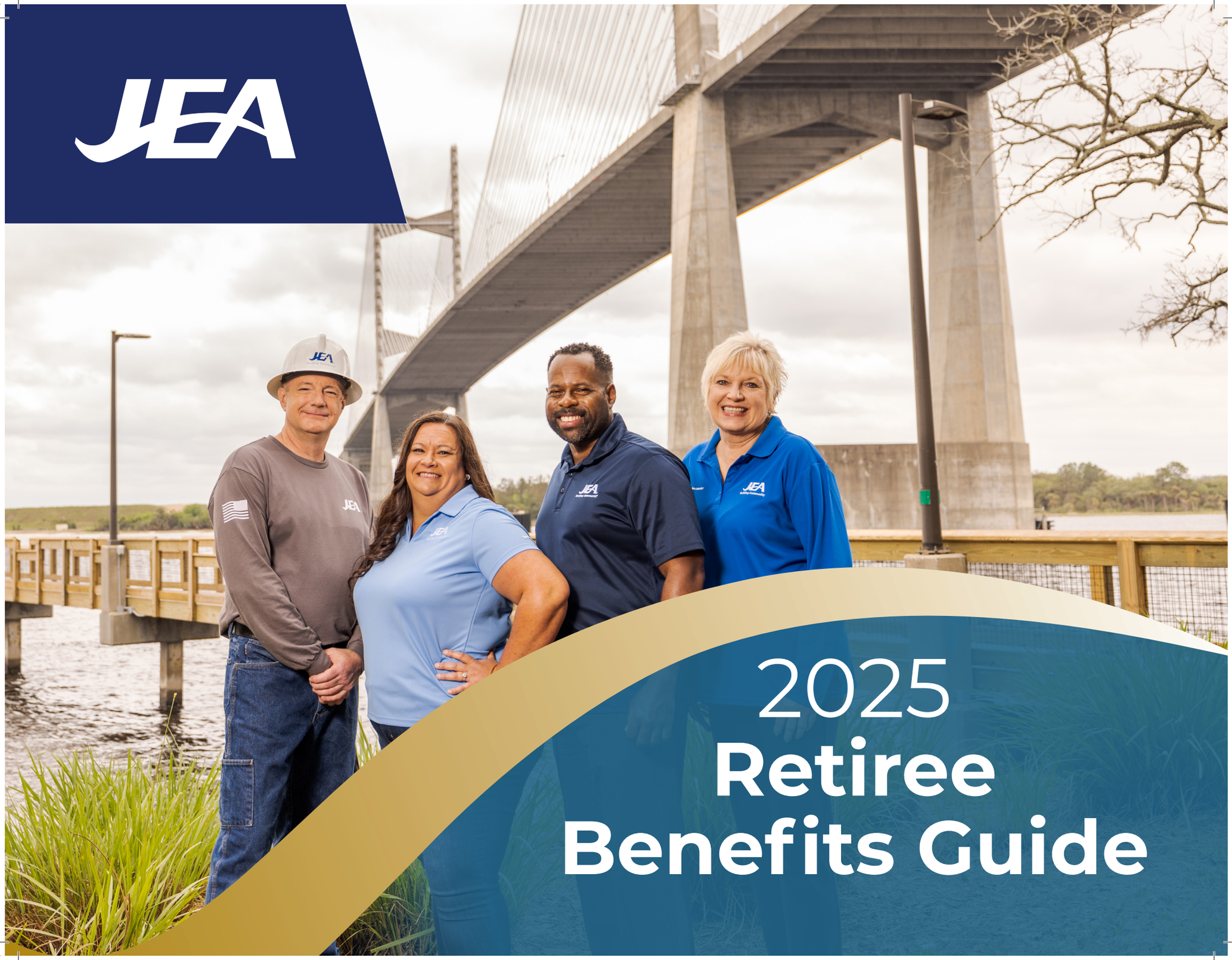

2025 Retiree Benefits Guide

This document is an outline of the coverage provided under your employer's benefit plans. It does not include all the terms, coverages, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your JEA Benefit Services.

Table of Contents

WELCOME

Dear Retiree,

JEA understands that your benefits are important to you and your family. Helping you understand the benefits available to you is essential. This Retiree Benefits Guide provides a description of our company's Retiree benefit program.

This guide is not a contract. It is not intended to cover all provisions of all plans, but rather it is a quick reference to help answer most of your everyday questions. Please refer to carrier benefit summaries and certificates for more details or contact **Benefits Services** at 1.904.665.5300.

Annual Enrollment is the ideal time to re-evaluate your benefits and ensure your benefits will meet your anticipated healthcare needs. Open enrollment is held November 6 - November 22, and changes in coverage are effective January 1 of the following year.

FLORIDA BLUE PROVIDES FOUR MEDICAL OPTIONS FOR RETIREES:

- Medicare Advantage
- PPO Plan 03768
- HMO Plan 47
- HDHP Plan 03160

We encourage you to review each section and discuss your benefits with your family members. Be sure to pay close attention to applicable copayments, deductibles, coinsurance, out-of-pocket maximums and bi-weekly premiums. This guide will give you an overview of your benefits and help prepare you for the enrollment process.

NEW for 2025!

We are thrilled to announce the launch of our new employee enrollment portal, Explain My Benefits (EMB). This user-friendly platform will provide you with a comprehensive overview of all available benefits, allowing you to make informed decisions about your coverage.

For 2025, we are pleased to announce there are not any plan changes for our plans. Medical and Vision rates will remain the same for 2025 with only a slight increase in the Dental rates.

Medicare Part D Creditable Coverage Notice is included in this Guide.

ELIGIBILITY AND ENROLLMENT

EMPLOYEE ELIGIBILITY

Retirees can continue medical, dental and vision benefits that they are currently enrolled in at time of retirement. Retirees can also elect life insurance. Each year during open enrollment retirees can make changes to their existing elections. All changes will be effective January 1.

If you should decline your retiree benefits, at any time or do not enroll in the coverage when you retire you may not rejoin the plan at a later date.

ELIGIBLE DEPENDENTS

As a retiree, you may enroll all covered dependents that are/were enrolled on the group plan at the time of retirement. Additional dependents cannot be added to any of the benefit plans after retirement. Any dependents removed from the plan cannot be enrolled at a later date.

WHAT IF I HAVE MORE THAN ONE MEDICAL PLAN?

If you are covered under JEA's medical plan and also have medical insurance somewhere else (such as through a spouse, TRICARE, etc.), your medical benefits will be subject to Coordination of Benefits (COB).

