REV 11/18/15

2017 MIAMI-DADE BENEFITS ELECTION FORM FOR GROUP HEALTH PLANS - Non-Redesign
(AFSCME Water & Sewer and TWU union employees)

(*Please refer to INSTRUCTIONS on reverse side) 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. Florida Statutes Section 817.234 (1) (b)

GROUP HEALTH PLANS (RATES INDICATED ARE BIWEEKLY)

1. MEDICAL - Select your medical plan enrollment level for 2017: *Opt-Out/Decline medical coverage for 2017 Refer to reverse side

<table>
<thead>
<tr>
<th>Plan Level</th>
<th>AVMED POS</th>
<th>AVMED HIGH HMO</th>
<th>AVMED LOW HMO</th>
<th>AVMED JACKSON FIRST Pilot HMO (TWU Employees Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$14.90</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$285.86</td>
<td>$180.17</td>
<td>$169.83</td>
<td>$112.02</td>
</tr>
<tr>
<td>Employee + Spouse\Domestic Partner (DP)</td>
<td>$344.54</td>
<td>$208.35</td>
<td>$196.42</td>
<td>$134.71</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$595.59</td>
<td>$287.77</td>
<td>$271.36</td>
<td>$197.84</td>
</tr>
</tbody>
</table>

2. DENTAL - Select your dental plan enrollment level for 2017: Decline dental coverage for 2017

<table>
<thead>
<tr>
<th>Plan Level</th>
<th>ENRICHED DENTAL</th>
<th>STANDARD DENTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DELTA</td>
<td>METLIFE</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$4.45</td>
<td>$2.59</td>
</tr>
<tr>
<td>Employee + 1 Dependent</td>
<td>$22.89</td>
<td>$8.03</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$45.72</td>
<td>$16.12</td>
</tr>
</tbody>
</table>

3. METLIFE VISION PLAN Select plan and enrollment level for 2017: Decline vision coverage for 2017

<table>
<thead>
<tr>
<th>Plan Level</th>
<th>Employee Only</th>
<th>Employee + 1 Dependent</th>
<th>Employee + Family</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1.91</td>
<td>$3.83</td>
<td>$7.03</td>
</tr>
</tbody>
</table>

4. DEPENDENT INFORMATION – If you made any changes for 2017, complete for all dependents to be covered. New participants must select: a primary care physician only if enrolling in the low option HMO plan and a dental provider if enrolling in a prepaid dental plan (MetLife DHMO or Humana-OHS). If you have any additional children to cover, mark here and list on a separate sheet. Are any of the dependents listed below new for 2017? YES NO

5. MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS ON THE REVERSE SIDE OF THIS APPLICATION.
IMPORTANT NOTICE – THIS BENEFIT ELECTION FORM IS TO BE USED ONLY UNDER SPECIAL CIRCUMSTANCES

All benefit plan elections and changes must be submitted online through the eNet portal (http://enet.miamidade.gov), Outside of the annual open enrollment period (Oct-Nov) or the new hire eligibility period, the only mid-year status changes permitted are those that conform to IRS Section 125 qualifying event rules. For more information refer to the Change in Status (CIS) forms or Benefits handbook at www.miamidade.gov/benefits.

Opting-Out or Cancelling Coverage: If you opt-out or cancel coverage, you cannot re-apply until the next open enrollment, unless you experience a qualifying event rules. The decision to waive coverage has consequences. Declining County medical coverage without enrolling in another group or marketplace health plan may result in a tax penalty. Go to www.Healthcare.gov for additional information regarding the Affordable Care Act’s individual mandate.

GROUP MEDICAL, DENTAL PLANS AND OPTIX VISION PLAN

1. Complete this section to select your medical coverage. To add or change coverage, mark the appropriate box indicating the plan and enrollment level you are electing. Adding or deleting dependents from your plan is considered a change.

2. Complete this section to select your dental coverage. To add or change coverage, mark the appropriate box indicating the plan and enrollment level you are electing. Adding or deleting dependents from your plan is considered a change.

3. Complete this section to select vision coverage. If you wish to make a change (ex., add or delete dependents, enroll for coverage or cancel coverage), please complete this section. This plan is available to all eligible employees regardless of Union affiliation.

4. If you made any changes to your medical, dental or vision plans, list in this section:
   - Yourself and all dependents to be covered in the medical, dental or vision plans. For each dependent listed provide social security #, sex, and date of birth. Check appropriate column to indicate those enrollees who will be covered for medical, dental and/or vision coverage
   - New enrollees must enter their participating provider’s ID#, if enrolling in a Low Option HMO plan, or a prepaid dental plan.

5. Carefully read the section below marked “Important Terms and Conditions”, then sign and date your forms. Make a copy and retain for your records.

