CareerSource Northeast Florida (CSNEFL) partners with the City of Jacksonville to provide Health, Dental, Vision, Life Insurance the Flexible Spending Account (FSA) benefits.

CSNEFL also participates in the Florida Retirement System (Pension & Investment), https://www.myfrs.com/ and the Florida Deferred Compensation Plan, https://myfloridacfo.com/deferredcomp/home

Additionally, Employees are eligible for performance incentives of up to 4% annually based on performance and funding availability.

careersourcenortheastflorida.com

1845 Town Center Blvd., Suite 250
Fleming Island, FL 32003

CareerSource NEFL is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. All voice telephone numbers on this website may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711. For program funding details in compliance with the Stevens Amendment, please visit https://careersourcenortheastflorida.com/about.

ONE CITY. ONE JACKSONVILLE.

YOUR GUIDE TO BENEFITS

Effective January 1 - December 31, 2023

BENEFITS FOR YOUR BUDGET AND LIFE.

CAREFULLY DESIGNED WITH YOU IN MIND

We're committed to making sure you get the benefits package that's right for you and your family. Our package combines the peace of mind that comes with excellent medical care.

Annual Enrollment is your chance to ensure that your benefits package is right for you. Medical coverage, dental and vision care, retirement benefits, and life insurance options are built around you and created to keep you in great shape, physically and financially.

Please take the time to read through this booklet and understand all the options available to you. As a whole, we think we've created a benefit package that gives you outstanding support, whether you're at work, at home or even on vacation.

WHAT'S HERE?

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Medicare Part D Creditable Notice is included in this guide.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.

This guide is meant to serve as a summary. If there are differences between this guide and the carrier contract, the contract will govern.

SELECTING YOUR PLANS

When you're first hired

Your **benefit eligibility date,** when your coverage begins, is the first day of the month following your employment date if you work 25 hours per week. If your employment date is the first day of the month, your benefits will be effective on your employment date. You must complete your enrollment prior to your eligibility date and all required documentation must be provided prior to your benefits eligibility date.

Any corrections must be made within the first 31 days of enrollment.

If you have a life change (life event)

Certain life events like marriage, divorce, birth or adoption of a child, or a change in employment status may allow you to change your coverage during the year. If this occurs, please contact Employee Benefits within **60 days** of the event - with required documentation - to update your benefits.

During Annual Enrollment

Annual Enrollment is your opportunity once each year to evaluate your benefit options and make selections for the following year.

Benefits selected at Annual Enrollment are effective January through December.

COVERING YOUR FAMILY

Dependent Eligibility

	Spouse	Children	
MEDICAL	√	√	*Until their 26th birthday unless they have access to group benefits through their own employer*
DENTAL	√	√	*Until the end of the year when they reach age 25*
VISION	√	√	*Until the end of the year when they reach age 25*
LIFE INSURANCE	√	√	*Until the end of the month when they reach age 26*

Disabled dependents: Children who became disabled before age 26 and rely on you for support are also eligible for health coverage. Please contact Employee Benefits if this applies to you.

Extended medical coverage: Children ages 26-30 may be eligible for extended medical coverage; please contact Employee Benefits for details.

Newborn medical coverage: Newborn children of a covered family member other than a spouse (such as grandchildren) are eligible until they reach 18 months as long as the child's parent remains covered.

FIND THE MEDICAL PLAN THAT'S BEST FOR YOU

COMPARE YOUR OPTIONS

General Employees Only	BLUEOPTIONS/ UF HEALTH EPO 03768	BLUECARE 48 HMO	BLUECARE 65 HMO HDHP	BLUEOPTIONS PPO 05782
	Florida Blue	**Florida Blue**	**Florida Blue**	**Florida Blue**
PROVIDER CHOICE	**In-Network care only** *Except in the case of a true emergency, the UF Health EPO plan only covers care through in-network providers*	**In-Network care only** *Except in the case of a true emergency, the BlueCare plan only covers care through in-network providers*	**In-Network care only** *Except in the case of a true emergency, the BlueCare plan only covers care through in-network providers*	**You may use any provider you choose** *However, you will receive better benefits and pay less for care if you use in-network providers*
REFERRALS REQUIRED	No (certain specialists require referrals separate from insurance)	No, but a primary care physician (PCP) designation is required	No, but a primary care physician (PCP) designation is required	No (certain specialists require referrals separate from insurance)

