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HEALTH > FINANCIAL > WELLNESS

2020

BENEFITS AT A GLANCE

JAN 2020

WELCOME

Dear Employee,

JEA understands your benefits are important to you and your family. Helping you understand the benefits available to you is essential. This Benefits Guide provides a description of our company's benefit program. Included in this guide are summary explanations of the benefits, as well as contact information for each provider.

This guide is not an employee/employer 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 common questions. Please see the carrier benefit summaries and certificates in the Employee Benefits site for more details.

TOP THINGS TO KNOW ABOUT THIS GUIDE AND YOUR BENEFITS

- Benefit summaries are available on-line on the GRID (http://hr/EB/sitepages/home.aspx)
- Please review the medical and dental plan comparison charts located on pages **6** and **12**, respectively.
- Contact information for each vendor is available on the respective benefit page and the back cover.

NEW FOR 2020!

Medical Plans

- Coverage Modifications (page 4)
- Paycheck deduction amounts (page 17)

Dental

- United Concordia: JEA subsidy provided in order for paycheck deductions to remain the same amount (page 17)
- Solstice: Decrease in paycheck deduction (page 17)

Paid Parental Leave

- Benefit overview (page 20)

CONTENTS

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.

ELIGIBILITY & ENROLLMENT

Employee Eligibility

Benefit eligible employees are provided an opportunity to participate in the JEA sponsored benefits program. You are eligible for benefits on your first day. You may change your coverage tier of the respective plan for the first time you enroll, add or remove a dependent or terminate a plan previously elected. All benefits discontinue on the termination date with JEA.

Eligible dependents include:

Your spouse	The person to whom you are legally married.
Your child	Through the end of the calendar year in which he/she turns age 26*, your biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.
Your child with a disability (disabled prior to age 26)	Your covered child who is permanently mentally or physically disabled. This child may continue health insurance coverage after reaching age 26* if you provide adequate documentation validating disability upon request and the child remains continuously covered in a State Group Insurance health plan. The child must be unmarried, dependent on you for care and for financial support.
Your stepchild	Through the end of the calendar year in which he/she turns age 26*, the child of your spouse for as long as you remain legally married to the child 's parent.
Your foster child	Through the end of the calendar year in which he/she turns age 26*, a 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. Foster children may be eligible to their age of maturity.
Legal guardianship	Through the end of the calendar year in which he/she turns age 26*, a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible until his or her age of maturity.
Your grandchild	A newborn dependent of your covered child. Coverage may remain in effect up to 18 months of age as long as the newborn's parent remains covered.
*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.

Qualifying Life Event

Elections made during your initial election period or at Open Enrollment may not be changed until the next annual Open Enrollment period, unless you experience a "Qualifying Life Event." A Qualifying Life Event allows you to make a change to your benefit elections within 30 days of the event. You may change your coverage tier of the respective plan for the first time you enroll, add or remove a dependent or terminate a plan previously elected.

Coverage will be effective the date of the Qualifying Life Event. A retro adjustment of the premium for the change in the level of coverage will be deducted from your pay check.

Examples of Qualifying Life Events include but are not limited to:

- Marriage
- Divorce or legal separation
- Birth, adoption, or legal custody of a dependent child
- Changes to your dependent's eligibility for benefits under another group health plan resulting in gain/loss of coverage
- Death

Documentation will be required, such as a marriage certificate, divorce decree, birth certificate, proof of loss/gain coverage, etc.

If you experience a Qualifying Life Event, contact Benefit Services at (904) 665-5300 and submit all required documents within **30 days** of the event.

Note: Health Savings Account (HSA) contributions can be changed at any time.

Your Responsibility

Before you enroll, make sure you understand the plans and ask questions. Always print out (from Oracle) your JEA Benefits Confirmation Statement with your enrollment choices and beneficiaries to keep for your records. After you enroll you should check your first paycheck to make sure the correct amount is being deducted and that all the benefits you elected are included.

MEDICAL INSURANCE
YOUR MEDICAL PLAN CHOICES

	Preferred Provider Organization (PPO)	High Deductible Health Plan with Health Savings Account (HDHP with HSA)	Health Maintenance Organization with Health Reimbursement Account (HMO with HRA)
What it is	**PPO:** A plan you may choose to receive care from any provider of your choosing. 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 when you choose an in-network provider.	**HDHP:** A health plan that meets certain federal government qualifications (deductible and out-of-pocket maximum) requires all non-preventive care be subject to the deductible and is paired with an HSA bank account. **HSA:** A special account owned by you with tax-free funds designated to pay for qualifying medical, dental, vision, and pharmacy expenses. Both you and JEA may contribute to an HSA.	**HMO:** 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 to be a covered expense. This plan encourages consumers to become educated in the care they're receiving and how much it costs. **HRA:** An employer-funded account to help you pay for medical expenses only.
Account Eligibility	Flexible Spending Account (FSA) only *See page 10 for more information on an FSA*	HSA Only *See page 8 for more information on an HSA*	HRA and FSA *See page 8 for more information on an HRA*

NEW FOR 2020!

