bewell+

Open Enrollment
Nov. 2 – 16, 2017
Enroll online
7 days a week/24 hours a day

2018 Open Enrollment

Guide for FPL Bargaining Employees

FPL®

October 18, 2017

Dear FPL bargaining employee,

Open Enrollment for 2018 benefits takes place Nov. 2- 16, 2017.

Review the materials in this package which contain your 2018 premiums and information about your NextEra Energy benefit offerings and the upcoming changes.

If you take no action during Open Enrollment, you will default into the same plans and coverage tiers you currently have; however, if you would like to contribute to a Flexible Spending Account, you must enroll during Open Enrollment, even if you are currently participating. Your election does not carry forward year to year.

Be prepared — dependent audit coming in 2018.

Open Enrollment is a great time to ensure that the dependents you cover on the NextEra Energy plans meet the Plan eligibility rules. Dependent audits will be conducted in 2018 to confirm that dependents enrolled in the plans are eligible. Examples of ineligible dependents include divorced spouses and former stepchildren (unless you are a legal guardian of them). Remember, you have an ongoing obligation to remove ineligible dependents when they lose eligibility.

If you have questions after reviewing the materials provided, please contact Employee Services.

Sincerely,

Dawn Nichols, Sr. Director Employee Benefits

Employee Services is here to help

Call **844-694-HR4U** for information

Extended hours during Open Enrollment:
Mon.-Fri., 8 a.m.-7 p.m. ET

Did you know?

- Your cost of employer-sponsored health plans are made up of two components:
  1. The Cost of Coverage: The amount you have deducted each pay period at the coverage level you enroll in (the employee contribution).
  2. The Cost of Care: The amount you pay at the time medical services are rendered; your deductible, copays, coinsurance at the doctor's office, etc.

- Below are some ways to help reduce the costs of your health care:

1. **Consider whether a Flexible Spending Account (FSA) is right for you**. An FSA is a tax-favorable account that can help you save money not only on your out-of-pocket health care expenses but also on dependent care expenses.

2. **Go to an in-network provider.** If you use an out-of-network provider, you will pay more out of pocket for your services; you will be required to file claim forms and you will be responsible for all non-covered costs. Always confirm that any providers you are referred to such as specialists, labs or X-ray facilities participate in the Cigna network to keep your out-of-pocket expenses to a minimum.

3. **Choose the right facility for the circumstances.** An emergency room visit will cost you more money and possibly more time than an urgent care or convenience care center if the situation doesn't require emergency room care. Remember Cigna's Telehealth may be used for most non-emergency conditions. Telehealth doctors can help diagnose, treat, and prescribe medication, if appropriate. For more information go to MyCigna.com.

4. **Use the Cigna Health Information Line for FREE.** As part of your medical plan, you have unlimited access to speak with a registered nurse any hour of the day or night, seven days a week, from any phone in the U.S. Call 800-564-8982 to speak with a nurse, who will ask a few questions about your symptoms and situation and direct you to the type of care you need.

5. **Manage your medications:**
   - Talk with your physician about the most cost-effective drug options and ask your physician or pharmacist if generic drugs are right for you.
   - For your maintenance medications (those you expect to take on an ongoing basis), obtain a 90 day supply through the home delivery program or at your local CVS pharmacy..
   - Compare medications at www.caremark.com. You can check the cost of a prescription before filling it, as well as track the status of your refills, including when they are mailed, and receive alerts via email on the status of your prescription(s).

2018 Benefits for FPL Bargaining Employees

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Open Enrollment for 2018 benefits begins Nov. 2, 2017, and ends at 11:59 p.m. EST Nov. 16, 2017. Enroll anytime during this period online at HR Direct > My Benefits > Enroll in Benefits

This guide applies to active, full-time bargaining employees of Florida Power & Light Company.

Open Enrollment

Enroll online at HR Direct>My Benefits>Enroll in Benefits, or NEE.com/EnrollNow from Nov. 2 – 16, 2017.

What benefits can I enroll in or change?

Benefits you can select or change during annual open enrollment:	**Benefits you can enroll in or change any time during the year:**	**Benefits for which you do not need to enroll *(automatically provided)*:**
Medical Dental Vision Additional Life Insurance and AD&D Insurance Dependent Life Insurance Health Care Flexible Spending Account Dependent Care Flexible Spending Account Long-Term Disability COLA	401(k) Plan	Basic Life Insurance Short-Term Disability Basic Long-Term Disability Employee Assistance Program Pension

What's changing for 2018?

- Out-of-Network changes
  - Increases to deductibles, coinsurance and out-of-pocket maximums
  - Benefits paid for out-of-network care are based on allowable charges. Allowable charges reflect a percentage of a fee schedule developed using a Medicare-based methodology. NextEra Energy's medical plan will change from 150% to 110% of the Medicare-based Maximum Reimbursable Charge. For some covered services, a reimbursement schedule is not available. In these cases, the allowable charge is based on a percentile of the amount most providers in your area typically charge for these services.
- You can contribute more into your Healthcare Flexible Spending Account:
  - The maximum allowable contribution has increased to $2,600
- Enhancement to the Vision plan with no change in premiums:
  - Standard progressive lenses are now free when you use an in-network provider
- Life Insurance and AD&D benefits will be insured and administered by MetLife:
  - Decrease in premiums for additional life
  - Increase in premiums for spouse and child life

Important Information about Open Enrollment

1. You will need your company SLID (system login ID) and network password to enroll online.

2. The deadline for enrolling during Open Enrollment is 11:59 p.m. Eastern Standard Time (EST) Nov. 16. No changes will be permitted after Open Enrollment unless you experience a qualified life event. Employee Services representatives are available to assist you Monday through Friday, 8 a.m. to 7 p.m. EST during Open Enrollment.

3. If you are currently enrolled in a medical plan and take no action during Open Enrollment, you will remain enrolled in your medical plan with the same dependent coverage.

4. If you would like to contribute to an FSA, you must enroll during open enrollment, even if you are currently participating. Your election does not carry forward year to year.

5. The elections for medical, dental and vision coverage are separate. This gives you the flexibility to elect different levels of coverage for each benefit. For example, you can elect Family coverage for medical, Employee plus Spouse coverage for dental and Employee Only coverage for vision.

6. Enrolling new dependents online for benefits coverage is a phased process. First, you must add them to your online record of eligible dependents. Then, you must separately enroll them for each benefit you would like them to have

(medical, dental, etc.). Entering them into your online record does NOT automatically enroll them for benefits. You are required to submit benefits eligibility documentation, such as a government-issued birth certificate to Employee Services by the end of open enrollment, Nov. 16, 2017, in order to cover any new dependents.

7. If you experience a qualified life event on or after Jan. 1, 2018, remember you must notify Employee Services within 30 days of the event date in order to make applicable benefit changes. Certain changes in eligibility for Medicaid benefits will continue to have a 60-day notification window due to applicable legal requirements.

8. Confirm that your elections are accurate: Once you save your elections, you will be emailed a confirmation form. Review the confirmation carefully to make sure it reflects the coverage and covered dependents you want. No changes will be processed after Nov. 16, 2017, unless you experience a qualified life event and make changes within 30 days of the life event.

If You Don't Enroll

We encourage you to review and confirm your selections during Open Enrollment. If you would like to contribute to an FSA, you must enroll during Open Enrollment, even if you are currently participating. Your election does not carry forward year to year. No changes are accepted after the end of Open Enrollment, November 16, 2017, unless you experience a qualified life event and make changes within 30 days of the life event.

Change your mind?
If you complete the enrollment process and later want to make a change to your elections, you can do so at any time before the close of Open Enrollment (11:59 p.m. EST Nov. 16, 2017).

Medical Plan

The Health Prime plan is available to you for medical coverage. You may also choose to waive medical coverage, although this is not recommended unless you have coverage through another source. To obtain additional information about the Health Prime plan, please see the medical chart. You can also find additional information about the plan and review the cost of the plan at **HR Direct > My Benefits > Enroll in Benefits**.

Utilizing in-network providers has the following advantages:

- Lower out of pocket expenses
- No charge for preventive services
- No worries about exceeding reasonable and customary rates where the provider can bill you for these amounts
- No claim forms to fill out

Out-of-Area

This plan is provided to employees who live in areas where there is no Cigna network available. It works like the Health Prime plan, except there is no network of physicians so all services are provided at the in-network level.

Waive Medical Coverage

You may select to waive medical coverage or choose to be covered by another NextEra Energy Employee. Remember, this waives coverage **for all medical benefits,** which include prescription drugs, mental health and substance abuse benefits. However, you and your eligible dependents will still be able to use the Employee Assistance Program (EAP).

