

## SCHEDULE OF BENEFITS

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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](http://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](http://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](http://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](http://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 (including the Preferred Network deductible and Out-of-Pocket Maximum) 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

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

*The deductible applies to all services unless noted as being waived in the Schedule below.*

	<b>Preferred Network</b>	<b>Participating/Out-of-Network</b>
<b>ACUPUNCTURE AND MASSAGE THERAPY</b> Limited to 25 visits per calendar year.	\$30 copay, then 100%	\$30 copay, then 80% of maximum allowable
<b>ALLERGY INJECTIONS/TESTING</b>	100%	100% of maximum allowable
<b>AMBULANCE (AIR AND GROUND)</b> 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
<b>ANESTHESIOLOGIST</b> Out-of-Network services are payable at 250% of the Medicare allowable.	100%	100% of maximum allowable
<b>ASSISTANT SURGEON</b> 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
<b>BIOFEEDBACK</b>	100%	100% of maximum allowable
<b>BREAST PUMPS</b> Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
<b>CHIROPRACTIC SERVICES AND X-RAYS</b>	\$30 copay, then 100%	\$30 copay, then 80% of maximum allowable
<b>CLINICAL TRIALS</b>	Standard of care paid the same as any other condition	Standard of care paid the same as any other condition
<b>CONTRACEPTIVE SERVICES</b>	100%	100% of maximum allowable - Participating Network \$30 copay, then 100% of maximum allowable - Out-of-Network

	Preferred Network	Participating/Out-of-Network
<b>COVID-19 BENEFIT</b>		
<b>Diagnostic Testing and Laboratory</b> 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
<b>COVID-19 Vaccine</b> Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
<b>COVID-19 Office Visits/Treatment</b> Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100% of maximum allowable
<b>CT SCAN</b>	\$30 copay, then 100%	\$30 copay, then 100% of maximum allowable
<b>DENTAL ACCIDENT</b>	Paid the same as any other condition	Paid the same as any other condition
<b>DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT TRAINING</b>	100%	100% of maximum allowable
<b>DIAGNOSTIC X-RAY, IMAGING AND LABORATORY</b>	100%	100% of maximum allowable
<b>DIETARY EDUCATION</b> Copay waived for services received from a Participating Network provider.	100%	\$30 copay, then 100% of maximum allowable
<b>DURABLE MEDICAL EQUIPMENT</b>	100%	100% of maximum allowable
<b>EMERGENCY ROOM &amp; SERVICES</b> Out-of-Network services are payable at 250% of the Medicare allowable.		
<b>ER Physician</b>	\$30 copay, then 100%	\$30 copay, then 100% of maximum allowable
<b>ER Services</b> 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

	<b>Preferred Network</b>	<b>Participating/Out-of-Network</b>
<b>FLU SHOTS</b>	100%	100% of maximum allowable
<b>GENETIC TESTING</b>	100%	100% of maximum allowable
<b>HEARING BENEFIT - Exams</b> Limited to one exam(s) per calendar year.	\$30 copay, then 100%	\$30 copay, then 100% of maximum allowable
<b>HEARING BENEFIT - Hearing Aids</b> 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
<b>HOME HEALTH CARE</b>	100%	100% of maximum allowable
<b>HOSPICE CARE</b>	100%	100% of maximum allowable
<b>IMMUNIZATIONS</b>	100%	100% of maximum allowable
<b>INFERTILITY TREATMENT AND FERTILITY PRESERVATION</b> 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
<b>INFUSION THERAPY</b>	100%	100% of maximum allowable
<b>INJECTIONS</b>	100%	100% of maximum allowable
<b>KIDNEY DIALYSIS (OUTPATIENT SERVICES)</b>	100%	100% of maximum allowable
<b>MEDICAL FACILITY SERVICES</b> <b>Inpatient</b> <b>First 120 Days Per Calendar Year</b>	100%	100% of maximum allowable

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

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



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

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

## PRESCRIPTION BENEFITS

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### Costco Health Solutions - Retail Pharmacies

<b>Generic Drugs</b>	\$10 Copay
<b>Brand Name Drugs</b>	
On Formulary Drug List	\$25 Copay
Not On Formulary Drug List	\$50 Copay
<b>Dispensing limit</b>	90 days

### Costco Health Solutions - Mail Order Prescriptions and Preferred Retail Pharmacies

<b>Generic Drugs</b>	\$10 Copay
<b>Brand Name Drugs</b>	
On Formulary Drug List	\$25 Copay
Not On Formulary Drug List	\$50 Copay
<b>Dispensing limit</b>	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.