High Deductible Health Plan (HDHP) Annual deductible changed from $1,500 per person / $3,000 per family to $1,750 per person / $3,500 per family

High Deductible Health Plan (HDHP) Out-of-Pocket Maximum changed from $5,000 per family to $7,000 per family

Preferred Provider Organization (PPO) In-network annual deductible changed from $750 per person / $1,500 per family to $1,000 per person / $2,000 per family

Preferred Provider Organization (PPO) Out-of-network annual deductible changed from $1,000 per person / $3,000 per family to $2,000 per person / $4,000 per family

Prescription drug coverage (All Plans) changed to Tier 2 (Preferred Brand) to 30% with $70 maximum copay, and Tier 3 (Non-Preferred Brand) 40% with $90 maximum copay. (Deductible applies first for HDHP w/HSA for all prescriptions.)

MEDICAL INSURANCE
YOUR MEDICAL PLAN CHOICES

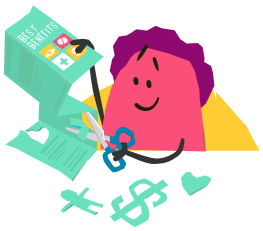
	PPO	HDHP with HSA	HMO with HRA
Is preventive care covered?	√ **Yes** *In-network preventive care is covered at 100%*		
Can I go to any doctor?	√ **Yes** *However, you will receive better benefits and pay less for care if you use in-network providers.*		X **No** *In-network providers must be used except 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.*		
Does the company help fund a healthcare account?	X **No** *You have access to a Flexible Spending Account funded by your pre-tax contributions*	√ **Yes** *A Health Savings Account is included with this plan funded through contributions made by you and JEA.*	√ **Yes** *Health Reimbursement Arrangement account is included with this plan funded through contributions from JEA*

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. One of the plans will pay first; your JEA plan is primary. The other plan will pay next; that plan is secondary. When our plan 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.



alex® is an online tool designed to help you craft the best benefit plan for you and your family. When you work with ALEX, you will be asked a few questions about your health care needs, it will crunch some numbers, and provide some recommendations about the health plan options that make the most sense for you.

Any information you provide to ALEX remains fully confidential and anonymous, so be honest about your health care needs and planned expenses. The recommendations you receive are only as good as the information you provide. Visit ALEX at https://benefits.myalex.com/JEA/2020.

MEDICAL INSURANCE
PLAN DETAILS

	Preferred Provider Organization	High Deductible Health Plan with Health Savings Account	Health Maintenance Organization with Health Reimbursement Account
In-Network Coverage	*BlueOptions Network*	*BlueOptions Network*	*BlueCare Network*
Calender Year Deductible (CYD) 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
Tier 4 (specialty)	20% to $250	DED then 20% to $250	20% to $250

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!

Available on the App Store

GET IT ON Google Play

FLORIDA BLUE

Group: 51541

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 w/HRA: $15 copay

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

TELADOC

Website: www.teladoc.com

Phone: 1-800-835-2362

HEALTH ACCOUNTS
HEALTH SAVINGS ACCOUNT (HSA) AND HEALTH REIMBURSEMENT ACCOUNT (HRA)

HSA: SAVINGS WHEN YOU NEED CARE

The HSA, administered by TASC, is a great way to handle medical, prescription, dental, and vision expenses not covered by your insurance. JEA provides a contribution, and you may make regular tax-free contributions to your account through payroll.

And that's not all:

- You own the account, even if you change plans or jobs
- Your funds roll over from year to year and any growth is tax-free
- Any withdrawal for qualified medical expenses is tax-free

Under the High Deductible Health Plan (HDHP) with HSA JEA will contribute **$1,000** for employees enrolling in single coverage, and **$2,000** for employees enrolling in family coverage.

	IF YOU CHOOSE INDIVIDUAL COVERAGE	IF YOU CHOOSE FAMILY COVERAGE
JEA contributes	**$1,000**	**$2,000**
You may contribute up to:	**$2,550**	**$5,100**
For a total maximum of:	**$3,550**	**$7,100**

AGE 55 OR OLDER? The IRS permits an extra **$1,000** per year in catch-up contributions.

