JEA®

Building Community®

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HEALTH FINANCIAL WELLNESS

2021

RETIREE BENEFITS AT A GLANCE

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 see the carrier benefit summaries and certificates for more details or contact Benefits Services at (904) 665-5300. We hope this guide will give you an overview of your benefits to help you be better prepared for the enrollment process.

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 4 - 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 3768 • HMO Plan 47 • HDHP Plan 3160

New for 2021!

Medical Plans

- Medicare Advantage coverage modifications (page 5)
- Paycheck deduction amounts (page 12)

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

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

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ELIGIBILITY & ENROLLMENT

Eligibility

Retirees can continue medical, dental and vision benefits that they are currently enrolled in at time of retirement. This may occur for your dependent(s) should you as a retiree not elect to enroll into eligible benefit coverage. 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.**

You may include the following dependents:

Your spouse	The person to whom you are legally married.
Your child(ren)	Through the end of the calendar year in which he/she turns age 26*. Includes: • your natural child • Step child • legally adopted child • child legally placed for adoption or foster care • A child for whom legal guardianship has been awarded to the covered retiree or the retiree's spouse • Unmarried children of any age who become mentally or physically disabled before reaching the age limit of 26* • Grandchildren - newborn child of a covered dependent from birth to 18 months
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	After the end of the calendar year in which he/she turns 26 through the end of the calendar year in which he/she turns 30. Your dependent may continue to have Medical coverage only if: they are unmarried, have no dependents of their own, are a resident of Florida, a full- or part-time student, **and** have no other health insurance.

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 Medicare, 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. Your Medicare plan will pay first; this plan is primary. The JEA plan will pay next; this plan is secondary. When Medicare is primary, it pays as if there is no secondary plan. When our plan is secondary, it pays benefits after the primary plan has paid benefits. 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.

MEDICAL INSURANCE

FLORIDA BLUE MEDICAL PLAN CHOICES

	Medicare Advantage and Preferred Provider Organization (PPO)	High Deductible Health Plan (HDHP)	Health Maintenance Organization (HMO)
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.*		X **No** *In-network providers must be used except for emergency care.*
Do I need a referral to see a specialist?	X **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.*		

Important Insurance terms

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.**

MEDICAL INSURANCE
MEDICARE ADVANTAGE OPTION

Medical coverage (Elite PPO)

In-Network Coverage	
Deductible DED	$0
Coinsurance (your share)	20%
Out-of-Pocket Maximum	$1,000 per person
Preventive Care	**Covered 100% in-network**
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

Pharmacy coverage (Elite Rx)

Retail Prescriptions (up to 31 days) Standard Retail	
Tier 1 (preferred generic)	$8
Tier 2 (generic)	$15
Tier 3 (preferred brand)	$40
Tier 4 (non-preferred drug)	$70
Tier 5 (specialty)	33% off of the cost
Mail Order Prescriptions (90 days)	
Tier 1 (preferred generic)	$0
Tier 2 (generic)	$3
Tier 3 (preferred brand)	$30
Tier 4 (non-preferred drug)	$60
Tier 5 (specialty)	33% off of the cost

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

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.

