

Miami-Dade County Employee Benefits

At Miami-Dade County we want the best, so we offer the best. As a member of the MDC family, you will have access to our comprehensive Total Rewards package. We have worked diligently to create a benefits program that will meet the diverse needs of our employees.

Learn about living in [South Florida](#).

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Group Benefits Eligibility

Employee Eligibility

- Any full-time career-service employee who has completed 60 days of employment is eligible. Coverage becomes effective the first of the month following or coincident to 60 days of employment, as long as timely benefit elections are made. Employees must access the online New Hire Benefits Enrollment website through the eNet portal, to enroll in the County benefit plans.
- Any part-time employee who consistently works at least 60 hours biweekly and has completed 60 days of employment. Coverage becomes effective the first of the month following or coincident to 60 days of employment provided timely benefit elections are made. The part-timer must continue to satisfy the minimum number of working hours requirement to remain eligible for benefits.
- Employees must be actively at work for disability or group life benefits to become effective.
- All employees are eligible to participate in the deferred compensation plan.
- Upon certain Qualifying Events, ex-spouses, children who cease to be dependents, employees going from full-time to part-time status and dependents of a deceased employee may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Contact your [Department Representative \(DPR\)](#)  for further questions regarding your eligibility for group benefits.

Dependent Eligibility

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 coverage children, domestic partner and children of a domestic partner will be deducted post-tax and subject to imputed income tax.

Coverage for a Spouse\Domestic Partner ends on the effective date of the divorce\dissolution of domestic partnership.

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

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

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

- Is not married and has no dependents (i.e. children, spouse\domestic partner), and
- Is not provided or otherwise have available 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 on an ongoing basis.

It is the employee's responsibility to contact their benefits specialist or human resource 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. 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.

Note: MDC 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 in Calendar Year 2017. Employees will be required to provide documentation, such as birth or marriage certificates, for any dependents enrolled for healthcare benefits. More details regarding the audit will be provided separately.

Online Benefits Enrollment

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

- Before you begin the online enrollment process review these steps in the [Benefits Handbook](#) 
- To access the online New Hire Benefits Enrollment website, logon to [eNet](#)

Changing Coverage

Change In Status (CIS)

Mid-year changes from one health plan to another are not permitted after the open enrollment. Once the annual open enrollment period closes, you may add or delete dependents to your health plan only under limited circumstances: a qualifying event (QE). Changes must be reported within 45 days of a qualifying event (60 days to add newborns/adoption, or placement for adoption).

Complete a Change in Status (CIS) form and Plan Status Change form and submit to the Benefits Administration Unit. Election changes must be consistent with the event and result in loss or gain of insurance coverage. A partial list of permitted mid-year changes appears below.

Qualifying Events (QE)

- Marriage/Divorce
- Eligibility for Medicare/Medicaid/Florida Kid Care
- Employment change from full-time to part-time
- Change in Number of Tax Dependents or vice versa (employee or spouse)
- Spouse's employer's open enrollment
- Birth of a child
- Beginning or end of employment of a spouse
- Unpaid LOA (employee or spouse) resulting in gain or loss of insurance coverage
- Adoption of a child or placement for adoption
- Significant change in health coverage due to spouse's employment

Covered Dependents

Children age 26 and under:

The Patient Protection and Affordable Care Act (PPACA) extended the limiting age for dependent children to the end of the calendar year in which the dependent turns age 26. Former eligibility criteria for this group, such as marital status, financial dependency, student status no longer apply.

Consequently, employees cannot remove a dependent child from coverage due to marriage, or initial employment, unless the child gains other group insurance and enrolls in it. Moving out of the employee's home and losing financial dependency on the parent are not QEs that would permit the dependent's coverage to be canceled. The only event that now makes the child ineligible for coverage is enrolling in other group insurance coverage.

FSA Period of Coverage/Changes

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. A partial lists of permitted qualifying events under your employer's plan(s) appear on the following page.

Election changes must be consistent with the event. For example: if you get divorced, an IRS special consistency rule allows you to lower or cancel your Healthcare FSA coverage for the individual involved. The Benefits Administration Unit of Risk Management, will review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within 45 days (60 days to add newborns) of an event that is consistent with one of the events on the following page, you must complete and submit a flexible benefits change in status form and health plan status change forms to your [Department Personnel Representative](#)  (DPR).

These forms may be obtained online at the benefits website. Documentation supporting your election change request is required. Do not delay submission of your change in status and health plan status change forms while you gather your documentation. Simply forward the forms to your DPR and present your documentation as soon as it becomes available. Upon the approval and completion of processing your election change request, your existing elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the beginning of the pay period after your election change request has been received by the Benefits Administration Unit, unless otherwise provided by law. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption or placement for adoption which become effective as of the event date. Payroll changes to delete a dependent become effective the first day of the pay period following receipt by the Benefits Administration Unit.

Your period of coverage for FSAs is your full plan year, unless you make a permitted mid-plan year election change, terminate employment or lose eligibility for group coverage. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

IRS Special Consistency Rules Governing Changes in Status

1. **Loss of dependent eligibility** - If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of coverage eligibility under another employer's plan** - If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment

status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.

3. **Dependent care expenses** - You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Appeals Process for Denied Changes

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

- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied
- any additional documents, information or comments you think may have a bearing on your appeal

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

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

Medical Insurance

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

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

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

We are excited to offer eligible employees the [MDC Jackson First HMO Plan Option](#)  as an additional option to your current healthcare choices. Another recent change - Bariatric services will be covered under the offered HMO plans. This added coverage will be limited to Jackson facilities/providers only. Previously, bariatric services were only covered under the POS plan. You must meet specific criteria to qualify for coverage. Please contact AvMed at 800-682-8633 for the specific criteria that needs to be met in order to qualify for coverage and for any further details about your coverage.

The available medical plans are:

[Plan Redesign](#) - Medical Plans Available

Applies to all non-bargaining employees, and bargaining employees in AFSCME Aviation, AFSCME General, AFSCME Solid Waste, GSAF Professional, GSAF Supervisors, IAFF and PBA Rank & File/Supervisory

- [AvMed Select Network HMO](#)
- [AvMed Jackson First](#)
- [AvMed High Option HMO](#)

- [AvMed POS](#)
- [AvMed Jackson First \(PBA only\)](#)

Non Plan Redesign - Medical Plans Available

Applies to AFSCME Water & Sewer, and Transport Workers Union

- [AvMed Low Option HMO](#)
- [AvMed Jackson First \(Transport Workers Union only\)](#)
- [AvMed High Option HMO](#)
- [AvMed POS](#)

Fire Union Plan

Members of the DCFF fire union may be eligible for coverage in their Union-sponsored plan. Contact your Union office for further details. If you enroll in the Fire Union-sponsored health plan, you may elect the Vision Plan, but you cannot participate in of any County-sponsored dental plans.

Additional Medical Plan Information:

Prescription Drug Information

- [2017 Preferred Medication List for HMO](#)
- [2017 Preferred Medication List for POS and Medicare Eligible](#)
- [Progressive Medication Program](#)
- [Prescription Medication Quantity Limits \(2017\)](#)
- [Pharmacy Benefits Manager](#)
- [CVS Caremark Mail Order Form](#) 

Find a Doctor, Facility, Hospital, Urgent Care Provider or Pharmacy

- [MDC Select Network](#)
- [MDC Jackson First Network](#)
- [Elite Network](#)
- [Behavioral Health Providers](#)
- [PHCS Directory](#)
- [Pharmacy](#)

For additional medical plan information, go to the [AvMed website](#).

