Benefit Summary

Puget Sound Energy, Inc. - IBEW Employee Group OPTIONS

Group Number: 6170700

GroupHealth

Effective Date 1/1/2016	**Health Plan** Options	**Ref** RQ-98526

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	Inside Network	Outside Network
Plan deductible	No annual deductible	Individual deductible: $400 per calendar year Family deductible: $1,200 per calendar year
Individual deductible carryover	4th quarter carryover applies	4th quarter carryover applies
Plan coinsurance	No plan coinsurance	Plan pays 80%, you pay 20% of the Allowed Amount.
Out-of-pocket limit	Individual out-of-pocket limit: $2,000 per calendar year Family out-of-pocket limit: $4,000 per calendar year Out-of-pocket expenses for the following covered services are included in the out-of-pocket: All cost shares for covered services	Individual out-of-pocket limit: $2,400 per calendar year Family out-of-pocket limit: $5,200 per calendar year Out-of-pocket expenses for the following covered services are included in the out-of-pocket: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as in-network
Lifetime maximum	Unlimited	Same as in-network maximum
Outpatient services (Office visits)	$20 copay	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Covered in full **Outpatient surgery:** $20 copay	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** No copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Value based/preferred generic/preferred brand/non-preferred $4/$8/$25/$50 copay per 30 day supply	Preferred generic/preferred brand/non-preferred $13/$30/$55 copay per 30 day supply
Prescription mail order	$5 discount per 30 day supply	Not covered
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay	No copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network
Chemical dependency	**Inpatient:** Covered in full **Outpatient:** $20 copay	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%	Covered at 80%, deductible applies

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$75 copay	$75 copay
Hearing exams (routine)	$20 copay	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $20 copay	Visit limits shared with in-network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Covered in full **Outpatient:** $20 copay. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Covered in full **Outpatient:** $20 copay	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Covered in full **Outpatient:** $20 copay	Shared with in-network **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 60 days per calendar year Covered in full **Outpatient:**60 visits per calendar year $20 copay	**Inpatient:** Day limits shared with in-network Deductible and coinsurance apply **Outpatient:** Visit limits shared with in-network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year	Day limits shared with in-network benefit, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	**Inpatient:** Covered in full **Outpatient:** $20 copay Women's sterilization procedures are covered in full.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.

Temporomandibular Joint (TMJ) **services**	**Inpatient:** Covered in full **Outpatient:** $20 copay	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	$20 copay	Not covered
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered