferred Compensation

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

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

Plan Features

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

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

The minimum Contribution is \$10 per pay period and the maximum Contribution is 100% of your gross taxable salary or \$19,000 (whichever is less) as of January 1, 2020. **The maximum contribution is determined annually by the IRS and may have changed since this Benefits Guide was published.**

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

457 Roth Funding Option

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

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

Emotional Wellness Program

Employee Assistance Program (EAP)

What is role of the Miami-Dade's Employee Assistance Program?

The Miami-Dade Employee Assistance Program is a confidential service which focuses on assisting those who are struggling with personal problems that may be affecting their ability to function at home, work or in the community. EAP counselors focus on supporting employees with internal and external resources that assist in setting the foundation for restoration or enhancement of emotional and mental wellness.

Who can use the EAP?

The Employee Assistance Program is available to all Miami-Dade employees and their eligible family members and dependents.

What kind of problems does the EAP help with?

Some of the needs and concerns employees have brought to the EAP are:

- Family/Marital Problems
- Anxiety/Emotional Problems
- Stress Management needs
- Substance Abuse/Alcohol Abuse
- Financial Problems
- Death of a loved one
- Anger Management
- Community Resources such as Childcare

BEHEALTHY ◦ BEWELL ◦ BEWISE



Employee Support Service (ESS): Supporting Miami-Dade County employee wellness and enhancing work-life balance and engagement

BEHEALTHY

Physical Wellness: WellnessWorks

- On-site and Off-site Physical Wellness Initiatives
- Participate in Quarterly Wellness challenges
- On-site coaching with Wellness Coaches and Nutritionist
- Gym Discount Program for \$25 per month and the ability to choose from 9,000+ gyms

Emotional Wellness: Employee Assistance Program (EAP)

- Engaging Miami-Dade Employees in events that promote Emotional Wellness
- Free and Confidential on-site counseling and services in the OTV South building by appointment and walk-in
- Experienced Licensed and/or Masters level clinical staff to support employees and their covered dependents

Occupational Wellness: Employee Recognition Programs

- Partnering to build and plan worksite wellness and employee appreciation events to support Occupational Wellness
- Educational Fairs to promote a healthy workforce
- Capturing employee innovations through the IDEA Rewards Program

BEWELL

Physical Wellness: WellnessWorks

- Earn \$20 for completing PHA and \$20 for completing Biometric Screenings yearly
- Participate in Wellness challenges and be entered to win cash and prizes
- Earn 75 Wellness points and per quarter be entered in a drawing for \$250. Keep it going and you can be entered into an annual drawing of \$500 for completing all 4 quarters
- Participate in Free Nutrition Coaching and Free Health Coaching to jumpstart your healthy lifestyle and meet your personal goals

Emotional Wellness: Employee Assistance Program (EAP)

- Free and Confidential services for employees and their eligible dependents
- Referrals within the employees' insurance network to support employees and their families Emotional Wellness
- Community referrals to resources that may support needs such as childcare or eldercare

Occupational Wellness: Employee Recognition Programs

- Incentives and rewards for participation in employee recognition events and contests
- Employee Service Awards to celebrate employee milestones
- Employee Discount Program featuring Discount Ninja
- IDEA Machine/ IDEA Rewards Program offers up to \$5,000 for successfully implemented suggestions that improve efficiency and/or service in County departments

BEWISE

Physical Wellness: WellnessWorks

- Participate in on-site and off-site Wellness training and events
- Check out WellnessWorks online courses to learn more about wellness topics and how to apply them to becoming a healthier you
- Sign-up and Benefit from Healthy Roads tracking and incentives
- Read Wellness Watch newsletters to get tips to promote every day wellness

Emotional Wellness: Employee Assistance Program (EAP)

- Participate in on-site Employee and Supervisor trainings on subjects such as managing stress, mental health in the workplace, managing Depression and Anxiety, and signs and symptoms of substance use
- Take advantage of on-site resources on Emotional Wellness, Mental Health, Stress Management and Substance Use

Occupational Wellness: Employee Recognition Programs

- Stay informed through digital communication such as What's New, the Bargain Hunter and Payday Message
- Attend Worth It Wednesday\$, Lunch and Learns and Education Fairs where County partners and discount merchants share knowledge and valuable incentives

For more information visit: www8.miamidade.gov/global/humanresources/benefits/home.page



Wellness (in Partnership with AvMed)

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

GUIDANCE & COUNSELING

- Health coaching
- Nutritional consultations
- Health education courses
- Bi-annual Health Fairs

CHALLENGES

- Wellness challenges
- Annual 5k Family Fun Event
- Other events to promote physical activity, weight loss, general health, and prevention

SUPPORT TOOLS

- Gym discounts
- Smoking cessation
- Wellness Watch Newsletter

- Weight Watchers

ONLINE SERVICES

- Personal Health Assessments
- Wellness Portal

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

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

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

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

With AvMed, you get the tools you need to get started with ONE program. Get on the road to **YOU**, improved.