Contribution maximums are based on 2020 IRS limits and are pro-rated on a monthly basis for coverage lasting less than 12 months.

HSA Eligibility:

You must be enrolled in the HDHP with HSA to have the HSA. You cannot contribute to an HSA if you have other medical coverage (like Medicare or TRICARE) or if you are a dependent on someone else's tax return. In this scenario, you may still enroll in the medical plan. **JEA will make the contribution on your behalf to a health care FSA instead.**

The first time you elect an HSA with JEA you will need to set up an account on-line with TASC (the plan administrator). Please set up your account after your HSA debit card is received.

HRA: JEA-FUNDED MEDICAL CARE

The HRA - a Health Reimbursement Arrangement - is an account established by JEA and administered by TASC for your use when you enroll in the HMO with HRA plan. Funds in the account can be used to pay for qualified medical expenses incurred by you and your covered family members. **Any remaining funds at the end of the year are carried over to the next year up to the annual deductible limit.**

	IF YOU CHOOSE INDIVIDUAL COVERAGE	IF YOU CHOOSE FAMILY COVERAGE
JEA contributes	**$600**	**$1,200**

Unlike an HSA, you are not able to make your own contributions to an HRA. However, you are able to contribute to a Health Care Flexible Spending Account (FSA) to pay for qualifying expenses with pre-tax dollars. Any remaining balance in the FSA is forfeited at the end of the year. TASC administers the HRA accounts.

HEALTH ACCOUNTS
HEALTH SAVINGS ACCOUNT (HSA) AND HEALTH REIMBURSEMENT ACCOUNT (HRA)

COMPARING YOUR OPTIONS

Remember that you aren't just choosing an HRA or an HSA, you're also choosing a health plan. You'll need to consider a variety of factors: your general health, whether you expect to receive any expensive treatment or have surgery this year, medications, who you cover, etc. to make the best decision for you.

HSA vs HRA: A Comparison

	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Eligibility	Must be enrolled in the HDHP through JEA and meet eligibility qualifications for an HSA (see page 8).	Must be enrolled in the HMO through JEA
JEA Contribution*	Single coverage: $1,000 | Family coverage: $2,000	Single coverage: $600 | Family coverage: $1,200
Your ability to contribute	You may contribute on a tax-free basis either through payroll deductions or on your own, up to the maximums listed on page 8 (depending on your coverage level).	You are not permitted to contribute to an HRA per IRS regulations.
Eligible Dependents	In most cases, HSA funds may be used for qualified dependents regardless of their medical plan enrollment.	Dependents must be enrolled in the HMO HRA plan through JEA to be eligible for HRA funds.
Rollover	100% of unused funds roll over each year. No exceptions.	Any funds at the end of the year are carried over to the next year up to the annual deductible
Portability (ability to take unused funds with you)	A health savings account belongs to you; you may take the account with you if you leave JEA. The money in the account is always yours.	If you terminate employment with JEA or change your medical plan, the HRA amount will be forfeited.
Eligible expenses	Medical, pharmacy, dental, and vision expenses that fall under the IRS Publication 502 eligibility guidelines.	Medical and pharmacy expenses only.
How to pay for expenses	You will receive a Visa debit card that will allow you to pay for expenses.	You will receive a Mastercard debit card that will allow you to pay for expenses.
Compatibility with an FSA	**Health Care FSA**: Not eligible **Dependent Care FSA**: may participate; no impact to eligibility	**Health Care FSA**: Eligible to make contributions **Dependent Care FSA**: may participate; no impact to eligibility

The choice is yours based on your individual needs. If you're considering the HDHP with HSA for the first time and have questions about how it may impact your taxes, we encourage you to contact a qualified tax professional to determine what it means for you. Alex can also help you decide which option is best for you (https://benefits.myalex.com/JEA/2020).

*** Prorated JEA contribution for accounts effective after Jan 1, 2020**

TASC

Website: www.tasconline.com

Phone: 1-800-422-4661

FLEXIBLE SPENDING ACCOUNTS
HEALTH AND DEPENDENT CARE

Flexible Spending Accounts Can Save You Money

Pay for qualifying health care and dependent care expenses with tax-free money using a Flexible Spending Account (FSA), administered by TASC. You may generally enroll in one or both accounts depending on your needs.

You will receive a debit card from TASC to pay for your eligible expenses. Estimate carefully - any leftover funds at the end of the year are forfeited per IRS regulations.

HEALTH CARE FSA

Pay for qualifying medical, pharmacy, dental, and vision expenses using pre-tax funds with a Health Care FSA.

Contribution Maximum	**$2,700** ($112.50 per paycheck)
Time period for claims	**January through December**
Time period to submit claims	**through March 31, 2021**

Good to know:

If you are enrolled in the HDHP with HSA, you are not eligible for a Health Care FSA.

DEPENDENT CARE FSA

Pay for qualifying dependent care on behalf of an eligible individual with pre-tax funds. Eligible individuals are typically defined as a dependent child under the age of 13 or a tax dependent or spouse who is physically or mentally incapable of self-care.

Contribution Maximum	**$5,000** ($208.33 per paycheck) | **$2,500** if married filing separately
Time period for claims	**January through December**

Good to know:

Eligible expenses must be necessary for you and/or your spouse to work, attend school, or look for work.

Only the amount you contributed year to date is available at any one time.

TASC

Website: www.tasconline.com

Phone: 1-800-422-4661

Download TASC's mobile app to manage your FSAs

Available on the App Store

GET IT ON Google Play

WELLNESS PROGRAM

Wellness Program

JEA is committed to helping employees live a healthy lifestyle. For over 25 years, the JEA Wellness Program has been a part of the employee benefit package. The program has and will continue to provide the structure and initiatives that are of value.

The purpose of the JEA Wellness Program is to assist employees in:

- Achieving optimal health,
- Lowering health risk factors,
- Improving their quality of life,
- Performing at their maximum capability, and
- Reducing healthcare expenditures due to preventable illnesses.

The JEA Wellness Program helps employees develop a healthy lifestyle by focusing on the employee's needs and interests through our programs that positively engage employees in all areas of their life.

HealthCheck360
Real Results for Real People

JEA has partnered with a recognized wellness vendor, HealthCheck360 along with Corporate Fitness Work; who specializes in management of fitness facilities. Both partners will assist you in taking your goals to the next level and are devoted to improving health and overall wellbeing. You will get motivation and support along your journey to wellness. With HealthCheck360, you will receive a personalized, confidential report of your health status after your wellness screening. From there, you will have access to health coaches to help you better understand your results and set personal wellness goals. Keep an eye out for wellness challenges, recipes, webinars, and more to make focusing on your health fun and easy.

You have access to:

Health Education provided in the form of lunch & learns, quarterly health topics, grab-n-go information stations, health resource library topics and telephonic health coaching.

On-site health screenings provided annually. A comprehensive on-site screening program will be made available to include screenings for blood pressure, glucose, cholesterol, triglycerides and creatinine; along with a Personal Health Assessment (PHA) about family history and lifestyle habits. Employees are also provided with the opportunity to speak with a healthcare professional about their basic health needs.

Life style change incentive programs are offered year round to encourage participation in healthy living activities, stress management, tobacco cessation, healthy eating, exercise and weight management.

In addition, we added more resources to improve our program such as:

- **Mobile app** to make participating in the program easier.
- **Challenges**, both company-wide and challenge-a-friend options are available
- **Condition Management** nurses are available for those that have a chronic condition like diabetes or hypertension and need some assistance to better manage their condition

To learn more about HealthCheck360, visit: https://www.healthcheck360.com/videos

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. You are responsible for balance billing charges.

	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		
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, 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 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

FOCUS ON YOUR VISION

Keep your eyes healthy and your vision sharp with comprehensive vision coverage offered through **EyeMed**. 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.

Visit: 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 *all 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 1-800-664-5295 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 AND AD&D INSURANCE

Basic (JEA-provided) life and AD&D insurance

As an employee of JEA, you are provided with life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you. Make sure you designate a beneficiary in Oracle who will receive your life insurance payment if you pass away while covered under this policy.

Voluntary AD&D insurance options

To supplement the AD&D coverage provided by JEA, you have the option to purchase additional AD&D coverage for yourself and your dependents. You may elect up to five times annual salary to a maximum of $500,000.

Voluntary life insurance options

To supplement the life insurance coverage provided by JEA, you have the option to purchase additional life insurance coverage for yourself and your dependents through Standard. **You must cover yourself to cover your dependents, and a beneficiary designation is required to enroll in additional life insurance.** Your cost for coverage depends on your coverage amount and is available at enrollment.

AD&D

AD&D, or Accidental Death & Dismemberment insurance, is attached to the basic and voluntary life insurance policies you receive through JEA.

Your AD&D coverage is for the same amount as your life insurance and can pay a benefit in one of two ways:

1. If your death is caused due to a covered accident, the AD&D benefit pays in addition to your life insurance. This is sometimes called a "double indemnity" because your beneficiary receives both the life insurance amount and the AD&D amount.
2. If, as the result of a covered accident, you either lose a covered body part (such as a limb) or lose the function of a covered body part, you may receive a percentage of the total AD&D benefit depending on the functions that have been lost.

COVERAGE AMOUNTS

For you

Your life insurance and AD&D benefit amounts depend on your business unit and your salary. Additional life insurance options are based on multiples of your salary as indicated by your business unit to a maximum of $250,000.

Business Unit	Basic Life and AD&D	Voluntary Life Options
JEA Appointed	3 times your salary to $500,000	1x 2x salary
JEA M&C	2 times your salary to $350,000	1x 2x salary
JEA IBEW, AFSCME & LIUNA	Your annual salary to $350,000	1x 2x 3x salary
PEA IBEW	Your annual salary to $350,000	1x 2x salary
JSA	Your annual salary to $250,000	1x 2x 3x 4x 5x salary

As a new employee, you may elect up to the **guarantee issue limit of $250,000** with no medical questions required. Requests to enroll at a later date will be subject to medical questions and approval by Standard.

For your dependents

Voluntary life insurance options for your spouse and one or more child(ren) are the same regardless of business unit:

Dependent	Voluntary Life and AD&D Coverage Options
Spouse	$10,000 $15,000 $25,000
Child(ren)	$10,000

STANDARD

Group: 755562

Phone: 1-800-628-8600

DISABILITY INSURANCE

THE **IMPORTANCE** OF DISABILITY INSURANCE

Think of disability insurance as insurance for your paycheck. The bills don't stop just because your paycheck stops. Disability insurance helps you fill the financial gap while you get better. Or, in the event you cannot return to work, long-term disability insurance can provide you and your family with a continued source of income.

Did you know? Just over 1 in 4 of today's 20-year olds will become disabled before they retire.

Source: U.S. Social Security Administration, Fact Sheet February 7, 2013

You have the opportunity to purchase both Short-Term Disability Insurance (STD) and Long-Term Disability Insurance (LTD) through Standard Life Insurance Company. If you elect this coverage as a newly eligible employee, no medical questions are required. Any request to enroll at a later date will be subject to medical questions and approval by Standard. Disability insurance does not pay for injuries received on the job, and benefits are reduced if you receive other payments (such as Social Security).

Short-Term Disability Insurance

	Short-Term Option One	Short-Term Option Two
When benefits begin	On your **8th** days of inability to work	On your **15th** day of inability to work
How much it pays	**60%** of your income to **$750** per week	**60%** of your income to **$1,000** per week
How long payments last	Up to **25** weeks if you remain unable to work	Up to **24** weeks if you remain unable to work

- Your cost for coverage depends on your income and the benefit option you choose and will be available at enrollment.
- Short-term Disability and Paid Parental Leave is coordinated with other JEA benefit program to prevent receipt of over 100% of earnings (e.g. Annual Leave).

Long-Term Disability Insurance

When benefits begin	After **180** days of inability to work
How much it pays	**60%** of your income to **$5,000** per month
How long payments last	Until your Social Security Normal Retirement Age if you remain unable to work

- Your cost for coverage depends on your age and income and will be available at enrollment.
- This plan has a ***pre-existing condition exclusio***n, which means the plan will not pay for any conditions you received treatment for during the *12 months* before coverage began for the first *12 months* the policy is in effect.

STANDARD

Group: 755562

Phone: STD & LTD Claim Intake: 800-378-2395
STD & LTD Claim Status: 800-368-1135

Please refer to our company retirement plans when making your decision regarding disability insurance.

PAYCHECK DEDUCTIONS
YOUR COST FOR COVERAGE

Cost for coverage per paycheck (24 pay periods per year)

Medical Insurance

Coverage Level	PPO	HMO with HRA	HDHP with HSA
Employee Only	$46.20	$28.07	$0.00
Employee + Spouse	$286.29	$227.13	$158.63
Employee + Child(ren)	$242.76	$190.96	$129.88
Employee + Family	$475.62	$384.53	$283.74

Dental Insurance

Coverage Level	DHMO	Low PPO	High PPO
Employee Only	$6.03	$13.32	$19.86
Employee + Spouse	$10.56	$22.11	$32.98
Employee + Child(ren)	$13.07	$24.80	$37.00
Employee + Family	$16.59	$38.76	$57.81

Vision Insurance

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

It is your responsibility to ensure your on-line benefits enrollment information is correct. If a premium deduction error occurs, notify Benefit Services immediately at **(904) 665-5300** or **Benefits@JEA.com**.

