BAY HARBOR ISLANDS



EMPLOYEE BENEFITS GUIDE

PLAN YEAR | 2024-2025

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

Brown & Brown

WELCOME TO YOUR 2024 BENEFITS!

Town of Bay Harbor Islands offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

This enrollment booklet has been designed to provide you with the knowledge you need to make the best possible benefit decisions. If after reviewing the enclosed information you have any questions, please contact Human Resources.

BENEFIT PLANS

EFFECTIVE OCTOBER 1, 2024

Information provided in this booklet is intended to serve as a convenient reference guide. If any information contained in this booklet differs from any plan documentation, please refer to plan documentation.

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

TABLE OF CONTENTS

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors.
For general information contact Human Resources.

COMPANY	PLAN	CONTACT INFORMATION
BAY HARBOR ISLANDS	Human Resources	Shaun Sharon Gelvez Director of Human Resources 305-607-1327 sgelvez@bayharborislands-fl.gov
BB	Benefits Consulting Team	Michelle Kent | EB Service Leader 954-331-1469 michelle.kent@bbrown.com Analisa VanDelinder | Sr. Claims Specialist 954-331-1361 analisa.vandelinder@bbrown.com Rich Ducharme | EB Practice Leader 954-331-1415 rich.ducharme@bbrown.com
Florida Blue	Medical	Customer Service 1-800-352-2583 floridablue.com
Florida Blue	Dental	Customer Service 1-877-325-3979 floridabluedental.com
United Healthcare	Vision	Customer Service 1-800-839-3242 myuhcvision.com
MetLife	Basic Life Voluntary Life & AD&D	Customer Service 1-800-638-6420 online.metlife.com
MetLife	Short & Long Term Disability	Customer Service 1-800-300-4296 online.metlife.com
Colonial Life Making benefits count.	Supplemental Insurance	Matthew Leggett 954-616-5123 matthewl@colonialfl.com | coloniallife.com
Aflac	Supplemental Benefits	Tracy Reeves | Agent 954.270.7543 tracyl_reeves@us.aflac.com | aflac.com
spot pet insurance	Pet Insurance	Customer Service 1-800-905-1595 spotpet.link/bayharbor
masa	MASA	Customer Service 1-800-643-9023 masaaccess.com

ENROLLMENT

Town of Bay Harbor Islands is pleased to have the opportunity to offer you a wide variety of benefits to choose from to fit your personal/family needs.

Please take the time to review all sections of this enrollment booklet carefully. If after reviewing the enclosed information you have questions on any of the items enclosed, please feel free to contact Human Resources.

CAFETERIA PLAN

Town of Bay Harbor Islands currently offers a Cafeteria Plan which provides a valuable tax benefit to both the Company and it's employees.

A cafeteria plan is a benefit plan authorized by Section 125 of the Internal Revenue Code, which allows employees to elect benefits on a pre-tax basis. Elections are made once per year and are irrevocable for that plan year (October 1, through September 30) unless a Family Status Change occurs. A Family Status Change allows employees to add, change or drop coverage during the plan year due to the following reasons listed below (this list is not all inclusive):

- Marriage or Divorce
- Death of a spouse or dependent child of the participant
- Birth or Adoption of a child
- Switching from Full-time to Part-time, vice versa
- Medicare eligibility

Not all Family Status Change events will allow the same election change for each benefit offered. Employees will have 30 days from the change in family status to make changes to the current plans.

ELIGIBILITY

WHO'S ELIGIBLE
All active, full-time employees who work 30 hours or more in one work week – part time, per diem, temporary & seasonal employees excluded.

COBRA eligible individuals are eligible to enroll in the medical, dental and vision plans as applicable. If terminated during the Plan Year you will be eligible to continue that participation through COBRA continuation.

When you enroll, you can also cover your eligible dependents.

WHO CAN BE COVERED?
Eligible dependents include:
- Legal spouse/Domestic Partner (Same and Opposite Sex Covered)*
- Your natural child(ren), legally adopted children or stepchildren.**

Age limits vary as follows:
FL STATUTES FOR MEDICAL – up to age 30 under the guidelines of the State of Florida (FSS 627.6562)
DENTAL AND VISION IS - up to Age 30

**Declaration of Domestic Partnership Registration is required. Please see the Miamidade.gov or Broward.gov website for more information for the county in which you reside.*
***You will be required to show birth certificate if children have a different last name, legal documentation for either the adoption of a child or the court order to cover step children.*

WAITING PERIOD
Newly hired employees must satisfy a waiting period before they are eligible for benefits. Your benefits will become effective the first of the month following start of employment.

BENEFITS END
Last day of the month following termination.

MEDICAL INSURANCE

Town of Bay Harbor Islands is pleased to announce that **effective October 1, 2024** our medical coverage will be with **Florida Blue**.

To search for In-Network Providers, go to **floridablue.com**

Florida Blue	BLUECARE PREDICTIBLE COST 55 HMO
SERVICES	**IN-NETWORK ONLY**
Calendar Year Deductible (CYD) Individual / Family	None
Coinsurance	N/A
Provider Services	**Open Access**
Primary Care Office Visit	VCP* $0 / PCP $10
Specialist Office Visit	$10
Adult Wellness (Includes Preventive Lab)	$0
Hospital Services Inpatient Hospital Fee	$250 per admission
Inpatient Physician Services	$0
Outpatient Hospital Fee	$150
Outpatient Physician Services	$0
Emergency Room (waived if admitted)	$100 per visit
Ambulatory Surgery Center Fee	$100
ASC Physician Services	$10
Minor Diagnostic Lab / X-Ray	VCS** $10 / Independent Clinical Lab: $0 / Independent Diagnostic Testing Center: $10
Major Diagnostic (MRI,CAT, NM, PET)	Physician Office: $75 / Independent Diagnostic Testing Center: $50
Urgent Care	VCP*: $0 - Visits 1-2, $10 remaining visits / Network: $10 Copay per visit
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	N/A $2,500 / $7,500
Lifetime Maximum	Unlimited
Prescription Drugs (30 day supply) Tier 1 / Tier 2 / Tier 3 / Tier 4	$10 / $50 / $80 / 20%
Mail Order (90 Day Supply)	$25 / $125 / $200 / NC

For more detailed information regarding the medical benefits, refer to the summary of benefits.

**VCP: Value Choice Provider - for more info please see page 9*
***VCS: Value Choice Specialist*

MEDICAL INSURANCE

Town of Bay Harbor Islands is pleased to announce that **effective October 1, 2024** our medical coverage will be with **Florida Blue**.