Medical Provisions Explained

About the Deductible

The deductible is the amount of covered medical expenses you pay each year before the plan starts to pay benefits. There are varying individual and family deductible requirements for in-network and out-of-network services.

For individual coverage, you must meet the individual medical deductible each year before the plan starts to pay in-network or out-of-network medical benefits.

The family deductible provides protection against higher medical expenses for families. Once deductible expenses from any combination of covered family members reach the family deductible, no further deductibles are required from anyone in your family for the rest of the plan year. Any one family member, however, cannot contribute (nor will they have to satisfy) more than the individual deductible amount toward the family deductible.

Eligible medical charges count toward the medical deductible, **except:**

- Any charges that are not covered by the plan or that exceed the plan's eligible charge limits
- Copayments
- Prescription drug copayments or coinsurance
- Penalties for failure to obtain a pretreatment review

About Copayments and Coinsurance
You share in the cost of your medical care through copayments and coinsurance. A copayment is a flat dollar amount that you pay at the time you receive medical services. Coinsurance is the percentage of charges that you pay for covered medical services and supplies after the deductible has been satisfied.

About the Annual Out-of-Pocket Maximum
Your plan includes a maximum on the amount of money you pay out of pocket each year for your share of covered medical and prescription expenses. The out-of-pocket maximum limits the amount you pay out of your pocket during the year. Once you reach the out-of-pocket maximum, the plan pays 100 percent of most covered charges for the rest of the calendar year.

The following do not count toward the annual medical out-of-pocket maximum:

- Any charges that are not covered by the plan or that exceed the plan's eligible charge limits; or
- Penalties for failure to obtain a pretreatment review.

Copays or coinsurance for prescription drugs count towards meeting the out-of-pocket maximum.

Using a Primary Care Physician
Even though it is not required to select or use a primary care physician (PCP) in the health plan, it still makes sense. You already know you will save money on your office visit copays when you go to an in-network provider, but establishing a relationship with one PCP who knows your medical and family history ensures if you become sick or injured, your doctor will have your medical information readily available and can quickly respond on your behalf

PCPs include family practitioners, general practitioners, internists or pediatricians for children under 18. To locate a PCP or any participating provider, go to www.myCigna.com or call Member Services at 800-395-8712.

Emergency, Urgent Care and Telehealth
As health plan participants, you and your enrolled dependents are covered for emergency medical services anywhere, even when you are traveling. You do not need any authorization before receiving emergency care, but you should notify your PCP (or have someone call for you) for follow-up care.

For non-emergency situations, call your PCP or speak with a nurse through the Cigna Health Information Line (800-564-8982) for instructions on where to get help. Telehealth and urgent care centers are more cost-effective solutions when symptoms occur unexpectedly, and are severe enough that delaying treatment could cause a more serious problem and you cannot see your PCP.

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. Most urgent care centers are open late and on weekends and holidays.

Telehealth provides you with 24/7 access to board certified primary care doctors and pediatricians via video and phone with the ability to diagnose and write prescriptions if necessary. The cost per visit is typically less than a standard office visit and provides an affordable and convenient option compared to care delivered in higher cost facilities. Telehealth does not take the place of your primary care physician and is available through AmwellforCigna.com or MDLIVEforCigna.com.

When to use Telehealth

- For non-emergency medical issues (i.e., allergies, insect bites, cold, flu, fever, pink eye, ear infections, etc.)
- If you reside in a rural area with less access to health care resources
- Your schedule does not allow you to see your doctor or pediatrician
- You are traveling and need non-emergency medical care
- When it's not convenient to leave your home or workplace

EAP, Mental Health and Substance Abuse Treatments
Employee Assistance Program (EAP), mental health and substance abuse benefit is available. Pre-certification is necessary for the maximum benefit. Participants must first contact Cigna at 800-395-8712 to initiate the treatment process. From there, your Personal Health Team adviser will arrange and coordinate a treatment plan that puts you in contact with a qualified local provider.

Even if you waive medical coverage, you and your family may use EAP. EAP offers eight free, confidential initial counseling sessions through an experienced EAP provider to help identify and resolve concerns such as relationship problems, emotional or stress issues, alcohol, drug or other dependencies, or other personal issues.

Medical Coverage Chart –

All percentages in the chart reflect the coinsurance that the employee pays for after the plan deductible has been met.

Health Prime		
This chart reflects what an employee pays for covered healthcare services.	**In-network**	**Out-of-network**
Deductible – what you pay before the plan pays anything (excluding preventive care). Applies to the out-of-pocket maximum.		
Individual	$750	$2,250
Family	$2,250	$6,750
Out-of-Pocket Maximum – The most you will pay in a calendar year before the plan pays all allowable charges (including deductible, coinsurance and copays).		
Individual	$7,150	$21,450
Family	$14,300	$42,900
Coinsurance (%) – Portion you pay after you meet the medical plan deductible; applies to the out-of-pocket maximum. Copay ($) – Amount you pay for the service; not subject to the plan deductible but does apply to the out-of-pocket maximum.		
Preventive services	FREE	well child up to age 17 covered at 50% of allowable charges up to 18 visits; adults covered at 50% of allowable charges; no deductible
Primary Care Physician (PCP) / Specialist office visit (Includes Mental Health and Substance Abuse)	20%	50%
Lab/X-ray	No additional charge if done at doctor's office 20%	50%
Telehealth	20%	No coverage
Urgent Care	$75 copay	$75 copay
Emergency Room	$500 copay	$500 copay
Hospital / Surgical Center In-patient hospital, semi-private room (including hospital physician, maternity)	20%	50%
Mental Health in-patient (including substance abuse) – must pre-authorize		
Outpatient facility/surgery (including hospital physician)		
Mental Health outpatient (including substance abuse) – must pre-authorize		
Physical, Speech, Occupational and Cardiac Therapy (max of 100 combined visits). Massage therapy is included but is not subject to the annual max.)		
Chiropractic (max 25 visits)		

This is not a comprehensive list of services. For additional information please visit HR Direct > My Benefits.

Prescription Drugs

The prescription drug benefit plan is administered by Caremark. You are automatically enrolled in this plan when you enroll in the medical plan. Prescription drugs are covered, whether you receive them from retail pharmacies or through the home delivery program. The Caremark network includes more than 68,000 pharmacies nationwide.

Your prescription drug benefit plan will only allow **three** 30-day fills (including refills) at a network retail pharmacy for a maintenance drug. After these **three** fills, you must have 90-day supply prescriptions filled by the home delivery prescription drug service, which is CVS Caremark Mail Service Pharmacy, or at a local CVS pharmacy. The fourth time a maintenance prescription for a 30-day supply is presented to a retail pharmacy, coverage for it will be denied. Note: this process does not restart each calendar year.

Preferred brand drugs (Tier 2 medications) have a separate annual deductible of $100 per covered individual. Therefore, each covered person has to satisfy a $100 annual deductible before the plan will begin paying for preferred brand name prescriptions. Once covered members have satisfied their prescription drug annual deductible, they will only have to pay the copay amount for their preferred Tier 2 drug.

To obtain a list of participating pharmacies or a list of preferred drugs, or if you have questions about the availability of a generic drug for your medication, call Caremark at 888-766-5514 or visit their website at www.caremark.com. You will need to register the first time you visit, so have your ID card available.

Prior Authorization for Certain Drugs
Prescriptions for certain drugs require more information from your doctor to determine whether they can be covered by your benefit plan. Caremark Member Services can provide you with the information your physician will need to request a prior authorization for you.

If the request is approved, your doctor will receive confirmation, and the Caremark claim system will show that you have coverage for this prescription. The length of time that you will be covered for this drug depends on the diagnosis and the drug. Once the drug has been approved, you can go to a participating pharmacy to fill the prescription.

If the request for prior authorization is not granted, you and your doctor will be notified that the drug is not authorized for coverage under the plan. If the plan does not cover the drug or the quantities are limited for your use, your doctor may prescribe another suitable drug. Or, you can appeal the coverage determination by contacting Caremark Member Services at 888-766-5514.

Prescription Drug Coverage

Prescription Drugs	IN NETWORK	
	RETAIL 30-Day Supply	MAIL/CVS 90-Day Supply
Tier 1 - Generics Contain the same or similar active ingredients as the brand drug but cost less.	**$10** co-pay	**$20** co-pay
Tier 2 - Preferred Brand A lower cost brand drug $100 deductible per member for Tier 2 drugs	**$40** co-pay	**$80** co-pay
Tier 3 - Non-preferred Brand These drugs have a lower cost generic or preferred brand option available.	**35%** Max per script $150	**35%** Max per script $300
Tier 4 - Speciality Drugs that often require special handling (e.g., refrigeration during shipping) and administration (e.g.,injection or infusion).	**30%** Max per script $175	**30%** Max per script $350

Please note that if you use an out-of-network pharmacy, you will pay 35% coinsurance.

Dental Plan Options

Cigna Dental PPO
The Cigna Dental PPO option is available to those living in a Cigna Dental PPO network area. If you don't live in a Cigna network area, you will be eligible for the Cigna Dental Out-of-Area plan. With the PPO, if you go in-network, benefits are higher and you pay less for covered dental care. You have coverage if you use a dentist out-of-network, but you may be billed for the difference between the payment they receive from Cigna and their usual fees, and you may have to file your own claim.

Cigna Dental Care (DHMO)
When employees enroll in the DHMO, you will have the option to select a provider. If you go to a dentist who is not part of the DHMO network or a specialist without a referral, you are responsible for 100 percent of the charges. Be sure the dentist you choose is accepting new patients. If the office is not accepting new DHMO patients, you cannot select this dentist.

Where Can You Find a Cigna Network Dentist?
View a directory of participating dentists at www.cigna.com or call 800-395-8712.

Comparison of your Dental Options

Dental – In Network		
FEATURE	DPPO	DHMO
Preventive services[1] Routine exams, x-rays, cleanings, sealants	FREE	FREE
Basic services Fillings, root canals, etc.	15%	Copays[2]
Major services Bridges, crowns, etc.	50%	Copays[2]
Orthodontia	50% $1,500/child lifetime max Covers children age 23 and under	Copays[2] Covers adults and children
Annual Maximum[3]	$2,000/person	Unlimited

This is not a comprehensive list of services. For a full listing of services, including coinsurance, please see additional information in HR Direct > My Benefits.
[1] Annual visit limits apply. | [2] Varies by procedure; full DHMO schedule is available on HR Direct > My Benefits | [3]Maximums are combined for in and out of network.

Vision Plan

With Superior Vision Services, Inc., NextEra Energy offers a vision benefit that includes an extensive network of ophthalmologists, optometrists and optical companies throughout the country. For a complete list of network providers, call Superior Vision Services at 800-507-3800 or visit their website at www.superiorvision.com.

When you use an in-network vision provider, you pay less for eye care, and the plan pays the provider directly for covered services. You also receive a discount from these providers if you choose any eyeglass lens option or upgrade, or if you purchase additional eyewear, and contact lenses not covered by the plan. If you use a vision provider out-of-network, you'll have some coverage, but you won't receive the discount on additional pairs of eyewear and contact lenses, and you'll have to pay the provider directly and file a claim for reimbursement.

If you do not elect the full service vision program, you will be defaulted into family coverage under the Vision Discount Only-Free plan at no cost to you. Under the Vision Discount Only-Free plan you and your eligible dependents are entitled to discounts on frames, lenses, contacts, accessories and materials from specific in-network providers.

Vision Coverage – In-Network

Feature	In- Network
EYE EXAMS – Once every calendar year	
Opthalmologist	FREE
Optometrist	
LENSES – Once every calendar year	
Single Vision	FREE
Bifocal	
Trifocal	
Lenticular	
Standard Progressive	
FRAMES – Once every other calendar year	
Standard allowance	Up to $150
CONTACT LENSES* (per pair) – Once every calendar year	
Exam and Lenses (if medically necessary)	FREE
Exam and Lenses allowance (if elective)	Up to $150
Contact lenses fitting fee	$20 Copay

** Contact lenses fulfill the eyeglass lenses and frame benefit*
This is not a comprehensive list of services. For a full listing of services, including coinsurance, please see additional information in HR Direct > My Benefits.

Additional discounts for eyeglasses and contact lenses
In-network providers who are identified in the directory with a DP (discount plan) associated with their listing, provide the following additional discounts to vision plan participants:

Eye Exam	30% off (usual and customary)
Frames	30% off retail
Lenses: single vision, bifocal, trifocal and standard progressives	30% off retail
Disposable contact lenses	10% off retail
Add-on to Base lenses: lens options, contacts, other prescription materials	20% off retail
Discounts on Refractive Surgery / LASIK	15%-50% off retail

ID Cards

Medical plan ID cards will be mailed in late December for coverage that is effective Jan. 1 to employees and/or their dependents who were not previously covered; or to employees whose change in their medical plan causes the information on their ID card to no longer be accurate. ***Caremark Prescription Drug ID cards*** will be mailed in late December for coverage that is effective Jan. 1 to employees or dependents who were not previously covered by the company-sponsored medical plan. ***Dental plan ID cards*** for the DHMO will be distributed in late December for coverage that is effective Jan. 1 to employees and/or dependents who were not previously enrolled in the plan. There are no ***Vision plan ID cards***. Simply identify yourself as a member of the Superior Vision Services plan with NextEra Energy and give the provider your name and Social Security number.

Online Tools Available

Once enrolled in the medical plan, use www.myCigna.com to:

- Find participating providers and those designated as quality providers
- Find a center of excellence for planned hospital stays
- Request a replacement or additional ID card
- Review summaries and claims for medical and dental coverage
- Evaluate the costs of conditions and procedures with the Medical Cost Estimator
- View the status of medical or dental claims paid on your behalf

Once enrolled in the medical plan, use www.caremark.com to:

- Check drug costs & coverage
- Check covered drug list (formulary)
- Request a replacement or additional ID card
- Review plan summary
- Sign-up for mail service
- Track Rx spends
- Request new prescriptions and refills
- Enroll in alerts

Benefit Costs

Your benefit contributions will be deducted from every pay check. Deductions are withheld based on the pay period end date, not the actual pay check date (with the exception of contributions to an FSA, which are based upon the tax year in which such contributions are withheld).

Before-Tax and After-Tax Benefits: What's the Difference?

Dollars spent on most of your benefits are tax-free and are not subject to Social Security tax, federal income, state or local income taxes. This means the dollars you spend to help pay for benefits go directly to their cost without being taxed, thus increasing your take-home pay.

In contrast, dollars spent on after-tax benefits are first subject to Social Security tax, federal income and any state or local income taxes that you pay. By law, dependent life insurance and coverage for same-gender partners and/or their children must be offered on an after-tax basis.

Before-tax benefits include:	**After-tax benefits include:**
Medical	Dependent life insurance (spouse or same-gender partner and child)
Dental	Medical, Dental, Vision and Life deductions for covering same-gender partners and/or their children
Vision	
Additional Life insurance	
Accidental Death and Dismemberment (AD&D) insurance	
Long-term disability (LTD) insurance with COLA option	
Health care and dependent care FSAs	

Employee Biweekly Premiums

Medical

Health Prime / Out of Area	
Employee Only	$31.25
Employee & Spouse / SGP*	$134.38
Employee & Family / SGP & Child(ren)	$173.19
Employee & Child(ren)	$119.24

Dental

	PPO / Out of Area	DHMO
Employee Only	$3.82	$1.70
Employee & Spouse/SGP	$8.83	$3.50
Employee & Family/SGP & Child(ren)	$16.89	$6.96
Employee & Child(ren)	$11.15	$3.98

Vision

Employee Only	$3.22
Employee & Spouse/SGP	$6.90
Employee & Family/SGP & Child(ren)	$9.88
Employee & Child(ren)	$5.58

**Same-Gender Partner*

Please note: These rates do not take into account the tax consequences and imputed income associated with covering a same-gender partner who is not your spouse. Federal tax regulations require the company to impute income to you on the value of employer contributions to coverage for non-spouse same-gender partners and their children. In addition, your contributions for such coverage will be withheld on an after-tax basis.

Life and AD&D Insurance

Your coverage from the company for basic term life and accidental death and dismemberment (AD&D) insurance is equal to one time your annual base pay rounded up to the next $1,000 to a maximum of $150,000. To help ensure that you have as much protection as you need, you have the option of buying additional coverage of up to eight (8) times your annual base salary.

Effective Jan. 1, 2018, MetLife will be the insurer for the Life Insurance programs.

Coverage Levels:

Basic of 1.0 time your annual base pay (minimum $15,000,) rounded to the next $1,000, includes matching basic AD&D	Provided by the company at no cost to you	Total coverage equal to 1.0 time your annual base pay (maximum of $150,000)
Optional coverage of 1.0 time your annual base pay	Add-on to the basic option	Total coverage equal to 2.0 times your annual base pay
Optional coverage of 2.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 3.0 times your annual base pay
Optional coverage of 3.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 4.0 times your annual base pay
Optional coverage of 4.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 5.0 times your annual base pay
Optional coverage of 5.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 6.0 times your annual base pay
Optional coverage of 6.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 7.0 times your annual base pay
Optional coverage of 7.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 8.0 times your annual base pay
Optional coverage of 8.0 times your annual base pay	Add-on to the basic option	Total coverage equal to 9.0 times your annual base pay (maximum of $3,000,000)

If you want to increase your life insurance during open enrollment, or in connection with a qualifying life event, you can increase by more than one coverage level at a time; however, doing so will require evidence of insurability/proof of good health (EOI). Please note that if you do not pass EOI, then you will not be able to increase your life insurance at any point in the future, until EOI is passed.