Medical Plan Forms

- [AvMed Affidavit of Eligibility \(26+ - 30 years\)](#) 
- [AvMed Away from Home Program](#) 
- [Transition of Service Form](#) 
- [AvMed MDC/JHS Claim Reimbursement form](#) 
- [RX Mail Order Form](#) 

Additional Medical Plan Services

- [SmartShopper](#) 
- [Virtual Visits](#) 

Alternative Medical Plans

The County is sensitive to the fact that some of our employees, ineligible for health coverage, are not aware of companies in the community that provide affordable healthcare to individuals. As a convenience, we have posted links to some of those resources.

Please direct all inquiries including those pertaining to eligibility, benefits, costs, and enrollment directly to the organizations listed below. Once again this information is being provided as a convenience to you. The benefits are not administered by Miami-Dade County.

[Health Insurance Marketplace](#)

[AvMed Individual Health Plan](#)

800-390-9355

[Blue Cross/Blue Shield of Florida](#)

Florida Blue Centers

877-465-1125

[Children's Health Insurance Plan](#) (Kids Now)

888-540-KIDS (5437)

[CIGNA Health](#)

866-438-2446

[United HealthCare](#)

Community Services

Florida Department of health

(305) 324-2400

www.floridahealth.gov/programs-and-services/

Jackson Health Systems

305-585-2222

www.jacksonhealth.org/patients-financial-assistance.asp

Other Alternatives (Pre-Paid Health Plans)

[Florida Health Solution](#)

(305) 269-2000

[ProMedical Plan PHC](#)

(877) 905-0500

Dental Insurance

You may enroll yourself and your eligible dependents for dental coverage even if you decline the medical coverage. There are three dental plans available:

Indemnity Standard or Enriched

Select the dentist of your choice. Benefits are payable at various coinsurance levels. A deductible is applied for services other than preventive and diagnostic. Annual maximum reimbursements are: \$1,000 per person for the Standard plan and \$1,500 per person for the Enriched plan. The Enriched plan also includes orthodontia.

- [Delta Dental Standard or Enriched Dental Indemnity plan](#) 
[Delta Dental Website](#)
[Delta Dental Provider Directory](#) 

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

- [Humana-OHS Standard or Enriched Dental Prepaid Plan](#) 
[Humana OHS Dental Website](#)
[Humana OHS Dental Provider Directory](#) 
- [MetLife DHMO Standard or Enriched Dental Prepaid Plan](#) 
[MetLife Dental Website](#)
[MetLife DHMO Provider Directory](#) 

Dental Plan Forms

- [Delta Dental Claim Form](#) 

Vision Insurance

The MetLife Vision Plan is available to all employees eligible for medical and dental coverage, regardless of union affiliation. Employees 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.

For more about this plan and how it works, get in touch with MetLife by calling the toll-free number: 1-877-638-2055.

Overview & Benefits

- [MetLife Vision Overview](#) 
- [MetLife Vision Benefits](#) 

Find a Participating Vision Provider

- [MetLife Vision Network Providers](#).
(Enter your Zip Code, and Select Your Plan: METLIFE VISION PPO)

Vision Plan Forms

- [MetLife Vision Claim form](#) 

Life Insurance

Basic Life

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

Plan Features

Benefits are payable for death from any cause to the beneficiaries you name.

- Beneficiary designations may be updated at any time
Go directly online to update this important information. The process is easy, secure and will take just a few minutes from any computer, 24/7. The beneficiary website can be accessed through the eNet portal at [eNet](#).
- If death results from accidental injuries, your beneficiary may be eligible to receive Group Accidental Death and Dismemberment Insurance (AD&D) equal to your annual base salary.
- Dismemberment benefits, up to the same amount as your group term basic life coverage, are payable for loss of hand, foot or sight of eye resulting from an accident. See your policy for plan provisions.
- Employee must be actively at work for coverage to start

Basic Life Coverage Enrollment

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 flex benefits using the online New Hire Benefits Enrollment website. Once you submit the online benefits enrollment, you will then be directed to the Online Beneficiary Designation link to list your beneficiary (ies) and complete the process. Both links are on the County's eNet portal and accessible 24/7 from any computer. You can also change your beneficiaries anytime using the eNet.

If you don't enroll for this benefit during your initial eligibility period, you may apply during Open Enrollment. However, at that time, coverage is subject to medical approval and may be denied. Contact your Departmental Personnel Representative or the Benefits Administration Unit at 305-375-4288 or 305-375-5633 for the required paperwork. You must be actively at work for coverage to be effective.

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

Group Term Optional Life Insurance

Although the County assumes the full cost for your basic life insurance with MetLife, you may purchase additional life insurance called Optional Life Insurance. Eligible employees can go online to www.metlife.com/MyBenefits.

Plan Features

If interested, you should elect coverage at the time you first become eligible for medical, dental, vision and basic life benefits.

- You may apply for coverage up to 5 times your annual adjusted base salary.
- Premiums are age-based and depend on the amount of coverage purchased. Contact your Departmental Personnel Representative or the Benefits Administration Unit at 305-375-4288 or 305-375-5633 for further details.

- You may reduce the level of coverage or cancel coverage at any time. However, if you wish to re-enroll for coverage or increase the coverage level you must submit an application during the annual optional life open enrollment subject to medical approval.
- Life insurance amounts in excess of \$50,000 may be taxable and may be included as taxable income on your W-2 form.
- An employee must be actively at work for coverage to begin. This also applies to increases in coverage.

Group Term Optional Life Coverage Enrollment

When first eligible, new employees may apply for optional life coverage using the New Hire Benefits Enrollment link on the County's eNet portal. Once you submit the online benefits enrollment, you will then be directed to the Online Beneficiary Designation link to complete the process. If you don't enroll during your initial eligibility period, an Optional Life open enrollment is held once a year in early spring. You may submit an application, but it will be subject to medical approval. You must be actively at work for coverage to be effective.

Will Preparation

Employees enrolled in the Optional Life Insurance plan have access to two value added services offered by Hyatt Legal Plans, a MetLife company:

1. Will Preparation
2. Estate Resolution Services

Beneficiaries can work with a Hyatt Legal attorney for assistance with probate-related items such as document preparation and related tax items. For further assistance, contact Hyatt Legal Plans at 1-800-821-6400, provide them with the Miami-Dade Group Number 25800 and your social security number Group Number 25800 and your social security number.

- [Will preparation service](#) 
- [Out-of-Network reimbursement feature for MetLife's will preparation service](#) 

Life Insurance Beneficiary Designation

Keep your beneficiary designations up-to-date. Your Life Insurance proceeds are payable to the beneficiaries you name and should be updated any time you experience a major life event, such as marriage, divorce, new baby, home ownership, a health scare, etc. Beneficiary designations may be updated online at any time. The process is easy, secure and will take just a few minutes from any computer, 24/7, through the [eNet](#) portal. Once you logon to eNet, go to the Secure eNet Services menu and click the Beneficiary Designation link.

The Beneficiary Designation online form applies to Life Insurance Only! To update other beneficiary designations (County Death Benefit, FRS, Deferred Comp., etc) contact your [DPR](#)  for instructions.