Coordination of Benefits is a practice used to ensure that insurance claims are not paid multiple times when someone is insured under multiple insurance plans. When your JEA plan is primary, the other plan is secondary and will pay next. When your JEA plan is secondary it pays benefits after the primary plan has paid benefits. The rules for determining which plan is primary and which plan is secondary vary based on the circumstances.

If you have more than one medical plan, let Florida Blue know when you enroll and they will work with your other insurance company on your behalf.

You may include the following dependents:

Your spouse	The person to whom you are legally married.
Your Child/ Foster Child/Legal Guardianship	Your covered biological child, legally adopted child, child placed in the home for the purpose of adoption, foster child, or child for which you have legal guardianship in accordance with applicable state and federal laws through the end of the calendar year in which he/she turns age 26*. The child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency through the end of the calendar year in which he/she turns 26*. *Foster children may be eligible to their age of maturity.* The child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal law through the end of the calendar year in which he/she turns 26*. **Your ward may be eligible until his or her age of maturity.*
Surviving spouse	Surviving spouses are eligible to remain on the plan with individual or children coverage following the death of a Retiree or after a Retiree converts to Medicare.
*Your over-age dependent	Your child after the end of the calendar year in which they turn 26 through the end of the calendar year in which they reach 30 if they are unmarried, have no dependents of their own, are dependent upon you for financial support, live in Florida or attend a school in another state, and have no other health insurance.

Medical Benefits

	Medicare Advantage and Preferred Provider Organization (PPO)	High Deductible Health Plan (HDHP)	Health Maintenance Organization (HMO) (Florida Residents Only)
Plan Description	You may receive care from any provider of your choosing. However, providers who contract with Florida Blue (in-network) perform their services at a discounted rate, which generally makes your cost for care much less expensive.	A health plan that meets certain qualifications (deductible and out-of- pocket maximum) and requires that all non-preventive care is subject to the deductible.	This plan has fewer copays than the PPO plan with more services subject to the deductible. You are limited to receive care from network providers. This plan encourages consumers to become educated in the care they're receiving and how much it costs.
Is preventive care covered?	**Yes.** In-network preventive care is covered at 100%		
Can I go to any doctor?	**Yes.** However, you will receive better benefits and pay less for care if you use in-network providers.		**No.** In-network providers must be used except for emergency care.
Do I need a referral to see a specialist?	**No.** Your insurance plan does not require a referral, but some specialists may require a referral from your doctor.		
Is there a limit on how much I pay in a year?	**Yes.** The out-of-pocket maximum is the most you'll pay in a year for in-network care.		

Medical Benefits

MEDICARE ADVANTAGE OPTION - Dental and Vision Benefits Included	
In-Network Coverage	
Deductible	$0
Coinsurance (your share)	20%
Out-of-Pocket Maximum	$1,000 per person
Preventive Care	
Primary Doctor Visit	$10 Copay
Specialist Doctor Visit	$25 Copay
Mental Health Counseling	$30 per visit
Independent Labs	Independent Facility: $0 Outpatient Hospital: $15
X-Rays	Independent Facility: $25 Outpatient Hospital: $100
Imaging: MRI / CT / PET	Independent Facility: $75 Outpatient Hospital: $100
Urgent Care Center	$25 (same in-network and out-of-network)
Emergency Room	$75 (same in-network and out-of-network)
Inpatient Hospitalization	$200 per day up to 5 days
Outpatient Hospital	$200

Out-of-Network Coverage (Plus balance billing)	
Deductible	$1,000 per person
Urgent Care Center	$25 (same in- and out-of-network)
Emergency Room	$75 (same in- and out-of-network)
Coinsurance (your share)	20% after deductible
Out-of-Pocket Maximum	$3,000 per person

Florida Blue Medicare Advantage is a health plan with options provided by JEA. To join the Medicare Advantage plan you must:

- Be entitled to Medicare Part A and enrolled in Part B
- Continue to pay your monthly Medicare B premium.

The Medicare Advantage plan will be deducted from your retirement check.

If you choose to enroll in the Medicare Advantage plan, you will use the health insurance cards provided by Florida Blue instead of the original Medicare card.

When you enroll in a Florida Blue Medicare Advantage plan you do not lose your Medicare coverage.

	MEDICARE ADVANTAGE OPTION - Dental and Vision Benefits Included	
Benefits and Coverage	In-Network	Out-of-Network
Annual Maximum Benefit	Unlimited	$750 per person
Specialist Visit	$25 copay for non-routine care	20% of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental
Preventive Care	$0	Member pays up front and is reimbursed 50% of non-participating rates for covered preventive dental services.
Comprehensive Services	$0	Member pays up front and is reimbursed 50% of non-participating rates for covered comprehensive dental services.

	MEDICARE ADVANTAGE OPTION - Dental and Vision Benefits Included	
	In-Network	Out-of-Network
Routine Eye Exam	$0 (One every 12 months)	Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount for an annual routine eye examination 1 every 12 months.
Specialist Visit	$25 copay for specialist to diagnose and treat eye diseases and conditions	20% of the Medicare-allowed amount after $1,000 out-of-network deductible for Medicare-covered specialist services to diagnose and treat diseases and conditions of the eye and diabetic retinal exams
Diabetic Retinal Exam	$0 (Yearly)	
Glaucoma Screening	$0 (once per year for members at high risk of glaucoma)	20% of the Medicare-allowed amount for glaucoma screening
Eyeglasses, Lenses, and Contacts	$0 copay, for one pair of eyeglasses or contact lenses after each cataract surgery Member responsible for any amount in excess of annual maximum plan benefit allowance. $250 maximum per year	20% of the Medicare-allowed amount after $1,000 out-of-network deductible for eyeglasses or contact lenses after cataract surgery **Member must pay 100% of the charges and submit the itemized receipt(s) for reimbursement of 50% of the in-network allowed amount for lenses, frames, or contacts.** Member is responsible for all amounts in excess of the 50% of the in-network allowed amount and/or any amounts in excess of the annual maximum plan benefit allowance for lenses, frames, or contacts. Total reimbursement is subject to the annual maximum plan benefit allowance.

Tips and Resources

TIPS FOR BEING A WISE HEALTHCARE CONSUMER

Understand your medical coverage. Read this guide and ask questions if there is something you don't understand. Establish a relationship with a doctor. Do not wait until you're sick to try to find a primary care doctor. Become an established patient by scheduling an initial exam. The doctor will then have your health history, which is an important tool in good medical care.