MEDICAL INSURANCE

TRADITIONAL MEDICAL PLAN DETAILS

	Preferred Provider Organization	High Deductible Health Plan	Health Maintenance Organization
In-Network Coverage	*BlueOptions Network*	*BlueOptions Network*	*BlueCare Network*
Deductible DED	$1,000 per person $2,000 per family	$1,750 single coverage $3,500 family coverage	$1,500 per person $3,000 family maximum
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 maximum	$5,000 per person $7,000 family maximum	$5,000 per person $10,000 family maximum
Preventive Care	**Covered 100% in-network**	**Covered 100% in-network**	**Covered 100% in-network**
Primary Doctor Visit	$25	DED then 20%	$25
Specialist Doctor Visit	$60	DED then 20%	$60
Maternity Care	Initial Visit: $60	DED then 20%	Initial Visit: $60
Mental Health Counseling	$60	DED then 20%	$60
Independent Labs	$25	DED then 20%	$25
X-Rays	$50	DED then 20%	DED then 20%
Imaging: MRI / CT / PET	$300	DED then 20%	DED then 20%
Urgent Care Center	$50	DED then 20%	DED then 20%
Emergency Room	DED then 20%	DED then 20%	DED then 20%
Inpatient Hospitalization	DED then 20%	**[Opt 1]** DED then 20% **[Opt 2]** DED then 25%	DED then 20%
Outpatient Hospital	DED then 20%	**[Opt 1]** DED then 20% **[Opt 2]** DED then 25%	DED then 20%
Out-of-Network Coverage (***plus balance billing***)			
Deductible	$2,000 | $4,000	$2,500 | $5,000	Not Covered
Urgent Care Center	DED then $50	DED then 20%	Not Covered
Emergency Room	DED then 20%	DED then 20%	In-Network DED 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

The out-of-network deductible and out-of-pocket maximum follows the same structure as in-network (i.e. per person / family maximum)

PHARMACY COVERAGE

Retail Prescriptions (up to 30 days)			
Tier 1 (generic)	$10	DED then $10	$10
Tier 2 (preferred brand)	30% to $70	DED then 30% to $70	30% to $70
Tier 3 (non-preferred brand)	40% to $90	DED then 40% to $90	40% to $90
Tier 4 (specialty)	20% to $250	DED then 20% to $250	20% to $250
Mail Order Prescriptions (90 days)			
Tier 1 (generic)	$20	DED then $20	$20
Tier 2 (preferred brand)	30% to $140	DED then 30% to $140	30% to $140
Tier 3 (non-preferred brand)	40% to $180	DED then 40% to $180	40% to $180

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

MEDICAL INSURANCE
TIPS AND RESOURCES

Florida Blue Resources

Nurseline (24/7!)

1-877-789-2583

Available 24/7, Nurseline can provide assistance for unexpected and ongoing health care 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 all are 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.

Download Florida Blue's mobile app to review claims, access your ID card, find a doctor, and more!

App Store Google Play

FLORIDA BLUE

Group: 51564

Website: www.floridablue.com

Phone: 1-800-664-5295

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 (1-888-476-2227) or use the comparison features on www.floridablue.com to compare your options.

TELADOC
SEE A DOCTOR ANYTIME

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. 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: $15 copay

HDHP: Meet your Calendar Year Deductible (CYD) first then $15 copay

TELADOC

Website: www.teladoc.com

Phone: 1-800-835-2362

DENTAL INSURANCE

Choose from three dental plans that balance cost and care for you and your family. Remember **balance billing** is when you are charged the difference between what your out-of-network dentist charges and what insurance pays.

	DHMO	Low PPO	High PPO
Benefits and Coverage	In-network only	In- and out-of-network	In- and out-of-network
Annual Deductible DED	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 (9430)	$0 copay		
Teeth Cleaning (1110)	$0 copay		
Full mouth/panoramic x-ray (0330)	$45 copay		
Basic Care	Fee schedule applies	DED then 40% *(plus balance billing if you go out-of-network)*	DED then 20% *(plus balance billing if you go out-of-network)*
Fillings (2140)	$0		
Extractions (7140)	$10		
Major Care	Fee schedule applies	DED then 60% *(plus balance billing if you go out-of-network)*	DED then 50% *(plus balance billing if you go out-of-network)*
Periodontal Scaling (4341)	$45		
Endodontics (3330)	$225		
Full or partial dentures (5110)	$260		
Crowns (2750)	$240		
Child & Adult Orthodontia	Benefit schedule applies	Not Covered	**Child**: You pay 50%; *$1,000 lifetime max benefit* **Adult**: Not Covered
Child Orthodontia (to age 19)	$2,050 copay		
Adult Orthodontia	$2,150 copay		

Major differences between the DHMO and PPO options:

Plan Feature Overview	*DHMO*	*PPO*
Insurance Company	Solstice	United Concordia
Provider choice	In-Network only.	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 Solstice 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.