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) the following death benefit amount determined by the employee's years of continuous County service:

- If the employee's longevity is less than ten (10) years, the beneficiary(ies) shall be eligible for the equivalent of one pay period's regular salary and \$2,000 dollars.
- If the employee's longevity is less than twenty (20) years, the beneficiary (ies) shall be eligible for the equivalent of two pay period's regular salary and \$4,000 dollars.
- If the employee's longevity is 20 years or more, the beneficiary (ies) shall be eligible for the equivalent of two pay period's regular salary and \$6,000 dollars.
- The beneficiary (ies) is eligible to continue the medical and dental coverage for either one or two pay periods based on the employee's longevity. The maximum duration of the continuation of coverage shall be two pay periods.

County Death Benefits Beneficiary Designation

If you need to update your Beneficiary Designation for this death benefit, contact your Departmental Personnel Representative or the Benefits Administration Unit at **305-375-4288** for the required form, or go to the Benefits web page under forms and click on the [County Death Benefit Beneficiary Designation](#)  under Beneficiary change forms.

Life Insurance Forms

- [MetLife Statement of Health Form - Life Insurance](#) 
- [Basic and Optional Life Insurance Online Beneficiary Designation](#) 
- [County Death Benefit Beneficiary Designation \(administered by Human Resources Department\)](#) 
- [County Accidental Death Insurance \(administered by Human Resources Department\)](#) 
- [Group/Optional Life Enrollment/Beneficiary Designation](#) 
- [Death Benefit Payment Form - \(County Resolution 81-02 Death Benefit\)](#) 

Flexible Spending Account

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 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.

Features

- IRS-approved reimbursement of eligible expenses tax free.
- Direct deposits from your pre-tax salary each pay period.
- You save income and FICA taxes each time you receive wages. You decide the amount to deposit.

Healthcare FSA

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

Maximum Annual Deposit: \$2,550 (including a \$52.52 annual administrative fee)

Grace period to use available funds: until March 15 of the following plan year.

Submit claims for reimbursement by: April 30

Partial List of Medically Necessary Eligible Expenses

- » Acupuncture
- » Ambulance service
- » Birth control pills and devices
- » Chiropractic care
- » Contact lenses (corrective)
- » Dental fees Diagnostic tests/health screening
- » Doctors' fees
- » Drug addiction/ alcoholism treatment Drugs
- » Experimental medical treatment
- » Eyeglasses (corrective)
- » Guide dogs
- » Hearing aids & exams
- » Injections and Vaccinations
- » In vitro fertilization
- » Nursing services
- » Optometrist fees
- » Orthodontic treatment
- » Over-the-counter items (RX may be required)
- » Prescription drugs to alleviate nicotine withdrawal symptoms
- » Smoking cessation program/treatments
- » Surgery
- » Transportation for medical care
- » Weight-loss programs/meetings
- » Wheelchairs
- » X-rays

Dependent Care FSA

Minimum annual deposit: \$10 per pay period (\$260 per year)

Maximum annual deposit: (including a \$52.52 annual administrative fee)

The maximum contribution depends on your tax filing status.

Grace period to use available funds: No Grace period; must use available funds by December 31 of the plan year

Submit claims for reimbursement by: April 30

Partial list of eligible expenses

- » After school care
- » Baby-sitting fees
- » Day care services
- » In-home care/au pair services
- » Nursery and preschool
- » Summer day camps

The maximum contribution depends on your tax filing status. If married filing separately, or single and not head of household, your maximum annual deposit is \$2,500. If married filing jointly, or single and head of household, the maximum annual deposit is \$5,000.

Is an FSA right for me?

If you spend \$260 or more on eligible medical expenses or \$260 or more on eligible dependent care expenses during your plan year, you may save money by paying for them with an FSA. The amount is deducted in small, equal amounts from your paychecks during the plan year. Determine your potential savings with a Tax Savings Analysis by visiting the "Tax Calculators" link at www.myFBMC.com.

Note: Budget conservatively. No reimbursement or refund of FSA funds will be available for services that do not occur within your plan year. IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

When may I enroll?

You may enroll in a Health Care or Dependent Care Flexible Spending Account (FSA) during your new hire eligibility period or during the annual open enrollment held in the fall.

What is the myFBMC Card®?

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

If you enroll in an HFSA, two cards will be sent in the mail (in a plain envelope); one for you and one for your spouse or eligible dependent. Keep your cards to use each plan year until their expiration date. Remember, you can go to www.myFBMC.com to see your account information and check for any outstanding Card transactions. To activate your myFBMC Card® visit www.myFBMC.com. You may also call 1-888-514-6845.

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

Additional Information

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

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

Flexible Spending Account Forms

- [Reimbursement Request](#) 
- [Direct Deposit](#) 

Group Legal Services

With the Group Legal Services plan, you have unlimited access to attorney consultation through the Telephone Legal Access Firm before potential legal issues become costly. This is an after-tax benefit.

Plan Provider

ARAG is a leading administrator of legal advisory plans and ARAG Insurance Company is rated A (Excellent) by A.M. Best Company.

Your After-tax Rates

(Level of Coverage / Bi-weekly Premium)

- Employee Only - \$7.29
- Employee & One Dependent - \$9.34
- Employee & Family - \$9.61

Your premiums will be deducted from your paycheck after taxes have been calculated.

Who are my eligible dependents?

- Your spouse (unless also an eligible County employee).
- All unmarried dependent children to the end of the calendar year turning 19. Coverage may be extended to the end of the calendar year turning 25 if the unmarried dependent child is a full-time or part time student or residing in the employee's household.

Important Note:

If you elect coverage for yourself and one dependent, the first dependent for whom you file a claim will be considered the only dependent covered under this plan. Changes to the plan, outside of the annual open enrollment period, are allowed only if a corresponding qualifying event is experienced and a timely request is made.

Participating Attorneys

To view a list of network attorneys and plan benefits, visit [ARAG website](#) or call 800-667-4300.

What's Covered?

Review your [Ultimate Advisor Legal Plan Details](#), which includes a short list covered services. For a complete list of covered matters and coverage levels, visit [ARAGLegalCenter.com](#) (enter access code 10277mdc).

What's Not Covered?

- Actions or disputes between you and your employer, or your employer's insurance carrier, unions, plan underwriter and any party when coverage is prohibited by law.
- Workers' Compensation, Unemployment Compensation, Class Actions, Interventions, and Amicus Curiae.
- Matters relating to patents, copyrights or appeal proceedings.
- Duplication of services previously claimed in relation to same matter.
- Probating of estates, title insurance, title search, title abstracting, filing fees, reporter's fees and court costs.
- Services regarding matters resulting from your occupation, including business interests, transactions, pursuits and partnerships.
- Any legal matter which occurs or is initiated prior to your effective date of coverage. This includes the dates for which an infraction occurs, a document is filed with the court or an attorney is hired.
- Preparing, completing, or filing of a federal, state, or local tax return
- Contingency fee cases and similar matters for which a fee is normally allowed by law
- Any action brought in Small Claims Court
- Any legal proceeding in which you are entitled to legal representation or reimbursement for the costs thereof from any source other than this policy or another legal expense policy
- Matters related to structural damage to dwellings, appurtenances and paved surfaces
- Property tax disputes

Additional Group Legal Services Information

- [ARAG - New Financial Counseling Partner](#) 
- [ARAG – Educational Materials](#) 

Terminated employees may purchase a conversion policy by contacting ARAG directly at 800-667-4300.

Short and Long Term Disability

Disability Income Protection

Chances are that you do not have enough money in your personal or other long-term savings accounts that would allow you to miss more than two months of work without suffering financial consequences.

