SCHEDULE OF BENEFITS

This Plan does not require the designation of a primary care provider or to obtain a referral for services received from a specialist. You shall have the free choice to obtain services from any licensed physician/provider or surgeon, acting within the license's scope. The level of benefits received is based upon your decision at the time treatment is needed to access care through either Preferred or non-preferred providers. Benefits are payable at the Preferred level by accessing your care through a Preferred Provider, Preferred Medical Facility or from a Preferred Hospital. Out-of-Network charges will be paid at the Out-of-Network level of benefits.

If you are receiving treatment for certain services, and your health care provider or facility is no longer contracted as a Preferred Network provider, you may be able to continue to see that provider temporarily, on an in-network basis. Please see the Continuity of Care provision within the Important Information section for more information.

Important Out-of-Network Benefit Notice: The maximum allowable charge for Out-of-Network physician services is based upon 125% of Medicare allowable and all Out-of-Network facility fees is based upon 150% of Medicare allowable (including deductible, out-of-pocket maximum, and coinsurance as applicable), unless otherwise indicated under a specific benefit in the Schedule of Benefits.

Patients who utilize covered services received from Out-of-Network providers, may be subject to balance billing, even if the benefit shows Out-of-Network coverage at 100%. In this instance, the Plan will pay 100% of the maximum allowable amount, not 100% of the charges billed by the provider. Charges over the maximum allowable amount that are billed by the provider are not covered by this Plan and you may be billed for the balance of the charges.

For example, if you are charged $150 but the maximum allowable amount for that service is $100:

- ***With Out-of-Network coverage at 100%, the Plan will pay $100 (minus any applicable copayments or deductibles). This is 100% of the maximum allowable amount. You may still be responsible for the amount billed by the Out-of-Network provider that is over the maximum allowable amount, in this example, $50. The Out-of-Network provider may balance bill you for the remaining $50.***
- ***With Out-of-Network coverage at 50%, the Plan will pay $50 (minus any applicable copayments or deductibles). This is 50% of the maximum allowable amount. You may still be responsible for the amount billed by the Out-of-Network provider that is over the allowable amount, in this example, $100. The Out-of-Network provider may balance bill you for the remaining $100.***

Your Preferred Provider Organization is:

If you live in Idaho/Oregon/Utah/Washington:
HMA Preferred Provider Network
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

If you live outside of WA, OR, ID, or UT:
PHCS Network
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

If you live in WA, OR, ID, or UT but are temporarily outside of your home state:
PHCS Network for Out-of-Area Access
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

You can access a directory of Preferred Network providers and facilities at any time on our online portal at www.accesshma.com. This directory is updated at least every 90 days. While we strive to provide accurate provider network status, the listings can change. We recommend you verify with your provider for the most up to date network contract status prior to receiving services.

Eligible expenses will be paid at the Preferred level when (any of the following apply):

- The services are billed by a Preferred provider, hospital or medical facility.
- The services are for non-emergent care provided by a non-preferred Assistant Surgeon or Anesthesiologist, where the medical facility and the primary surgeon are both Preferred providers.
- You live outside the area serviced by the Preferred provider organization.
- You receive emergency services (includes Ambulance, Anesthesiologist, Assistant Surgeon, Emergency Room Services, Primary Surgeon, and Urgent Care) inside or outside the network area.
- The services are for Durable Medical Equipment (DME) distributed by a Preferred provider but the DME company is non-preferred.
- The services are for non-preferred diagnostic testing, lab and imaging services, where the physician/provider who ordered the services is a Preferred provider. Eligible services will be covered based upon 250% of the Medicare allowable charge.
- The services are for a non-preferred inpatient physician visit, where the hospital or medical facility where the services were rendered is a Preferred provider. Eligible services will be covered based upon 250% of the Medicare allowable charge.

If you do not reside within the HMA Preferred PPO Network service area but travel to it, you must use a HMA Preferred PPO Network provider in order to receive services covered at the Preferred Network level of benefit.

This Schedule of Benefits is a summary of the benefits provided under this Plan. **Please read the entire booklet for details on specific benefit limitations, benefit maximums, waiting periods and exclusions.**

MEDICAL BENEFITS

	Preferred Network	Participating/Out-of-Network
INDIVIDUAL DEDUCTIBLE Per calendar year.	None	None
FAMILY DEDUCTIBLE Per calendar year.	None	None
INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$500	$500
FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$875	$875

Your individual and family out-of-pocket maximum includes eligible Medical and Prescription Drug expenses.

Your out-of-pocket maximums accumulate as a single amount. This means that you have one out-of-pocket maximum amount for Preferred, Participating, and Out-of-Network services combined.

Your benefit maximums (calendar year) are combined for Preferred, Participating, and Out-of-Network eligible expenses.