You automatically have accidental death and dismemberment (AD&D) equal to the amount of your basic life and you will have the option to purchase additional AD&D for you and your family. Changes made to your life insurance during open enrollment take effect Jan. 1, 2018[1].

Your life insurance benefit will be paid to your named beneficiaries at the time of your death.

The Old Plan (210) will remain available for those employees currently enrolled at a rate of $0.28 per $1,000. The company will provide 1.0 time your annual base pay and you will pay for coverage of 1.5 times your annual base pay for this coverage. If you are actively employed when you turn age 65, there will be a reduction in coverage and a change in plan code (260) on the date you turn 65.

Please note: If you are enrolled in the Old Plan in 2017 and elect a different option for 2018, you will not be allowed to re-elect the Old Plan at any time in the future.

[1] Changes to your coverage may be delayed if you are not actively at work on the day that coverage would otherwise begin.

Your Cost for Life Insurance
The cost of your life insurance coverage is based on your current age, your current base pay and the amount of additional coverage you select. See the following rate charts. Your contributions will automatically increase during the year as your age increases, and if your base pay increases. Contributions are withheld on a pre-tax basis.

Additional Life Insurance	
Age	**2018 Biweekly Premiums (per thousand in coverage)**
Up through age 29	$0.0226
30-34	$0.0263
35-39	$0.0300
40-44	$0.0388
45-49	$0.0651
50-54	$0.1048
55-59	$0.1878
60-64	$0.2497
65-69	$0.3918
70+	$0.6900

Additional Accidental Death and Dismemberment (AD&D)	
Age	**2018 Biweekly Premiums (per thousand in coverage)**
Employee Only	$0.0102
Employee + Family	$0.0185

Imputed Income
Federal regulations require the company to impute income to you on the value of your company-provided life insurance over $50,000, as well as on any life insurance you purchase on a pre-tax basis. Imputed income also may apply to dependent life insurance you purchase on your spouse or same-gender partner, and dependent children. Payroll deductions for your life insurance are made with before-tax dollars and with after-tax dollars for any dependent life insurance. This means that the value of your life insurance coverage over $50,000 (and any applicable dependent life insurance) will be included as taxable income on your W -2 form based on the IRS tax table.

Although imputed income tax applies to the value of employee life insurance over $50,000, it is important to have enough protection for your family. Be sure to select the level of coverage that will provide enough income to your beneficiaries if you die while an active employee.

Update Life Beneficiaries

Open Enrollment is a great time to review your beneficiary designations on file. You may review, add, update or change your life insurance plan beneficiary(ies) by going online to **HR Direct > My Benefits > Update Life Beneficiaries**.

Dependent Life Insurance

You may choose to purchase dependent life insurance for your spouse or same-gender partner, and/or dependent children who are under the age of 26. Because of legal requirements, dependent life insurance is offered on an after-tax basis. Dollars spent on after-tax benefits are first subject to Social Security tax, federal income and any state or local income taxes that you pay. Your confirmation form shows the amount you pay for this coverage.

Your cost for spouse or same-gender partner coverage and/or child dependent life depends on the amount of coverage you select; however, your cost to buy coverage for your child(ren) is the same no matter how many children you cover.

You may buy coverage for:

- Your lawful spouse or same-gender partner only
- Your children only
- Both your spouse or same-gender partner and children

Dependent Life Insurance Options
You may select spouse or same-gender partner and/or child life insurance as separate options. Upon new hire an employee can elect spouse coverage up to the guaranteed issue maximum of $50,000 without evidence of insurability (EOI). After this an employee can increase their spouse coverage one level each year up to a maximum of $50,000 without evidence of insurability. All spouse coverage above $50,000 or greater than one level per year requires evidence of insurability. Please note that if your spouse does not pass EOI, then you cannot increase your spouse life insurance coverage at any point in the future, until your spouse passes EOI.

You are automatically the beneficiary for Dependent Life Insurance. If both you and your spouse or same-gender partner work for the company, you may not cover each other under Dependent Life Insurance coverage, and only one of you can cover your dependent children.

Note: Your spouse, child or same-gender partner's coverage cannot exceed 100 percent of your total amount of life insurance (basic life plus additional life). Imputed income will apply to spouse or same-gender partner life coverage if your spouse or same- gender partner is age 40 or older as of Dec. 31, 2018.

2018 Dependent Life Insurance Costs

Spouse or Same-gender Partner-Dependent Life	Biweekly Premium	Child-Dependent Life	Biweekly Premium
$25,000	$1.32	$5,000	$0.18
$50,000	$2.63	$10,000	$0.37
$100,000	$5.25	$20,000	$0.74
$150,000	$7.88	N/A	-
$200,000	$10.50	N/A	-

Long-Term Disability Coverage (LTD)

Becoming disabled can affect your financial health as well as your physical health. With the FPL paid-time-off program, you have a disability program that protects you against minor as well as more serious illnesses and injuries.

Your paid-time-off program gives you time off if you are injured or sick and can't work. Except for the long-term disability cost-of-living adjustment (COLA) plan, these benefits are automatic and not part of the Open Enrollment process. This includes:

- A sick leave plan for non-work related illness or injury
- A short-term disability plan
- A long-term disability plan - 60% of pay (available to you at no cost)
- Workers' compensation

During Open Enrollment, you can choose the long-term disability plan with the COLA option for LTD coverage.

Effective Jan. 1, 2018 Liberty Mutual will administer the company's Short-Term Disability, Long-Term Disability, Family Medical Leave Act (FMLA) and State Leave programs.

If you are disabled before January 1, 2018, your STD and LTD claims will remain with Cigna through the duration of your claim. Cigna will transfer all FMLA leave requests to Liberty Mutual, therefore beginning January 1, 2018, your FMLA leave requests will be processed by Liberty Mutual.

Flexible Spending Accounts (FSA) Tips & Reminders

FSA's give you tax breaks on certain types of health care and work-related dependent day care expenses that you would normally pay on an after-tax basis. You can open a Health Care FSA, a Dependent Care FSA or both.

- If you currently have an FSA and you would like to continue your account for 2018, you must enroll during open enrollment. Your election does not carry forward year to year. You cannot change your contribution amount during the year, unless you experience qualified life event consistent with the change. You can contribute from a minimum of $120 a year up to a maximum of $2,600 in the Health Care FSA and up to $5,000 in the Dependent Care FSA. Contributions are not transferrable from one account to the other.
- You have until March 31, 2019, to submit claims incurred in 2018 to WageWorks. After this date, any unused account balance will be forfeited. This is an IRS rule.
- Your contributions are deducted pre-tax.
- When you have an eligible expense, pay it as usual. If enrolled in an FPL plan for your medical and/ or dental, WageWorks offers the automatic claims rollover feature. This feature enables WageWorks to receive information directly from Cigna to reimburse your out-of-pocket expenses without you having to fill out or submit a claim form. Visit www.wageworks.com to update your profile.
- Reimbursements from the Dependent Care FSA cannot exceed the amount that is in your account at the time you request reimbursement. Reimbursements from your Health Care FSA may exceed the amount that you have deposited, up to the full amount that you will deposit for the year.
- Expenses for a same-gender partner or same-gender partner's child are not eligible to be reimbursed by a health care FSA, unless the individual meets the Internal Revenue Code requirements of a qualified tax dependent. Please consult with a tax advisor to help you make this determination.
- You cannot be reimbursed through a Flexible Spending Account and claim a tax credit or a deduction for the same expense; nor can you use your FSA to pay for over-the-counter medications, unless you have a prescription from your health care provider. Please consult with a tax advisor for any questions.

Is an FSA right for you?

If you are still wondering if an FSA is for you, just ask yourself if you want to save on taxes and increase your disposable income. Take a look at the advantages below.

With an FSA you benefit from:

- Tax savings, because the money you deposit is taken out of your pay before taxes
- More disposable income because you keep some of the money that you'd pay in taxes
- Convenience because your deposits are made through easy payroll deductions and your reimbursements may be made through direct deposit.