On-site Health & Wellness Coaches can:

- **LISTEN** and clarify what YOU want to do in order to get – and stay – healthy;
- **WORK WITH YOU** to design an individualized action plan based on your Personal Health Assessment (PHA);
- **CO-CREATE** realistic goals and then break them down into smaller, achievable action steps;
- **ASSIST** in getting you the necessary screenings, biometrics, fitness options, immunizations, resources and follow-up care from your health providers;
- **ENCOURAGE, MOTIVATE AND SUPPORT** you toward reaching your goals; and...
- **CELEBRATE** your victories with you!

Call **1-888-245-6676** or **305-375-1511** or email wellnessworks@miamidade.gov to find out how to engage with the WellnessWorks on-site coaches to help on your journey to YOU, improved. All County employees on the AvMed health plan are eligible. Visit **www.AvMed.org/** **MDC/WellnessWorks** for more details.

Are you ready to take the next step towards wellness? Register for the WellnessWorks program at www.healthyroads.com. To reach a member of the wellness team or schedule an appointment email: wellnessworks@miamidade.gov.

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



Does the EAP tell anyone about me contacting them?

The EAP is designed to be a confidential resource and support for employees. The program is designed to ensure confidentiality. Employees that come to the EAP on a voluntary basis will have information released only to individuals authorized by the employee.

How does the EAP process work?

The employee can refer themselves to the program for consultation. Managers and Directors can also make mandatory referrals to the program in circumstances such as substance use. Additionally, a manager can call the EAP for consultation in regards to concerns about employees that may have personal struggles that are affecting their performance and assist employees in making an appointment directly.

An initial consultation is typically scheduled that day or the next business day. After the initial consultation, the employee and their EAP counselor will identify the best avenue to support the employee in their goals and/or provide referrals to resources such as legal aid, therapy, a health care facility or rehabilitation center.

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

What does it cost?

The internal EAP session is FREE to the employee. Referrals can be given to a provider covered by your health plan. However you may be required to pay co-payments for the services provided based on coverage levels, as you would for a doctor's visit.

How can I get in touch with the EAP and where are they located?

You can call 305-375-3293 to set up an appointment with a counselor. Emergency walk-ins are also accepted.

Our address is: 601 NW 1st Court., Suite 15-050, Miami, FL 33136

The hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m.

The Miami-Dade County Employee Assistance Program is located on the 15th Floor of the OTV South Building.

Employee Recognition

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

Employee Recognition Program

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

IDEA Rewards/ Employee Suggestion Program

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

Service Awards

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

Employee Discount Program

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

Disclosure Notices

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

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

Additional Benefits

On-Site Child Care

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

Tuition Reimbursement

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

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

Public Transportation Benefits

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

For additional information, including County employee discounts fees, visit www.miamidade.gov/transit/county-employee-discount.asp <http://cloud.guest.gobrightline.com/CTP?partner=CTP-MDCTPW>.

Benefit Reminders

- Use your enrollment period to preview your benefit choices before enrollment deadlines by logging in. Visit www.miamidade.gov/openenrollment for all benefits eligibility deadlines.
- New hires and newly benefit eligible employees must enroll/decline benefits coverage before the completion of the 60th day of eligible employment.

- Add/Remove dependents and submit required dependent eligibility proof documents for enrolled dependents to avoid cancellation of dependent coverage.
- Submit Affidavit of Eligibility every year for overage dependent children who have reached age 26 through age 30.
- Verify SSN or ITIN for all covered dependents on eNet.
- Verify personal information (address, email address, telephone number) on Blue Book with your DPR to ensure you receive applicable benefits notices.
- Designate and or/update beneficiaries (e.g. County Death Benefit, Basic Life, Supplemental Life, and Retirement Plans, if applicable)
- Enroll for your Florida Retirement System (FRS) plan election within the first 8 months of your employment by visiting <https://www.myfrs.com> or you will be defaulted to the Investment Plan (except Special Risk).
- Enroll in and submit an annual contribution for your Flexible Spending Account (FSA)