Once your out-of-pocket maximum is reached, your eligible expenses are paid at 100% of allowable charges for the remainder of the calendar year. Where a copay is applicable, only one copay is to be taken per day for related outpatient services rendered. There are some benefits that are not payable at the 100% coinsurance rate. The following expenses do not apply to the out-of-pocket maximum:

- Penalties.
- Ineligible charges.
- Balance billing from Out-of-Network providers.

A 5-day grace period will be allowed in determining whether or not an annual or monthly benefit limitation has been satisfied.

Please Note: Out-of-Network providers you see for care may bill higher than the maximum allowable charge. Amounts balance billed by the provider for the billed charges in excess of what this Plan will pay is patient responsibility.

PRE-AUTHORIZATION FOR INPATIENT MEDICAL FACILITY ADMISSIONS is required for full benefits. Failure to pre-authorize will result in the following: a $100 penalty, which will not apply towards the out-of-pocket maximum.

	Preferred Network	Participating/Out-of-Network
ACUPUNCTURE AND MASSAGE THERAPY Limited to 25 visits per calendar year.	$30 copay, then 100%	$30 copay, then 80% of maximum allowable
ALLERGY INJECTIONS/TESTING	100%	100% of maximum allowable
AMBULANCE (AIR AND GROUND) Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges. Limited contracted providers. See the "Please Note" at the bottom of page 18.	100%	100% of maximum allowable
ANESTHESIOLOGIST Out-of-Network services are payable at 250% of the Medicare allowable.	100%	100% of maximum allowable
ASSISTANT SURGEON Paid based upon the primary surgeon's allowed amount, whether contracted or maximum allowable charge. Out-of-Network services are payable at 250% of the Medicare allowable.	100%	100% of maximum allowable
BIOFEEDBACK	100%	100% of maximum allowable
BREAST PUMPS	100%	100% of maximum allowable
CHIROPRACTIC SERVICES AND X-RAYS	$30 copay, then 100%	$30 copay, then 80% of maximum allowable
CLINICAL TRIALS	Paid the same as any other condition	Paid the same as any other condition
CONTRACEPTIVE SERVICES	100%	100% of maximum allowable - Participating Network $30 copay, then 100% of maximum allowable - Out-of-Network

	Preferred Network	Participating/Out-of-Network
COVID-19 BENEFIT		
Diagnostic Testing and Laboratory Includes all related tests received the same day and includes services received in an emergency room, urgent care facility, physician's office, or other diagnostic testing facility or laboratory. Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges. Over the counter (OTC) tests are not covered under the medical benefits of the Plan. Please see the Pharmacy Benefits for details regarding the purchase of OTC tests.	100%	100% of maximum allowable
COVID-19 Vaccine Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
COVID-19 Office Visits/Treatment Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
CT SCAN	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
DENTAL ACCIDENT	Paid the same as any other condition	Paid the same as any other condition
DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING	100%	100% of maximum allowable
DIAGNOSTIC X-RAY, IMAGING AND LABORATORY	100%	100% of maximum allowable
DIETARY EDUCATION Copay waived for services received from a Participating Network provider.	100%	$30 copay, then 100% of maximum allowable
DURABLE MEDICAL EQUIPMENT	100%	100% of maximum allowable
EMERGENCY ROOM & SERVICES Out-of-Network services are payable at 250% of the Medicare allowable.		
ER Physician	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
ER Services Copay waived if admitted as an inpatient, treatment is for a life endangering condition, or if ordered by a physician.	$100 copay, then 100%	$100 copay, then 100% of maximum allowable

	Preferred Network	Participating/Out-of-Network
FLU SHOTS	100%	100% of maximum allowable
GENETIC TESTING	100%	100% of maximum allowable
HEARING BENEFIT - Exams Limited to one exam(s) per calendar year.	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
HEARING BENEFIT - Hearing Aids Limited to $4,000 every 3 years. Payment for services received from an Out-of-Network provider and hearing aids from a Preferred Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
HOME HEALTH CARE	100%	100% of maximum allowable
HOSPICE CARE	100%	100% of maximum allowable
IMMUNIZATIONS	100%	100% of maximum allowable
INFERTILITY TREATMENT AND FERTILITY PRESERVATION Limited to $10,000 per lifetime for medical benefits with an additional $10,000 per lifetime available under the pharmacy benefit for a total combined lifetime maximum of $20,000. If you reach the $10,000 maximum on the medical plan you may access unused portions of your pharmacy benefit to count towards medical expenses (and vice-verse). Please contact the City of Renton Human Resources Department for additional information. In no event will the total benefits available exceed $20,000 lifetime for both medical and prescription benefits combined. Limited to employee and spouse only.	100%	100% of maximum allowable
INFUSION THERAPY	100%	100% of maximum allowable
INJECTIONS	100%	100% of maximum allowable
KIDNEY DIALYSIS (OUTPATIENT SERVICES)	100%	100% of maximum allowable