Important Terms

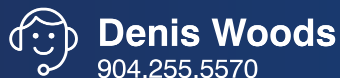
Copay – a flat fee you pay whenever you use certain medical services, like a doctor visit.

Deductible – the dollar amount you pay before your medical insurance begins paying deductible-eligible claims.

Coinsurance – the percentage of covered medical expenses you continue to pay after you've met your deductible and before you reach your out-of-pocket maximum.

Out-of-pocket maximum – the most you will pay during the **calendar year** for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Balance billing – the amount you are billed to make up the difference between what your out-of-network provider charges and what insurance reimburses. **This amount is in addition to, and does not count toward your out-of-pocket maximum.**



FLORIDA BLUE

Group: B3267

Website: www.FloridaBlue.com

Phone: 1.800.664.5295

MEDICAL INSURANCE PLAN INFORMATION

General Employees Only	BlueOptions 03768 UF Health Plan *EPO*	BlueCare 48 *HMO*	BlueCare 65 *HMO HDHP*	BlueOptions 05782 *PPO*
In-Network Coverage				
DEDUCTIBLE DED	$250 single; $500 family	$300 per person; $600 family max	$1,500 single; $3,000 family	$750 per person; $1,500 family max
OUT-OF-POCKET MAXIMUM	*Combined medical and pharmacy*	*Combined medical and pharmacy*	*Combined medical and pharmacy*	*Combined medical and pharmacy*
MEDICAL	$1,500 single; $3,000 family	$2,500 per person $5,000 family maximum	$5,000 single coverage $10,000 family coverage	$6,000 per person $12,000 family maximum
PHARMACY	$1,000 single; $2,000 family			
Preventive Care	**100% covered**	**100% covered**	**100% covered**	**100% covered**
PRIMARY DOCTOR VISIT	$10	$25	$25	$30
SPECIALIST DOCTOR VISIT	$30	$35	DED then 30%	$40
INDEPENDENT LABS	100% covered	100% covered	100% covered	100% covered
X-RAYS	$30	$30	DED then 30%	$35
IMAGING: MRI / CT / PET	$100	$300	DED then 30%	$300
URGENT CARE CENTER	$25	$30	$25	$35
EMERGENCY ROOM	DED then 20%	$300 then 30%	DED then 30%	$300 then 30%
INPATIENT HOSPITAL	DED then 20%	DED then 30%	DED then 30%	DED then 30%
OUTPATIENT SURGERY	DED then 20%	DED then 30%	DED then 30%	DED then 30%
Out-of-Network Coverage (*plus balance billing*)				
DEDUCTIBLE	No coverage	No coverage	No coverage	$1,000 per person; $2,000 fam. max
COINSURANCE	No coverage	No coverage	No coverage	50% after deductible
OUT-OF-POCKET MAXIMUM	No coverage	No coverage	No coverage	$9,000 per person; $18,000 fam. max

Retail Prescriptions (up to 30 days) | Mail Order Prescriptions (90 days)								
GENERIC	$10	$20	$10	$20	$10	$20	$10	$20
PREFERRED BRAND	$40	$80	$40	$80	$40	$80	$40	$80
NON-PREFERRED	$75	$150	$75	$150	$75	$150	$75	$150