To search for In-Network Providers, go to **floridablue.com**

Florida Blue	BLUEOPTIONS 03559 PREDICTIBLE COST PPO	
SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (CYD) Individual / Family	$500 / $1,500	$750 / $2,250
Coinsurance	80% / 20%	60% / 40%
Provider Services	**Open Access**	**Open Access**
Primary Care Office Visit	VCP* $0 / PCP $20	40% After CYD
Specialist Office Visit	VCS** $20 / Spec. $40	40% After CYD
Adult Wellness (Includes Preventive Lab)	$0	40% After CYD
Hospital Services Inpatient Hospital Fee	$600	40% After CYD
Inpatient Physician Services	20% After CYD	20% After INN CYD
Outpatient Hospital Fee	$200 per visit	40% After CYD
Outpatient Physician Services	20% After CYD	20% After INN CYD
Emergency Room (waived if admitted)	Facility $100 per visit / Physician 20% Aft Ded	
Ambulatory Surgery Center	$100 per visit	40% After CYD
ASC Physician Services	20% After CYD	40% After CYD
Minor Diagnostic Lab / X-Ray	VCS** $20 / Independent Clinical Lab: $0 / Indepent. Diagnostic Testing Center: $50	40% After CYD
Major Diagnostic (MRI,CAT, NM, PET)	$150	40% After CYD
Urgent Care	VCP*: $0 - Visits 1-2, $45 per remaining visits / Network: $45 Copay per visit	CYD + $45 per visit
Annual Out-of-Pocket Maximum Includes Deductible Individual / Family	Yes $2,500 / $5,000	Yes $5,000 / $10,000
Lifetime Maximum	Unlimited	Unlimited
Prescription Drugs (30 day supply) Tier 1 / Tier 2 / Tier 3	$10 / $50 / $80 / 20%	50%
Mail Order (90 Day Supply)	$25 / $125 / $200 / NC	N/A

For more detailed information regarding the medical benefits, refer to the summary of benefits.

**VCP: Value Choice Provider - for more info please see page 9*
***VCS: Value Choice Specialist*

Florida Blue

Value-Based Doctors

Helping you stay healthy, save time and spend less.

Value-based doctors put a special focus on helping you stay well. If you have a health condition, you can count on your doctor to make it simpler to get care and stay on a healthy track. This helps you save time, spend less and live your healthiest.

Why choose a value-based doctor?

A value-based doctor will help be sure you get the care you need to get and stay healthy. When you're sick, you'll have a team to manage and guide your care. This can mean fewer unnecessary tests and services, lower costs and better care.

Choose a value-based doctor and expect more:

- ✓ A personal doctor who'll have a relationship with you and your family.
- ✓ Primary care to help prevent more serious medical conditions later in life.
- ✓ A team that works with your other doctors to help ensure that you get the right care, at the right time.
- ✓ An ongoing wellness plan to guide your health care journey.
- ✓ Same day appointments, after-hours care and electronic communications.

Find a value-based doctor near you!

Here's how:

1. Log in to **floridablue.com**.
2. Click on *Tools* then *Find a Doctor & More*.
3. Choose *Primary Care* from *Provider Type*.
4. Choose *Accepting New (All) Patients* from *Accepting New Patients*.
5. By *Programs*, select one of the following from the drop-down menu: *Patient-Centered Medical Home* or *Accountable Care Program*.
6. Click *Search Now*.

Find a value-based doctor outside of Florida!

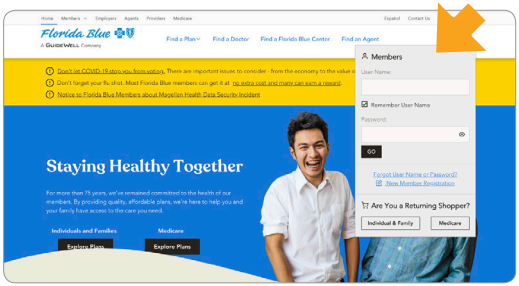
Here's how:

1. Log in to **bcbs.com/find-a-doctor** or call **800-810-2583**.
2. Click on *In the United States*
3. Enter your location and plan
4. Under *Advanced Search* choose *Blue Distinction Total Care* and *Blue Distinction Total Care+*.
5. Click *Search*

Log in. It's so easy!
Register at **floridablue.com**

Florida Blue
Your local Blue Cross Blue Shield

We are here to help you get the most out of your benefits. Log in. It's so easy! Register at **floridablue.com.** With your personalized member account—ID cards, benefits, doctors, cost-saving tools and more—are all at your fingertips! Simply log in at **floridablue.com** or the Florida Blue mobile app.



To register:

Click **Log in**, then **New Member Registration**.

If you have trouble logging in, call 800-352-2583 for help.

New Member Registration Steps

To get started, click on **Manage my plan**.

Step 1: Fill in your personal information and click **Continue**.

Step 2: Enter your email address and click **Continue**. Check your email for a confirmation code.

Step 3: Once you have the confirmation code from your email, enter the code and click **Continue**.

Step 4: Choose a **User Name** and **Password**. The **Password** must be typed in twice for security purposes. If you'd like to receive communications electronically, click the **Yes** box and then click **Continue**.

Step 5: Create three different security questions and type an answer below each. Click **Continue**.

Note: *The security questions will be used if you forget your* ***User Name*** *or* ***Password****.*

Step 6: Success! Click **Go** to log in to your account and start exploring.

Florida Blue

In the pursuit of health®

Download the Florida Blue Mobile App *today!*

Save Time. Save Money. Stay Healthy.

- Check plan benefits and see the status of your claims
- Find the nearest in-network doctor, Urgent Care Center or pharmacy
- Compare medical costs
- View your member ID card

As Easy as 1, 2, 3…

1. **Download the app –** available through the Apple App Store or Google Play
2. **Get Registered –** log in using your Florida Blue member account User ID and Password
3. **Get Started –** anytime, anywhere with Touch ID*

Stay informed and in control ***24 hours a day, 7 days a week!***

GET IT ON Google Play Download on the App Store

*If available on your mobile device.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an HMO affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

Take charge of your health

Florida Blue | Sanitas Medical Center
Network Provider

Finding the right doctor can help you get and stay healthy. As a Florida Blue member, you have access to doctors who put a special focus on helping you stay well while saving on out-of-pocket costs.

Your path to health can start today.

Sanitas Medical Center, a Value Choice Provider, offers Florida Blue members extra care—and they're in your plan's network. There, you'll get:

Primary Care for the whole family—as little as $0 for unlimited scheduled visits to your primary care doctor (PCP)*
- Annual wellness exam
- Health screenings
- Treatment for chronic conditions such as diabetes, COPD, high blood pressure and more

Specialist Care for as little as $20 per visit:**
- Cardiology
- Endocrinology
- Nutrition counseling—$0 if you have diabetes

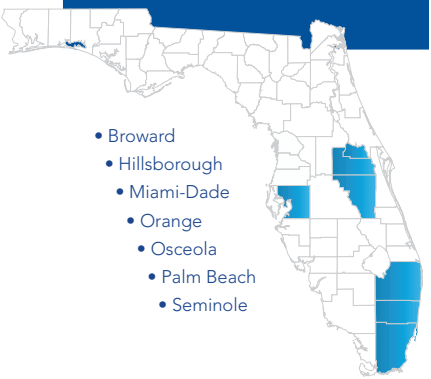
Urgent Care—as little as $0 for the first two visits
- Cold, flu and fever
- Infections and burns
- Minor sprains and breaks

Labs and Imaging
- Blood work
- Urinalysis
- X-ray, ultrasound, EKG and more

Virtual Visits
- Secure video, phone and text messaging
- Wellness visits and follow-up care
- Ideal for chronic condition management

At Sanitas Medical Center, you can
- Get all your health care services in one place
- Schedule evening and weekend appointments
- Lower costs for you to:
  - See your PCP
  - Visit a specialist
  - Go to urgent care
- Request a Spanish-speaking doctor

With Sanitas in **Tampa, South Florida** and **Central Florida,** there's sure to be an office near you. Search for Sanitas when you:
- Log in to **floridablue.com**
- Click *Find Care* in the Florida Blue mobile app.