Health Care FSA

You can contribute up to $2,600 for 2018 into a Health Care FSA. You can use your Health Care FSA for eligible expenses, including your dependents' expenses. Some types of expenses for which you can be reimbursed include:

- Medical, dental and prescription drug out-of-pocket amounts (for example, deductibles or copayments)
- Medical, dental or vision expenses over plan limits; orthodontia
- Medically approved weight loss programs for obesity (ask your physician if you qualify)
- Tobacco cessation programs, including prescriptions to treat nicotine withdrawal

Although many expenses are eligible for reimbursement from your FSA, some notable **ineligible** expenses include:

- Vitamins and toiletries used to promote general health and well-being;
- Over-the-counter medications without a physician prescription;
- Cosmetic surgery (unless it's restorative surgery following an accident or illness);
- Health care premiums; and
- Health care expenses of dependents who you cannot claim as federal tax dependents, such as same-gender partners.

You cannot deduct the same health care expenses from your federal income taxes that you pay from your FSA. Most of the time, it is to your benefit to participate in an FSA. However, you may wish to consult a tax advisor or call the IRS at 800-829-3676 to request the IRS Publication 502 Medical and Dental Expenses.

FSA Rx Only Debit Card

If you are not currently enrolled and enroll in the Health Care FSA with WageWorks for 2018 you will receive an FSA Rx only debit card. This card can only be used to pay for prescription drugs at a pharmacy or via mail order. This card will prevent you from having to pay out-of- pocket for covered prescription drug costs and is the reason we no longer have automatic claims reimbursement for prescriptions.

If you are not currently enrolled and enroll in the Health Care FSA during open enrollment, a Quick Start Guide from WageWorks will be mailed to your home before Jan. 1, 2018. This guide will provide you additional information on your FSA, as well as information for requesting additional FSA Rx only debit cards. You will only receive one FSA Rx only debit card. If you would like an additional card, you can reach out to WageWorks directly.

You may use your WageWorks prescription only debit card to pay at the pharmacy counter for your out-of-pocket prescription costs. Make sure you save your receipts for tax purposes. You may not use this card at doctors, dentists, hospitals and vision providers. In these instances, you can use the Pay Me Back claim form to access your account.

Dependent Care FSA

A dependent care FSA offers you a tax-free way to pay for the costs of a baby sitter, day care or other qualified dependent care program. To qualify, the dependent care must enable you and your spouse, if married, to work or attend school full-time. This account is an alternative to the tax credit for which you may be eligible on your federal income tax return.

Eligible dependents include:

- Your eligible dependent children under the age of 13; and
- Disabled dependents, no matter how old, who live with you more than half of the calendar year and who depend on you financially

Expenses eligible for reimbursement include the following when used to allow you to work:

- A baby sitter who is age 19 or older;
- A child care or adult care center that complies with state and local regulations;

- Licensed nursery schools (does not include kindergarten);
- Home care specialists and dependent care centers; summer day camp; and
- Dependent care duties performed by a housekeeper.

Expenses not eligible for reimbursement include:
- Expenses for any child over the age of 13 who is capable of self-care;
- Expenses for overnight camps;
- Payment to a relative you claim as a dependent; and
- Expenses of dependents whom you cannot claim as federal tax dependents, such as same-gender partners.

You cannot deduct the same dependent care expenses from your federal income taxes that you pay from your dependent care FSA. Most of the time, it is to your benefit to participate in an FSA. However, you may wish to consult a tax advisor or call the IRS at 800-829-3676 to request IRS Publication 503 Child and Dependent Care Expenses.

Contribution Limits if You are Married

If this is your situation:	**The maximum annual dependent care contribution is:**
You or your spouse earn less than $5,000 annually	The amount that the lower-paid spouse or same-gender partner earns annually[1]
Your spouse also participates in a dependent care account	$5,000 combined for both accounts

You can use the calculators at www.wageworks.com to help you determine how much you may wish to budget for your FSAs next year. If this is the first time you've used an FSA, try it out with at least a small amount.

[1] *If the employee is married with a spouse who has no earned income, the spouse is deemed to have earned income of $250 per month ($500 per month if there are two or more dependents) in each month that he or she is a full-time student or disabled*

Who is Eligible?

You are eligible for benefits discussed in this guide if you are a full-time bargaining employee of FPL. Some work-specific benefits, such as LTD, apply only to you as the employee. Other benefits offer coverage for eligible dependents. Eligible dependents include:

Your current spouse, unless:
- You and your spouse are legally separated if legal separation is recognized in your state of residence; or
- You and your spouse are claiming common law marriage in a state where it is not recognized

Your same-gender partner with whom you are currently:
- Publicly registered in a civil union, domestic partnership or similar formalization process in the state in which you reside or
- Same-gender partners, residing in a state where neither marriage nor public registration is available, as long as you and your same gender partner:
  - Are age 18 or older
  - Are not related
  - Have resided together for at least the last 12 consecutive months in an exclusive mutual committed long- term relationship as a family of indefinite duration where you are socially, emotionally, and financially interdependent with each other and agree to be responsible for each other's common welfare
  - Complete together and submit a notarized NextEra Energy Affidavit of Same-gender Partnership.

Note: All references to "partner" or "same-gender partner" in this guide refer to this definition of partner or same-gender partner unless otherwise noted with respect to such reference.

Imputed Income - federal tax regulations require the company to impute income to you on the value of coverage for same-gender partners and their children. In addition, your contributions for such coverage will be withheld on an after-tax basis.

Your children, including legally adopted children and stepchildren, who are under 26 years of age regardless of student, marital or employment status. Coverage will be terminated the end of the month in which the child turns 26.

Your same-gender partner's children, but only if you are also covering your same-gender partner, including legally adopted children who are under 26 years of age regardless of student, marital or employment status. Coverage will be terminated the end of the month in which the child turns 26.

Court-appointed children[1] (such as legal wards and foster children) of you, your spouse or your covered same- gender partner who do not have access to other coverage and who are either:

- Under the age of 19; or
- Between the ages of 19 and 24 and who (1) are full-time students during at least 5 months of the
  calendar year at an educational organization described in Section 170(b) (1) (A) (ii) of the Internal Revenue
  Code; (2) have the same principal place of residence with you for at least one-half of the tax year; (3) are
  unmarried; (4) are not claimed by any other individual as a tax dependent for federal tax purposes; and
  (5) Rely upon you for at least one-half of their support.

Disabled children[1]**,** age 26 and older, of you, your spouse or your covered same-gender partner, who satisfy all, the following:

- Are unmarried;
- Live at home with you;
- Are unable to support and care for themselves due to a mental or physical disability;
- Become disabled while covered by the health plan (note that dependent children under age 26 who are disabled would be eligible even if the disability occurred before being covered by the health plan); and
- Depend on you totally for financial support and maintenance.

Note: Continuation of coverage for mentally or physically disabled dependents age 26 or older must be approved by the plan administrator. You must supply written proof of the disability to Employee Services at least 60 days before the child's
26th birthday. If you provide the documentation after this date, your dependent may lose health coverage while the plan determines whether the dependent is eligible for disabled dependent coverage. You may call 844-694-4748 (HR4U), for the *Continuation of Health Coverage for Disabled Dependent* form.

Your child must also apply for Social Security disability benefits when you apply to continue health coverage through the Company if your child is not already on Social Security disability. A written copy of Social Security's decision must be supplied to the Company as soon as possible after you receive it. The claims administrator will review your dependent's status periodically and will require updated information from you and the disabled dependent's doctor. Failure to provide the updated information may result in loss of health coverage for the dependent.

[1]*All references to "your children" or "children" in this handbook refer to the definition of your children, your same-gender partner's children, court-appointed children and disabled children unless otherwise noted with respect to such reference.*

Qualified Life Events reminder:

Unless you experience a qualified life event, open enrollment is your ONLY chance to enroll in, change or drop certain benefits for 2017.

Certain qualified life events allow you to make changes to and enroll in benefits mid-year within 30 days of the event:

- Marriage
- Divorce
- Birth / adoption
- Loss or gain of benefit coverage for your spouse or child
- Death of a spouse or child

Important Deadlines for Qualified Life Events:

- You have 30 days from the life event to make changes to your benefits coverage and submit supporting documentation
- If you do not make changes within the 30-day deadline, you must wait until the next available Open Enrollment period to make changes to your benefits and the change will be effective January 1.
- If you do not remove your ineligible spouses and/or dependents within 30 days of the life event the following may result:
    - A requirement to re-pay any claims incurred after the spouse or dependent became ineligible
    - You may be subject to an audit or investigation to determine if fraudulent activity has occurred
    - Loss of COBRA rights – the right to continue medical/dental/vision coverage

Can you be covered by someone who also works for the Company?
Remember that you cannot have double coverage. This means you cannot cover yourself and also be covered as a dependent by another Company employee, such as your parent, spouse or same-gender partner's medical, dental, vision or dependent life election. Likewise, only you or your spouse or same-gender partner can cover your eligible children. If you both work for NextEra Energy, the most cost-effective medical coverage is probably for each of you to have
employee-only coverage, or for one to have employee-only and the other to have employee-plus-children coverage if applicable.

