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, call (425)-430-7659. 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.dol.gov/ebsa/healthreform or call (425)-430-7659 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan does not have a deductible.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$500 person/$875 family for Preferred, Participating & Out-of-Networks. Includes pharmacy.	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?	Penalties, ineligible charges, premiums, 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.
Will you pay less if you use a network provider?	Yes. See www.accesshma.com or call 1-800-700-7153 for a list of network providers.	You pay the least if you use a provider in the Preferred Network. You pay more if you use a provider in the Participating 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		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider or Out-of-Network Provider (You will pay the most)**	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	$30/visit	Only one copay applies per day.
	Specialist visit	$30/visit	$30/visit	————none————
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that are 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)	No charge	No charge	————none————
	Imaging (CT/PET scans, MRIs)	$30/visit for CT Scans; $100/visit for MRI's	$30/visit for CT Scans; $100/visit for MRI's	Only one copay applies per day per provider for MRI's.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pharmacycostco.com	Generic drugs	$10 copay		Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription); 12-month supply for certain contraceptives. See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	$25 copay		
	Non-preferred brand drugs	$50 copay		
	Specialty drugs	Contact Costco Health Solutions, your prescription drug vendor, for applicable cost		Please contact Costco Health Solutions, your specialty pharmacy, for more information on what is covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Preauthorization is required
	Physician/surgeon fees	$30/visit	$30/visit	————none————

[* For more information about limitations and exceptions, see the plan or policy document at www.rentonwa.gov.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider or Out-of-Network Provider (You will pay the most)**	
If you need immediate medical attention	Emergency room care	$30/visit for physician services; $100/visit for other services	$30/visit for physician services; $100/visit for other services	Copay waived if admitted. Copay does apply to the Out-of-Pocket Maximum.
	Emergency medical transportation	No charge	No charge	————none————
	Urgent care	$30/visit	$30/visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge for the 1st 120 days per year, then 20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	$30/visit	$30/visit	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit	$30/visit	Marital, sexual and family counseling are covered. Preauthorization is required for partial hospitalization and intensive outpatient.
	Inpatient services	No charge	No charge	Preauthorization is required. Residential treatment is covered for Preferred and Participating Networks only. Out-of-Network Inpatient Mental Health treatment is covered at 50% coinsurance.
If you are pregnant	Office visits	$30/visit	$30/visit	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	$30/visit	$30/visit	————none————
	Childbirth/delivery facility services	No charge	No charge for the 1st 120 days per year, then 20% coinsurance	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay.

[* For more information about limitations and exceptions, see the plan or policy document at www.rentonwa.gov.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider or Out-of-Network Provider (You will pay the most)**	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization is required.
	Rehabilitation services	$30/visit for outpatient; No charge for inpatient	$30/visit for outpatient; No charge for inpatient	Preauthorization is required for inpatient. Only one copay applies per day per provider. Swim therapy is covered.
	Habilitation services	$30/visit for outpatient; No charge for inpatient	$30/visit for outpatient; No charge for inpatient	Preauthorization is required for inpatient. Only one copay applies per day per provider.
	Skilled nursing care	No charge	No charge for the 1st 120 days per year, then 20% coinsurance	Preauthorization is required.
	Durable medical equipment	No charge	No charge	Preauthorization is required for equipment over $2,000.
	Hospice services	No charge	No charge	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If enrolled, please refer to vision benefit booklets.
	Children's glasses	Not covered	Not covered	If enrolled, please refer to vision benefit booklets.
	Children's dental check-up	Not covered	Not covered	If enrolled, please refer to dental benefit booklets.

**Note that you may incur additional charges for out-of-network providers. Please see the Summary Plan Description or contact HR for more details.

[* For more information about limitations and exceptions, see the plan or policy document at www.rentonwa.gov.]

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult, under separate policy)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult, under separate policy)
- Routine foot care (except diabetes)
- Weight loss programs

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

- Acupuncture (25 visits per year, combined with massage therapy.)
- Chiropractic care
- Hearing aids ($4,000 every 3 years)
- Infertility treatment ($10,000 lifetime maximum for medical and $10,000 lifetime maximum for prescription drugs, or combination totaling $20,000)
- Private-duty nursing (supplemental accident and transplants only)

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: the HMA COBRA team, 1-800-700-7153, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform . 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: 1-800-700-7153, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-700-7153.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-700-7153.]

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-700-7153.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-700-7153.]

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

[* For more information about limitations and exceptions, see the plan or policy document at www.rentonwa.gov.]

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	$00
Specialist copayment	$30
Hospital (facility) coinsurance	00%
Other coinsurance	00%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$00
Copayments	$40
Coinsurance	$00
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$100

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

The plan's overall deductible	$00
Specialist copayment	$30
Hospital (facility) coinsurance	00%
Other coinsurance	00%

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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$00
Copayments	$470
Coinsurance	$00
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$490

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

The plan's overall deductible	$00
Specialist copayment	$30
Hospital (facility) coinsurance	00%
Other coinsurance	00%

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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$00
Copayments	$250
Coinsurance	$00
What isn't covered	
Limits or exclusions	$00
The total Mia would pay is	$250

The plan would be responsible for the other costs of these EXAMPLE covered services.