Life and Disability Insurance

Life, AD&D, Short-Term Disability Insurance

Benefit	Your rate
Voluntary Life: Employee	$0.238 per $1,000
Voluntary Life: Spouse	$0.1895 per $1,000
Voluntary Life: Child(ren)	$0.1165 per $1,000
Voluntary AD&D: Employee	$0.032 per $1,000
Voluntary AD&D: Employee + Family	$0.048 per $1,000
Short-Term: Option One	$0.23 per $10 weekly benefit
Short-Term: Option Two	$0.20 per $10 weekly benefit

Long-Term Disability Insurance

Age	Your Rate*
17 – 24	$0.057
25 – 29	$0.065
30 – 34	$0.102
35 – 39	$0.151
40 - 44	$0.234
45 – 49	$0.371
50 – 54	$0.555
55 – 59	$0.674
60 +	$0.698

*Your rate is per $100 of monthly covered payroll

ADDITIONAL BENEFITS
VOLUNTARY BENEFITS AND LEGAL PLAN

AFLAC BENEFITS

AFLAC offers a selection of plans to help you meet financial obligations associated with accidents, illnesses, and certain diagnoses. Coverage is paid for through payroll deductions, and benefits are paid directly to you.

Your cost for coverage depends on the plan, and in some cases, your age. If your employment with JEA ends, you may take these benefits with you for the same cost you pay as an employee. Additional information is available on www.aflac.com/JEA, at enrollment, or from our AFLAC representative, Susan Knight (904-241-2482).

Hospital Indemnity Plan

Pays for hospital confinements or outpatient surgeries due to injury, illness or pregnancy. Pays cash benefits directly to you to help offset the costs associated with hospital confinements.

Cancer Plan

AFLAC pays a cash benefit upon the initial diagnosis of a covered cancer. A variety of, other benefits are also payable throughout the cancer treatment such as chemotherapy, radiation and surgery. You can use these cash benefits to help pay, out of pocket medical expenses, the rent or mortgage, groceries or utility bills.

The plan offers a $75 wellness benefit for each covered person each year.

Accident Plan

AFLAC pays cash benefits directly to you in the event of an accident, either on or off the job. The accident plan, has no deductibles, copayments or lifetime limit. You are covered 24 hours per day, 7 days a week.

This plan offers a wellness benefit of $60 payable after it has been in force for 12 months.

AFLAC

Website: www.aflac.com

Phone: 1-800-922-3522

LEGAL PLAN

JEA offers full-time employees the opportunity to purchase Legal Assistance through US Legal Services with post-tax payroll deductions. The Family Protector is a comprehensive legal protection program designed to help individuals and their families deal with various personal issues in a dignified, affordable manner. This program includes, but is not limited to, free services such as:

- Telephonic legal advice
- Review of legal documents
- Simple wills for member & spouse
- Credit repair assistance

You can upgrade your Legal Plan to include the Identity Theft Program which covers a $25,000 identity theft expense reimbursement. The policy also covers lost wages up to $500 per week for a maximum of four weeks.

U.S. LEGAL

Website: www.uslegalservices.net

Phone: 1-800-356-5297

EAP
EMPLOYEE ASSISTANCE PROGRAM

JEA offers all employees and their families a confidential Employee Assistance Program (EAP) through Health Advocate. You are automatically enrolled and have free, unlimited, **confidential** access to licensed counselors 24 hours a day, 7 days a week for assessment, short-term problem resolution, and community resource referrals.

In addition, each employee and family member can receive up to 5 face-to-face visits with a counselor for each issue each calendar year.

Available EAP services include:

Core Services

General counseling for:

- stress and depression
- family and relationship challenges
- marriage counseling
- substance abuse
- child care and work life services
- educational resources
- grief and elder care resources

Financial Planning

Resources such as:

- investment plans
- retirement and estate planning
- debt reduction and budget management
- bankruptcy
- tax support
- college funding

Legal Services

Referrals and discounts for services such as:

- creating or modifying a will
- consumer issues
- criminal matters
- living wills and power of attorney
- separation and divorce
- traffic matters

Mediation Referrals

Such as:

- divorce
- child custody
- estate settlement
- family disputes
- real estate matters
- collections
- contractual disputes.

HEALTH ADVOCATE

Website: www.healthadvocate.com

Phone: 1-866-695-8622

TIME AWAY FROM WORK

Time Away from Work

JEA has a comprehensive leave program which includes accrued annual/personal leave for vacation, sick, or personal reasons, Family Medical Leave (FML), and leave of absence (LOA) without pay. In addition to our leave programs, we also have 11 paid holidays and a Personal Leave Day, dependent upon the applicable bargaining unit agreement or employment plan.