Disability Income Protection Insurance plans can provide you with a weekly (STD) benefit or monthly (LTD) benefit if you become disabled, as defined in the policy. Choose short term (STD) or long term (LTD) disability income protection insurance, or both.

An employee must be actively at work for coverage to begin. Minimum requirement for active employment is 60 hours bi-weekly. Refer to the Benefits Handbook for additional information.

Short-Term Disability (STD)

This plan can provide up to 60% of your weekly salary, with a maximum benefit of \$500 (STD Low Option Plan) or \$1,000 (STD High Option Plan) per week. STD benefit payments are issued in arrears on a weekly basis, and benefits can continue for each period of disability, but not beyond the maximum benefit period of 26 weeks.

STD benefits start to accrue after you meet the definition of disability and satisfy a 14-consecutive-day waiting period, or the expiration of all sick leave, whichever is later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you.

Long-Term Disability (LTD)

This plan can provide up to 60% of your monthly salary, with a maximum benefit of \$2,000 (LTD Low Option Plan) or \$4,000 (LTD High Option Plan) per month. The minimum monthly benefit is the greater of \$100, or 10 percent of the gross monthly benefit before deductions for other income benefits.

Employees may also elect the **Premier LTD Plan**, which features a 90-day waiting period instead of 180 days, and offers a monthly benefit of 66 2/3 % of the employee's adjusted salary up to a maximum of \$7,000 per month. Enrollment in the Premier LTD cannot be combined with the regular STD and LTD plans because the plans are mutually exclusive.

LTD benefits start to accrue after you meet the definition of disability as defined in the policy and satisfy the waiting period of 180 days.

Before LTD benefits will begin, an employee must exhaust any short-term disability or the expiration of all sick leave, whichever occurs later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you. As long as you are receiving LTD benefits from MetLife, your monthly premiums are waived.

Pre-existing limitation clause applies.

Short-Term and Long-Term Disability Monthly Premiums

METLIFE STD/ Premium Per \$100 Weekly Benefit

Low Option (\$500 max weekly benefit) - \$1.20

High Option (\$1,000 max weekly benefit) - \$1.20

METLIFE LTD/ Premium Per \$100 of Covered Monthly Payroll

Low Option (\$2,000 max monthly benefit) - \$0.192

High Option (\$4,000 max monthly benefit) - \$0.230

Premier LTD (\$7,000 max monthly Benefit) - \$0.320

Additional Disability Information

- [MetLife Disability Plans](#)
- [Benefits Cost Calculator](#)

Disability Forms

- [MetLife Statement of Health form - STD/LTD](#)
- [STD Disability Claim form](#)
- [LTD Claim form - Employee Statement](#)
- [LTD Claim form - Employer Statement](#)
- [LTD Claim form - Attending Physician Statement](#)

Deferred Compensation

When you retire, you'll want to maintain the lifestyle you currently have. Social Security and the Florida Retirement System are not intended to replace all of your income at retirement. It is wise to start a savings plan now. The

Deferred Compensation Plan is a tax deferred savings plan that can be used at retirement to supplement your Florida Retirement System and Social Security benefits.

Plan Features:

- Contributions are taken from your gross salary before Federal Withholding taxes are calculated.
- Your contributions are invested in the products of your choice.
- You don't pay Federal Withholding Income taxes on your investment contributions or earnings until you receive the money.
- Social Security taxes on contribution amounts continue to be deducted from your gross salary.
- Governed by Section 457 Internal Revenue Code.
- Minimum Contribution: \$10 per pay period
- Maximum Contribution: 100% of your gross taxable salary or \$18,000 (whichever is less) as of January 1, 2015.
- You might contribute into [ICMA-RC](#) or [Nationwide](#) investments accounts.

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.

Contribution and Withdrawal

The County offers two providers [ICMA-RC](#) and [Nationwide](#) with a number of investment and withdrawal options.

Loans

The deferred compensation plan allows loans for all purposes.

Loans Topics

Frequently asked questions and answers to the most commonly asked questions pertaining to general loans - [Nationwide](#) Retirement Solutions and [ICMA-RC](#) 457(b) Deferred Compensation Plans.

Deferred Compensation Notices

- [Pension Plan Pretax Direct Rollover form](#)
- [Catch Up](#)

Tuition Refund Program

Miami-Dade County's Tuition Refund Program was adopted by the Board of County Commissioners on August 27, 1963 to encourage County employees to improve their effectiveness by obtaining additional training. The information outlined in this web site provides the procedures that should be followed to participate in this employee development benefit.

- [Administrative Order No. 7-4](#) 
- [Approval Form](#) 
- [Authorization for Educational Institution to Disclose Financial and Course Information](#) 
- [Claim Form](#) 
- [FAQ's](#) 
- [Search accredited postsecondary institutions](#)
- [Tuition Refund Processing Checklist](#) 
- [Tuition Refund Program Workflow](#) 
- [Tuition Reimbursement Claim Form](#) 

Employee Support Services

What is the purpose of the Miami-Dade Support Services (ESS)?

The Miami-Dade Employee Support Services is a benefit designed to provide a confidential service to employees whose personal problems are affecting their ability to function on the job, at home, or in society. Professional counselors at ESS can help you sort out the problems and choose the appropriate and workable solutions for you and your family. Please see the [ESS Manual](#)  for more details.

Who can use ESS?

Employee Support Services are available to all Miami-Dade employees and their eligible dependent family members.

What kinds of problems can we help with?

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

Family/Marital Problems

Family problems can be devastating. ESS can offer guidance in obtaining effective professional help.

Stress/Anxiety/Emotional Problems

The majority of us, at one time or another, experience mild anxiety or depression. Occasionally, however, these problems can be quite severe. ESS can assist you in obtaining appropriate professional help.

Alcoholism and Drug-Related Problems

Alcoholism is the nation's number one drug problem. Miami-Dade recognizes addiction as an illness which is treatable. There has been an increasing incidence of addiction to one or more of a wide variety of both "hard" drugs like heroin, Ecstasy, and cocaine or prescription drugs, such as tranquilizers or sleeping pills. Whether your concern is for yourself or a member of your family, ESS can be an initial source of help.

Financial Problems

ESS will help you in finding a financial counselor to help resolve your financial problems.

Are our services confidential?

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

How does ESS work?

The employee can refer him or herself for a consultation in any of the problem areas outlined above (financial, stress, family, and substance abuse).

The employee's supervisor can also make a mandatory referral in cases of identified substance abuse. Additionally, the supervisor can recommend consultation with ESS if family troubles are identified as adversely affecting the employee's performance.

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

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

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

What is the cost to you?

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

Employee Recognition Programs

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

The goal of the County's Employee Recognition Programs is to show appreciation for an employee's achievement and motivate employees to continue exceeding in their performance. The Employee Recognition Program is governed by [Administrative Order 7-30](#). 

Contact Information:

Communications Department Employee Recognition Program

Stephen P. Clark Center
111 NW 1st Street, 23rd Floor
Miami, FL 33128

Telephone: 305-375-1389

Email: FLOGOM@miamidade.gov

Wellness

The journey to a healthy lifestyle begins with ONE step. Change starts with ONE decision. Get on the road to YOU, improved.

Through Wellness Works, you can participate in activities, events, programs and wellness education to help improve your health. You can also earn points to be entered into drawings for great prizes. We have exciting incentives and resources for you to take advantage of in 2017. [Miami-Dade County's Wellness Works program](#) now offers on-site coaches, a nutritionist and prenatal advisor to improve your health as well as incentive rewards for completing your personal health assessment and annual biometric screening.