SOLSTICE (DHMO)

Group: 13211

Network: S500B

Website: www.solsticebenefits.com

Phone: 1-877-760-2247

UNITED CONCORDIA (PPO)

Group: 950130000 (Low), 950140000 (High)

Network: Advantage Plus 2.0

Website: www.unitedconcordia.com

Phone: 1-800-332-0366

VISION INSURANCE

EyeMed

FOCUS ON YOUR VISION

Keep your eyes healthy and your vision sharp with comprehensive vision coverage offered through **EyeMed**. All services are available once every 12 months; frames are available once every 24 months.

		In-Network	Out-of-Network
Copays	Eye Examination	$10 Copay	Up to $40 reimbursement
	Materials	$20 Copay	N/A
Glasses	Lenses - Single	Covered after copay	Up to $30 reimbursement
	Lenses - Bifocal	Covered after copay	Up to $50 reimbursement
	Lenses - Trifocal	Covered after copay	Up to $70 reimbursement
	Frames	$120 allowance	Up to $84 reimbursement
Contacts	Elective Contact Lenses ⓘ	$120 allowance	Up to $96 reimbursement
	Standard Contact Fit & Follow-up`	Up to $55 allowance	N/A
	Medically Necessary Contacts	Covered in full	Up to $210 reimbursement

ⓘ 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.

Introducing: eyesiteonwellness.com

Get expert advice you can use!

Articles for all things vision:

Healthy Vision:
Your precious little peepers are surrounded by danger and disease. But you can protect them. Maybe even make them better. We'll show you how.

Vision By Age:
Eyes change with time. So do your vision needs. Learn how to look after eyes of all ages.

Vision Technology:
Technology is transforming vision right before our eyes. How does the digital experience do things differently? The answers are right here.

Eyewear Style & Care:
What to think of first – and how to make it last. Let's make sure your contacts, glasses or shades fit your life, personality and look.

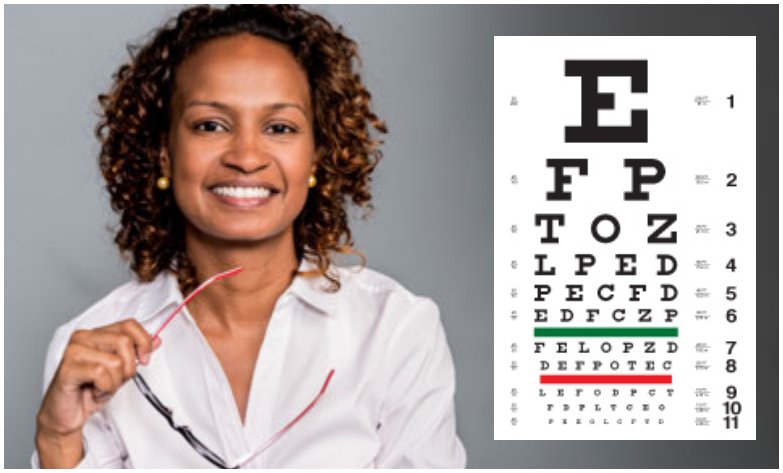
EYEMED

Group: 1012485

Network: Insight

Website: www.eyemed.com

Phone: 1-866-939-3633



PROVIDER SEARCH
LOCATING IN-NETWORK PROVIDERS

How to locate in-network providers for each of your benefit plans.

	Website	Network Name	Instructions and Notes
Medical Insurance *Plans*	www.floridablue.com	BlueOptions (PPO or HDHP) BlueCare (HMO)	• Choose 'find a doctor' • Either log in with your member ID or choose 'BlueOptions' or 'BlueCare' under 'health plans' • Enter the criteria and click 'search' Call 1-877-352-2583 for assistance
Medicare Advantage	Website: www.bcbs.com	Medicare Advantage PPO	Call 1-800-926-6565 for assistance
Dental Insurance *Plans*	DMO www.solsticebenefits.com/provider-search.aspx PPO www.unitedconcordia.com	Plan S500B PPO Advantage Plus 2.0	Call 1-877-760-2247 for assistance Call 1-800-332-0366 for assistance
Vision Insurance	www.eyemed.com	Insight Network	Call 1-866-800-5457 for assistance

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

NOTES

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.