Annual/Personal Leave

Annual/personal leave accrues on a bi-weekly basis. Employees must be in a paid status in order to accrue annual leave. Refer to your Collective Bargaining Agreement or the JEA Appointed Staff Employment Plan for more comprehensive details and accrual rates.

Paid Parental Leave (New Effective January 1, 2020)

Eligible employee may take up to six (6) weeks of Paid Parental Leave per 12 month period immediately following the birth or adoption of an employee's child. Refer to the Paid Parental Leave Policy for more details.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) provides eligible employees of JEA job-protected leave for specified family and medical reasons. JEA* Policy requires that accrued annual leave (or Paid Paternal Leave) and FML leave run concurrently. Eligible employees are entitled to twelve workweeks of FML in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of their job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- twenty-six workweeks of FML during a rolling 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent, or next of kin (military caregiver leave).

**See the Department of Labor's list of potential covered/eligible leave definitions.*

Leave of Absence (LOA) Without Pay

If an employee does not qualify for FMLA, yet requires time for their own personal health reasons, a leave of absence (LOA) may be available. Please see the Civil Service and Personnel Rules and Regulations and/or the JEA Appointed Staff Employment Plan for details on these plans. Any time granted without pay will adjust your service and pension eligibility dates.

All leave options work in tandem with short and/or long-term disability. For questions regarding leave, please call 904-665-5300.

Holidays

Employees are given paid holidays each year, provided the employee is not on a leave without pay status when the holiday occurs. Employees must be paid the day before and the day after the holiday in order to be paid for the holiday.

- New Year's Day
- Martin Luther King Jr's Birthday
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day
- Personal Leave Day

IMPORTANT TERMS

- **Allowed Charge or Negotiated Rate** – The maximum amount upon which payment will be based for benefit covered services.
- **Balance Billing** – When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.
- **Beneficiary** – You must list a beneficiary for each of 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 (If under 18, claim payments will be placed in a trust).
- **Calendar Year Deductible (CYD)** – Amount, if any, a member owes per calendar year before the carrier will begin to pay for covered services.
- **Coinsurance** – Your share of the costs of the allowed amount of a covered service, a percent of the allowed amount for the service, after your deductible has been met.
- **Copayment** (copay) – A fixed dollar amount you pay for covered services, usually due when you receive the service.
- **Dependent Care Flexible Spending Account (FSA)** - An employer sponsored benefit that enables employees to set aside pre-tax contributions to pay for eligible daycare expenses.
- ***DHMO** – Dental plan with a restricted network. All dental services must be coordinated with your primary care dental provider.
- **Health Reimbursement Account (HRA)** – Tax-advantaged account available for employees enrolled in the Health Maintenance Organization Plan (HMO). Employer funded account; employees cannot make contributions. Funds can only be used towards medical expenses for covered members under the HMO medical plan. Beginning January 1, 2020, any remaining funds at the end of the year are carried over to the next year (up to the annual deductible limit).
- **Health Savings Account (HSA)** – Tax-advantaged account available to members enrolled in the High Deductible Health Plan (HDHP). Employer funded account, and employees can make pre-tax contributions. Balance will roll over at the end of the calendar year. Account balances over $2,000 can be invested in mutual funds. Funds can be used for any eligible tax dependent for medical, dental, or vision out-of-pocket expenses.
- **Healthcare Flexible Spending Account (FSA)** – Tax-advantaged account available for employees to lower their taxable income with pre-taxed contributions. Unused balance does not roll over at the end of the calendar year. Funds can be used only for any eligible tax dependent for medical, dental or vision out-of-pocket expenses.
- **In-Network** – Providers and facilities that are part of the network of providers with which it has negotiated allowable charges. Insured individuals pay less when using an in-network provider.
- **Out-of-Pocket Maximum** – The maximum amount you pay each calendar year for covered services including coinsurance and deductibles. Once you reach your out-of-pocket maximum, the plan pays 100% for covered services.
- **Out-of-Network** – Providers and facilities that are not a part of the network of providers. Balance billing does apply.
- **Pharmacy Tier** – Drugs are grouped into tiers. The tier that your medication is in determines your portion of the drug cost.
  - Tier 1 Preferred Generic
  - Tier 2 Preferred Brand Name
  - Tier 3 Non-preferred Brand Name
  - Tier 4 Usually includes specialty medications

*Or arrangement as listed on page 12.

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 –

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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). You will be required to submit a signed statement when other coverage is the reason for waiving enrollment originally.

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 dependents. However, you must request enrollment within X days after the marriage, birth, adoption, or placement for adoption.

In addition 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.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 obtain more information, contact JEA Benefit Services at 904.655.5300 or Benefits@JEA.com.