*Applies to scheduled visits to member's primary care doctor. $0 primary care and urgent care visits and reduced cost specialist visits do not apply to Health Savings Account (HSA) plans; the deductible will still apply. Only first two (2) urgent care visits for non-HSA plans are $0, after that urgent care cost share applies.

Specialist locations and specialties subject to change. Visit **mysanitas.com/fl for the latest information.

Sanitas is an independent medical center, serving people insured by Florida Blue (or other Blue Cross Blue Shield plans), original Medicare or self-paying for medical treatment.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate. You may access the Nondiscrimination and Accessibility Notice at floridablue.com/ndnotice.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

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BetterYou STRIDES

Earn rewards for taking care of your health!

Better You Strides Rewards is a personalized wellness and rewards program to help you on your health journey. Now, you and family members ages 18 or older on your plan can each **earn up to $100** in rewards.

How to earn points

Each healthy activity has a point value. Every 100 points you earn equals $1 in rewards. Your health journey is unique to you. Here are some examples of activities you may be able to complete to earn points:

- Get your yearly flu shot.
- Complete your online health assessment.
- Complete your annual wellness exam.
- Get your mammogram.
- Get your COVID vaccine.
- Get your colonoscopy.
- Complete a personal challenge.
- And more!

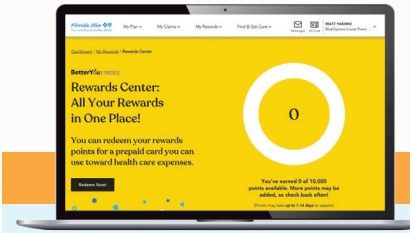
Redeem points for rewards

When you redeem your points, we'll mail you a prepaid card you can use for doctor visits, dental care, prescriptions, vision care (including screenings, eyeglasses, and contacts), chiropractic care, and more. As you earn rewards throughout the year, they can be added to your card. Just go to the Rewards Center in your Florida Blue member account to redeem your points in a few clicks!

Ready to get started?

Click here or if you haven't already joined the rewards program, follow these steps:

1. Log in to your member account at **FloridaBlue.com**. If you don't have a member account, you'll need your member ID number to create one. Family members 18 and older on your plan must create their own member account to join the rewards program.
2. At the top of your home page, click **My Rewards**.
3. In the dropdown menu, click **Rewards Center** to join the rewards program.
4. After activation, visit the **My Rewards** menu and click **My Healthy Activities**. You'll find a list of all the activities you can complete to earn rewards.



Questions?

If you have questions about Better You Strides Rewards, call the number on the back of your member ID card. We'll be glad to help you get the most from this personalized program.

Florida Blue
Your local Blue Cross Blue Shield

EMERGENCY ROOM | URGENT CARE

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and it may cost hundreds, if not thousands, of dollars. In fact, Harvard University reported that 62% of personal bankruptcies are caused by medical expenses, making medical debt the leading cause of bankruptcy in America.

If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for your condition?

VS

The Emergency Room (ER) is equipped to handle life-threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.

You should go to the nearest Emergency Room if you experience any of the following:

- Compound fractures
- Deep knife or gun shot wound
- Moderate to severe burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries
- Severe abdominal pain
- Severe chest pain or difficulty breathing
- Signs of a heart attack or stroke
- Suicidal or homicidal feelings
- Uncontrollable bleeding

Urgent Care Centers (UCC) are not equipped to handle life-threatening injuries or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.

Some examples of conditions that require a visit to an Urgent Care Center include:

- Control bleeding or cuts that require stitches
- Diagnostic services (X-rays, lab tests)
- Ear infections
- High fever or the flu
- Minor broken bones (e.g., toes, fingers)
- Severe sore throat or cough
- Sprains or strains
- Skin rashes and infections
- Urinary tract infections
- Vomiting, diarrhea or dehydration

Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses. Although Urgent Care Centers are usually more cost-effective, they are not a substitute for emergency care.

PHARMACY DISCOUNT INFORMATION

Walmart Pharmacy

Visit walmart.com/pharmacy

Your Medical ID Card is not required for the low prices on meds.

$4.00 30 Day Supply / $10.00 90 Day Supply - Generic Only

Since Prescription prices are not regulated, the cost of a prescription may differ by more than $100 between pharmacies. GoodRx is the #1 medical app for iOS and Android. Get prescription drug prices on-the-go, with coupons built into the app.

- Type your drug name (like Lipitor, Gabapentin, etc.)
- Set your location
- Compare prices, print coupons, save up to 80%

GoodRx

ANDROID APP ON Google play

Download on the App Store

www.goodrx.com

AHF PHARMACY™

Visit ahfpharmacy.org

AHF Pharmacy Services – Specializing in Medications to treat HIV/AIDS

The information contained in this flyer is subject to change without notice.
Please contact the above pharmacies for the most updated information.

DENTAL INSURANCE

Town of Bay Harbor Islands is pleased to announce that **effective October 1, 2024** we will move our dental coverage with **Florida Blue**.

To search for In-Network Providers, go to **floridablue.com**

Florida Blue	BLUEDENTAL CARE	BLUEDENTAL CHOICE PLUS	
BENEFITS	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible (Family Max)	N/A	$50 / $150	$50 / $150
Deductible Waived – (Class I)	N/A	Yes	Yes
Benefit Description Preventive (Class I) Basic (Class II) Major (Class III)	 N/A N/A N/A	 100% 100% 60%	 100% 100% 60%
Maximum Annual Benefit	Unlimited	$3,000	$3,000
Orthodontic Treatment	$2,435 Child / Adult	$1,000 Child & Adult	
BENEFITS BASED ON	**Contracted Rates**	**Fee Schedule**	**80th Percentile**
Routine Exams - 0120	No Charge	100%	100%
Teeth Cleaning - 1110	No Charge	100%	100%
Full Mouth/Panoramic X-rays - 0330	No Charge	100%	100%
Simple Extractions - 7140	$45	100%	100% limited to 1X per tooth per lifetime
Resin composite restorations - 2331	$0	100%	100%
Root Canal (Endodontics) - 3330	$210	100%	100%
Perio. Scaling/Root Planning - 4341	$50 per quad	100%	100%
Full or Partial Dentures - 5110	$325 + Lab	60%	60%
Crowns - 2740	$245 + Lab	60%	60%
Implants	50% up to annual max of $1,500 and a $10,000 lifetime max benefit	60%	60%

For more detailed information regarding the dental benefits refer to the certificate of coverage.

VISION INSURANCE

Town of Bay Harbor Islands is pleased to announce that **effective October 1, 2024** we will continue our vision coverage with **United Healthcare**.
To search for In-Network Providers, go to **myuhcvision.com,** and click on “Find a vision provider”.