Online Enroll Instructions

What you need to know before you log in:

1. **Your SLID.** Sometimes referred to as your username, Login ID, Network ID, etc. Your SLID is your System Login ID. It is a unique set of seven letters and numbers (alphanumeric) assigned to you. It is not your personnel number, email address or Social Security number. If you do not know your SLID you will need to obtain it before starting the open enrollment process. You can obtain your SLID in any of three ways:
   - You can go to the Corporate Portal; Under *Who's Who* on the right-hand side click on Org Chart. In the *Look for box* search for your own name as it appears on your pay stub. Click on the *Detailed* tab and your SLID will appear on the bottom of the page highlighted in black in the column next to your name (third column) called EMP SLID along with other information;
   - You can contact Employee Services at 844-694-4748 (HR4U) or
   - You can contact the ITSC Help Desk at 305-552-4357 or toll-free at 877-375-4672 (outside of Florida). If you are also going to need your password, then calling the Help Desk is your best option.

2. **Your network password.** Your network password is assigned to you when you begin your employment with the Company. However, after your initial login you would have been required to create your own password. Passwords expire every 60 days, so if it has been more than 60 days since you last logged in to the network, you will need to have your password reset. Additionally, if you have never logged in, or no longer recall your password, you will need to obtain a password before you can proceed.

   To have your password reset you will have to call the ITSC help desk at 305-552-4357 or toll-free at 877-375-4672 (outside of Florida). When you call, it is best to be in front of a laptop or workstation computer connected to the network. Please be advised no one but you can call to obtain your password. When you call you will need to verify your name, personnel number and last four digits of your Social Security number. Your password will be reset with a temporary password. You will receive an email verifying that the change was made and the next time you log in to the network with the temporary password, you will be required to change the password in order to connect to the network.

3. **Your and your dependents' personal information.** You will need basic information, such as your legal address and the names of your dependents, but you will also need information that you will want to verify beforehand, such as date of birth and Social Security number for you and each of the dependents you plan to cover under one or all of the health plans. Prepare a list containing all of this information so it will be easily available to you before you start to enroll.
   Doing so will make the process go faster and easier. Even if you are not adding dependents, it is still helpful to have
   this information handy, so you may review what is already in the system for them.

4. **Your enrollment choices.** By the time you start to enroll, you should have already reviewed all the materials sent to you as well as any additional plan information online. At this stage, you should be ready to make your selection, which will greatly speed up the enrollment process. In addition, for security reasons if you do not take any action on the site for 30 consecutive minutes, the system will automatically log you out and any elections you have made will be lost.

5. **Time to complete the process.** Try to set aside time to accomplish this task when you will not be interrupted and can devote yourself to this process. Need help? Remember we're here to assist you.

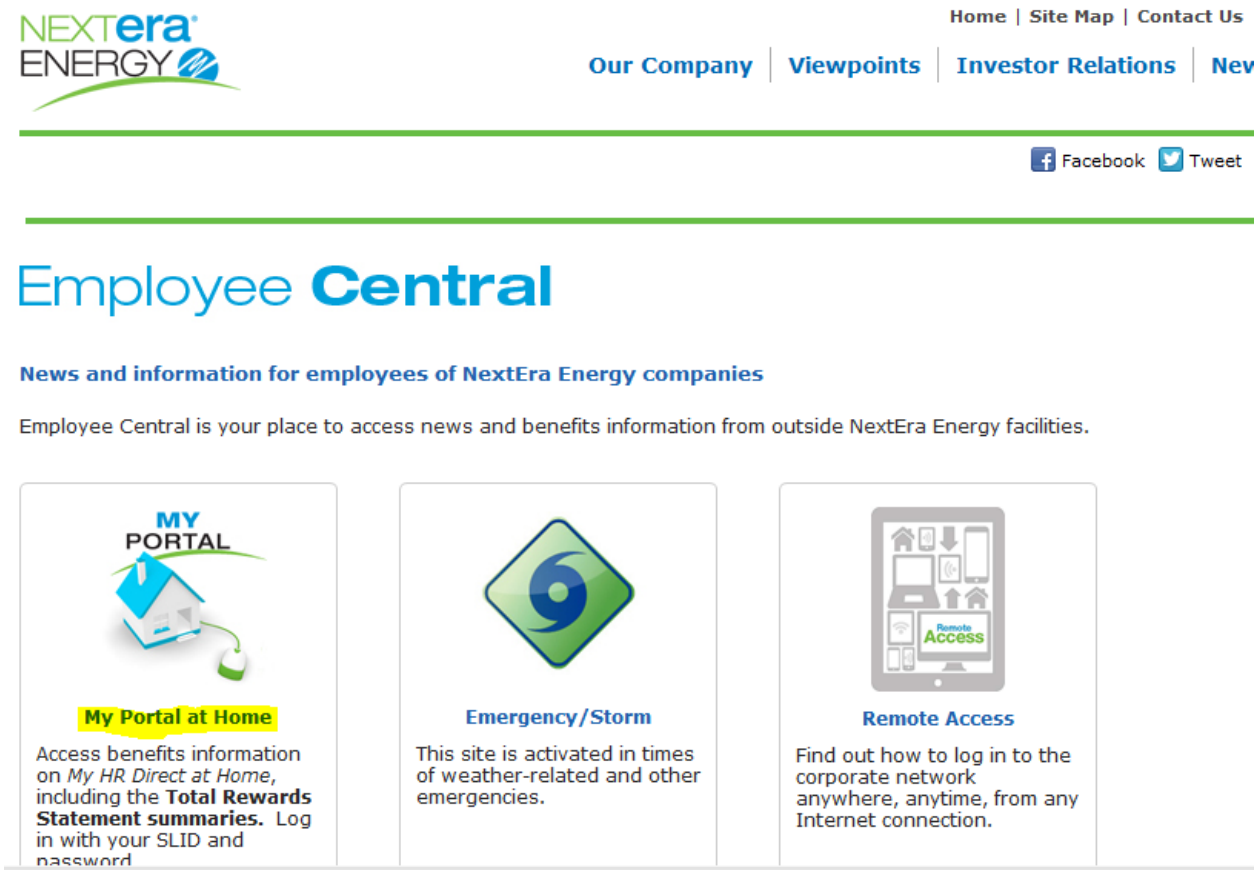
Don't wait until the last day of open enrollment to enroll.

Open Enrollment will last from Nov. 2, 2017, through Nov. 16 2017, and you can access the benefits enrollment online 24 hours a day, seven days a week, until 11:59 p.m. EST Nov. 16. After 11:59 p.m. Nov. 16, you will not be able to change your benefits for another year unless you experience a qualified life event and notify Employee Services within 30 days.

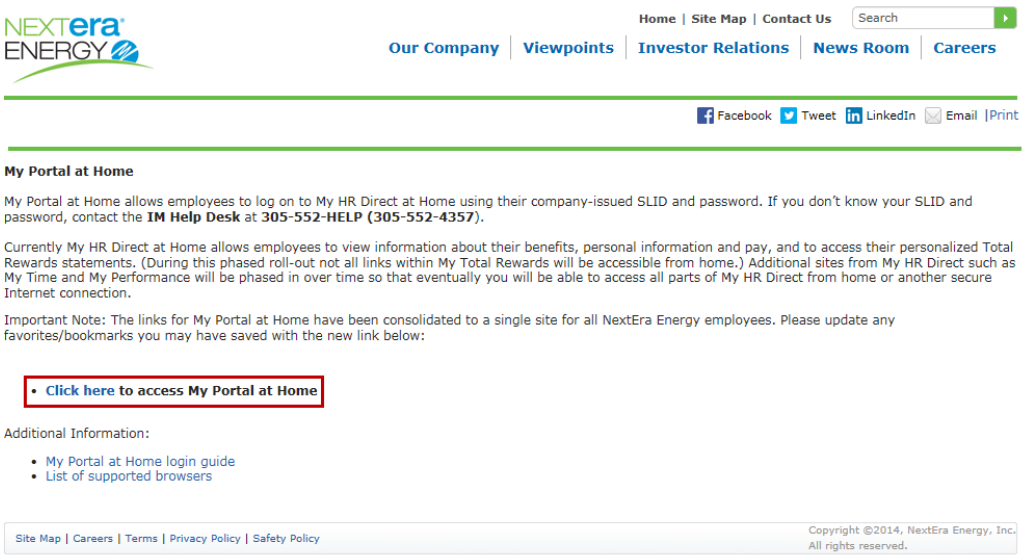
My Portal At Home

Guide to logging in from home to My Portal at Home over the internet
For FPL bargaining employees