Additionally, established patients generally have priority in scheduling appointments.

Use network providers. The doctors and hospitals who are part of the BlueOptions network have agreed to negotiated prices for the services they provide, so you'll generally pay less from your own pocket.

Save the emergency room for emergencies. A hospital emergency room is no place to get care for a common illness. Going to the emergency room for non-emergencies can be very expensive and time-consuming.

Consider an Urgent Care Center, Teladoc, or Convenience Clinic (usually inside drugstores) instead. Shop around. When you need something like an MRI or surgery, contact a Florida Blue Care Consultant (888.476.2227) or use the comparison features on www.floridablue.com to compare your options.

Claims

Send Claims to:
Florida Blue P.O. Box 1798
Jacksonville, FL 32231-0014

Florida Blue

FLORIDA BLUE RESOURCES

Group: 51541
Website: www.floridablue.com
Phone: 1.800.664.5295

Nurseline (24/7)
1.877.789.2583
Available 24/7, Nurseline can provide assistance for unexpected and ongoing healthcare questions, including when it's time to seek care from a doctor.

Care Consultant
1.888.476.2227
A dedicated team featuring nurse care advocates, benefit specialists, and community resource experts who are all available to help you make more informed health care decisions.

Condition Management
1.800.955.5692
Assistance with rare or chronic conditions, cancer, transplants, high-risk pregnancy, prenatal care, and more.

Integrated Care Management
1.800.955.5692
Case management for complex cases including transition of care, pediatric conditions, NICU, and Hospice.

Medical Benefits

FLORIDA BLUE
Group: 51541
www.floridablue.com
1.800.664.5295

TRADITIONAL MEDICAL PLAN DETAILS

	Preferred Provider Organization Plan #: 03768	High Deductible Health Plan Single Plan #: 03160 Family Plan #: 03161	Health Maintenance Organization Plan #: 47 (Florida Residents Only)
In-Network Coverage	**BlueOptions Network**	**BlueOptions Network**	**BlueCare Network**
Calendar Year Deductible (CYD) Deductible	$1,350 per person $2,700 family	$1,850 single coverage $3,700 family coverage	$1,600 per person $3,200 family
Coinsurance (your share)	20% after the deductible	20% after the deductible	20% after the deductible
Out-of-Pocket Maximum	$5,000 per person $10,000 family	$5,000 single coverage $7,000 family coverage	$5,000 per person $10,000 family
Preventive Care	**Covered 100% In-Network**	**Covered 100% In-Network**	**Covered 100% In-Network**
Primary Doctor Visit	$30	Deductible then 20%	$30
Specialist Doctor Visit	$60	Deductible then 20%	$60
Maternity Care	Initial Visit: $60	Deductible then 20%	Initial Visit: $60
Mental Health Counseling	$60	Deductible then 20%	$60
Independent Labs	$25	Deductible then 20%	$25
X-Rays	$50	Deductible then 20%	Deductible then 20%
Imaging: MRI / CT / PET	$300	Deductible then 20%	Deductible then 20%
Urgent Care Center	$55	Deductible then 20%	Deductible then 20%
Emergency Room	Deductible then 20%	Deductible then 20%	Deductible then 20%

	Preferred Provider Organization Plan #: 03768	High Deductible Health Plan Single Plan #: 03160 Family Plan #: 03161	Health Maintenance Organization Plan #: 47 (Florida Residents Only)
Inpatient Hospitalization	Deductible then 20%	(Opt 1) Deductible then 20% (Opt 2) Deductible then 25%	Deductible then 20%
Outpatient Hospital	Deductible then 20%	(Opt 1) Deductible then 20% (Opt 2) Deductible then 25%	Deductible then 20%
Out-of-Network Coverage (plus balance billing)			
Deductible	$2,000/$4,000	$2,500/$5,000	Not Covered
Urgent Care Center	Deductible then $50	Deductible then 20%	Not Covered
Emergency Room	Deductible then 20%	Deductible then 20%	In-Network Deductible then 20%
Coinsurance (your share)	40% after deductible	40% after deductible	Not Covered
Out-of-Pocket Maximum	$10,000/$20,000	$10,000/$10,000	Not Covered

PHARMACY COVERAGE

Retail Prescriptions (up to 30 days)			
Tier 1 (generic)	$5	Deductible then $5	$5
Tier 2 (preferred brand)	25% to $40	Deductible then 25% to $40	25% to $40
Tier 3 (non-preferred brand)	30% to $70	Deductible then 30% to $70	30% to $70
Tier 4 (specialty)	20% to $250	Deductible then 20% to $250	20% to $250
Mail Order Prescriptions (90 days)			
Tier 1 (generic)	$10	Deductible then $10	$10
Tier 2 (preferred brand)	25% to $80	25% to $80	25% to $80
Tier 3 (non-preferred brand)	30% to $140	Deductible then 30% to $140	30% to $140

Specialty medications are generally used to treat rare or complicated conditions (autoimmune disorders, cancer, etc.)

Note: Diabetic Supplies (e.g., glucose monitors and batteries, test strips, alcohol wipes, insulin syringes, needles and lancets) are covered at 100% under the HMO with HRA and PPO plans; and are covered at 100% after DED under the HDHP with HSA plan.

Mail Order Pharmacy:
Home delivery pharmacy is serviced by Amazon Pharmacy: pharmacy.amazon.com/myw

To get started with Amazon Pharmacy home delivery services, log in to your Florida Blue member account and see the Pharmacy section under My Plan.

Dental Benefits

MAJOR DIFFERENCES BETWEEN THE DHMO AND PPO OPTIONS:

Plan Feature Overview	DHMO *(Florida Residents Only)*	PPO
Insurance Company	MetLife	MetLife
Provider choice	In-Network only, you must designate a primary dentist from a list of providers.	Choose any dentist, though we encourage you to choose an in-network dentist to help save on costs.
Seeing a specialist (oral surgeon, periodontist, etc.)	A referral is required from MetLife for oral surgery, periodontics, and endodontists.	No insurance referral is required, though the specialist may require one from your dentist.
Seeing an out-of-network dentist	Out-of-network care is not covered.	You pay your deductible, any applicable coinsurance, and any applicable balance billing.
Paying for care	Pay a set copay for each service you receive designated by a specific coverage code.	Pay a percentage of the negotiated amount after you meet your deductible.

