This 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 healthcare services. NOTE: Information about the cost of this plan (called the premium or "dues" in this plan) 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, visit www.pensions.org or call Member Services at 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711). 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.pensions.org or call 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For member/family each: Network: 1.5% of member's compensation band[1] Out of Network: 2.5% of member's compensation band; capped at 2.5% combined. Does not apply to preventive care, office visits, or prescription drug. Copayments and coinsurance amounts don't count toward the network deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes.	Preventive services, prescription, and office visit copayments.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	5% of member's compensation band for all network medical, behavioral health, and prescription drug costs (capped at $5,000 for individual and $10,000 for family combined), 15% of member's	The out-of-pocket limit 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 healthcare expenses.

[1] Deductibles and coinsurance amounts are based on salary range, subject to a minimum and maximum salary.

Important Questions	Answers	Why This Matters
	compensation band for out of network, for family combined. Prescription drug costs, other than non-preferred brand drugs and certain non-essential specialty pharmacy drugs, are capped at a family coinsurance maximum of $3,000.	
What is not included in the out-of-pocket limit?	Premiums (dues), balance-billed charges, certain non-essential specialty pharmacy drugs, and healthcare expenses this plan doesn't cover do not apply to your total maximum out-of-pocket limit.	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.myqhealthpcusa.org or call 1-855-497-1237 for a list of network providers.	If you use an in-network provider or other healthcare provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network provider or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers, in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. As the plan does not pay for out-of-network services, it is less costly to use network providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

⚠ 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	50% coinsurance	Does not count toward deductible or out-of-pocket limit
	Specialist visit	$45 copayment/visit	50% coinsurance	Does not count toward deductible or out-of-pocket limit
	Preventive care/screening/ immunization	No charge	50% coinsurance for office visit; no charge	For visit with primary care physician, pediatrician, or gynecologist (See

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			for screenings and immunizations	preventive schedule on www.pensions.org for frequency.)
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com. You can also call 1-855-497-1237 for personalized assistance.	Preventive generic drugs	$5 copayment/prescription (retail, 30-day fill); $15 copayment/prescription (retail, 90-day fill); $12.50 copayment/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preventive preferred brand drugs	$20 copayment/prescription (retail, 30-day fill); $60 copayment/prescription (retail, 90-day fill); $50 copayment/prescription (mail, 90-day fill)	Not covered	
	Preventive non-preferred brand drugs	Does not apply		
	Generic drugs	$10 copayment/prescription (retail, 30-day fill); $30 copayment/prescription (retail, 90-day fill); $25 copayment/prescription (mail, 90-day fill)	Specified copayment/prescription (retail, 30- or 90-day fill)	Prior authorization or step therapy program may apply
	Preferred brand drugs	30% coinsurance, min $20 to max $100 (retail, 30-day fill); 30% coinsurance, min $60 to max $300 (retail, 90-day fill); 30% coinsurance, min $50 to max $250 (mail, 90-day fill)	30% of contracted rate	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	50% coinsurance, min $50 to max $150 (retail, 30-day fill); 50% coinsurance, min $150 to max $450 (retail, 90-day fill); 50% coinsurance, min $125 to max $375 (mail, 90-day fill)	50% of contracted rate	Prior authorization or step therapy program may apply.
	Specialty drugs	Same percentages and minimums and maximums as above for preferred and non-preferred brands other than non-essential specialty pharmacy drugs, which will have no maximum co-insurance	Same percentages of contracted rate as above for preferred and non-preferred brands	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	———————— none ————————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	———————— none ————————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Pre-certification required within 48 hours if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	To nearest appropriate facility
	Urgent care	$45 copayment/visit	40% coinsurance	———————— none ————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	———————— none ————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Pre-certification required
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification required (within 48 hours of admission for mental health and substance abuse inpatient services)
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	————————none————————

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits annually of up to 8 hours each
	Rehabilitation services	20% coinsurance	40% coinsurance	——————none——————
	Habilitation services	20% coinsurance	40% coinsurance	See Guide to Your Healthcare Benefits.
	Skilled nursing care	20% coinsurance	40% coinsurance	180 days maximum annual limit for extended care facilities
	Durable medical equipment	20% coinsurance	40% coinsurance	—————— none ——————
	Hospice services	20% coinsurance	40% coinsurance	—————— none ——————
If your child needs dental or eye care	Children's eye exam	$25 copayment (with VSP provider)	Reimbursed up to $45 after $25 copayment	Limited to one exam per year. Plan reimburses up to $45 if you use an out-of-network provider.
	Children's glasses	Not covered	Not covered	
	Children's dental checkup	Not covered	Not covered	

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.)