2017 Wellness Watch

Wellness Watch newsletter provides Miami-Dade County employees with the latest wellness news, programs and events.

- [January](#) 
- [February](#) 
- [March](#) 

2017 Wellness Events

- [Event Calendar](#)
- [Walk Your Way Wellness Works Steps Challenge](#)
- [Mercedes-Benz Corporate Run](#)

Personal Health Assessment

Have you completed your Personal Health Assessment this year? This is an online tool that helps you understand your current health status. By completing this questionnaire, you will receive a personalized scorecard including recommendations and resources to help you target possible risks while saving on healthcare costs. Employees that complete their PHA's prior to June 20th will receive a \$20 incentive reward. The reward is subject to payroll taxes.

Additional Wellness Information

- [Wellness Works On-site Coaches](#) 

Smoking Cessation

The Florida Department of Health offers smoking cessation resources under its [Tobacco Free Florida](#) initiative.

Employee Discount Program

Through the [Employee Discount Program](#), employees can take advantage of products and services at a reduced rate, offered by some companies through their special discount programs.

Paid Time Off & Leave of Absence

Holidays & Leave

Miami-Dade County offers a generous leave package to employees, including:

- two weeks of annual leave,
- military leave,
- family medical leave for eligible employees,
- up to 13 paid holidays in accordance with pertinent bargaining agreement
- 12 sick days for full time employees.
- In addition to annual and sick leave, employees also receive a floating holiday and a birthday holiday.

For more detailed information about the County's leave package, see the County's [Leave Manual](#). 

For the list of job classifications by bargaining agreement, please refer to [collective bargaining agreement](#).

Holidays Observed by Miami-Dade County

The following are the 11 County-observed holidays, unless otherwise specified by collective bargaining agreement.

All County offices (including libraries) will be closed on all 11 County holidays.

- New Year's Day
- Martin Luther King's Birthday
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving Day
- Friday after Thanksgiving
- Christmas Day

[View the pay schedule](#) 

Additional Holidays for County Employees

In addition to the 11 Observed County Holidays, County employees receive:

- **Floating Holiday**
The Floating Holiday is to be taken at the mutual convenience of the employee and the department. This holiday is not compensable and cannot be accrued or transferred from one fiscal year to the next. Only career employees having more than nine pay periods of County service are eligible to use this holiday. The employee earns this holiday at the beginning of each fiscal year (October 1st).
- **Birthday Holiday**
The Birthday Holiday is also taken at the mutual convenience of the employee and the department and must be taken within six months of occurrence or it is forfeited. Neither the Birthday Holiday nor the Floating Holiday is paid out at termination.

Employees who are out of pay status for any portion of the day before or after a holiday will not be eligible to be paid for, or bank, the holiday.

Holidays Observed by Miami-Dade County Transit

Normally-scheduled County Metrobus, Metrorail and Metromover service is provided on all holidays except for:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day, and
- Christmas Day, when service operates on a Sunday schedule.

On these holidays, Metrobus, Metrorail, and Metromover will follow the Sunday schedule.

Leave of Absence

A leave of absence is an approved absence without pay for a maximum period of one year. This section addresses maintenance of group benefits while in a no-pay status. Questions regarding eligibility for leave of absence, including the process to request approval, must be directed to your departmental personnel representative.

A leave of absence is an approved absence without pay for a maximum period of one year.

- [Frequently Asked Questions](#) 

Leave Pool Donation

An earned leave pool is an optional department benefit for employees who wish to participate in the donation and distribution of leave for assistance following a serious illness or injury according to earned leave pool guidelines.

Special [leave donation pools](#)  may be established on an ad hoc basis by a department to assist an employee who has experienced a serious illness or injury and who has exhausted all appropriate leave available.

Family Medical Leave Act (FMLA)

Family medical leave encompasses time off required under the Family and Medical Leave Act of 1993 and related U.S. Department of Labor rules, and the Family Leave Ordinance (FLO) as authorized by Ordinance 91-142 and 93-118 of Miami-Dade County.

If you determine that you need to take family medical leave, please contact your DPR PDF and fill out the appropriate form(s).

- [FMLA Request Form](#) 
- [FMLA Designation Form](#) 
- [FMLA Medical Certification Form Employee](#) 
- [FMLA Medical Certification Form Family Member](#) 

Maintaining Group Benefits While On An Approved Leave Of Absence (LOA) Without Pay

Group Benefits cost depends on the type of leave. If your leave is illness related (i.e. Family Medical Leave-FMLA, disability, worker's compensation, maternity etc.), you will be responsible for paying the benefit plan deductions that are usually withheld from your biweekly paycheck. If your leave is not illness related (i.e. educational, suspension, personal, etc.), you will be responsible for paying both the employee cost and County contributions. Your Department Personnel Representative (DPR) will provide you with an LOA information package, billing notice and remittance form. Contact your DPR for additional information related to military leave.

Making payments while in Leave Of Absence (LOA)

The first payment is due within two weeks of your last insurance payroll deductions. Thereafter, premium payments are due biweekly, in advance of the pay period to be covered. If coverage is cancelled due to non-payment of premiums when due, you will only be allowed to re-enroll during the next annual open enrollment period. Your DPR will provide you with a leave of absence package that explains the payment process to maintain your insurance coverage while on leave. It also includes instructions on where payments must be sent. If you do not receive this information when on an approved LOA, please follow-up with your DPR immediately.

Deleting Dependents from Coverage

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

Temporary Health Insurance Cancellation While On An Approved Leave Of Absence

You may submit a completed Change in Status Form and Benefits Election Change Form within 45 days of being in a leave without pay status to temporarily cancel your health insurance coverage. To reinstate coverage upon returning to pay status (within 45 days), submit a new Change in Status form and Insurance Status Change Form to your DPR requesting the coverage reinstatement. Be aware that life insurance and disability will not be automatically reinstated. You will be subject to the medical review process and approval is not guaranteed by the insurance carrier. If approved, coverage will not be effective until you are actively at work.

Reporting Changes in Family Status

Complete the [Flexible Benefits Change in Status Form](#)  and the [Benefit Election Change Form](#) , if you experience a family status change (adding newborn, divorce, etc.). Submit the forms to your DPR within 45 days of the event (60 days for newborns, adoption\placement for adoption). If the status change results in a premium adjustment, contact your DPR to determine the cost for the current employee biweekly rates. Follow-up with your DPR if you do not receive a revised LOA billing notice. Do not delay the payment for this reason, otherwise you risk having your coverage cancelled for non-payment. It is the employee's responsibility to submit the insurance payments in a timely manner and for the correct amount.

Insurance Coverage Cancellation for Non-Payment of Premiums

If your coverage is cancelled for non-payment of premiums, you must wait until the annual open enrollment period to re-enroll. Coverage will be effective January 1, except for optional life insurance and income protection (disability) which are subject to medical review and approval is not guaranteed. If approved, coverage will not be effective until you are actively at work.

Military Active Duty Leave & Military Reserve Leave

Military Reserve Leave and Military Active Duty Leave are two distinctly different types of leave and are not interchangeable.

- Military Reserve Leave is designed to pay the employee his/her normal salary for the two weeks summer camp or other training.
- Military Active Duty Leave pays the employee for up to 30 days during a state of emergency or time of war.

For example, if you are called to military active duty for six months commencing March 1, your 30th day of military active duty leave will be March 30th. On March 31st, military reserve leave, though it may be available, may not be used. Military Reserve Leave cannot be used to cover for any of the period during which you are on military active duty. The converse also applies.