MetLife

METLIFE (DHMO)
Group: 236091
Network: MET245 FL
www.metlife.com/mybenefits
1.800.942.0854

METLIFE (PPO)
Group: 236091
Network: PDP Plus
www.metlife.com/mybenefits
1.800.GET.MET8
1.800.438.6388

JEA

CHOOSE FROM THREE DENTAL PLANS THAT BALANCE COST AND CARE FOR YOU AND YOUR FAMILY:

	DHMO *(Florida Residents Only)*	Low PPO	High PPO
Benefits and Coverage	**In-network only**	**In- and out-of-network***	**In- and out-of-network***
Annual Deductible	Not applicable	$50 / $150	$50 / $150
Annual Maximum Benefit	Unlimited	$750 per person	$5,000 per person
Preventive Care	$0 copay	100% covered (plus balance billing if you go out-of-network)*	100% covered (plus balance billing if you go out-of-network)*
Routine office visit (0150)	$0 copay		
Full mouth/panoramic x-ray (0330)	$0 copay		
Basic Care	Fee schedule applies	Deductible then 40% (plus balance billing if you go out-of-network)*	Deductible then 20% (plus balance billing if you go out-of-network)*
Fillings (2140)	$0		
Extractions (7140)	$5		
Major Care	Fee schedule applies	Deductible then 60% (plus balance billing if you go out-of-network)*	Deductible then 50% (plus balance billing if you go out-of-network)*
Full or partial dentures (5110)	$325		
Crowns (2750)	$245		
Child and Adult Orthodontia	Benefit schedule applies	Not Covered	Child: You pay 50%; $1,000 lifetime max benefit Adult: Not Covered
Child Orthodontia (to age 19)	$1,850 copay		
Adult Orthodontia	$1,850 copay		

**Remember, balance billing is when you are charged the difference between what your out-of-network dentist charges and what insurance pays. You are responsible for balance billing charges.*

Vision Insurance

FOCUS ON YOUR VISION

Keep your eyes healthy and your vision sharp with comprehensive vision coverage offered through EyeMed. Eye360 is an addition to both Vision Plans. Utilize a Eye360 PLUS Provider to receive a $0 exam copay and an additional $50 frame allowance. The diabetic plan covers office visits and diagnostic testing once every 6 months.

EYEMED
Group: 1012485
Network: Insight
www.eyemed.com
1.866.939.3633

Plan Feature Overview	Basic	Premium
	Member Cost	Member Cost
Exam		
Exam	$10	$10
Retinal imaging	up to $39	up to $39
Contact lens fit and follow up exam		
Fit and follow-up Standard	Up to $40	Up to $40
Fit and follow-up Premium	10% off retail price	10% off retail price
Frame	$0 copay, 80% balance over $120 allowance	$0 copay, 80% balance over $150 allowance
Lenses		
Single Vision	$20	$10
Bifocal	$20	$10
Trifocal	$20	$10
Lenticular	$20	$10
Progressive Std - Tier III	$85 - $130	$10 - $55

Elective contact lenses are available in lieu of glasses (lenses and/or frames). You are not eligible for glasses for 12 months after you receive elective contacts, and vice-versa.

Plan Feature Overview	Basic	Premium
Lens Options		
Anti-reflective coating Std - Tier II	$45 - $68	$45 - $68
Photochromic	$75	$75
Polycarbonate	$40	$40
Scratch coating	$15	$0
Tint	$15	$0
UV	$15	$0
All other lens options	20% off retail price	20% off retail price
Contact Lenses		
Conventional	$0 copay; 15% off balance over $120 allowance	$0 copay; 15% off balance over $150 allowance
Disposable	$0 copay; 100% of balance over $120 allowance	$0 copay; 100% of balance over $150 allowance
Medically necessary	$0 copay	$0 copay
Frequency based on calendar year		
Exam	12 months	12 months
Lenses or contact lenses	12 months	12 months
Frame	24 months	12 months
Plan Details		
Eye360	$0 exam copay at PLUS providers $170 frame allowance	$0 exam copay at PLUS providers $200 frame allowance
Diabetic Plan	▪ An office visit and diagnostic testing once every 6 months ▪ Diagnostic tests such as gonioscopy, extended ophthalmology, fundus photography and scanning laser (offered at the provider's discretion)	

Teladoc

SEE A DOCTOR ANYTIME (MEDICAL, AND DERMATOLOGY AND MENTAL HEALTH)

You and your covered family members have access to Teladoc which allows you to contact a licensed doctor from anywhere at anytime.

Using a computer or your cellphone, reach a doctor for assistance with things like a cold, minor injuries, sinus infections, upset stomach, and fevers. Teladoc providers can write prescriptions when appropriate, and you don't have to travel to a doctor's office and wait!

Register online at www.teladoc.com. Or call: 1.800.835.2362

When you register, you will need to answer some medical questions just like you would for a doctor you see in person. After you've registered, you may contact a doctor when you need them using the contact methods available.

PPO and HMO: $0 copay

HDHP: Meet your Calendar Year Deductible (CYD) first then $0 copay

Explain My Benefits

BENEFIT ENHANCEMENTS FOR JEA EMPLOYEES

Effective communication about your benefits is crucial for managing and maximizing your resources. As a result, we are excited to introduce our new mobile app designed to make your benefits experience easier and more accessible.

With the new app, you can:

- Receive timely notifications about important benefit updates
- Connect directly with insurance providers
- Access the Benefits Guide and educational videos

Download the App at this website:
embbenefits.com/jea

Or scan the QR Code:

Company code: JEA

You can also visit jeabenefits.com to review the Benefits Guide, important documents, videos, and plan details. As part of the JEA team, your value to us is immeasurable, and we hope these new tools will help you make the most of understanding and accessing your benefits.

These resources are also available to your qualifying dependents.

Life Insurance

THE STANDARD

Group Voluntary Retiree Life Insurance is available on the following schedule. In order to increase retiree life insurance coverage, existing retirees are required to submit a medical Evidence of Insurability form (medical questions) and be approved by Standard.

STANDARD
Group: 755562
1.800.628.8600

COVERAGE AMOUNTS

- $5,000
- $10,000
- $15,000

You must list a beneficiary for your life insurance plans. Your beneficiary can be a person or a trust. If listing a child, the child must be over the age of 18 to receive the benefits.

Be sure to keep this information up-to-date.