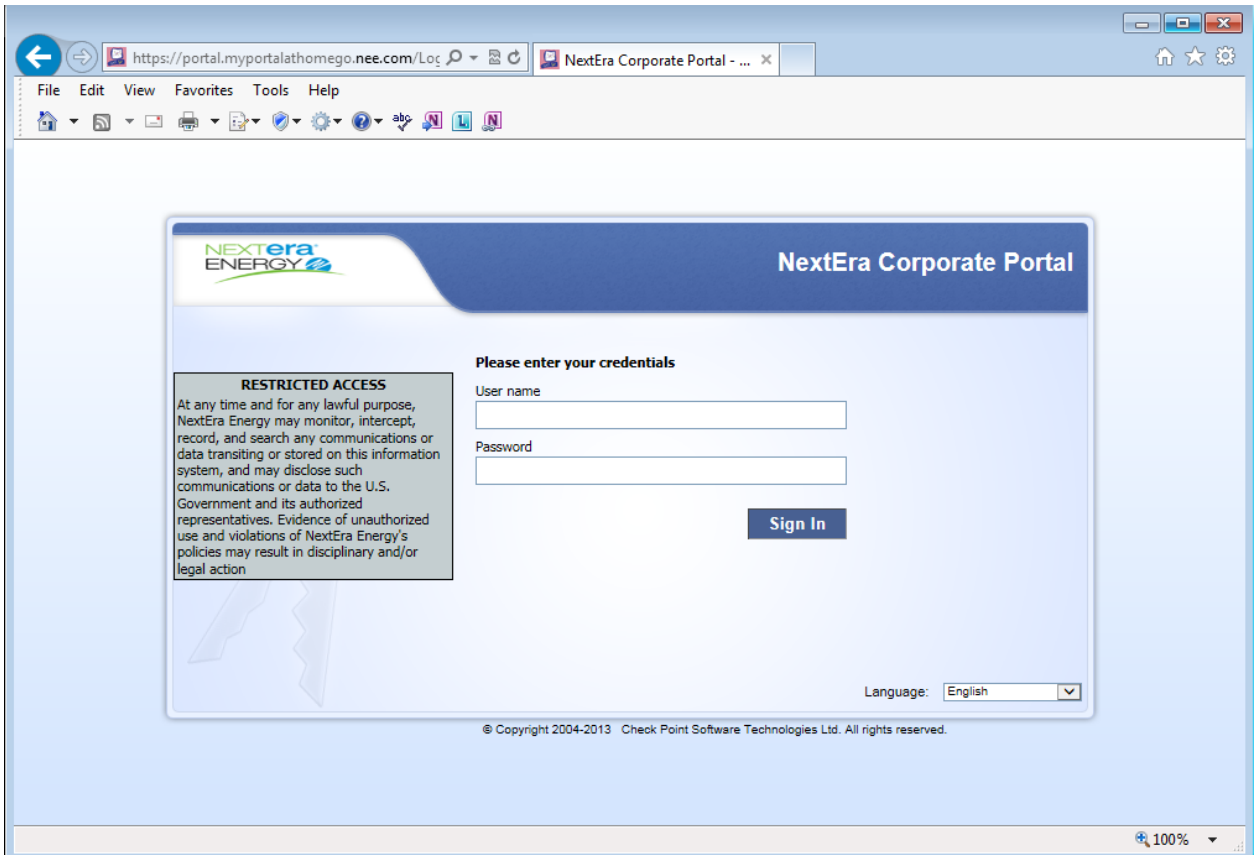
1) From your Internet browser, enter the URL http://www.NEE.com/EnrollNow.
You will be presented with the following screen. From this screen click on the **My Portal** graphic or the link titled **My Portal at Home**.



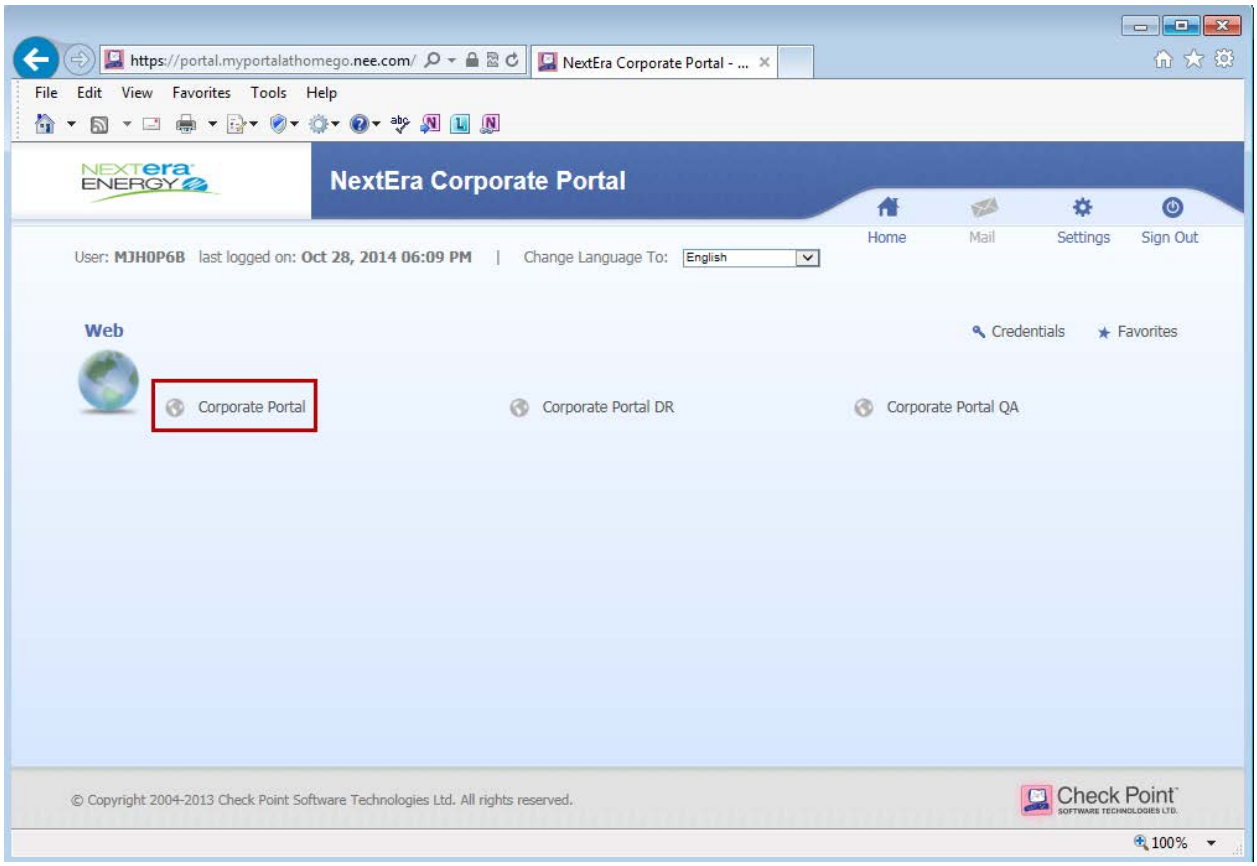
2) You will next be presented with the following screen. Click on the link that says **Click here to access My Portal at Home**. **NOTE:** This link will only work if you are not connected to the NEE network.



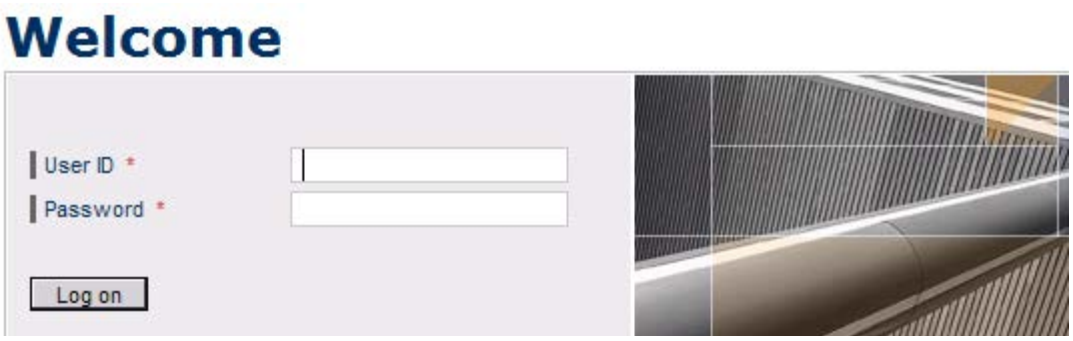
3) You will next be presented with the following login screen.
   a. In the username field enter your work Network ID/**SLID**.
   b. In the password field, enter your work **network password**.
   c. Click the **Sign In** button or press Enter to continue.