SEEKING CARE WHEN YOUR REGULAR DOCTOR ISN'T AVAILABLE

General Employees Only	**Convenience Clinic** *Generally staffed by a Nurse Practitioner and located inside a drugstore (Walgreens or CVS)*	**Urgent Care** *Urgent care centers handle non-life threatening situations, and many are staffed with doctors and nurses who have access to x-rays and labs onsite.*	**Emergency Room** *Emergency rooms are meant for true medical emergencies and can handle trauma, x-rays, surgical procedures and life threatening situations*
OPEN HOURS	Days, evenings, weekends	Days, evenings, weekends	24 hours a day, 7 days a week
TYPICAL VISIT LENGTH	Less than 30 minutes	Less than an hour	Several hours depending on severity
YOUR COST	Primary Care copay ($10-$30)	Urgent Care copay ($25 - $35)	Deductible or copay then coinsurance
TREATMENT FOR	• Flu and cold • Coughs and sore throat • Earaches and fevers • Vomiting, diarrhea, stomach pain • Minor cuts • Rashes *Note: Most Convenience Clinics do not treat children under 2 years of age.*	• Flu and cold • Coughs and sore throat • High fevers • Vomiting, diarrhea, stomach pain • Cuts and severe scrapes • Stitches • Dehydration • Minor broken bones • Minor injuries and burns • Rashes	• Allergic reactions to food, animal or bug bites • Severe broken bones • Chest pain • Constant vomiting or continuous bleeding • Severe shortness of breath • Deep wounds • Weakness or pain in a leg or arm • Head injuries • Unconsciousness

NEW TELEMEDICINE OPTIONS

TELADOC (MEDICAL, DERMATOLOGY, MENTAL HEALTH)

Teladoc

Employees enrolled in one of the four Florida Blue plans can use Teladoc.

OPEN HOURS	Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.
TYPICAL VISIT LENGTH	Less than 30 minutes
YOUR COST	$10 for the BlueOptions 03768 plan $15 for the BlueCare 48 & 65 plans $20 for the BlueOptions 5782 plan
WEBSITE	Teladoc.com
CALL	1.800.Teladoc (835.2362)

1

SETUP YOUR ACCOUNT

Set up your account by web or mobile app.

Online:
Go to Teladoc.com and click **"set up account"**.

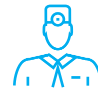
Mobile app:
Download the app and click **"Activate account"** Visit **teladoc.com/mobile** to download the app

Call Teladoc:
Teladoc can help you register your account over the phone

2

PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.



3

REQUEST A CONSULT

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

It's simple to get started or engage with Better You Strides!

REGISTER NOW by logging into your member account at **www.floridablue.com**, click Health & Wellness, then Better You Strides.

GET REWARDED FOR YOUR HEALTHY BEHAVIORS

EARN POINTS

- Earn points each time you complete a verified activity or achieve a wellness goal.
- Earning points helps you work toward a higher Status Level.

EARN BUCKS

Healthy activities accrue points **and** earn you a $75 incentive gift card for each Status Level up to Platinum.

GET REWARDED

Choose gift cards from a variety of 38 retailers / vendors.

Here's how many points you need to move up in Status Levels:

	Level	Requirement
	Bronze	**1,200 Points** **$75 Gift Card**
	Silver	**2,400 Points** **$75 Gift Card**
	Gold	**3,600 Points** **$75 Gift Card**
	Platinum	**4,800 Points** **$75 Gift Card**

Points do not roll over from year to year.
All full-time employees are eligible to participate

Website: www.FloridaBlue.com
Phone: 800.352.2583
Denis Woods-COJ Rep:
904.255.5570