United Healthcare	IN-NETWORK	OUT-OF-NETWORK
BENEFITS		
Eye Exam	$10 Copay	Reimbursement up to $40
Single Lens	$25 Copay	Reimbursement up to $40
Bifocal Lens	$25 Copay	Reimbursement up to $60
Trifocal Lens	$25 Copay	Reimbursement up to $80
Selected Frames	$130 allowance + 30% discount over	up to $45
Contact Lenses: Contact Lenses Exam & Fitting	$40 Copay	Up to $40
Elective Contacts	$125 allowance	Up to $100
FREQUENCY		
Eye Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 12 Months	

For more detailed information regarding vision benefits refer to the summary of benefits.

BASIC LIFE & ACCIDENT DEATH & DISMEMBERMENT (AD&D) INSURANCE

Town of Bay Harbor Islands will continue to provide Life and AD&D insurance provided at **NO COST** to all active full-time employees working 30 hours or more per week. **Effective October 1, 2024** this coverage will be provided through **MetLife.**

- The life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan.
- The Accidental Death & Dismemberment benefit will be paid in the event of loss of life or limb by accident while covered under the plan.
- You are not eligible to receive benefits if you are receiving worker's compensation benefits.

MetLife	BASIC LIFE & AD&D INSURANCE
Benefit	All Eligible Active Employees
Life Benefit	1 x earnings to a maximum of $350,000, minimum of $50,000
AD&D Benefit	1 x earnings to a maximum of $350,000, minimum of $50,000
Guarantee issue	$350,000 Employees & $10,000 Retirees
Reduction Formula: At Age 70	50% Reduction

Refer to Certificate of Coverage to review all limitations and exclusions.

VOLUNTARY LIFE & AD&D INSURANCE

Town of Bay Harbor Islands is pleased to offer voluntary life insurance within its benefits program. This plan is offered through the convenience of payroll deductions and it is designed to supplement your personal insurance needs. This coverage will be provided through **MetLife.**

MetLife	VOLUNTARY LIFE & AD&D INSURANCE
Benefit Class I	All Eligible Active Employees
Employee Benefit	increments of $10,000 up to $500,000 not to exceed 5x annual earnings
Spouse	increments of $5,000 up to a maximum of $100,000 not to exceed 50% of the employee's amount
Children	15 days to 6 months $100. 6 months to 19 (26 if full time student) increments of $1,000 up to $10,000
Guarantee Issue Amount	Employee $150,000, Spouse $25,000 and Child $10,000

Refer to Certificate of Coverage to review all limitations and exclusions.

Rates per $1000	Employee	Spouse (rates based on EE's age)
Under 25	$0.072	$0.072
25-29	$0.072	$0.072
30-34	$0.096	$0.096
35-39	$0.108	$0.108
40-44	$0.146	$0.146
45-49	$0.224	$0.224
50-54	$0.360	$0.360
55-59	$0.553	$0.553
60-64	$0.823	$0.823
65-69	$1.524	$1.524
70-74	$2.472	$2.472
75-79	$2.472	$2.472
80-84	$2.472	$2.472
AD&D	$0.021 Employee & Spouse $.051 Child	
Child	$0.24 per $1,000	

DISABILITY INSURANCE

Town of Bay Harbor Islands is pleased to announce that our Disability Insurance will be provided through **MetLife effective October 1, 2024**.

Disability Insurance is intended to protect your income in case you become ill or injured. Short term disability provides a weekly benefit for non-occupational short-term illness or injury. Long term disability provides a monthly benefit for long-term illness or injury.

MetLife	SHORT TERM DISABILITY
Eligibility	All Eligible Active Employees
STD Benefit	60%
Maximum Weekly Benefit	$1,250
Benefit Duration	11 Weeks
Elimination Period (days) Accident Illness	 14 Days 14 Days

MetLife	LONG TERM DISABILITY	
Eligibility	All Eligible Active Employees	
LTD Benefit	**Public Safety Members**	**All Other Active Members**
Maximum Monthly Benefit	$8,000	$6,000
Benefit %	66.667%	
Elimination Period	90 Days	
Maximum Benefit Period	Social Security Normal Retirement Age	
Pre-existing Condition Limitation	3/12	

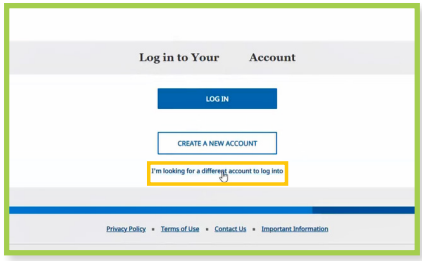
MyBenefits Registration

Pre-Registration

Upon navigation to either online.metlife.com/benefits or mybenefits.metlife.com, you'll see the following screen:

Enter the name of your employer or association into the field in the upper-right corner. A drop-down menu of organizations may appear with options to choose from (if more than one match is found).

You'll be taken to a screen that asks you to select whether you would like to login with an existing username or create a new account. The interface will vary based on your employer.

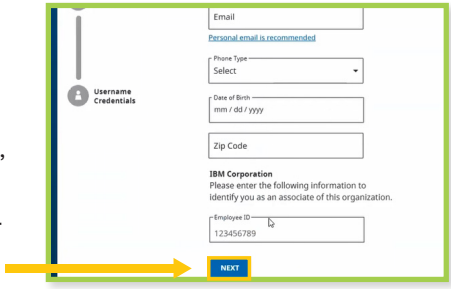


Regardless of the interface, select **"Create a New Account"** or **"Register Now."**
If you believe you have selected the wrong employer interface, click on the link that reads **"I'm looking for a different account to log into"** or **"Looking for a different employer or association?"** This link will take you to a webpage where you can register as a common user.

Registration

From here, you'll be taken to Step 1 of the registration process.

1. Enter your first name, last name, email address
2. Select the type of phone number you have (mobile or landline) and the enter your phone number
3. Enter your social security number, date of birth, and zip code
4. After entering all of this information, you may be prompted to enter information specific to your employer, depending on how your organization has set up its registration process. For example, you may be asked to enter your employee ID. Upon entering the information, click **"Next"**.



MetLife

Navigating Life Together

Registration Continued

If your identifying information does not match publicly available information about your identity, you may be prevented from creating an account.

Next, you'll be asked to verify your identity via a **verification code** on the screen below. Select whether you'd like to receive the code via text message or voice message, and sometimes an email if that information is already available to MetLife.

You'll be taken to the screen below. Retrieve the code, then enter it in the text field. The code will expire after 15 minutes, in which case you will need to generate another code. Click **"Next"**.