- Cosmetic surgery
- Dental care
- Experimental or investigational medical treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture if provided by a physician or a state-licensed acupuncturist
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Hearing aids (and fittings)
- Most coverage provided outside the United States
- Routine eye exam through VSP

Your Rights to Continue Coverage: There is an agency that can help if you want to continue your coverage after it ends. The contact information for the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov. 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. For more information on your rights to continue coverage, contact Member Services at 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711).

Your Grievance and Appeals Rights: The U.S. Department of Health and Human Services 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 on how 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 Quantum Health at 855-497-1237 (TTY: 711). You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? **Yes.**
This plan does provide minimum essential coverage.

Does this plan meet the Minimum Value Standards? **Yes.**
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-773-7752 (TTY: 711).

Korean (한국어): 한국어로 도움이 필요하시면, 1-800-773-7752 (TTY: 711) 로 전화하십시오.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-773-7752 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-773-7752 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-773-7752 (TTY: 711).

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

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 prenatal care and a hospital delivery)

The plan's overall deductible	**$875**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$875
Copayments	$0
Coinsurance	$2,365
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,240**

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

The plan's overall deductible	**$875**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$875
Copayments	$405
Coinsurance	$945
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,225**

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

The plan's overall deductible	**$875**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$875
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,260**

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

This 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 healthcare services. NOTE: Information about the cost of this plan (called the premium or "dues" in this plan) 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, visit www.pensions.org or call Member Services at 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711). 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.pensions.org or call 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$2,000 individual/$2,000 family Network deductible does not apply to office visits, preventive care services, diagnostic tests, imaging tests, urgent care, and prescription drug expenses. Copayments and coinsurance amounts don't count toward the network deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes.	Preventive services, prescription, and office visit copayments.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Total maximum out of pocket of $5,000 individual/$10,000 family.	The out-of-pocket limit 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 healthcare expenses.
What is not included in the out-of-pocket limit?	Premiums (dues), balance-billed charges, certain non-essential specialty pharmacy drugs, and healthcare expenses this plan doesn't cover do not apply to your total maximum out-of-pocket limit.	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.myghealthpcusa.org or call 1-855-497-1237for a list of network providers.	If you use an in-network provider or other healthcare provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network provider or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers, in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. As the plan does not pay for out-of-network services, it is less costly to use network providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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
		Network Provider (You will pay the least)	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	$40 copayment/visit	Not covered	——————none——————
	Specialist visit	$60 copayment/visit	Not covered	——————none——————
	Preventive care/screening/ Immunization	No charge	Not covered	For visit with primary care physician, pediatrician, or gynecologist. (See preventive schedule on www.pensions.org for frequency.)
If you have a test	Diagnostic test (X-ray, blood work)	$65 copayment/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$200 copayment/visit	Not covered	Pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com. You can also call 1-855-497-1237 for	Preventive generic drugs	$6 copayment/prescription (retail, 30-day fill); $18 copayment/prescription (retail, 90-day fill); $15 copayment/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preventive preferred brand drugs	$30 copayment/prescription (retail, 30-day fill); $90 copayment/prescription (retail, 90-day fill);	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
personalized assistance.		$75 copayment/prescription (mail, 90-day fill)		
	Preventive non-preferred brand drugs	Does not apply		
	Generic drugs	$12 copayment/prescription (retail, 30-day fill); $36 copayment/prescription (retail, 90-day fill); $30 copayment/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preferred brand drugs	35% coinsurance, min $35 to max $150 (retail, 30-day fill); 35% coinsurance, min $105 to max $450 (retail, 90-day fill); 35% coinsurance, min $85 to max $375 (mail, 90-day fill)	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Same percentages and minimums and maximums as above for preferred brand drugs other than non-essential specialty pharmacy drugs, which will have no maximum co-insurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	———————— none ————————
	Physician/surgeon fees	20% coinsurance	Not covered	———————— none ————————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Pre-certification required within 48 hours if admitted
	Emergency medical	20% coinsurance	20% coinsurance	To nearest appropriate facility

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	transportation			
	Urgent care	$60 copayment/visit	Not covered	———————— none ————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fees	20% coinsurance	Not covered	———————— none ————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Pre-certification required
	Inpatient services	20% coinsurance	Not covered	Pre-certification required (within 48 hours of admission for mental health and substance abuse inpatient services)
If you are pregnant	Office visits	20% coinsurance	Not covered	———————— none ————————
	Childbirth/delivery professional services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
	Childbirth/delivery facility services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	100 visits annually of up to 8 hours each
	Rehabilitation services	$40 copayment/visit	40% coinsurance	———————— none ————————
	Habilitation services	20% coinsurance	Not covered	See Guide to Your Healthcare Benefits.
	Skilled nursing care	20% coinsurance	Not covered	180 days maximum annual limit for extended care facilities
	Durable medical equipment	20% coinsurance	Not covered	———————— none ————————
	Hospice services	20% coinsurance	Not covered	———————— none ————————
If your child needs dental or eye care	Children's eye exam	$25 copayment (with VSP provider)	Not covered	Limited to one exam per year. Plan reimburses up to $45 if you use an out-of-network provider.
	Children's glasses	Not covered	Not covered	
	Children's dental checkup	Not covered	Not covered	