Patient Protection – If your group health plan requires or allows the designation of a primary care provider, 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. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan will make 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, or 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.

Summary of Benefits and Coverage

Availability of Summary Health Information.

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about your health plan option(s). This summary is in a standard format, as regulated by the Patient Protection and Affordable Care Act, to help you compare options. The standard format enables readers to conduct an apples-to-apples comparison.

We are pleased to provide you with the Summary of Benefits and Coverage (SBC) for your plan(s) along with the Health and Human Services uniform glossary that is to be paired with the SBC when distributed to employees.

The SBC(s) are available here: http://hr/EB/sitepages/home.aspx.

The glossary can be found here: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf

A complimentary paper copy is available upon request by calling (904) 665-5300. Participants and beneficiaries may request an electronic SBC from their employer.

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.

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

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.

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 testing description. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

The information from your HRA and the results from you 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.

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.

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).

Michelle's Law – Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status.

The JEA Self-Funded Medical Plan generally permits an employee to enroll a child until the end of the calendar year in which the child turns age 30 if: the child is unmarried, the child has no dependents of his/her own, the child is a student (full-time or part-time) in any state or is a Florida resident, the child has no other health coverage, and the child is not entitled to Medicare.

Michelle's Law requires a plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- "Dependent child" means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- "Medically necessary leave of absence" means a leave of absence or any other change in enrollment of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury which is medically necessary and which causes the dependent child to lose student status under the terms of the plan.

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, a plan must treat the dependent child as eligible for coverage until the earlier of:

- one year after the first day of the leave of absence, or
- the date that plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same plan benefits as other dependent children covered under the plan. Further, any change to plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the plan.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law extension of eligibility, contact: JEA Benefits Services, 21 West Church Street, Jacksonville, FL 32202, phone: (904) 665-5300, e-mail: Benefits@JEA.com.

ANNUAL DISCLOSURES
CONTINUED

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, 2019. Contact your State for more information on eligibility –

CHIP STATE CONTACT INFORMATION

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)
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
Florida Medicaid	Website: http://flmedicaidtplrecovery.com/hipp/ 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: http://www.indianamedicaid.com Phone 1-800-403-0864
Iowa Medicaid	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
Kansas Medicaid	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
Kentucky Medicaid	Website: https://chfs.ky.gov Phone: 1-800-635-2570
Louisiana Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
Maine Medicaid	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 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/seniors/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: (855) 632-7633 | Lincoln: (402) 473-7000 | Omaha: (402) 595-1178

Nevada Medicaid	Medicaid Website: https://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: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/ index.htm | Phone: 1-800-692-7462
Rhode Island Medicaid	Website: http://www.eohhs.ri.gov/ Phone: 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	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
Washington Medicaid	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
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/publications/p1/p10095.pdf Phone: 1-800-362-3002
Wyoming Medicaid	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, 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

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.

If you do decide to join a Medicare drug plan and drop your current JEA coverage, be aware that you and your dependents may 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 have 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: This notice will be updated each year. You will receive 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 from Medicare every year. 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, 2020

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, 2019

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. 20201
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
wellness@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

DENTAL

DHMO (SOLSTICE)
Web Address: www.solsticebenefits.com/provider-search.aspx
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

TELADOC

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

FLEXIBLE SPENDING ACCOUNTS (TASC)
HEALTH REIMBURSEMENT ACCOUNT (HRA) (TASC)

Web Address: www.tasconline.com
Member Services: (800) 422-4661

HEALTH SAVINGS ACCOUNT (HSA) (TASC)

Web Address: www.tascparticipant.lh1ondemand.com
Member Services: (800) 350-3778

WELLNESS (HealthCheck360)

Web Address: www.healthcheck360.com
Member Services: (866) 511-0360

LIFE, AD&D, AND DISABILITY (STANDARD)

LIFE, AD&D, AND DISABILITY

Web Address: www.standard.com
Life Insurance: Member Services: 800-628-8600
LTD & STD: Claim Intake: 800-378-2395 Claim Status: 800-368-1135

FMLA

FMLA (FMLA SOURCE)

Web Address: www.fmlasource.com
Member Services: 1-877-462-3652

OTHER

EMPLOYEE ASSISTANCE PROGRAM (HEALTHADVOCATE)

Web Address: .www.healthadvocate.com
Member Services: (866) 695-8622

AFLAC

Agent: Susan Knight (904) 241-2482 or (904) 993-4427
Web Address: www.aflac.com
Member Services: (800) 922-3522

LEGAL PLAN (US LEGAL SERVICES)

Web Address: www.uslegalservices.net
Member Services: (800) 356-5297

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