COVERAGE AMOUNTS

Coverage Amount
• $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.

STANDARD

Group: 755562

Phone: 1-800-628-8600

YOUR COST FOR COVERAGE
BASED ON 24 PAY PERIODS PER YEAR

Medical Insurance

Coverage Level	Medicare Advantage*	PPO	HMO	HDHP
Retiree Only	$143.00	$404.86	$370.21	$293.89
Retiree + Spouse	$286.00	$865.68	$791.57	$628.80
Retiree + Child(ren)	---	$782.12	$715.20	$568.10
Retiree + Family	---	$1,229.07	$1,123.88	$892.95

*Any additional dependent's covered on the Medicare Advantage plan cost an additional $143.00 per person.

Dental Insurance

Coverage Level	DHMO	Low PPO	High PPO
Retiree Only	$6.03	$13.83	$20.63
Retiree + Spouse	$10.56	$22.97	$34.26
Retiree + Child(ren)	$13.07	$25.76	$38.43
Retiree + Family	$16.59	$40.26	$60.05

Vision Insurance

Coverage Level	Vision Plan
Retiree Only	$2.10
Retiree + 1	$4.21
Retiree + 2 or more	$6.76

Life Insurance

Coverage Level	Life Insurance
$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 **(904) 665-5300** or **Benefits@JEA.com**.

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; **Web** www.medicare.gov 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.
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 the 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.

ANNUAL DISCLOSURES
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 –
A federal law called 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.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact JEA Benefit Services at 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 the 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 – 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.

Wellness Program - JEA's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008 and the Health Insurance Portability and Accountability Act, as applicable, among others.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 904.665.5300 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol ratio, high-density lipoproteins (HDL), low-density lipoproteins) LDL, triglycerides, glucose, nicotine, total cholesterol, gamma-glutamyl transferase (GGT), blood urea nitrogen (BUN), creatinine, total bilirubin, aspartate aminotransferase (AST), alanine transaminase (ALT), alkaline phosphatase (ALK) phosphate (PHOS), total protein, albumin and globulin. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Employees who elect to participate in the biometric screening event during 2020 in the JEA Wellness program will be eligible to receive beginning January 2021 a $20 wellness credit per pay period (up to $480 for the calendar year) to employees who complete the biometric screening, health survey and achieve a health score of a 75+ or improve last year's score by 5+ points or successfully complete a reasonable alternative as established with the HealthCheck360 health coach. Also, when completing the biometric screening and health survey, 10,000 Pride Points will be received.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HealthCheck360 at 866-511-0360.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and they may also be used to offer you services through the wellness program, such as educational seminars or health related campaigns and resources. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information: JEA is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and JEA may use aggregate information it collects to design a program based on identified health risks in the workplace, the Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are representatives from HealthCheck360 and possibly health coaches you may utilize through HealthCheck360 in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted and no information you provide as part of the wellness program will be used in making any employment decision. The Wellness Team completes annual HIPAA training, sign a Confidentiality Agreement and keep all information locked and secured. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Florida Blue may also receive wellness program information when necessary to assist with wellness program services.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice or about protections against discrimination and retaliation, please contact the Manager of Benefit Services at 904.665.5300.

Michelle's Law – Michelle's Law requires group health plans to provide continued coverage for a 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, 21 West Church Street, Jacksonville, FL 32202 at 904.665.5300, e-mail: Benefits@JEA.com.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act – 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.