Retiree Contributions

Premiums shown are per pay period

MEDICAL INSURANCE

Coverage Level	Medicare Advantage and Dental Benefits*	PPO	HDHP	HMO
Retiree Only	$176.27	$425.32	$308.73	$388.92
Retiree + Spouse	$346.53	$909.43	$660.57	$831.58
Retiree + Child(ren)	N/A	$821.64	$596.81	$751.35
Retiree + Family	N/A	$1,291.19	$938.09	$1,180.68

*Any additional dependent's covered on the Medicare Advantage plan cost an additional $152.86 per person.

DENTAL INSURANCE

Coverage Level	DHMO	Low PPO	High PPO
Retiree Only	$6.29	$13.72	$20.47
Retiree + Spouse	$11.01	$22.79	$33.99
Retiree + Child(ren)	$13.21	$25.56	$38.13
Retiree + Family	$18.56	$39.95	$59.58

VISION INSURANCE

Coverage Level	Basic Plan
Retiree Only	$1.93
Retiree + 1	$3.87
Retiree + 2 or more	$6.22

OPTION 2 VISION INSURANCE

Coverage Level	Premium Plan
Retiree Only	$4.05
Retiree + 1	$8.12
Retiree + 2 or more	$13.04

LIFE INSURANCE

Coverage Level	Your Rate
$5,000	$1.65
$10,000	$11.96
$15,000	$22.27

It is your responsibility to ensure your on-line benefits enrollment information is correct. If a premium deduction error occurs, notify Benefits Services immediately at 1.904.665.5300 or Benefits@JEA.com.

Medicare and Your JEA Coverage

Turning 65 and becoming eligible for Medicare can mean changes for your JEA medical insurance, especially when you make the choice to retire. This guide will provide you with general information intended to help you make an educated decision.

As variances do exist, we strongly encourage you to contact Medicare at **1-800-MEDICARE** or **www.medicare.gov** to confirm the steps you will need to take to ensure continued coverage.

Eligibility

You are generally eligible for Medicare the first of the month in which you reach age 65, or the first of the month prior if your birthday is on the first of the month. Medicare A is usually automatic, especially if you have begun receiving Social Security payments. The action you take for Part B depends on your status with JEA. The illustration below assumes that you and your eligible spouse, if applicable, are enrolled in the JEA medical insurance plan both as an active employee and an eligible dependent, and into retirement.

	If you are...	Under 65		Over 65	
	And...	Actively Working	Retired	Actively Working	Retired
For You:	**Primary Coverage**	JEA Active Coverage	JEA Retiree Coverage (same as active coverage)	JEA Active Coverage*	Medicare *JEA Retiree is Secondary*
	Medicare Impact	No impact yet	No impact yet	*May* defer Part B until you retire	Must enroll in Medicare B to have coverage
For Your Spouse: Under 65	**Primary Coverage**	JEA Active Coverage	JEA Retiree Coverage	JEA Active Coverage*	JEA Retiree Coverage
	Medicare Impact	No impact yet	No impact yet	No impact yet	No impact yet
For Your Spouse: Over 65	**Primary Coverage**	JEA Active Coverage	Medicare	JEA Active Coverage*	Medicare *JEA Retiree is Secondary*
	Medicare Impact	*May* defer Part B until you retire	Must enroll in Medicare B to have coverage	*May* defer Part B until you retire	Must enroll in Medicare B to have coverage

* If you're also enrolled in Medicare, Medicare will pay secondary to the JEA medical plan. However, deferral of Part B until retirement is generally permissible.

How Medicare interacts with your JEA benefits:

MEDICARE B AND YOUR JEA MEDICAL PLAN:

If Medicare is listed as primary for you and/or your spouse, enrollment in Medicare B is required to receive your full coverage benefit. Due to Medicare rules, if you are not enrolled in Medicare B but Medicare is primary for you, you will be responsible for the portion that Medicare would ordinarily pay.

MEDICARE D AND YOUR JEA PHARMACY COVERAGE:

We have determined that, for 2025, your JEA Medical plan has 'creditable' prescription drug coverage, which means that your JEA drug plan pays, on average, 'as much or more' than Medicare D requires. Once Medicare is primary for you, you will likely not need to enroll in a separate Part D plan as long as you remain enrolled in the JEA medical plan. You will receive an annual creditable coverage certification notice from JEA confirming the status each year.

MEDICARE C:

If you are enrolled in the retiree medical plan through JEA, you are likely not eligible to enroll in a Medicare C (Medicare Advantage plan) or a MediGap plan. For more information on this limitation, please contact Medicare directly at **1-800-MEDICARE** or www.medicare.gov.

Medicare eligibility while you're actively working:

IF YOU ARE ENROLLED IN THE EPO/HMO/PPO PLAN WHEN YOU BECOME ELIGIBLE FOR MEDICARE:

- Turning 65 and/or enrolling in Medicare would not cause you to lose eligibility for the EPO/HMO/PPO Plan.
- While actively working, your Medicare status should not impact how the EPO/HMO/PPO Plan pays your claims.

IF YOU ARE ENROLLED IN THE HDHP PLAN WHEN YOU BECOME ELIGIBLE FOR MEDICARE:

- Turning 65 and/or enrolling in Medicare would not cause you to lose eligibility for the HDHP Plan.
- While actively working, your Medicare status should not impact how the HDHP Plan pays your claims.
- **Enrolling in Medicare (even Medicare A) prevents you from being able to contribute to the HSA account**.

See the following page for details.

Medicare and a Health Savings Account (HSA):

IN THE FOLLOWING SCENARIOS, THESE TERMS ARE USED:

- **Eligible Individual:** An individual deemed eligible to contribute to an HSA as per IRS Regulations. This individual is enrolled in a qualified High Deductible Health Plan (HDHP), is not covered by any other insurance, and is not enrolled in Medicare.
- **Ineligible Individual:** An individual deemed not eligible to contribute to an HSA as per IRS Regulations. In the following scenarios, this means an individual who is enrolled in Medicare.

Q: If I am eligible for Medicare but not enrolled in Medicare Part A or Part B, may I contribute to a Health Savings Account (HSA)?

A: Yes, as long as you are enrolled in the High Deductible Health Plan (HDHP). IRS regulations state that an individual ceases to be eligible to make HSA contributions starting with the month he or she is "entitled to benefits" under Medicare. In this case, "entitled to benefits" means eligibility and enrollment in Medicare.

