Regarding: **Medical Summary of Benefits and Coverage (SBC)**

Dear Employee,

We are pleased to provide you the attached Summary of Benefits & Coverage (SBC) for the group medical plans offered to our eligible participants for the plan year which begins on October 1, 2019 and ends September 30, 2020.

Please be advised that an SBC is available for the plans being offered to our group plan participants and their eligible dependents. The SBC follows a prescribed format as established under the Affordable Care Act legislation and outlines the benefits of each medical plan in detail with definitions and descriptions.

SBC's are available for the following offered plans:

Carrier	Plan Name
Florida Blue	BlueChoice 0727 Basic Plan
Florida Blue	**BlueChoice 0702 Traditional Plan**

Please refer to the SBC for further information about cost sharing responsibilities such as, deductibles, co-pays and coinsurance, as well as the selected network. Printed copies of the SBCs for all plans, as well as the standard glossary, are available free of charge in the Human Resources office. For a more comprehensive description of specific plan benefits refer to the Certificate of Coverage (COC) . You may contact Human Resources at (772) 344-4345 with additional questions.

Sincerely,

Claudia McCaskill

Claudia McCaskill
HR Manager, Benefits

Florida Blue

BlueChoice 0702

with Rx $10/$30/$50

Coverage Period: 10/01/2019 - 09/30/2020

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$300** Per Person/**$900** Family. Out-of-Network: Combined with In-Network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Out-of-Network Per Admission Deductible; **$50** In-Network/ **$50** Out-of-Network Per ER Visit. There are no other specific deductibles..	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$1,500** Per Person/**$4,500** Family. Out-Of-Network: Combined with In-Network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

SBCID: 1861934

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per Visit	Deductible + 30% Coinsurance	Physician administered drugs may have higher cost shares.
	Specialist visit	$40 Copay per Visit	Deductible + 30% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	30% Coinsurance	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: 10% Coinsurance/ Independent Diagnostic Testing Center: $40 Copay per Visit	Independent Clinical Lab: 30% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	$40 Copay per Visit	Deductible + 30% Coinsurance	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $20 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$30 Copay per Prescription at retail, $40 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$50 Copay per Prescription at retail, $60 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $40 Copay per Visit/ Hospital: Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	————none————
	Physician/surgeon fees	Ambulatory Surgical Center: $35 Copay per Visit/ Hospital: Deductible + 10% Coinsurance	Ambulatory Surgical Center: Deductible + 30% Coinsurance/ Hospital: Deductible + 10% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Per Visit Deductible + Deductible + 10% Coinsurance	Per Visit Deductible + Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
	Urgent care	$20 Copay per Visit	Deductible + $20 Copay per Visit	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Per Admission Deductible + Deductible + 30% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: $40 Copay per Visit / Hospital: Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	————none————
	Inpatient services	Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$40 Copay on initial Visit	Deductible + 30% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Per Admission Deductible + Deductible + 30% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 40 visits.
	Rehabilitation services	Physician Office: $40 Copay per Visit/ Outpatient Rehab Center: Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 70 visits Combined OP Cardiac Rehab, Physical, Speech, Massage and Spinal Therapies. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Deductible + 10% Coinsurance	Deductible + 30% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$300**
- **Specialist Copayment** **$40**
- **Hospital (facility) Coinsurance** **10%**
- **Other Coinsurance** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$300**
- **Specialist Copayment** **$40**
- **Hospital (facility) Coinsurance** **10%**
- **Other Coinsurance** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,570**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$300**
- **Specialist Copayment** **$40**
- **Hospital (facility) Coinsurance** **10%**
- **Other Copayment** **$50**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$690**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

1. Free aids and services to people with disabilities to communicate effectively with us, such as:
   1. Qualified sign language interpreters
   2. Written information in other formats (large print, audio, accessible electronic formats, other formats)
2. Free language services to people whose primary language is not English, such as:
   1. Qualified interpreters
   2. Information written in other languages

If you need these services, contact:

1. Health and vision coverage: 1-800-352-2583
2. Dental, life, and disability coverage: 1-888-223-4892
3. Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Health and vision coverage (including FEP members):

Section 1557 Coordinator

4800 Deerwood Campus Parkway, DCC1-7

Jacksonville, FL 32246

1-800-477-3736 x29070

1-800-955-8770 (TTY)

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Dental, life and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800–368–1019
1-800–537–7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 - 008-253-3852 (رقم هاتف الصم والبكم: 1 - 008-559-0778). اتصل برقم 1 - 008 - 333 - 7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: ફોન કરો 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี 1--800--352--2583 (TTY: 1--800--955--8770) หรือ FEP โทร 1--800--333--2227

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه :اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود. با شماره 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP : با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíílnih 1-800-333-2227.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

Supplement to BlueChoice 0727 Basic & BlueChoice 0702 Traditional SBC

Coverage Period 10/01/2019 – 09/30/2020

Other Covered Benefits for Employees of the City of Port St. Lucie
Wellness Incentive Program & Employee Health Center

Employee Health Center – The City of Port St. Lucie provides employees and their dependents covered under the City's BlueChoice 0727 Basic or BlueChoice 0702 Traditional Health plans access to an employee health center. Eligible services received through the City's Employee Health Center are covered at 100% for covered employees and their dependents. There are no deductibles or copayments for services or prescriptions received at the Employee Health Center.

There are four Employee Health Center locations:

1. 2266 SW Best Street, Port St. Lucie, FL 34984
2. 305-B NE Park Street, Okeechobee, FL 34972
3. 3405 NW Federal Highway, Jensen Beach, FL 34957
4. 7195 S George Blvd., Sebring, FL 33875

For more information regarding the Employee Health Center, please contact Human Resources at (772) 344-4345.

Wellness Incentive Program– The City of Port St. Lucie provides employees covered under the City's BlueChoice 0727 Basic or BlueChoice 0702 Traditional Health Plans the opportunity to participate in a voluntary Wellness Incentive Program. All employees enrolled in the health plan are eligible to receive incentives earned for achieved wellness targets for fiscal year 2019 - 2020.

For additional information regarding the Wellness Incentive Program, please contact Human Resources at (772) 344-4345.

Health Reimbursement Account (HRA) – The City of Port St. Lucie provides a Health Reimbursement Account for employees who were enrolled in the City's BlueChoice 0727 Basic or BlueChoice 0702 Traditional Health plans, that met and achieved wellness targets for plan year 10/1/18 through 9/30/19 plan. These employees will receive anywhere from $25 to $500 based on the wellness targets they achieved during the plan year 10/1/18 through 9/30/19. HRA monies are funded by the City and can be used for any qualified medical, dental, vision and hearing expense that is incurred.

How does it work? – When you incur an eligible expense, you can pay the charge with your HRA debit card instead of paying out of pocket and submitting for reimbursement. You can utilize your debit card at health care providers and pharmacies that are providers of qualified medical services and accept debit MasterCards.

If your provider or merchant does not accept MasterCard debit cards or you choose not to use it, you will need to pay for your expenses and submit a request for reimbursement. Make sure when you submit your reimbursement form you supply the appropriate documentation such as an Explanation of Benefits (EOB) and receipt of payment for the services rendered.

For additional information regarding the City of Port St. Lucie's Health Reimbursement Account visit www.chard-snyder.com or call (800) 982-7715.