	Preferred Network	Participating/Out-of-Network
MEDICAL FACILITY SERVICES		
Inpatient **First 120 Days Per Calendar Year**	100%	100% of maximum allowable
Subsequent Days	100%	80% of maximum allowable
Outpatient Surgical Facility	100%	100% of maximum allowable
Miscellaneous Services	100%	100% of maximum allowable
MEDICAL SUPPLIES	100%	100% of maximum allowable
MENTAL HEALTH SERVICES		
Inpatient	100%	50% of maximum allowable
Residential Treatment	100%	50% Participating Network Not Covered - Out-of-Network
Outpatient	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
Applied Behavioral Analysis	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
MRI Only one copay applies per day, per provider.	$100 copay, then 100%	$100 copay, then 100% of maximum allowable
NATUROPATHIC SERVICES	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
OBESITY TREATMENT (NON-SURGICAL)	Paid the same as any other condition	Paid the same as any other condition
ORTHOTICS	100%	100% of maximum allowable
PHYSICIAN SERVICES		
Inpatient Services **First 120 Days Per Calendar Year**	100%	100% of maximum allowable
Subsequent Days	100%	80% of maximum allowable
Office Visits Only one copay applies per day, per provider.	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
PRE-ADMISSION TESTING	100%	100% of maximum allowable

	Preferred Network	Participating/Out-of-Network
PREVENTIVE CARE	100%	Not Covered
PREVENTIVE COLONOSCOPY	100%	Not Covered
Fecal DNA Testing With Cologuard® Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
PREVENTIVE LAB & X-RAY	100%	100% of maximum allowable
PREVENTIVE MAMMOGRAPHY	100%	100% of maximum allowable
PROSTHETICS	100%	100% of maximum allowable
RADIATION AND CHEMOTHERAPY	100%	100% of maximum allowable
REHABILITATION SERVICES		
Inpatient	100%	100% of maximum allowable
Outpatient Only one copay applies per day, per provider.	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
SECOND SURGICAL OPINION	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
SKILLED NURSING FACILITY CARE		
First 120 Days Per Calendar Year	100%	100% of maximum allowable
Subsequent Days	100%	80% of maximum allowable
STERILIZATION (ELECTIVE)	$100 copay, then 100%	$100 copay, then 100% of maximum allowable
SUBSTANCE USE DISORDER SERVICES		
Inpatient	100%	100% of maximum allowable
Outpatient	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
SURGEON FEES	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
TELEHEALTH MDLIVE	100%	Not Covered

	Preferred Network	Participating/Out-of-Network
TELEMEDICINE	Paid the same as any other condition	Paid the same as any other condition
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	Paid the same as any other condition	Paid the same as any other condition
TRANSPLANTS		
Transplants	100%	100% of maximum allowable
Donor Benefits	100%	100% of maximum allowable
URGENT CARE FACILITY Out-of-Network services are payable at 250% of the Medicare allowable.	$30 copay, then 100%	$30 copay, then 100% of maximum allowable
VISION THERAPY (ORTHOPTICS) Limited to a 24 visit lifetime maximum.	100%	Not Covered
WIGS	100%	100% of maximum allowable
OTHER MISCELLANEOUS ELIGIBLE CHARGES	100%	100% of maximum allowable

Benefit maximums described herein are combined for the Preferred Network, Participating Network, and Out-of-Network.

PRESCRIPTION BENEFITS

Costco Health Solutions - Retail Pharmacies

Generic Drugs	$10 Copay
Brand Name Drugs	
On Formulary Drug List	$25 Copay
Not On Formulary Drug List	$50 Copay
Dispensing limit	90 days

Costco Health Solutions - Mail Order Prescriptions and Preferred Retail Pharmacies

Generic Drugs	$10 Copay
Brand Name Drugs	
On Formulary Drug List	$25 Copay
Not On Formulary Drug List	$50 Copay
Dispensing limit	90 days

The Prescription Benefits include a $10,000 lifetime maximum for prescription medication purchased for the treatment of infertility with an additional $10,000 per lifetime available under the medical benefit for a total combined lifetime maximum of $20,000. If you reach the $10,000 maximum on the pharmacy plan you may access unused portions of your medical benefit to count towards pharmacy expenses (and vice-verse). Please contact the City of Renton Human Resources Department for additional information. In no event will the total benefits available exceed $20,000 lifetime for both medical and prescription benefits combined. Limited to employee and spouse only.

This Plan requires your pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at your request, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Costco Health Solutions at 877/908-6024.

Over the Counter COVID-19 Tests

Over the Counter (OTC) COVID-19 Tests can be purchased point-of-sale at retail pharmacy locations, and are eligible for coverage under the pharmacy benefits of this Plan with no up-front out-of-pocket cost to you. Coverage will be limited to 8 tests per person every 30 days, based upon the purchase date of the test. If you paid up front for an OTC Covid-19 test and need to submit for reimbursement you must contact the PBM for claim submission instructions.