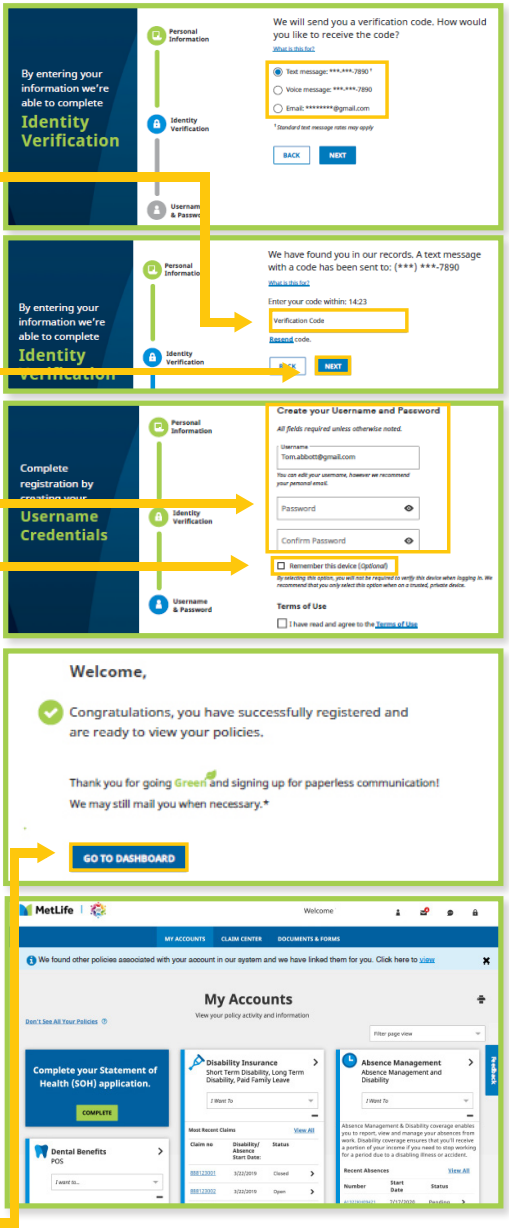
1. Your email address will be a suggested username in the first text field. We recommend using this as your username, but you may change it.
2. Enter and confirm your desired password in the next two text fields.

Your password must:

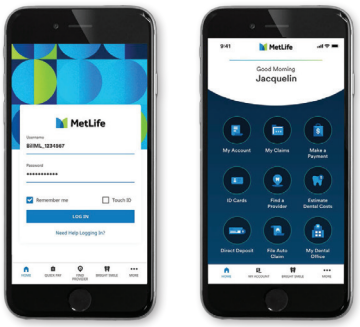
- Contain 8-20 characters
- Contain a lowercase letter
- Contain an uppercase letter
- Contain a number
- Not contain special characters other than a hyphen or underscore

3. If you'd like MetLife to remember your device, so that you don't have to verify your identity every time you login to your online account, select the **"Remember this Device"** checkbox. Your device will be remembered for a maximum of six months.
4. Choose whether you'd like to receive paperless documents by selecting one of the radio buttons at the bottom of the page. You may view the eConsent Policy by clicking on the relevant links.
5. Click **"Submit"**. Upon successful submission, you will receive a congratulatory confirmation message.

Finally, select **"Go To Dashboard"** and you will be taken to your Dashboard.



Introducing our updated mobile app



MetLife Auto & Home® has made it easier for you to access your policies with our **updated mobile app**. Whether you're looking for your auto ID cards on the go or would like to make a premium payment from your phone, it's simpler than ever. New and updated features include:

Easy ID card access
Access your auto insurance ID cards on your mobile device and request permanent ID cards be sent to you by mail.*

Coverage details at your fingertips
Viewing coverage details for your auto, home, and PELP policies is even easier.

Expanded payment information
In addition to paying bills, also review payment and billing details easily, including your payment history.

Submit an auto claim
Auto insurance customers, including GrandProtect® and Combo℠ customers, can submit a claim, prefill the accident location, date, and time if filing a claim from the accident scene, and upload accident scene and vehicle damage photos.

If you already have our app on your mobile device, please make sure it is up to date to access all of the new features. Not a user of the mobile app yet? Download it from the Apple Store® or Google Play℠ store today.

For more policy, billing, and claim information, please log in to MetLife's Online Service Center at online.metlife.com.

* This feature is not available for GrandProtect® policy packages.

MetLife Auto & Home | 700 Quaker Lane | Warwick, RI 02886

MetLife

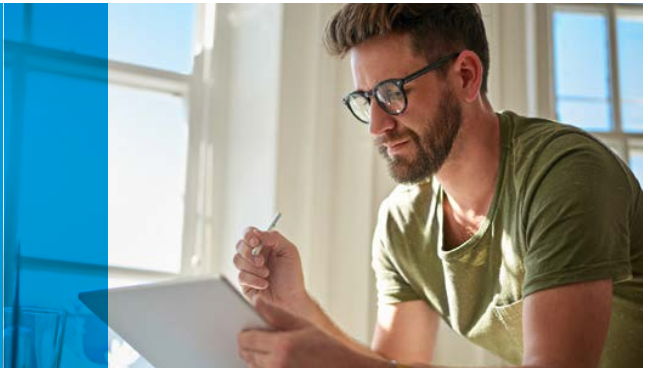
EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employee Assistance Program

Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.



Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "TELUS Health" on iTunes App Store or Google Play. Log in with the user name: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

The program's experienced counselors provided through TELUS Health — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to 5 in person, phone or video consultations with licensed counselors for you and your eligible household members per year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to one.telushealth.com, user name: metlifeeap and password: eap

MetLife

Navigating life together

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Answers to important questions

Are Employee Assistance Program services confidential?
Yes. Any personal information provided to TELUS Health stays completely confidential.*

How do I get help?
Getting professional help is just a phone call away. Simply call 1-888-319-7819 to speak with a counselor or to schedule an in person, phone, or video conference appointment. These services are available 24 hours a day, 7 days a week.

When is the right time to call?
That's up to you. Counselors are here whenever you need them —whether you simply need to talk or want guidance on something you are going through.

Is my Employee Assistance Program included with my MetLife coverage?
Yes. There is no cost to you because your employer pays for the services provided within our program. While we offer a broad range of services, there may be some assistance that's not included. You can still work with counselors for these services by arranging to pay for them directly.

Does the program have any limitations?
While we offer a broad range of services, we may not cover all services you may need. Your Employee Assistance Program does not provide:

- Inpatient or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment or services for intellectual disability or autism
- Counseling services beyond the number of sessions covered or requiring longer term intervention
- Services by counselors who are not TELUS Health providers
- Counseling required by law or a court, or paid for by Workers' Compensation

Does the program offer Cognitive Behavioral Therapy (CBT)?
Many TELUS Health EAP providers are trained in this type of counseling and the foundation of TELUS Health' CareNow digital programs, available through the programs website and mobile app, are built upon Cognitive Behavioral Therapy (CBT) techniques. CareNow provides instant access to a range of self-service programs developed by world leading experts, focused on behavior change in the areas of anxiety, stress, depression, and more.

When you need some support, we're here to help.

Phone
1-888-319-7819

Web
one.telushealth.com
user name: metlifeeap
and password: eap

Mobile App
user name: metlifeeap
and password: eap

*MetLife and TELUS Health abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.

Some restrictions may apply to all of the above-mentioned services. Please contact your employer or MetLife for details. EAP services provided through an agreement with TELUS Health. TELUS Health is not a subsidiary or affiliate of MetLife. Information disclosed directly to TELUS Health is not disclosed to MetLife, and therefore not subject to MetLife's privacy policy.

Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Ask your MetLife group representative for costs and complete details

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 1016
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COLONIAL WORKSITE INSURANCE

Colonial Life is offering **Town of Bay Harbor Island** employees the opportunity to purchase supplemental coverage. Through **Colonial Life**, you will have the option of getting more coverage should you or your immediate family become ill. Benefits are paid regardless of other coverage. This benefit is voluntary and it is paid for entirely by employee payroll deductions, and the company does not contribute towards the premium for these plans.

DISABILITY INSURANCE

This plan replaces a portion of your income if you become disabled because of a covered accident or a covered sickness.

CRITICAL ILLNESS INSURANCE

- Cancer
- Heart Attack
- Stroke
- Kidney Failure
- Hospital Confinement
- Major Organ Transplant among others.

Colonial Life℠
Making benefits count.

ACCIDENT INSURANCE

Supplemental accident insurance policy is a medical indemnity plan that provides employees and their families with hospital, physician, accidental death and catastrophic accidental benefits in the event of a covered accident.

GROUP HOSPITAL INSURANCE - Colonial Life's Hospital Insurance helps with medical costs associated with a hospital stay that your health insurance may not cover.

GROUP TERM LIFE INSURANCE - Colonial Life's Term Life insurance can help provide financial security for your family.

Employee only and Family coverage is available.

These are your own policies. If you leave the company or retire, you can take the policy with you and pay the same premium. **Colonial Life** will bill you directly.

AFLAC SUPPLEMENTAL INSURANCE

See how Aflac can help improve your benefits package

Health insurance wasn't designed to cover everything. That's why there's Aflac. Aflac pays you cash directly to you, unless assigned otherwise. You can use your benefits your way- whether it's to help with medical bills or any other expense that affects your financial security.

Supplemental insurance plans

Accident Insurance
Individual accident insurance can help with unexpected expenses associated with an accidental injury, so you can focus on getting better.

Cancer/Specified-Disease Insurance
Aflac cancer/specified-disease policy provides robust benefits so you can seek the treatment you need while easing the financial concerns that often accompany it– before, during and after diagnosis.

Hospital Confinement Indemnity Insurance
Health insurance isn't meant to cover all expenses associated with hospitalization – like deductibles and copays. Aflac hospital insurance can help minimize those out-of-pocket costs so you can focus on recovery.

Critical Illness (Specified Health Event) Insurance
An Aflac specified health event policy is designed to help with the costs of treatment if you experience a covered health event.

Supplemental Dental Insurance
Help keep a bright, healthy smile with Aflac's dental policy. Our policy provides benefits for dental care, paid directly to you (unless otherwise assigned).

Short-Term Disability Insurance
What if you couldn't work due to injury or illness? Aflac Short-Term Disability insurance helps replace some of your income and keeps working when you can't.

Contact your Aflac benefits advisor to learn more about our products and services.

Tracy Reeves
954.270.7543
TLRRose@aol.com / tracyl_reeves@us.aflac.com

Aflac®

PET INSURANCE

spot pet insurance

America's Favorite Pet Insurance!

Get Peace Of Mind Today With Our Pet Coverage

Accidents

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

Illnesses

Spot plans cover exams for qualified illnesses and related treatment, including things like surgeries & medications.

Wellness

Spot's **optional** Preventive Care plans focus on routine care and regular check-ups to help ensure their routine wellbeing.

We Take Care of Our Pack

- Vet Exam Fees
- Behavioral Issues
- Dental Illnesses
- Surgery
- Microchip Implantation
- Unexpected Emergencies
- Hereditary Conditions
- Prescription Medications
- Diagnostics
- X-rays & Tests
- Cancer & Growths
- And Much More...

Unleash More with Spot

Spot Perks

Special discounts on pet products and services from your favorite brands.

24/7 Pet Telehealth Line

Get unlimited 24/7 virtual pet care from vet experts for your pet.

Flexible Plans For Any Budget

Customize your annual limit, deductible and reimbursement rate to make your pet and wallet happy.

Simple & Easy Claims Process

1. Visit Any Vet in the U.S or Canada
2. Submit Your Claim Online
3. Get Cash Back for Covered Vet Bills!

BAY HARBOR ISLANDS

Get Your Special Discount*

https://spotpet.link/bayharbor

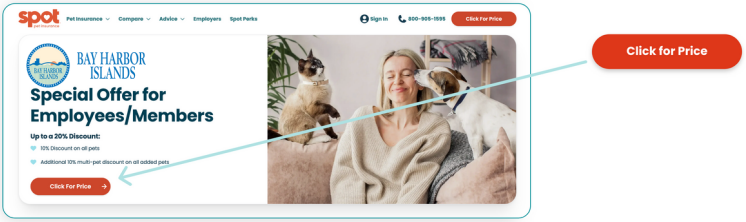
*10% employee discount available on all pets. Not available in HI or TN. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254) or United States Fire Insurance Company (NAIC #21113. Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

PET INSURANCE

Whether you're a new pet parent or exploring your options, follow this easy guide to help find the right plan for your BFF today.

1 Start the Quote Process

- Open your browser and go to your company's designated landing page: https://spotpet.link/bayharbor
- Click on the "**Click for Price**" button.



2 Enter Your Pet's and Your Own Information

- You will be prompted to enter information about your pet. This includes:
  - Pet's **name**, **age**, whether it's a **dog or cat**, **gender**, and **breed**.
- You can also "**Add Another Pet**" and receive a 10% multi-pet discount on each additional pet after the first!

- Finish off the section by entering your own basic information.
  - Your **zip code**, **email address**, **first & last name**, and **mobile number** (optional).

3 Create Your Plan

- After clicking "**Select your coverage**," you'll be presented with two different plan options (accompanied by an overview of what can be covered under each):

Accident + Illness **OR** **Accident Only**

BAY HARBOR ISLANDS

- Once you choose your plan, customize it even more by adjusting:
  - The **annual limit**
  - The **reimbursement rate**
  - The **annual deductible**

Get Your Special Discount*
https://spotpet.link/bayharbor

*10% group discount available on every pet. Not available in HI or TN.
iting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581), A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254) or United States Fire Insurance Company (NAIC #21113, Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

PET INSURANCE

How to Get a Quote & Enroll: A Step-By-Step Guide

spot pet insurance

4 Explore Preventive Coverage Plans

- For an additional fee, you'll have the option to add a wellness plan.
- You can choose between our **Gold Plan** or our more comprehensive **Platinum Plan**.

Gold
Up to $250/yr in benefits

Dental Cleaning	$100	Wellness Exam	$50
Dog DHLPP or Cat FVRCP Vaccine/ Titer	$20	Dog Heartworm or FeLV Screening	$20
Rabies and/or Dog Lyme or Cat FIP Vaccine/Titer	$20	Deworming	$20
Fecal Test	$20		

Platinum Recommended for dogs ages 3-5
More reimbursements · More benefits

Dental Cleaning or Spay/ Neuter	$150	Wellness Exam	$50
Dog DHLPP or Cat FVRCP Vaccine/Titer	$25	Dog Heartworm or FeLV Screening	$25
Rabies and/or Dog Lyme or Cat FIP Vaccine/Titer	$25	Deworming	$75
Fecal Test	$25	Flea/Heartworm Prevention	$25
Health Certificate	$25	Dog Bordetella or Cat FELV Vaccine/Titer	$25
Urinalysis	$25	Blood Test	$25

Note: Preventive care plans can help prevent future illnesses and help support your pet's overall health and longevity.