DENTAL INSURANCE

DENTAL CARE THAT MAKES YOU SMILE

OFFERED BY HUMANA

General Employees Only	Silver PPO		Gold PPO		Platinum PPO		DHMO Plan	
DENTIST CHOICE	**You may use any provider you choose.** *However, you will receive better benefits and pay less for care if you use providers in the Humana Dental newtork.*						**In-Network care only** *The DHMO plan requires you to choose a Humana dentist as your primary care dentist.*	
MAXIMUM BENEFIT	**$1,500 per person per year**		**$2,000 per person per year**		**$5,000 per person per year**		**Not applicable**	
DEDUCTIBLE DED	$50 per person; $150 family max		$100 per person; $300 family max		$500 per person; $1,500 family max		**Not applicable**	
Humana PPO Coverage							**In-network only** *(examples of charges)*	
PREVENTIVE CARE	100% covered *(no deductible)*	80% covered *(no deductible)*	100% covered *(no deductible)*	100% covered *(no deductible)*	100% covered *(no deductible)*	80% covered *(no deductible)*	ROUTINE OFFICE VISIT (9430) TEETH CLEANING (1110) FULL MOUTH X -RAYS (0330)	No charge No charge No charge
BASIC SERVICES	DED then 20%	DED then 50%	DED then 20%	DED then 20%	DED then 20%	DED then 20%	FILLINGS (2140) EXTRACTIONS (7140)	$5 No charge
MAJOR SERVICES	DED then 50%	DED then 50%	DED then 50%	DED then 50%	DED then 50%	DED then 50%	ENDODONTICS (3330) PERIODONTAL SCALING (4341) FULL / PARTIAL DENTURES (5110) CROWNS (2752)	$250 $55 $375 $270
ORTHODONTIA	Not covered		50%; $2,000 lifetime maximum		50%; $5,000 lifetime maximum		CHILD: $1,900 | ADULT: $1,900	

HUMANA

Group: 773983

Website: www.Humana.com

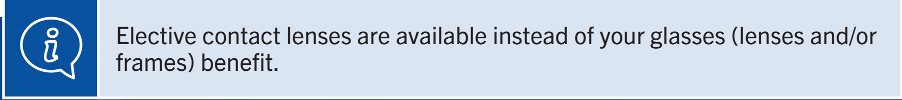
Phone: 800.233.4013

VISION COVERAGE

FOCUS ON YOUR VISION

OFFERED BY VSP

General Employees Only		Basic Plan		Premier Plan	
		In-Network *(Advantage Network)*	Out-of-Network ***(allowance)***	In-Network *(Advantage Network)*	**Out-of-Network *(allowance)***
Copays	EYE EXAMINATION	$10 copay *(**12** months)*	*Up to $41*	$10 copay *(**12** months)*	*Up to $41*
	MATERIALS	$20 copay (lenses & frames)	*Does not apply*	$20 copay (lenses & frames)	*Does not apply*
Glasses	LENSES - SINGLE	Covered after copay *(**24** months)*	*Up to $45*	Covered after copay *(**12** months)*	*Up to $45*
	LENSES - BIFOCAL	Covered after copay *(**24** months)*	*Up to $65*	Covered after copay *(**12** months)*	*Up to $65*
	LENSES - TRIFOCAL	Covered after copay *(**24** months)*	*Up to $100*	Covered after copay *(**12** months)*	*Up to $100*
	FRAMES	$110 allowance; 20% off balance *(**24** months)* *$60 allowance at Walmart/Sam's Club/Costco*	*Up to $70*	$130 allowance; 20% off balance *(**24** months)* *$70 allowance at Walmart/Sam's Club/Costco*	*Up to $70*
Contacts	ELECTIVE	$110 allowance *(**24** months)*	*Up to $105*	$130 allowance *(**12** months)*	*Up to $105*
	MEDICALLY NECESSARY	Covered in full	*Up to $210*	Covered in full	*Up to $210*



VSP

Group: 30099995

Website: www.vsp.com

Phone: 800.877.7195

FLEXIBLE SPENDING ACCOUNTS

TAX FREE FUNDS FOR LIFE'S EXPENSES

HEALTH AND DEPENDENT CARE

Pay for qualifying health care and dependent care expenses with tax-free money using a Flexible Spending Account (FSA), administered by Ameriflex.