Example 1: Mary, age 66, is covered under the HDHP. Although she is eligible for Medicare, she is not actually entitled to Medicare because she did not apply for benefits under Medicare (i.e., enroll in Medicare Part A or Part B). If Mary is otherwise an eligible individual according to the IRS, she may contribute to an HSA.

Example 2: In March 2025, John turns age 65 and applies for and begins receiving Social Security benefits. He is automatically enrolled in Medicare. As of March 1, 2025, John is no longer an eligible individual and may not contribute to an HSA.

(IRS Administrative, Procedural, and Miscellaneous Notice 2004-50)

Q: If I am an "otherwise eligible individual" according to the IRS who is age 65 or older and thus eligible for Medicare, but am not enrolled in Medicare Part A or Part B, may I make the additional HSA catch-up contribution for persons age 55 or older?

A: Yes. (IRS Administrative, Procedural, and Miscellaneous Notice 2004-50)

Q: What if I am an "eligible individual" but my spouse is on Medicare? What contributions can I make to an HSA?

A: Although your spouse is ineligible to contribute to an HSA, you can still contribute to an HSA. Moreover, if you have family coverage under the HDHP, you can contribute up to the applicable family limit to an HSA. Additionally, you may also contribute the catch-up amount if you are age 55.

(IRS Administrative, Procedural, and Miscellaneous Notice 2004-50 Q&A 31, example 5 and Q&A 32)

Important Terms

Term	Definition
Copay	A flat fee you pay whenever you use certain medical services, like a doctor visit.
Deductible	The dollar amount you pay before your medical insurance begins paying deductible-eligible claims.
Coinsurance	The percentage of covered medical expenses you continue to pay after you've met your deductible and before you reach your out of pocket maximum.
Out of pocket maximum	The most you will pay during the calendar year for covered in-network expenses. This includes copays, deductibles, coinsurance, and prescription drugs.
In-Network	Providers and facilities that contract with Florida Blue. When you remain in the network, your cost for care is lower due to negotiated costs.
Balance billing	The amount you are billed to make up the difference between what your out-of-network provider charges and what insurance reimburses. This amount is in addition to (and does not count toward) your out-of-pocket maximum.

Frequently Asked Questions

WHAT ABOUT MY SPOUSE? IF WE ARE BOTH MEDICARE ELIGIBLE, WILL WE BE ON SEPARATE PLANS?

Yes, you would both be on your own Florida Blue Medicare Advantage plan.

WHAT IF I AM MEDICARE ELIGIBLE BUT MY SPOUSE IS NOT 65?

You can enroll in Florida Blue Medicare Advantage plan with your Medicare Part A and B. Your spouse can remain on the JEA benefits until he/she is eligible for Medicare Part A and B.

HOW DO COPAYS WORK WHEN VISITING MY DOCTOR?

Copays are predictable costs when paying for health services. When you visit your doctor, you may be asked fort payment at the time services are rendered.

IF I'M NO LONGER ON THE PLAN CAN MY SPOUSE CONTINUE COVERAGE?

Yes, your spouse may continue medical, dental and/or vision coverage currently enrolled in by paying the necessary cost.

MY SPOUSE AND I LIVE HALF THE YEAR IN ANOTHER STATE. ARE THERE ANY RESTRICTIONS?

No. With the Florida Blue Medicare Advantage Plan you have flexibility to use doctors and hospitals across the country. You will need to use providers who accept Blue Cross & Blue Shield to get for the greatest benefit.

DOES THE FLORIDA BLUE MEDICARE ADVANTAGE PLAN COVER PRESCRIPTION DRUGS?

Yes. Prescription drug coverage with protection through the "coverage gap" for generic drugs and more are covered under the Florida Blue Medicare Advantage Plan.

Frequently Asked Questions

WHAT IS MEDICARE?

Medicare is a Federal health insurance program for people age 65 and older, people of any age with permanent kidney failure, and certain disabled people under age 65.

HOW CAN I CONTACT MEDICARE?

Phone: 1.800.633.4227
Website: www.medicare.gov

Mailing Address:
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850.

WHAT IS MEDICARE A?

Part A (Hospital Insurance) helps pay for inpatient care in hospitals and skilled nursing facilities and for home health and hospice care. If an individual is eligible, Part A is usually premium-free; this is, the individual doesn't pay a premium because the individual paid Medicare taxes based on the hours they worked.

Part A is also available for a monthly premium to individuals who never paid Medicare taxes while working.

WHAT IS MEDICARE B?

Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists.

If an individual chooses to enroll in Part B, the monthly premium is deducted from their Social Security, Railroad Retirement, or Civil Service Retirement payment. If an individual does not receive any of the above payments, Medicare will bill the individual. The Part B premium often changes on a yearly basis and can vary by individual based on certain criteria.

WHAT IS THE FLORIDA BLUE MEDICARE ADVANTAGE PLAN?

The Medicare Advantage plan is a health plan option that is offered by JEA.

To join an individual must be entitled to Medicare Part A and enrolled in Part B. The individual will continue to pay monthly Medicare Part B premium. In addition, the Medicare Advantage plan will have its own monthly premium.

Legal Notices

YOUR RIGHTS

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Human Resources with any questions you have.

HIPAA SPECIAL ENROLLMENT RIGHTS

This notice applies with respect to the JEA Self-Funded Medical Plan but not the Medicare Advantage Plan

A federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision." If you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

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

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

If you are enrolled in this plan through the special enrollment provision, note that special enrollees must be offered the same benefits that would be available when enrolling for the first time. Special enrollees cannot be required to pay more for the same coverage than other individuals who enrolled when first eligible for this plan.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact JEA

Benefit Services at 1.904.655.5300 or Benefits@JEA.com.

PATIENT PROTECTION

Florida Blue generally requires the designation of a primary care provider for the HMO plan. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Florida Blue designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Florida Blue at www.floridablue.com. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Florida Blue or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health

care professionals who specialize in obstetrics or gynecology, contact Florida Blue at www.floridablue.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This notice applies with respect to the JEA Self-Funded Medical Plan but not the Medicare Advantage Plan.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all 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 at 1.800.664.5295.

MICHELLE'S LAW

This notice applies with respect to the JEA Self-Funded Medical Plan but not the Medicare Advantage Plan.

JEA's Group Medical Plan provides dependent coverage for the children of its participants until a child has attained age 26, regardless of the child's status as a student. For a child covered under JEA's Group Medical Plan after attaining age 26, Michelle's Law requires continued coverage for that dependent child covered under the plan if the child loses eligibility under JEA's Group Medical Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under JEA's Group Medical Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under JEA's Group Medical Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan - for example, by reaching age 26 or 30 as applicable.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. The written certification must be provided to JEA Benefit Services. (See contact info below.)