Military Leave Eligibility

Eligible employees must either:

- Be a member of the Armed Forces Reserve or the National Guard and be activated or whose active duty is extended during a period when an appropriate public official declares a state of emergency during peacetime; OR
- Enter the Armed Forces during a period of declared war between the United States and a foreign government; OR
- Be called to active duty in the Armed Forces or National Guard during wartime; OR
- Be ordered to duty out of the country.

What Time Period does Military Active Duty Leave cover?

In addition to the 30 days of Military Reserve Leave, a maximum of 30 days of paid Military Active Duty Leave may be granted each time you are called to active duty (official orders must be submitted).

To be eligible for more than one paid 30 day Military Active Duty Leave period in one fiscal year, you must have returned to work between deployments. Employees whose deployment overlaps fiscal years will be granted a maximum of 30 days of Military Active Duty Leave at the beginning of each fiscal year.

Customarily, upon expiration of the 30 days Military Active Duty Leave, if you did not return to work, you would have been placed in a Military Leave of Absence status until your return. However, on September 25, 2001, the Board of County Commissioners passed Resolution R-1059-01 authorizing additional compensation to County employees on active military duty as a result of the United States' response to the terrorist attacks of September 11, 2001.

Once the 30 days of military active duty leave have been exhausted, you may use your accrued leave time. However, per US Code Title 38, Section 4316(d), an employee's consent must be given in order for the employee's annual leave to be used. Therefore, a leave request form specifying the amount, type of leave (annual, holiday or compensatory) and dates to be covered must be submitted to your supervisor for approval.

Military Leave Request & Employee Status

Once an employee has received their official military orders to report for military active duty. The employee must present official orders, when available, and a Leave Request to his/her supervisor.

An employee on Military Leave will remain in active status, earn pay periods, and accrue sick and annual leave. In other words, status, anniversary, and leave conversion dates will not change.

- Longevity bonus awards will be paid when due,
- Sick to annual leave conversion will occur, and
- Employees will be eligible for merit increases.

In the event that a County observed holiday falls during the period that you are on active military duty, you will be able to accrue the holiday leave. However, if you exceed the maximum allowable holiday leave time, you will be paid for the holiday.

Military service time is considered creditable service for layoff retention purposes. Should a layoff occur, there will be no break in your seniority calculations, therefore you will be treated as if you had been physically in the workplace.

Should your annual leave balance exceed the maximum allowable limit on your leave anniversary date, you will not lose the excess hours. The leave hours will be preserved, and upon your return from active duty service, you will have at least one year from your return date to use the excess annual leave.

How Will I Receive the Difference in Compensation?

Applies to Active Duty Only: Upon receipt of copies of your military pay stub, the additional compensation will be paid to you. It is preferable for us to receive your military pay stubs at the end of every military pay period. We will be unable to process requests for payments without these pay stubs. These should be forwarded to:

Human Resources Department
Payroll and Information Management
111 NW 1st Street, Suite 2010
Miami, Florida 33128

Alternatively, they may be faxed to 305-375-5247 or e-mailed to ISD-HRSST@miamidade.gov. The calculation of the supplement is based on the difference between your net military pay, excluding allowances, and your net County pay, including any pay exceptions to which you were entitled.

Payroll Deductions

Should you have any questions or concerns about payroll deductions, please contact the Payroll and Information Management Division of Human Resources at 305-375-4011.

If you have questions specifically related to garnishments, please contact the Payroll Unit of the Finance Department at 305 375-5165.

In the event that you have an existing overpayment or are overpaid during the course of your deployment, the overpayment procedures governed by your collective bargaining unit will be followed, provided your supplemental pay is sufficient to cover the repayment installments.

Military Leave & Insurance

Making Changes to Your Insurance or Spending Account

Employees preparing for Military Leave can make changes to their insurance benefits, spending accounts (Health Care and Dependent care), and deferred compensation contributions before leaving. If you wish to change your insurance or spending account benefits they must complete a Change in Status Form and fax it along with a copy of your military orders to the Benefits Administration Unit. You can obtain change forms by calling the Benefits Administration Unit at 305-375-5633 or 305-375-4288.

Making Changes to Your Deferred Compensation Account

If you wish to make changes to your deferred compensation contribution, you can do this by:

- logging on to your provider's website,
- calling your provider's customer service number, or
- by submitting a change form for your applicable provider and forwarding it for processing to:

Human Resources
Benefits Administration Unit
111 NW 1st Street, Suite 2340
Miami, Florida 33128.

Any questions concerning your deferred compensation accounts can be directed to your provider by calling customer service or logging on to their website:

[NACO/Nationwide Retirement Solutions](#) at 877-677-3678 or [ICMA Retirement Corporation](#) at 800-669-7400.

Will the County Continue Paying Its Insurance Contribution If I am in a No Pay Status?

Yes, the County will continue paying its contribution. However, if you are enrolled for dependent insurance, the Point of Service (POS) medical plan, enriched dental plan, vision or optional life, you will need to remit the bi-weekly premium that is deducted from your pay check to the Benefits Administration Unit in order to assure continuation of coverage.

Who Will Notify me of What Premiums, if any, I Need to Pay While in a No Pay Status?

Your Departmental Personnel Representative will provide you with a leave of absence benefits package and remittance form. This will identify the premiums you will need to pay in order to maintain coverage and give you the option of what benefits, if any, you wish to cancel.

May I Cancel Insurance Coverage for my Dependent (s) While on Military Leave?

Yes, you may cancel coverage for your dependents within 45 days of being placed on military leave. You need to submit a completed Flexible Benefits Change in Status Form and Insurance Status Change Form to the Benefits Administration Unit. Contact your Departmental Personnel Representative to obtain these forms.

If I request cancellation of insurance while on active duty, or if coverage is cancelled for non-payment of premiums, may I request reinstatement upon

Yes, you must request reinstatement within 45 days from return to work. There is no waiting period after the request is received.

Is life insurance payable to my beneficiaries if I die while on duty?

Yes, group basic life insurance and optional life, if enrolled, are payable for death from any cause. Accidental Death and Dismemberment benefits are not payable for death/injuries due to acts of war (declared or undeclared).

Military Leave & Florida Retirement System

An employee on active military leave will receive service credit with the Florida Retirement System (FRS).

Upon your return from military active duty, you must send a copy of your DD214 to Human Resources in order to receive service credit for the period of military active duty.

If you remained in partial pay status during your period of military active duty, you will have already received service credit for the period you were out. However, you must still send in your DD214 so that Human Resources can provide payroll information to FRS and ensure that your service is credited at your full rate of pay.

The mailing address for all DD-214 correspondence is:

Miami-Dade Human Resources Department
111 NW 1st Street, Suite 2010
Miami, FL 33128
Attention: Lynn Garcia and Rohan Robotham.

Additional information concerning [FRS Benefits](#) may be obtained online.

Returning to Work After Military Leave

The time period for returning to work depends on the duration of your military service and receiving an honorable discharge.

- For periods of military service of 1 to 30 days: You must report back to work at the beginning of the first regularly scheduled work day that falls at least eight hours after the end of the employee's military service, including allowance for safe return travel.
- For periods of military service of 31 to 180 days: You must report to work within 14 days after completing your military service.
- For periods of military service of 181 days or more: You must return to work no later than 90 days after completing your military service.

All of these periods are customarily extended to two years if you are hospitalized or are slow to return to health because of an injury incurred or aggravated during your military service. Situations where the period extends beyond two years will be reviewed on a case by case basis.