Health Care FSA

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

Contribution Maximum	**$3,050** ($127.08 per paycheck)
Time period for claims	**January 2023 through March 15, 2024**
Time period to submit claims	**Through March 31, 2024**

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 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 2023 through March 15, 2024**
TIME PERIOD TO SUBMIT CLAIMS	**Through March 31, 2024**

GOOD TO KNOW:

- To be reimbursable, eligible expenses must be necessary for you and your spouse (if applicable) to work, attend school, or look for work.
- Only the amount you've contributed year to date is available at any one time.

PARKING AND TRANSIT

Pay for qualifying commuter, transit, vanpooling, and parking expenses with tax-free money using a Commuter Benefit account administered by Ameriflex.

Transit Benefits
Save money for public transportation taken to and from work.

Parking Benefits
Parking passes may be purchased with your Ameriflex debit card, or out-of-pocket and be reimbursed via direct deposit or check from Ameriflex.

Vanpooling Benefits
Share a commute with a group of people through an official vanpooling or rideshare system (six or more adults, excluding the driver) and use your Ameriflex debit card to pay.

WILL THIS PLAN HELP YOU?
See the Commuter expenses information on **www.coj.net/benefits** for more information on this benefit.

AMERIFLEX

Website: www.myameriflex.com

Phone: 888.868.3539

CARE FOR YOURSELF AND YOUR FAMILY

EMPLOYEE ASSISTANCE PROGRAM

The City offers all full-time 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 **six** face-to-face visits with a counselor for each issue each calendar year.

Available EAP services include:

Core Services
General counseling for stress, depression, family issues, substance abuse, child care, work life services, educational resources, marriage counseling and elder care resources.

Financial Planning
Resources for investment plans, estate planning, debt reduction, retirement planning, bankruptcy, tax support, college funding, and budget management.

Legal Services
Referrals and discounts for services such as creating or modifying a will, consumer issues, criminal matters, traffic citations, living wills, power of attorney, separation and divorce.

Mediation Referrals
Referrals for divorce, child custody, estate settlement, family disputes, real estate matters, financial collections, and contractual disputes.

HEALTH ADVOCATE

Website: www.healthadvocate.com

Phone: 1.877.240.6863
904.296.9436

LIFE INSURANCE

COVERAGE FOR THE UNEXPECTED

Paid for by First Coast Workforce Development Consortium

As an employee of the City of Jacksonville working at least **30 hours** per week, you are provided with life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you through Standard.

COVERAGE AMOUNTS:
Please refer to the Certificate of Coverage for your Bargaining Unit to identify the level of coverage for you, your spouse, and your dependent child(ren).

Make sure you designate a beneficiary who will receive your life insurance benefit if you pass away while covered under this policy. Forms are available on the Compensation and Benefits website (**www.coj.net/benefits**).

Additional Coverage Options

FOR YOU

Please refer to the Certificate of Coverage for your Bargaining Unit to identify your additional life insurance coverage options through Standard.

FOR YOUR DEPENDENTS

If you work at least 30 hours per week, you have two life insurance options for your eligible dependents:

Option	For your Spouse	For your Child(ren)
One	$10,000	$5,000
Two	$20,000	$10,000

INTRODUCING AD&D

AD&D, or Accidental Death & Dismemberment insurance, is attached to the life insurance you receive through the City of Jacksonville. Your AD&D coverage is for the same amount as your life insurance, and can pay a benefit in one of two ways, death or dismemberment.

1. **Death**: 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. **Dismemberment**: 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.

PORTABILITY: IF YOU LEAVE THE CITY

If you lose eligibility for life insurance through the City due to ending your employment, retiring, or reducing your hours, you may choose to continue your life insurance coverage. Contact Standard within 31 days of the date you lose eligibility for details and to begin the process.

STANDARD

Group: 750973

Website: www.standard.com

Phone: 1.800.628.8600

ANNUAL NOTICES

THIS SECTION CONTAINS IMPORTANT INFORMATION ABOUT YOUR BENEFITS AND RIGHTS. PLEASE READ THE FOLLOWING PAGES CAREFULLY AND CONTACT EMPLOYEE BENEFITS WITH ANY QUESTIONS YOU HAVE.

