



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.rentonwa.gov or by calling 425-430-7659.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$500 person / \$875 family for Preferred Network & Out of Network.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, emergency room copays, MRI copays, penalties, ineligible charges, sterilization copays, prescription drug card charges and copays, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.accesshma.com or call 1-800-700-7153 for a list of Preferred Network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness		\$25/visit	-----none-----
	Specialist visit		\$25/visit	-----none-----
	Other practitioner office visit	\$25/visit for chiropractor and acupuncture	\$25/visit, then 20% co-insurance for chiropractor and acupuncture	Acupuncture and massage therapy are limited to a combined 10-visit limit per calendar year.
	Preventive care/screening/immunization	\$25/visit	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)		No charge	-----none-----
	Imaging (CT/PET scans, MRIs)		\$100/MRI and \$25/CT scan	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.envisionrx.com .	Generic drugs		\$10/prescription (retail) \$10/prescription (mail-order)	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription)
	Brand Name drugs		On Performance Drug List \$25/prescription (retail) \$25/prescription (mail-order)	
	Non-Preferred Brand drugs		Non On Performance Drug List \$50/prescription (retail) \$50/prescription (mail-order)	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription)

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City of Renton Employee Health Care Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014

Coverage for: Individual, Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Specialty drugs	Contact EnvisionRxOptions Specialty Pharmacy, your prescription drug vendor for applicable cost.		Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		-----none-----
	Physician/surgeon fees	\$25/visit		-----none-----
If you need immediate medical attention	Emergency room services	\$100/visit		Co-pay is waived if admitted to hospital directly from emergency room, or treatment is for life endangering condition, or ordered by a physician.
	Emergency medical transportation	No charge		-----none-----
	Urgent care	\$25/visit		-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge for 1 st 120 days per calendar year, then 20% coinsurance for remainder of the calendar year.	Services must be pre-authorized to avoid a \$100 penalty.
	Physician/surgeon fee	\$25/visit		-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25/visit		Limited to 20 visits per calendar year.
	Mental/Behavioral health inpatient services	50% co-insurance		Limited to 5 days maximum per calendar year.
	Substance use disorder outpatient services	\$25/visit		-----none-----
	Substance use disorder inpatient services	No charge		-----none-----
If you are pregnant	Prenatal and postnatal care	\$25/visit		Limited to Employee & Spouse only. Dependent Maternity is not covered.

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	Delivery and all inpatient services	No charge		Services must be pre-authorized for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a \$100 penalty. Limited to Employee & Spouse only. Dependent Maternity is not covered.
If you need help recovering or have other special health needs	Home health care	No charge		Must be pre-authorized or may result in denial of the claim.
	Rehabilitation services	Inpatient covered in full, Outpatient is subject to \$25/visit then covered in full.		Must be pre-authorized or may result in denial of the claim.
	Habilitation services	\$25 copay	\$25 copay	Limited to Neurodevelopmental therapy services for children up to age 7.
	Skilled nursing care	No charge	No charge for the 1 st 120 days per calendar year, then 20% coinsurance for remainder of the calendar year.	Must be pre-authorized or may result in denial of the claim.
	Durable medical equipment	No charge		DME over \$1,000 must be pre-authorized or may result in denial of the claim.
	Hospice service	No charge		Must be pre-authorized or may result in denial of the claim.
If your child needs dental or eye care	Eye exam	\$25/visit		All combined vision benefits are limited to \$550 every 2 calendar years.
	Glasses	No charge		
	Dental check-up	No charge		\$1,600 calendar year benefit maximum. Oral exams are limited to twice per calendar year.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult – See Dental Plan)
- Dental check-up (Child – See Dental Plan)
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limited to a 10-visit limit per calendar year)
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Eye exam (Combined Exam/Hardware/Laser Eye Surgery maximum of \$550 every 2 calendar years)
- Glasses (Combined Exam/Hardware/Laser Eye Surgery maximum of \$550 every 2 calendar years)
- Hearing aids (limited to \$500 every 36 months, when medically necessary)
- Private-duty nursing (limited to services in connection with the supplemental accident benefit of the plan)
- Habilitation services (limited to Neurodevelopmental therapy services for children up to age 7)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-7153. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at (800) 700-7153. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,350
- Patient pays \$190

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$40
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$190

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,260
- Patient pays \$1,140

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$900
Coinsurance	\$0
Limits or exclusions	\$240
Total	\$1,140

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.