Should you decide not to return to work immediately, you must notify your supervisor and submit a leave request form to authorize the use of your annual, holiday or compensatory time to cover the absence. As soon as your discharge papers become available, they should also be submitted to your supervisor.

Should you have any questions concerning this information or relating to your employment with the County, please contact Payroll and Information Management at 305-375-4011.

COBRA

Continuation of health care coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires most group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated. COBRA requires continuation coverage to be offered to covered employees and their covered dependent(s) when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce from a covered employee, a covered employee becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan. The COBRA participant pays the full premium, since employer contributions no longer apply, plus a 2% administration fee. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from your health plan or FBMC.

COBRA information packets are sent by the insurance carriers to terminating employees within fourteen (14) days of notification of termination from County service. The County's notification to the plans is through a biweekly listing issued after the employee's department processes the termination through the payroll system. Group medical, dental, vision and basic/optional life insurance coverage (if enrolled) ceases the last day of the pay period in which the termination date falls and for which the employee experiences a regular insurance deduction or made direct payments to the Benefits Administration Unit (if on an unpaid leave of absence). If you exercise your rights under COBRA, upon receipt of your initial premium the insurance plan will reinstate your coverage retroactive to the group benefits termination date (without a gap).

The HIPAA certificates will be issued by your medical insurance carrier, at the same time the COBRA notice is issued. For more information, please contact the insurance carrier. The employee or a family member has the responsibility of directly informing the Benefits Administration Unit of a divorce, or a child losing dependent status. Requests must be made on a timely basis (no later than 45 days from the qualifying event). Basic/optional life insurance coverage is not subject to COBRA. If covered under the basic or optional life plan, the terminating employee will have the opportunity to convert to a private policy without being subject to evidence of insurability and will receive a conversion notice by mail. Employees may convert up to the volume of life insurance in force at the termination of employment, or convert amounts as determined by the Metropolitan Life Insurance Company. To obtain the life insurance conversion rates, contact the insurance carrier at the phone number listed on the conversion notice.

Continuation of Coverage for Medical, Dental and Vision Health Plans

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

Healthcare Flexible Spending Accounts (FSA) Continuation of Coverage Period

If you fund your Healthcare FSA entirely, you may continue your Healthcare FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Healthcare FSA for the year.

For example, if you elected a maximum Healthcare FSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Healthcare FSA for the remainder of the plan year or until such time that you receive the maximum Healthcare FSA benefit of \$1,000. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time. If your employer funds all or any portion of your Healthcare FSA, you may be eligible to continue your Healthcare FSA beyond the plan year in which the qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special contribution rules for employer-funded Healthcare FSAs. If you have questions about your employer-funded Healthcare FSA, call FBMC at 1-800-342-8017.

Notification of Rights under COBRA

COBRA information is sent by the health plans to terminated employees, or part-timers losing eligibility due to reduced hours, within 14 days of notification of termination from County service or reduction in hours. The plans also provide COBRA notice to dependent children losing eligibility due to reaching the age limit. For loss of group insurance coverage due to events such as divorce, marriage of a dependent child, the Benefits Administration Unit will notify the plans to issue COBRA information upon receipt of timely notice from the employee/dependent.

Electing Continuation of Coverage under COBRA

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

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

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

Deadline for selecting continuation of health care coverage under COBRA

A qualified beneficiary must elect COBRA coverage within 60 days from whichever date is later

- the employee's loss of group health plan coverage or
- the envelope postmark date that the Election Notice was mailed to the qualified beneficiary

If a qualified beneficiary fails to meet this deadline, he or she will be deemed to have declined COBRA coverage.

Qualified Beneficiaries under COBRA

- the person must be a covered employee, the spouse of a covered employee, or the dependent child of a covered employee; and
- the person must be covered by a group health plan immediately before the qualifying event occurs.

Medical, Dental and Vision Plans

Except for your employer's Healthcare FSA Plan, the same open enrollment rights are extended to COBRA qualified beneficiaries as are available to active employees.

Healthcare FSA Plan

In accordance with COBRA, your employer's plan offers limited COBRA continuation rights to qualified beneficiaries who have under spent their MFSA accounts as of the date of the COBRA qualifying event.

Unless otherwise elected, the spouse and dependents of the person electing COBRA will be covered. Only qualified beneficiaries have election rights and may elect separate COBRA coverage with:

- a separate Healthcare FSA at the elected annual limit in effect at the time of the COBRA qualifying event and
- a separate COBRA premium through the end of the plan year in which the COBRA qualifying event occurs.

COBRA Qualifying Events

As a general rule, there is a COBRA "qualifying event" if:

- a covered employee's termination of employment occurs other than due to gross misconduct. This includes retirement.
- there is a reduction in a covered employee's hours of employment.
- a covered employee dies.
- a covered employee becoming entitled to Medicare.
- a covered employee experiences a divorce or legal separation.
- a child ceases to qualify as a dependent under the terms of the plan.

HIPAA Provisions

HIPAA gives a person already on COBRA specific enrollment provisions to add dependents only if such a person:

- acquires a new dependent, or
- if an eligible dependent declines coverage because of alternative coverage and
- later loses such coverage due to certain qualifying reasons

Spouse or dependents who are added under this paragraph do not become Qualified Beneficiaries and their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

Continuation of Coverage Costs

Generally, each qualified beneficiary may be required to pay 102 percent of the cost of group health coverage. For Healthcare FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

The monthly COBRA premium for coverage is the monthly premium you were paying via salary reductions before the date of the COBRA qualifying event, plus any contributions made by your employer. Under COBRA, your premium must be paid by check or by money order. Administration fee of 2% may apply. The health plan will provide information on where to remit payments.

COBRA Rates

[2017 COBRA Rates non-redesign](#) 

[2017 COBRA Rates redesign](#) 

Making Payments for Continuation of Coverage

If you elect continuation of coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact FBMC to confirm the correct

amount of your first payment (for FSAs). Your health plan will notify you of the exact premium payable. Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

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 an employee receives a paycheck, they receive one month of service credit; if the employee participates in the defined contribution plan a contribution is made to their account and the employee is responsible for managing their investments.

FRS Retirement Eligibility

In order to qualify for the retirement benefit, an employee must be vested. Effective July 1, 2011, the legislature amended the retirement plan and redefined normal retirement age and the vesting requirements for new members. In addition, FRS members must contribute 3% of their salary towards their retirement benefit, on a pre-tax basis (the salary is reduced by the amount of the employee contribution before determining the federal income tax deduction); 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.

Members Enrolled in the FRS Prior to July 1, 2011

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

- Vesting for [FRS](#) Pension Plan benefit eligibility will be after the completion of **6 years** of creditable service.
- The average final compensation (AFC) used in calculating retirement benefits will be the **highest 5 fiscal years** of salary.
- Members of the Regular Class, Senior Management Service Class and Elected Officers' Class will reach their normal retirement date:
 1. The first day of the month the member reaches **age 62 and is vested**; or
 2. The first day of the month following the month the member completes **30 years** of creditable service, **regardless of age** before age 62.

- Members of the Special Risk Class will reach their normal retirement date:
 1. The first day of the month the member reaches **age 55 and is vested**; or
 2. The first day of the month following the month the member completes **25 years** of creditable service in the Special Risk Class, **regardless of age** before age 55; or
 3. The first day of the month following the date the member reaches **age 52** and completes **25 years** of service comprised of Special Risk Class service and up to **4 years wartime military service** purchased under Section 121.111, Florida Statutes.