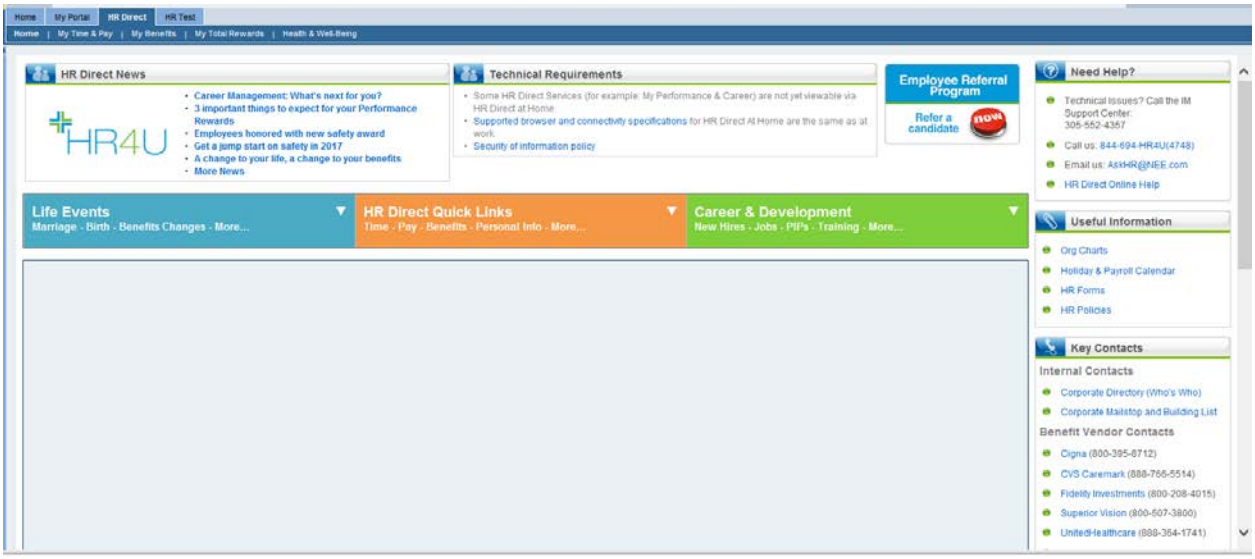
4) After clicking the Sign In button with the correct username and password, the following screen will appear. Click the **Corporate Portal** link in the NextEra Energy Web Links section to continue.



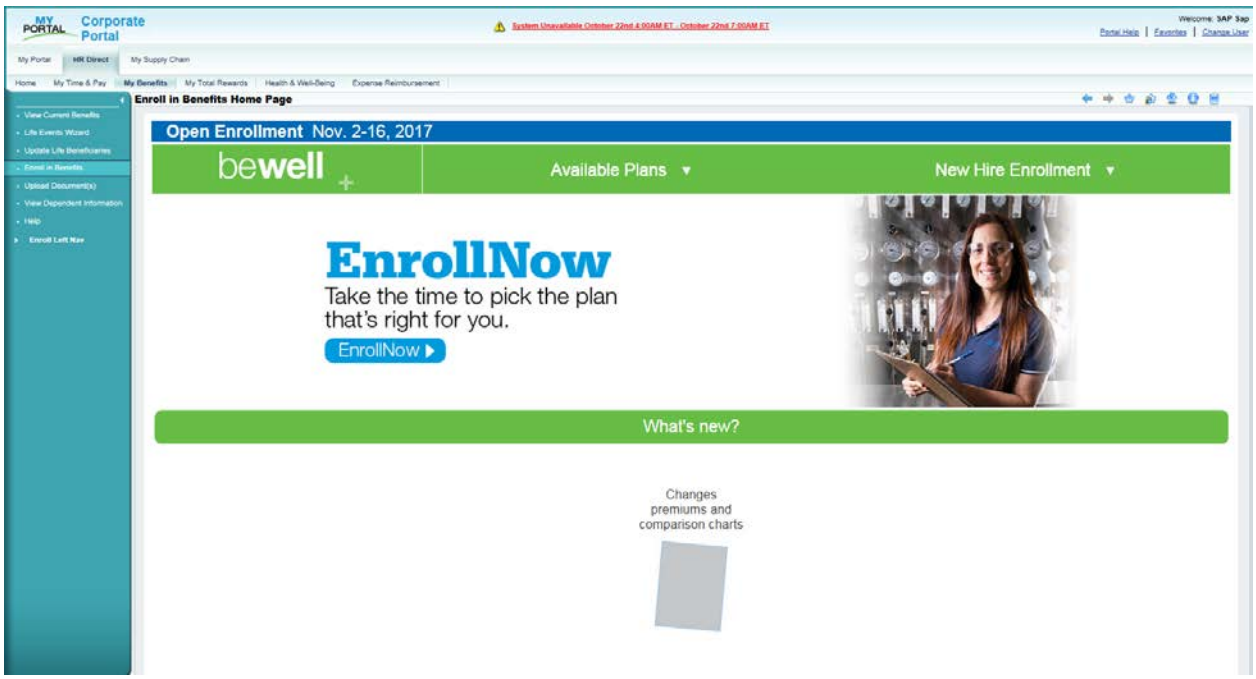
NOTE: After clicking the Corporate Portal link, you *may* be presented with another login screen similar to the one shown below. If so, enter your SLID and network password to proceed.



5) After clicking the Corporate Portal link, a screen *similar* to the screen below will appear under the **HR Direct** tab. This is the HR Direct At Home, home page. From this page you can click on the **My Benefits** tab, then **Enroll in Benefits** to review your benefit plan options for 2018 and begin the Open Enrollment process. Please note that the screen print provided below may look different than what you see when you log in.



Each of the different pages will appear exactly as they do when you access these pages through the internal NextEra Energy Corporate Portal. You will have access to all of the same services and transactions that you have as if you were connected to the NextEra Energy internal network.



Employee Services is here to help

Call **844-694-HR4U** or submit a request online at AskHR
Extended hours during Open Enrollment:
Nov. 2 – Nov. 16, 2017
Mon.-Fri., 8 a.m.-7 p.m. ET

Standard hours excluding holidays:
Mon.-Fri., 8 a.m.-5 p.m. ET
Tues., 10 a.m.-5 p.m. ET

The descriptions contained in this communication are based on official plan documents. If there is a disagreement, the plan documents always govern.

To the extent changes in terms of coverage under the medical and prescription plans are described herein, this document and its attachments constitute both a summary of material modifications ("SMM") and a summary of material reductions ("SMR") in coverage, under the Employee Retirement Income Security Act ("ERISA"). It describes changes made to the summary plan description ("SPD") for the NextEra Energy, Inc. Employee Health and Welfare Plan ("Plan"). This document along with the SPD, the summaries of benefits and coverage ("SBCs") and any other applicable SMMs and SMRs together constitute the most current SPD for the Plan. The SPDs and SBCs can be found on HR Direct > My Benefits.

Below are four legally required reminders about your health coverage.

1) Medicare Part D - If you are enrolled in Medicare or have a covered dependent who is enrolled in Medicare, this notice provides you with basic information about how the NextEra Energy prescription drug coverage compares to Medicare Part D. Medicare Part D is the Medicare prescription drug benefit that became available in January 2006. If you or your dependent is enrolled in Medicare and currently covered under a NextEra Energy health plan, you can choose to either enroll in a Medicare Part D plan or remain covered under the NextEra Energy health plan.

We have determined that our prescription drug coverage is, on average for all plan participants, expected to pay out this year as much as the standard Medicare Part D prescription drug benefit. This means that our prescription drug coverage is considered Creditable Coverage.

Because your existing NextEra Energy coverage is Creditable Coverage in 2018, you can keep your existing NextEra Energy coverage and not pay extra if you or your dependent later decides to enroll in Medicare Part D coverage. Be aware, however, that you could be subject to a late enrollment penalty (i.e., a higher premium) if you enroll in a Medicare Part D plan after a break in coverage of 63 days or more.

2) Women's Health and Cancer Rights - The NextEra Energy medical plan provides coverage for mastectomy-related services, including reconstruction and surgery to achieve symmetry between breasts, prostheses, and complications resulting from a mastectomy, including lymphedema, as specified by the Women's Health and Cancer Rights Act of 1998.

3) Notice of Privacy Practices for Protected Health Information - The HIPAA Privacy Rule gives individuals a right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information.

4) 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 program.