Premium Assistance Under Medicaid and 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, 2020. Contact your State for more information on eligibility –

Alabama Medicaid	Website: http://myalhipp.com/ Phone: 1-855-692-5447
Alaska Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Arkansas Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
California Medicaid	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
Colorado Medicaid Child Health Plan Plus	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program - HIBI Customer Service: 1-855-692-6442
Florida Medicaid	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
Georgia Medicaid	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
Indiana Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
Iowa Medicaid	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki awki Phone: 1-800-257-8563
Kansas Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
Kentucky 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://kidshealth.ky.gov/Pages/index.aspx - Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
Louisiana Medicaid	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	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 - TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. - TTY: Maine relay 711
Massachusetts Medicaid And CHIP	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
Minnesota Medicaid	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
Missouri Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Montana Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
Nebraska Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 - Lincoln: 402-473-7000 - Omaha: 402-595-1178

Nevada Medicaid	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
New Hampshire Medicaid	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 - Toll free number for the HIPP program: 1-800-852-3345, ext 5218
New Jersey Medicaid & Chip	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
New York Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
North Carolina Medicaid	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
North Dakota Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Oklahoma Medicaid & Chip	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
Oregon Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
Pennsylvania Medicaid	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
Rhode Island Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
South Dakota Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
Texas Medicaid	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
Utah Medicaid And Chip	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
Vermont Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
Virginia Medicaid & Chip	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
Washington Medicaid	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
West Virginia Medicaid	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Wisconsin Medicaid And Chip	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Wyoming Medicaid	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, 2020, or for more information on special enrollment rights contact either:

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, Menu Option 4, Ext. 61565

MEDICARE 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 coverage will not be affected.

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

If you do decide to join a Medicare drug plan and drop your current JEA coverage, be aware that you and your dependents will not be able to get this coverage back.

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 63 continuous 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, 2021

Name of Entity / Sender: JEA

Contact / Position-Office: Manager of Benefit Services

Address: 21 West Church Street, Jacksonville, FL 32202

Phone Number: (904) 665-5300

ANNUAL DISCLOSURES

JEA SELF-FUNDED HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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, 2020

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.
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 communications of protected health information in confidence**.
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.
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. **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.
7. **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.

PRIVACY PRACTICES CONTINUED

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 use or disclose your health information without your permission for health care providers to provide you with treatment.

Payment: We may use or disclose your 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 benefits 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 by 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 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 for 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 health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

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 genetic 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 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 health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your protected health information; and (iii) 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, 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 organization's Web site (if applicable Web site exists) for 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, Pat Maillis 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
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20211
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

JEA Self-Funded Health Plan
Pat Maillis
Privacy Officer
21 West Church St.
Jacksonville, FL 32202
(904) 665-5300

IMPORTANT CONTACTS

BENEFIT SERVICES

benefits@JEA.com
Main Number: (904) 665-5300

PAYROLL

Payroll@JEA.com
Main Number: (904) 665-4408

HEALTH AND WELFARE PLANS

MEDICAL (FLORIDA BLUE)

Web Address: www.FloridaBlue.com
Member Services: (800) 664-5295

TELADOC

Web Address: www.teladoc.com
Member Services: (800) 835-2362

DENTAL

DHMO (SOLSTICE)
Web Address: www.solsticebenefits.com
Member Services: (877) 760-2247

PPO (UNITED CONCORDIA)
Web Address: www.unitedconcordia.com
Member Services: (800) 332-0366

VISION (EYEMED)

Web Address: www.eyemed.com
Member Services: (866) 939-3633

RETIREE LIFE

RETIREE LIFE (STANDARD)

Web Address: www.standard.com
Member Services: (800)-628-8600

OTHER

EMPLOYEE ASSISTANCE PROGRAM (HEALTHADVOCATE)

Web Address: .www.healthadvocate.com
Member Services: (877) 240-6863

PENSION AND RETIREMENT SERVICES

City Pension Office
Main Number: (904) 255-7280

Empower
Main Number (904) 255-5569

Mass Mustual (Retirement Plan)
Main Number: (800) 743-3274

INSURANCE PREMUM BILLING (P&A ADMIN SERVICES)

Web Address: www.padmin.com
Member Services: (800) 688-2611

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