Members First Enrolled in the FRS on or After July 1, 2011

- Vesting for [FRS](#) Pension Plan benefit eligibility will be after the completion of **8 years** of creditable service.
- The average final compensation (AFC) used in calculating retirement benefits will be the **highest 8 fiscal years** of salary.
- Members of the Regular Class, Senior Management Service Class and Elected Officers' Class will reach their normal retirement date:
 1. The first day of the month the member reaches **age 65 and is vested**; or
 2. The first day of the month following the month the member completes **33 years** of creditable service, **regardless of age** before age 65.
- Members of the Special Risk Class will reach their normal retirement date:
 1. The first day of the month the member reaches **age 60 and is vested**; or
 2. The first day of the month following the month the member completes **30 years** of creditable service in the Special Risk Class, **regardless of age** before age 60; or
 3. The first day of the month following the date the member reaches **age 57** and completes **30 years** of service comprised of Special Risk Class service **and up to 4 years wartime military service** purchased under Section 121.111, Florida Statutes.

Under the defined benefit plan, an employee's annual benefit will be determined by multiplying the years of service by a percentage value and by the average of the five highest years of creditable salary. An employee may retire before reaching normal retirement age, but the annual benefit will be reduced by 5% for each year under normal retirement date. With the defined contribution plan, the employee's benefit amount depends on the investment returns earned on contributions.

Salaries Exceeding Federal Limits

Federal law, under section 401(a)(17) of the Internal Revenue Code, limits the amount of annual salary that may be applied towards retirement under a qualified retirement plan. Employees who initially became members of the FRS on or after July 1, 1996, are subject to a \$150,000 limit, incrementally indexed for cost-of-living increases after 1996. Employees who initially became members of the FRS before July 1, 1996, are subject to a higher limit (also adjusted annually by the IRS to reflect cost-of-living increases).

The current limits are:

Date

7/01/2011

Member on or after 7/01/1996

\$245,000

Member prior to 7/01/1996

\$363,820

Disability Retirement

Retirement benefits may be provided to employees with eight years of creditable service who become totally and permanently disabled. Employees who become disabled in the line of duty may become eligible for disability benefits regardless of their length of service.

Additional information on the FRS is available by calling 1-844-377-1888 or [online](#) or www.MyFRS.com

As a supplement to the retirement benefits under the FRS, Miami-Dade County offers employees a deferred compensation program.

FRS Notices

- [FRS Contribution Rate](#)

Retirees

Continuation of Insurance after retirement

You must complete and submit a Retiree Insurance Application to the Benefits Administration Unit to continue your coverage into retirement. You will be billed for these benefits after your retirement date.

Your Optional Life insurance will be cancelled upon your retirement. You can convert up to the total benefit amount, to a whole life policy, directly with the Insurance Carrier. Information about how to do so, and the costs involved will be mailed to you with your billing calendar.

Your Vision Insurance will be cancelled upon your retirement. You may convert to an individual policy by contacting the carrier directly. Information about how to do so will be mailed to you with your retirement packet.

Making insurance payments after retirement

Once the Benefits Administration Unit confirms your last payroll deduction, an Annual Retiree Billing Calendar will be mailed to you, provided you have submitted the Retiree Insurance Application. This billing calendar will include a monthly premium breakdown for the balance of the calendar year. You will be responsible to pay your insurance premiums through the current billing month, and no later than 15 days from the date of the billing notice. Thereafter, premiums are due on the first day of the month. For that reason, we recommend that you budget for approximately three months of insurance premiums, since your first pension check may not arrive for approximately sixty (60) days from the date of retirement.

If you and/or your covered dependent turn 65, subsequent to your retirement, there will be a change in your premium. If a plan election is required, you will receive information from us approximately (3) months prior to your/or your spouse's 65th birthday. If no election is required we will send you a new billing calendar prior to the month your premium changes.

Insurance payment options

Most retirees elect to have their premiums withheld from their monthly pension checks issued by the Florida Retirement System (FRS). To have your insurance premiums deducted from your FRS check, you must complete a Payroll Authorization Form and remit with your application or with your first premium payment to the Benefits Administration Unit. Deductions begin about 60 days thereafter. You are responsible to send your payments to the Benefits Administration Unit until pension deductions begin. The insurance deduction will be reflected on your FRS check stub.

You may also elect to pay your premium by check or money order. Payments are due in our office on the first day of each month. Accounts are subject to cancellation if the premium payment is not received by the 30th day of the month for which payment is due. Make checks payable to Board of County Commissioners and indicate your Social Security Number on all checks.

Health Insurance Subsidy (HIS) eligibility

The Health Insurance Subsidy Program is an additional benefit available to eligible FRS retirees to help cover some of the cost of maintaining health insurance coverage (the subsidy is provided by the **state of Florida**, not by Miami-Dade County). Eligible retirees receive \$5.00 per month for each year of service credit earned at retirement. The subsidy is at least \$30 per month and no more than one-hundred fifty dollars (\$150) per month. It is intended to help offset the cost of your health insurance coverage. You may contact the Division of Retirement at (850) 488-4742 for any Subsidy questions, or write to:

Division of Retirement

P.O. Box 9000
Tallahassee, Florida 32315-9000

Cancellation of insurance under the Retiree Group

You may cancel your medical insurance coverage at any time. The insurance company or the County will not cancel your coverage unless:

- premiums are not paid on a timely basis

- coverage under the Master Contract is cancelled
- you move out of the service area
- you are enrolled under an HMO and become eligible for Medicare
- your covered dependent children reach the contract limiting age

You may only cancel your dental coverage:

- if you elect cancellation at the end of a calendar year; or
- you enroll under an HMO Medicare Plan; or
- you cancel your entire coverage with the Retiree Group

Adding spouse to retiree health insurance plan

You need to apply to add your spouse to your medical/dental insurance plans within 30 days following the date of marriage or the date your spouse loses his/her insurance coverage. You need to send us a written request and a marriage certificate, when applicable.

Health insurance plan after retiree's death

If you die, dependents covered under your retiree medical and/or dental insurance, may continue their coverage, as long as timely premium payments are received. Your spouse/DP can continue indefinitely and your dependent children until the limiting age. This applies to the AvMed and the dental plans.

Canceling insurance after becoming eligible for Medicare

If you cancel your medical coverage upon becoming eligible for Medicare, dependents covered under your retiree medical and/or dental insurance may continue, as long as timely premium payments are received. All cancellations are irrevocable; once cancelled, coverage will not be reinstated. This applies to the AvMed plan as well as the dental plans. However, your dependent(s) may not continue dental coverage if you do not elect to continue dental coverage yourself.

Retiree Forms and Information

Election/Enrollment Forms

- [Retiree Group Life Beneficiary Designation Form](#) 
- [2017 Retiree Election Form – Under 65](#) 
- [2017 Retiree Election Form – Over 65](#) 
- [FRS Insurance Payroll Deduction Authorization Form](#) 

Claim forms

- [AvMed MDC/JHS Claim Reimbursement form](#) 
- [MetLife Dental Expense Claim form](#) 
- [Insurance Cancellation Request Form](#) 

Deferred Compensation

- [NRS form](#) 
- [ICMA-RC form](#) 
- [Pension Plan Pretax Direct Rollover form](#) 
- [Catch Up](#) 

Retiree Handbooks

- [2017 Retiree Handbook - Under Age 65](#) 
- [2017 Retiree Handbook - Over Age 65](#) 