5 Review and Compare Plans

- Once you've selected and customized your plan, click "**Proceed to Checkout.**" You will see a summary of the costs and coverage details.
- Review the details carefully to ensure the plan meets your needs.

6 Choose a Payment Plan and Finalize

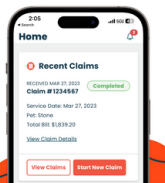
- Choose between being billed **monthly**, or **annually**.
- Provide your payment details and billing information.
- Read and accept the policy terms and conditions, and click "**Complete Purchase.**"

That's it! Following these steps should help you get a quote and enroll in a Spot Pet Insurance Plan.

Additional Tips:

- If you need further assistance, please contact our team by calling **800.905.1595**
- Get convenient access to your policy details, claim status, and more by downloading the Spot Pet Insurance app on your smartphone.

Download on the App Store · GET IT ON Google Play



BAY HARBOR ISLANDS

Get Your Special Discount*
https://spotpet.link/bayharbor

*10% group discount available on every pet. Not available in HI or TN.
Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581, A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254) or United States Fire Insurance Company (NAIC #21113, Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

MASA MEDICAL TRANSPORTATION SOLUTIONS

MASA Medical Transport Solutions™

Any Ground. Any Air. Anywhere.™

EMERGENT PLUS MEMBERSHIP BENEFITS

$14 per month

Emergent Air Transportation	In the event of a serious medical emergency, Members have access to emergency air transportation into a medical facility or between medical facilities. Please see your Member Services Agreement for the complete terms, conditions and limitations of this benefit.
Emergent Ground Transportation	In the event of a serious medical emergency, Members have access to emergency ground transportation into a medical facility or between medical facilities. Please see your Member Services Agreement for the complete terms, conditions and limitations of this benefit.
Non-Emergent Inter-Facility Transportation	In the event that a member is in stable condition in a medical facility but requires a heightened level of care that is not available at their current medical facility, Members have access to non-emergent air or ground transportation between medical facilities. Please see your Member Services Agreement for the complete terms, conditions, and limitations of this benefit.
Repatriation/ Recuperation	In the event that a Member is hospitalized more than 100-miles from their home, Members have access to air or ground medical transportation into a medical facility closer to Member's home for the purposes of recuperation. Please see your Member Services Agreement for the complete terms, conditions and limitations of this benefit.

Did You Know?

16-Million people are sent to the emergency room through a ground or air ambulance every year.*

Insurance companies typically **DO NOT** cover all air and ground ambulance expenses which can result in a bill in excess of $60,000.

Emergent Ground Ambulance transports can cost as much as

$5,000

Non-Emergent Air Medical transports can cost more than

$20,000

Emergent Air Ambulance transports often cost more than

$60,000

MASA MTS PROVIDES ULTIMATE PEACE OF MIND

Trust MASA MTS to provide you and your family peace of mind against the financial burden of medical transport bills by enrolling in a MASA MTS membership at an affordable GROUP RATE.

*SOURCE: National Hospital Ambulatory Medical Care Survey

The descriptions of the services offered by MASA are for marketing purposes only and do not represent the terms and conditions contained within each applicable Member Services Agreement. Please review the applicable Member Services Agreement for the completed terms and conditions of any service offered by MASA.

B2B_EMERGENT_PLUS_FLYER

NOTICE OF MEDICARE PART D CREDITABLE COVERAGE

FOR MEDICARE-ELIGIBLE EMPLOYEES ENROLLED IN THE FLORIDA BLUE PLANS

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

2. **Town of Bay Harbor Islands** has determined that the prescription drug coverage offered by the Florida Blue plans, are on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. **Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15th through December 7th.** However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

In addition, if you lose or decide to leave employer/union-sponsored coverage, you will be eligible to join a Part D plan at the time using an Employer Group Special Enrollment Period.

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your Town of Bay Harbor Islands coverage will not be affected. If you decide to join a Medicare drug plan and drop your employer sponsored prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop coverage or lose your group coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Note: You'll get this notice each year. You may also request a copy.

For more information about your option under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will be mailed a copy from Medicare each year. For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (or see "Medicare & You" Handbook)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	October 1, 2024
Name of Entity/Sender:	Town of Bay Harbor Islands
Contact / Position:	Shaun Sharon Gelvez | Director of Human Resources
Address:	9665 Bay Harbor Terrace, Bay Harbor Islands, FL 33154
Phone Number:	305-607-1327

HEALTHCARE REFORM

NOTICE OF HEALTH CARE REFORM CHANGES

As a reminder, the following changes to our **Town of Bay Harbor Islands** Medical Plans are still valid for the 2024 plan year.

- The lifetime benefit limit will be unlimited on essential services. There will be no annual limit on essential benefits.

Essential benefits may include:

- o Ambulatory Patient Services
- o Emergency Services
- o Hospitalization
- o Maternity and Newborn Care
- o Mental Health and Substance Abuse Disorders
- o Prescription Drugs
- o Rehabilitative and Facilitative Services and Devices (including durable medical equipment)
- o Laboratory Services
- o Prevention and Wellness Services
- o Chronic Disease Management
- o Pediatric Services, including oral and vision care

- Certain Preventive services are now covered 100% at no charge when you use **Florida Blue** network providers.

These include:

- o Routine adult physical
- o Routine Well child Exams
- o Routine Gynecological exams (includes pap and related fees)
- o Colorectal Cancer Screening
- o Routine mammograms

- Most Generic Oral Contraceptive Medications & Products for $0 cost-share. (FDA Approved Contraceptive Methods for women). Items available without a prescription are not covered under the Health Care Reform law.

- Pre-existing Condition exclusions do not apply

- Dependents are covered until age 26 – Age 30 if specific criteria are met. Dependents under age 26 may enroll within 30 days of renewal for coverage effective October 1, 2024.

- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

- Gynecological and obstetric services: Authorization or referral for gynecologic or obstetric care will not be required.

- Appeals: Covered persons will have the right to an internal appeal and external review for coverage determinations or claims.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS & YOUR HEALTH COVERAGE

Form Approved OMB No. 1210-0149 (expires 12-31-2026)

PART A: General Information

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Town of Bay Harbor Islands	4. Employer Identification Number (EIN) 59-6000273	
5. Employer address: 9665 Bay Harbor Terrace	6. Employer phone number: 305-607-1327	
7. City: Bay Harbor Islands	8. State: FL	9. ZIP code: 33154
10. Who can we contact about employee health coverage at this job? Shaun Sharon Gelvez | Director of Human Resources		
11. Phone Number (If different from above)	12. Email address: Sgelvez@bayharborislands-fl.gov	

Here is some basic information about health coverage offered by this employer:
• As your employer, we offer a health plan to:
☐ All employees. Eligible employees are:

☒ All Full-time Eligible Employees and COBRA Participants

• With respect to dependents:
☒ We do offer coverage. Eligible dependents are:

Spouse/Same-Sex Domestic Partners (Registered). Dependents of employees up to age 26; and dependents who are age 26+ under the guidelines of the State of Florida (FSS 627.6562)

☐ We do not offer coverage.