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's Law, please contact JEA Benefit Services, 225 N. Pearl St., Jacksonville, FL 32202 at 1.904.665.5300, e-mail: Benefits@JEA.com.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

This notice applies with respect to the JEA Self-Funded Medical Plan but not the Medicare Advantage Plan.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care

provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.
For information on precertification, contact your plan administrator at 800.664.5295.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

This notice applies with respect to the JEA Self-Funded Medical Plan but not the Medicare Advantage Plan.

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 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 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

myalhipp.com
855.692.5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
myakhipp.com | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – MEDICAID

myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
dhcs.ca.gov/hipp
1.916.445.8322 | Fax: 1.916.440.5676 |
Email: hipp@dhcs.ca.gov

COLORADO – MEDICAID AND CHIP

Health First Colorado
www.healthfirstcolorado.com
Member Contact Center: 1.800.221.3943 |
State Relay 711
Child Health Plan Plus (CHP+)
hcpf.colorado.gov/child-health-plan-plus
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

FLORIDA – MEDICAID

www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp
1.877.357.3268

GEORGIA – MEDICAID

GA HIPP Website: medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp
1.678.564.1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/ programs/ third-party-liability/childrens-health-insurance-program- reauthorization-act-2009-chipra
1.678.564.1162, Press 2

INDIANA – MEDICAID

Health Insurance Premium Payment Program
All other Medicaid
www.indiana.gov/medicaid | 1.800.457.4584
Family and Social Services Administration
www.in.gov/fssa/dfr | 1.800.403.0864

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid | 1.800.338.8366
Hawki: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki | 1.800.257.8563
HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp | 1.888.346.9562

KANSAS – MEDICAID
https://www.kancare.ks.gov
1.800.792.4884
HIPP Phone: 1.800.967.4660

KENTUCKY – MEDICAID
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: kynect.ky.gov | 1.877.524.4718
Medicaid: chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID
www.medicaid.la.gov or www.ldh.la.gov/lahipp
1.888.342.6207 (Medicaid hotline) or 1.855.618.5488 (LaHIPP)

MAINE – MEDICAID
Enrollment: www.mymaineconnection.gov/benefits/s/?language=en_US
1.800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium: www.maine.gov/dhhs/ofi/applications-forms
1.800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP
www.mass.gov/masshealth/pa
1.800.862.4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – MEDICAID
mn.gov/dhs/health-care-coverage

mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

1.800.657.3739

MISSOURI – MEDICAID
www.dss.mo.gov/mhd/participants/pages/hipp
1.573.751.2005

MONTANA – MEDICAID
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1.800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – MEDICAID
www.ACCESSNebraska.ne.gov
Phone: 1.855.632.7633 | Lincoln: 1.402.473.7000 | Omaha: 1.402.595.1178

NEVADA – MEDICAID
dhcfp.nv.gov
1.800.992.0900

NEW HAMPSHIRE – MEDICAID
www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
1.603.271.5218 | Toll free number for the HIPP program: 1.800.852.3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP
Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid
1.609.631.2392
CHIP: www.njfamilycare.org
1.800.701.0710
CHIP Premium Assistance Phone: 1.609.631.2392

NEW YORK – MEDICAID
www.health.ny.gov/health_care/medicaid
1.800.541.2831

NORTH CAROLINA – MEDICAID
https://medicaid.ncdhhs.gov
1.919.855.4100

NORTH DAKOTA – MEDICAID
www.hhs.nd.gov/healthcare
1.844.854.4825

OKLAHOMA – MEDICAID AND CHIP
www.insureoklahoma.org
1.888.365.3742

OREGON – MEDICAID AND CHIP
healthcare.oregon.gov/Pages/index.aspx
1.800.699.9075

PENNSYLVANIA – MEDICAID AND CHIP
Medicaid: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
1.800.692.7462
CHIP: www.pa.gov/en/agencies/dhs/resources/chip
1.800.986.KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP
www.eohhs.ri.gov
1.855.697.4347 or 1.401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID
www.scdhhs.gov
1.888.549.0820

SOUTH DAKOTA – MEDICAID
dss.sd.gov
1.888.828.0059

TEXAS – MEDICAID
www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
1.800.440.0493

UTAH – MEDICAID AND CHIP
Utah's Premium Partnership for Health Insurance (UPP) medicaid.utah.gov/upp/
Email: upp@utah.gov | 1.888.222.2542
Adult Expansion Website: medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program
medicaid.utah.gov/buyout-program/
CHIP: chip.utah.gov

VERMONT – MEDICAID
dvha.vermont.gov/members/medicaid/hipp-program
1.800.250.8427

VIRGINIA – MEDICAID AND CHIP
coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid and CHIP: 1.800.432.5924

WASHINGTON – MEDICAID
www.hca.wa.gov
1.800.562.3022

WEST VIRGINIA – MEDICAID - CHIP
dhhr.wv.gov/bms or mywvhipp.com
Medicaid: 1.304.558.1700
CHIP Toll-free: 1.855.MyWVHIPP (855.699.8447)

WISCONSIN – MEDICAID AND CHIP
www.dhs.wisconsin.gov/badgercareplus/p-10095
1.800.362.3002

WYOMING – MEDICAID
health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
1.800.251.1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

MEDICARE PART D NOTICE

IMPORTANT NOTICE FROM JEA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with JEA and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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 (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide a minimum standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. JEA has determined that the prescription drug coverage administered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU 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.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current JEA group medical coverage will not be affected.

You can keep your JEA group medical coverage if you elect Medicare Part D and the JEA group medical coverage will coordinate with Medicare Part D coverage.

If you do decide to join a Medicare drug plan and drop your current JEA group medical coverage, be aware that you and your dependents will not be able to get this coverage back until our plan's next annual open enrollment, unless you experience a qualifying life event that allows sooner re-entry into the plan under our plan's rules.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you leave nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through JEA changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook.

You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- 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).

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).

Date: January 1, 2025
Name of Entity/Sender: JEA
Contact / Position-Office: Manager of Benefit Services
Address: 225 N. Pearl St., Jacksonville, FL 32202
Phone Number: 1.904.665.5300

ANNUAL DISCLOSURES

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.