IMPORTANT TERMS AND CONDITIONS

- I authorize my employer to deduct from my pay the cost of any pre and post tax benefits I have elected. I understand the contribution to my Social Security account may be reduced for pre-tax contributions based on my income after reduction.
- I also agree to pay any return check service fees charged in accordance with Florida Statute 832.07 if, while on an unpaid leave of absence, my personal check is returned unpaid by the Bank.
- I agree for myself and covered members of my family to be bound by the benefits, deductibles, co-payments, exclusions, limitations and other terms of the Contracts, Agreements, and Plan Documents. I understand that my Group Health premiums will automatically be paid tax-free through salary reduction. Any premium attributable to a domestic partner and their child (ren) or children after the calendar year in which they turn age 26 will be post tax and subject to imputed income tax.
- I certify that the information supplied in this application is true to the best of my knowledge.
- I understand that once this form is submitted, I cannot request a change of medical, dental or vision plan carriers until the next annual open enrollment. A change of coverage type may be requested to add a newly acquired dependent within 45 days of the event (60 days for newborns, adoptions, placement for adoption), or to add or delete existing dependents subject to the requirements of Flexible Benefits and HIPAA. Please refer to the online Benefits Handbook for specifics.
- I agree to complete and submit to any provider of health services such consents, release, and other assignments as are reasonably necessary in accordance with its rights under the health benefit plans or Insurance policies. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. In addition, I authorize any provider of health services to release information concerning the health, condition, or treatment of any covered person, upon written request, whenever such information is considered necessary for the proper disposition of a claim submitted for payment, or in fulfillment of obligations.
- I understand that eligible married or unmarried, natural children (whether or not they live with the employee), children of a domestic partner, adopted children, stepchildren may be covered by the medical plan to the end of the calendar year in which the child turns 26 (providing dependent is not offered coverage at work). Proof of eligibility must be submitted to the health plan. Eligibility documents may be forwarded to the DPR for submission to the health plan. For unmarried children who satisfy the criteria under Florida Statute 627.6562, medical coverage may also be extended to the end of the calendar year the child turns 30. To enroll a new dependent child age 26+ to 29, proof of prior health coverage without a break of more than 63 days, is required. Note: For the dental, vision, and legal plans the limiting age for unmarried dependent children is the end of the calendar year the dependent reaches age 26 (end of the calendar year), effective 01/01/16. Physically or mentally disabled dependents may continue coverage beyond the limiting age, upon receipt of acceptable medical evidence as requested by the plans. Employees must contact the plan regarding extension of benefits for disabled dependents.
- I agree to submit proof of eligibility to the health plan for all dependent(s) enrolled. In addition, I will submit on an annual basis for each dependent child enrolled age 26+ to 29: 1) Affidavit of Eligibility and 2) Proof of Florida residency, or student status. My dependent(s) will not be enrolled without the legal documentation. Premiums attributable to a domestic partner or their children will be deducted post tax and subject to imputed income tax.

NEW HIRES

I understand that for ALL dependents to be enrolled, legal documents (example: marriage certificate, birth certificate, certificate of domestic partnership, etc.) must be attached to this form and submitted to Human Resources Dept. Benefits Administration. The following documents are required to enroll a dependent age 26+ to age 29: 1) Affidavit of Eligibility and 2) Proof of Florida residency, or student status. My dependent(s) will not be enrolled without acceptable documentation.

Rev 10/27/16
2017 MIAMI-DADE BENEFITS ELECTION FORM FOR GROUP LEGAL SERVICES, DISABILITY INCOME PROTECTION AND FLEXIBLE BENEFITS

(*Please refer to INSTRUCTIONS on reverse side) 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. Florida Statutes Section 817.234 (1) (b)

<table>
<thead>
<tr>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>CITY</td>
<td>STATE</td>
</tr>
<tr>
<td>DATE OF BIRTH (MMDDYYYY)</td>
<td>HOME PHONE</td>
<td>WORK PHONE</td>
</tr>
<tr>
<td>DEPARTMENT</td>
<td>EMPLOYEE STATUS</td>
<td>DATE OF HIRE (MMDDYYYY)</td>
</tr>
<tr>
<td>CHANGE TYPE: OPEN ENROLLMENT</td>
<td>NEW HIRE</td>
<td>EFFECTIVE DATE (MMDDYYYY)</td>
</tr>
</tbody>
</table>

ALL RATES ARE BIWEEKLY, EXCEPT IN SECTION 8

GROUP LEGAL SERVICES (After tax)

6. Complete only if you wish to enroll or make a change to your Group Legal Plan for 2017. Decline Group Legal for 2017 __________

- Employee Only $7.29
- Employee + 1 Dependent $9.34
- Employee + Dependents $9.61

DISABILITY INCOME PROTECTION (After tax)

7. Complete only if you wish to enroll or make a change for 2017

<table>
<thead>
<tr>
<th>METLIFE STD</th>
<th>Premium Per $100 Weekly Benefit</th>
<th>METLIFE LTD</th>
<th>Premium Per $100 of Covered Monthly Payroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Option ($500 max weekly benefit)</td>
<td>$1.20</td>
<td>Low Option ($2,000 max monthly benefit)</td>
<td>$0.192</td>
</tr>
<tr>
<td>High Option ($1,000 max weekly benefit)</td>
<td>$1.20</td>
<td>High Option ($4,000 max monthly benefit)</td>
<td>$0.230</td>
</tr>
<tr>
<td>Premier Plan ($7,000 max monthly benefit)</td>
<td>$0.320</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employee must be actively at work for new disability coverage to take effect.