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

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer including a description of any required information or documentation.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit **https://www.medicare.gov/medicare-and-you.**

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa.** (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov.**

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH, OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than:

- ✔ 48 hours following a vaginal delivery; and
- ✔ 96 hours following a delivery by cesarean section.

A group health plan may also not require a physician or other health care provider to obtain authorization from the plan for prescribing the minimum hospital stay for the mother or newborn. However, the health plan may impose cost sharing, such as deductibles or coinsurance, on hospital stays related to childbirth.

COVERAGE REQUIREMENTS

The NMHPA sets limits on benefits that are provided for hospital stays after childbirth. However, nothing in the law or regulations requires a mother to give birth in a hospital or stay in the hospital for a specific period of time after giving birth. Also, the NMHPA does not require group health plans to provide any benefits for hospital stays related to childbirth. However, if the plan provides these benefits, it must comply with the NMHPA's minimum requirements.

HOSPITAL LENGTH OF STAY

The final regulations clarify when a hospital stay connected with childbirth begins.

• When a delivery occurs in the hospital, the stay begins at the time of delivery, not at the time of admission or beginning of labor.

• If there are multiple births, the stay begins at the time of the last delivery.
• For deliveries that occur outside of the hospital, the stay begins at the time the mother or newborn is admitted.

The decision of whether a hospital stay is connected with childbirth is a medical decision to be made by the attending provider.

ATTENDING PROVIDER DEFINITION
The regulations provide an exception to the NMHPA's general rule regarding length of hospital stay for situations where the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than 48 or 96 hours, as applicable.

The attending provider is "an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child." The final regulations definitively state that the definition of attending provider does not include a plan, hospital, managed care organization or other issuer.

PROHIBITION ON INCENTIVES
The NMHPA contains a number of prohibitions designed to prevent benefits from being improperly limited. The regulations clarify that a group health plan may not deny a mother or her newborn coverage under the plan to avoid the NMHPA's requirements or provide payments or rebates to a mother to encourage her to accept lesser benefits than those provided for by the NMHPA.

Also, a group health plan may not penalize an attending provider for giving care in accordance with the NMHPA or provide incentives to induce an attending provider to discharge a mother or newborn before the end of the required time period. However, a group health plan may negotiate with an attending provider the compensation for care provided for hospital stays related to childbirth in general.

Authorization and Cost-sharing The final regulations state that a plan may not require a physician or other health care provider to obtain authorization for prescribing a hospital stay in accordance with the NMHPA. In addition, a group health plan may not restrict benefits for a portion of a hospital length of stay provided for by the NMHPA in a way that is less favorable than benefits for a previous portion of the stay.

The regulations do not prohibit imposing cost-sharing, such as deductibles or coinsurance, on hospital stays related to childbirth. However, the cost-sharing must be consistent for the entire stay and cannot be higher for a later portion of the mandated length of stay.

NOTICE REQUIREMENTS
The notice requirements with respect to the NMHPA differ depending on the type of plan or coverage involved. The regulations explain the differences as follows:

• ERISA Plans. ERISA's rules for summary plan descriptions (SPDs) require all group health plans to describe the federal or state law requirements applicable to the plan relating to hospital lengths of stay in connection with childbirth for the mother or newborn. The DOL provided model language regarding the NMHPA in the SPD rules. See below for this model language.

• State and Local Government Plans. Plans that are subject to the NMHPA must provide a notice with specific language describing the federal requirements. The final regulations clarify that the notice can either be included in the plan document that describes benefits or in the type of document the plan generally uses to inform participants and beneficiaries of plan benefit changes. Further, any time a plan distributes one or both of these documents after providing the initial notice, the applicable statement must be included in one or both documents.

• Health Insurance Issuers in the Individual Market. Health insurance issuers in the individual market must also provide notice in the insurance contract containing specific language regarding the federal rules.

STATE INSURANCE MANDATES

The NMHPA and the final regulations do not apply to health insurance coverage (and group health plans that provide benefits only through health insurance coverage) in certain states that have adopted laws similar to the NMHPA. The final regulations clarify that a state law qualifies for this exception if it requires the health insurance coverage to do one of the following:

• Provide for at least a 48-hour hospital length of stay after childbirth (96 hours for a cesarean delivery);
• Provide for maternity and pediatric care in accordance with guidelines for care following childbirth established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics or any other established professional medical association; or
• Require, in connection with coverage for maternity care, that the hospital length of stay decision is made by the attending provider in connection with the mother or with the mother's consent.

ENFORCEMENT

There are no specific penalties for failing to comply with the NMHPA. However, plan participants or the DOL could use ERISA's enforcement scheme to compel compliance with the NMHPA's requirements. For example, a plan participant could bring a lawsuit for benefits due under the NMHPA, and could seek interest and attorneys' fees. In addition, the Internal Revenue Service (IRS) may impose an excise tax of $100 per day on a group health plan that does not comply with the NMHPA, subject to certain limitations and exceptions depending on the nature of the noncompliance.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ENROLLMENT NOTICE - WHCRA

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. The required coverage includes:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

MICHELLE'S LAW

MICHELLE'S LAW—COVERAGE FOR DEPENDENT STUDENTS

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22.

The Affordable Care Act (ACA) further expanded coverage requirements for dependents, effective for plan years beginning on or after Sept. 23, 2010. Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status.

COVERAGE REQUIREMENTS

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for **up to one year** while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under Michelle's Law, a dependent child is entitled to the **same level of benefits** during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

NOTICE REQUIREMENTS

Group health plans are required to provide notice of the requirements of Michelle's Law, in language understandable to the typical plan participant, along with any notice regarding a requirement for certifying student status for plan coverage.

IMPACT OF the ACA

plans. Under the ACA, if a group health plan or insurer provides dependent coverage for children, the plan or insurer must continue to make the coverage available until the child attains age 26, regardless of student status. Thus, the impact of Michelle's Law on group health plans will generally be limited to health plans that provide coverage to dependent students who are age 26 or over.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a co-payment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as co-payments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Florida law also provides some protection for balance billing. If your insurance* provider is from Florida, then you can't be balance billed for emergency services. You are only responsible for paying your copay, deductible, and coinsurance.

Certain services at an in-network hospital or ambulatory surgical center When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're *never* required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:

o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
o Cover emergency services by out-of-network providers.
o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact No Surprises Help Desk at (800) 985-3059. Visit **cms.gov/nosurprises/consumers** for more information about your rights under federal law.

*Florida law does not apply to insurance plans from other states or employer -owned insurance plans. Federal law does not provide protection for those.

MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medic-aid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA NOTICE

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

HIPAA NOTICE

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

HIPAA NOTICE

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: *We use health information about you to develop better services for you.*

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

HIPAA NOTICE

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Benefit plans are subject to change. Town of Bay Harbor Islands reserves the right at any time, in its sole discretion, to amend, modify, reduce the benefits provided by, or terminate any of its plans. Any amendment, modification, reduction or termination may be made without prior notice to participants, except as required by law. This Benefit Booklet is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this benefit booklet conflicts in any way with the Certificate of Coverage, the COC shall prevail. It is recommended that you review your COC for an exact description of the services, and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information.

Note: While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.