EFFECTIVE DATE: October 1, 2024

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the JEA Self-Funded Medical Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices to you by HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your

employer on behalf of a group health plan, from which it is possible to identify you and that relates:

1. your past, present, or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present, or future payment for the provision of health care to you.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the health plan that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request. If you receive this notice in electronic form, you have the right to request a paper copy at any time. We will promptly provide you with a paper copy.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. We reserve the right not to agree to a given requested restriction.
3. Request to receive confidential communications of protected health information. You have the right to request in writing that we communicate with you about your protected health information in a specific way (for example, home or office phone) or send mail to a different address. Your request must specify your preferred method of contact. For example, you can ask that we only contact you at work or by mail. We will consider all reasonable requests. We must approve requests if you tell us you would be in danger if we do not.
4. Inspect and obtain a copy of the protected health information contained in your medical or billing records and in any other of the organization's health records used by us to make decisions about you. We will provide a copy or summary of your protected health information, usually within 30 days. You also have the right to request that we send your protected health information to another person. Your request must be in writing and include the name and address of the person who is to receive the records. If we do not maintain the protected health information that you request, but we know where the information is maintained, we will let you know where to send your request. We may charge you a reasonable, cost-based fee for providing you with a copy of your information.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person (your personal representative) can exercise your rights and make choices about your protected health information. We will make sure that the person has this authority and can act for you before we take any action.
7. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;· that occurred before April 14, 2003;
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to you, a covered dependent, or your personal representative;
   - disclosures made pursuant to an authorization from you.

8. Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

We may use and/or disclose your medical information for the following purposes:

Treatment: We may disclose your protected health information without your permission to health care providers who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.

Payment: We may use or disclose your protected health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefit under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

To Carry Out Certain Operations Relating to Your Benefit Plan: We also may use or disclose your protected health information without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health care professionals, placing contracts for stop-loss insurance and conducting quality assessment activities.

To Plan Sponsor: Your protected health information may be disclosed to the plan sponsor as necessary for the administration of this health benefit plan pursuant to the restrictions imposed on plan sponsors in the plan documents. These restrictions prevent the misuse of your information for other purposes.

Health-Related Benefits and Services: We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified y you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: We may contract with individuals or entities known as Business Associates to perform functions on our behalf or to provide certain types of services. An example might include a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your protected health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Limited Data Sets: We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets. These circumstances include public health, research, and health care operations purposes.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits or work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies for activities authorized by law. These activities include audits, investigations, inspections, and licensure.

Law Enforcement: We may disclose protected health information if asked to do so by a law enforcement official (a) in response to a court order, subpoena, warrant, summons or similar

process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; (d) about a death that we believe may be the result of criminal conduct; (e) about criminal conduct at the Plan Sponsor's office(s); and (f) in emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA protected health information related to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research: We may share your protected health information for health research purposes; however, usually we will first need to get your written authorization.

For Purposes For Which We Have Obtained Your Written Permission: All other uses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

INFORMATION WE COLLECT ABOUT YOU

We collect the following categories of information about you from the following sources:

- Information that we obtain directly from you, in conversations or on applications or other forms that you fill out.
- Information that we obtain as a result of our transactions with you.
- Information that we obtain from your medical records or from medical professionals.
- Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

GENETIC INFORMATION

We will not use or disclose genetic information or results from genetic services for underwriting purposes, such as:

- Rules for eligibility or benefits under the health plan;
- The determination of premium or contribution amounts under the health plan;
- The application of any pre-existing condition exclusion under the health plan; and
- Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your protected health information and to notify you if there is a breach of your unsecured protected

health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this Notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If we make a material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by posting the revised Notice of Privacy Practices on the JEA intranet by the effective date of the material change, and providing a hard copy of the revised Notice in the Plan's next annual mailing.

Your health information will not be used or disclosed without your written authorization, except as described in this Notice.

The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your protected health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your protected health information; (iii) uses and disclosures of your protected health information for fundraising purposes; and (iv) other uses and disclosures not described in this Notice. Except as noted above, you may revoke your authorization in writing at any time.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY FOR E-MAIL COMMUNICATION

If you choose to communicate with us via e-mail, please be aware of the following due to the nature of e-mail communication: (a) privacy and security of e-mail messages are not guaranteed (b) we are not responsible for loss due to technical failures and (c) e-mail communication should not be used for emergencies or time and content sensitive issues.

POTENTIAL IMPACT OF STATE LAW

In some circumstances, the privacy laws of a particular state, or other federal laws, provide individuals with greater privacy protections than those provided for in the HIPAA Privacy Regulations. In those instances, we are required to follow the more stringent state or federal laws as they afford the individual greater privacy protections. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, sexually transmitted diseases, and reproductive rights.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

You will be provided a hard copy for review at the time of enrollment (or by the Privacy compliance date for this health plan).

Thereafter, you may obtain a copy upon request, and the Notice will be maintained on the JEA intranet for review and downloading.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this Notice or would like additional information, you may contact our HIPAA Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Centralized Case Management Operations
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Email: OCRComplaint@hhs.gov
Tel: 202.619.0257
Toll Free: 1.877.696.6775
https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

JEA Self-Funded Health Plan
HIPAA Privacy Officer
225 N. Pearl St.
Jacksonville, FL 32202
904.665.4132

Notes

Notes

Contacts

Service	Provider	Network Name	Contact Information
Benefit Services			Benefits@JEA.com 1.904.665.5300
Payroll			Payroll@JEA.com 1.904.665.4408
Medical	Florida Blue	BlueOptions (PPO or HDHP) BlueCare (HMO)	www.FloridaBlue.com 1.800.664.5295
Medicare (Includes Medical, Dental, and Vision)	Medicare Advantage	Medicare Advantage PPO	www.bcbs.com 1.800.926.6565
Vision	EyeMed	Insight Network	www.eyemed.com 1.866.939.3633
Dental	MetLife	MET245 FL PDP Plus	DHMO 1.800.942.0854 PPO 1.800.438.6388 www.metlife.com/mybenefits
Virtual Medical, Dermatology, and Mental Health	Teladoc		www.teladoc.com 1.800.835.2362
Retirement	Empower - COJ DC Pension COJ - DB Empower - JEA Savings Plans		cojdcp.com | 1.904.255.5569 citypension@coj.net | 1.904.255.7280 www.participant.empower-retirement.com 1.800.701.8255
Explain My Benefits			embbenefits.com/pc-jea/

If you experience issues with the websites or have questions about navigating the directories, please contact the company by using the contact information provided on each coverage page.


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