Decline STD coverage for 2017 __________
Decline LTD coverage for 2017 __________

SPENDING ACCOUNTS

8. Complete if you wish to participate in either or both Flexible Spending Accounts for 2017. Participation does no carryover from the previous year; you must re-enroll during open enrollment.

- A. HEALTH CARE SPENDING ACCOUNT

- B. DEPENDENT CARE SPENDING ACCOUNT

Example: $500.00

IMPORTANT - These benefits apply to plan year 2017 only. The County necessarily reserves the right to amend or terminate any of the benefits at any time.

I certify that the information supplied in this application is true to the best of my knowledge. I hereby authorize my employer to reduce my gross salary before Federal and Social Security taxes are calculated by the total amount of annual salary reduction indicated above in the election I made in Section 8. I hereby authorize my employer to deduct from my pay any benefits I have elected on an after-tax basis. I understand that the cost of disability income protection plan(s) for plan year 2017 will be based on salary and option(s) selected. I understand the contribution to my Social Security account may be reduced if contributions will be based on my income after reduction. I understand that the funds in the Spending Accounts cannot be used only to reimburse expenses covered by another plan. I understand that expenses for which I am reimbursed cannot be claimed on my income tax returns or eligible for coverage under any other insurance plan. I understand that the amount of salary reduction will include the items specified above and will continue in effect through 2017 unless I terminate employment or file an approved Change in Status before the end of the year. I understand and agree that my employer and benefit plans will not incur any liability resulting for my failure to sign or accurately complete this election form.

9. FEES will be charged where applicable, see reverse side for amounts. 10. My signature below certifies I have read and agree to the terms\conditions above.
6. GROUP LEGAL SERVICES

Complete this section to select Group Legal coverage. To add or change coverage, mark the appropriate box indicating the enrollment level you are electing. Adding or deleting dependents from your plan is considered a change. Cover only those dependents who may utilize this plan.

7. DISABILITY INCOME PROTECTION

Review your current coverage. Add and/or cancel the coverage you want by marking the appropriate box(es).

- **STD Low** Option: Biweekly Premium = Adj. Biweekly Salary (capped at $1,666.67) ÷ 2 x 0.60 x 0.0120
- **STD High** Option: Biweekly Premium = Adj. Biweekly Salary (capped at $3,333.34) ÷ 2 x 0.60 x 0.0120
- **LTD Low** Option: Biweekly Premium = Adj. Biweekly Salary (capped at $1,538.76) x 26 ÷ 12 x 0.00192
- **LTD High** Option: Biweekly Premium = Adj. Biweekly Salary (capped at $3,077.52) x 26 ÷ 12 x 0.00230
- **Premier LTD** Option: Biweekly Premium = Adj. Biweekly Salary (capped at $4,846.16) x 26 ÷ 12 x 0.00320

Enrollment in the Premier LTD Plan cannot be combined with the regular STD and LTD Plans. You may enroll for STD and/or regular LTD coverage, or enroll in the Premier LTD Plan alone. The plans are mutually exclusive due to the overlap in the elimination periods. (Visit the online calculator at [http://www.miamidade.gov/benefits/calculator](http://www.miamidade.gov/benefits/calculator))

8. FLEXIBLE BENEFITS PLAN

Review your current elections. You must complete this section if you wish to participate in either or both Spending Accounts. Participation does no carryover from the previous year; you must re-enroll during open enrollment. Refer to the worksheet in your Benefits Handbook for guidance. Write the annual amount in the boxes provided.

- **A. Healthcare Spending Account**
  - Minimum annual contribution: $260 for the full plan year
  - Maximum annual contribution: $2,550 less annual administrative fee of $52.52, or $2,497.48 (2,550 minus $52.52).

- **B. Dependent Care Spending Account**
  - Minimum annual contribution: $260 for the full plan year
  - Maximum varies depending on your tax filing status:
    - Married, filing separately, maximum: $2,500 less annual administrative fee of $52.52, or $2,497.48
    - Married, filing jointly, maximum: $5,000 less annual administrative fee of $52.52, or $4,947.48
    - Single, head of household, maximum: $5,000 less annual administrative fee of $52.52, or $4,947.48

9. FEES

The biweekly administrative fees are as follows:
- Health Care Spending Account $ 2.02
- Dependent Care Spending Account $ 2.02
- Maximum Biweekly fee for one account or both FSA accounts combined: $ 2.02 ($52.52 annually)

10. Carefully read the section marked "Important." If you made any changes to your benefits or you are participating in a Flexible Spending Account(s), please sign, date and return your form.