HIPAA Special Enrollment Rights – A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

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

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Compensation & Benefits **904.255.5555**.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete a "Form for Employee to Decline Coverage." On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

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: **www.coj.net/benefits**.

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 **904.255.5555**.

Participants and beneficiaries may request an electronic SBC from Compensation & Benefits.

Women's Health and Cancer Rights Act of 1998 – If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed on your medical plan ID card.

Newborns' and Mothers' Health 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

ANNUAL NOTICES (CONTINUED)

THIS SECTION CONTAINS IMPORTANT INFORMATION ABOUT YOUR BENEFITS AND RIGHTS. PLEASE READ THE FOLLOWING PAGES CAREFULLY AND CONTACT EMPLOYEE BENEFITS WITH ANY QUESTIONS YOU HAVE.

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

Patient Protection – The disclosure is applicable to the following plan(s): Florida Blue - Bluecare 48, Florida Blue - Bluecare 65; UF Health EPO plan.

Designation of Primary Care Providers: Florida Blue generally requires the designation of a primary care provider and UF Health allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our networks and who is available to accept you or your family members. 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 UF Health providers.

Designation of Pediatricians as Primary Care Providers: For children, you may designate a pediatrician as the primary care provider.

Access to OBGYN without Referrals: You do not need prior authorization from Florida Blue or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Florida Blue at **www.floridablue.com** for UF Health providers.

Wellness Program – Florida Blue's Better You Strides (BYS) is a voluntary wellness program available to all full-time employees and eligible dependents. 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 Cholesterol and Glucose testing. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of activity based points for completing various items. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive points for these items.

Additional incentives of up to unlimited points per year may be available for employees who participate in certain health-related activities including step challenges, vision exams, dental exams, fitness activities, mammograms, colonoscopies, and many more, or achieve certain health outcomes including lowered cholesterol, lower risk of heart disease, diabetes, quitting smoking, losing weight, increased happiness, improved mental wellbeing, improved financial wellbeing and others.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Chief of Compensation and Benefits at **904.255.5555**.

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and BYS may use aggregate information it collects to design a program based on identified health risks in the workplace, BYS 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 individual(s) who will receive your personally identifiable health information is BYS 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. Additional Protections are maintained by BYS. 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, Florida Blue 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 Chief of Compensation and Benefits at **904.255.5555**.

ANNUAL NOTICES (CONTINUED)

THIS SECTION CONTAINS IMPORTANT INFORMATION ABOUT YOUR BENEFITS AND RIGHTS. PLEASE READ THE FOLLOWING PAGES CAREFULLY AND CONTACT EMPLOYEE BENEFITS WITH ANY QUESTIONS YOU HAVE.

Michelle's Law – Requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under City of Jacksonville's Group Health Medical Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under City of Jacksonville's Group Health Medical Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under City of Jacksonville's Group Health Medical Plan and was enrolled as a student at a post-secondary educational institution.

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

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

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

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's law, please contact Chief of Compensation and Benefits at **904.255.5555**.

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 **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your state for more information on eligibility.

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

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/ Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 617.886.8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other- insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

MEDICARE D NOTICE

IMPORTANT NOTICE FROM THE CITY OF JACKSONVILLE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Jacksonville 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. The City of Jacksonville 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 City of Jacksonville coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Jacksonville 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 The City of Jacksonville 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 Compensation and Benefits for further information. NOTE: You'll get this notice each year. You will receive it before the next period you can join a Medicare drug plan and if this coverage through The City of Jacksonville 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 non-creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2023

Name of Entity / Sender: The City of Jacksonville

Contact / Title: Compensation and Benefits

Address: 117 West Duval Street, Suite 150
Jacksonville, FL 32202

Phone Number: 904.255.5555

NOTICE OF PRIVACY PRACTICES

We take your privacy seriously. You may obtain a copy of our Notice of Privacy Practices by either:

- Calling the Employee Benefits Department at **904.255.5555**, or
- Logging onto **www.coj.net/benefits**

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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