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.)		
• Cosmetic surgery • Dental care • Experimental or investigational medical treatment	• Long-term care • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture if provided by a physician or a state-licensed acupuncturist • Bariatric surgery	• Chiropractic care • Infertility treatment • Hearing aids (and fittings)	• Most coverage provided outside the United States • Routine eye exam through VSP

Your Rights to Continue Coverage: There is an agency that can help if you want to continue your coverage after it ends. The contact information for the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov. 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. For more information on your rights to continue coverage, contact Member Services at 1-800-773-7752 (800-PRESPLAN) (TTY: 711).

Your Grievance and Appeals Rights: The U.S. Department of Health and Human Services 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 on how 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 Quantum Health at 855-497-1237 (TTY: 711). You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? **Yes.**
This plan does provide minimum essential coverage.

Does this plan meet the Minimum Value Standards? **Yes.**
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-773-7752 (TTY: 711).

Korean (한국어): 한국어로 도움이 필요하시면, 1-800-773-7752 (TTY: 711) 로 전화하십시오.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-773-7752 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-773-7752 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-773-7752 (TTY: 711).

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

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 prenatal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$2,000
Copayments	$0
Coinsurance	$2,140
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,140**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$2,000
Copayments	$420
Coinsurance	$720
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,140**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$2,000
Copayments	$320
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,480**

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

This 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 healthcare services. NOTE: Information about the cost of this plan (called the premium or "dues" in this plan) 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, visit www.pensions.org or call Member Services at 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711). 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.pensions.org or call 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$3,000 individual/$6,000 family Copayments and coinsurance amounts don't count toward the network deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. If you are in a family, the family deductible must be met prior to the plan paying for any covered service Check your plan document to see when the deductible starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes.	Preventive services.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Total maximum out of pocket of $5,000 individual/$10,000 family.	The out-of-pocket limit 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 healthcare expenses.
What is not included in the out-of-pocket limit?	Premiums (dues), balance-billed charges, and healthcare expenses this plan doesn't cover do not apply to your total maximum out-of-pocket limit.	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.myqhealthpcusa.org or call 1-855-497-1237 for a list of network providers.	If you use an in-network provider or other healthcare provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network provider or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers, in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. As the plan does not pay for out-of-network services, it is less costly to use network providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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
		Network Provider (You will pay the least)	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	20% coinsurance	Not covered	——————none——————
	Specialist visit	20% coinsurance	Not covered	——————none——————
	Preventive care/screening/ immunization	No charge	Not covered	For visit with primary care physician, pediatrician, or gynecologist. (See preventive schedule on www.pensions.org for frequency.)
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com. You can also call 1-855-497-1237 for personalized assistance.	Preventive generic drugs	$6 copayment/prescription (retail, 30-day fill); $18 copayment/prescription (retail, 90-day fill); $15 copayment/prescription (mail, 90-day fill) Not subject to deductible	Not covered	Prior authorization or step therapy program may apply.
	Preventive preferred brand drugs	$30 copayment/prescription (retail, 30-day fill); $90 copayment/prescription (retail, 90-day fill); $75 copayment/prescription (mail, 90-day fill) Not subject to deductible	Not covered	
	Preventive non-preferred brand drugs	Does not apply		

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Generic drugs	30% coinsurance subject to $150 max copayment/prescription (retail, 30-day fill); $450 max copayment/prescription (retail, 90-day fill); $375 max copayment/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preferred brand drugs			
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Same percentages and minimums and maximums as above for preferred brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	———————— none ————————
	Physician/surgeon fees	20% coinsurance	Not covered	———————— none ————————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Pre-certification required within 48 hours if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	To nearest appropriate facility
	Urgent care	20% coinsurance	Not covered	———————— none ————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fees	20% coinsurance	Not covered	———————— none ————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Pre-certification required
	Inpatient services	20% coinsurance	Not covered	Pre-certification required (within 48 hours of admission for mental health and substance

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				abuse inpatient services)
If you are pregnant	Office visits	20% coinsurance	Not covered	———————— none ————————
	Childbirth/delivery professional services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
	Childbirth/delivery facility services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	100 visits annually of up to 8 hours each
	Rehabilitation services	20% coinsurance	Not covered	———————— none ————————
	Habilitation services	20% coinsurance	Not covered	See Guide to Your Healthcare Benefits.
	Skilled nursing care	20% coinsurance	Not covered	180 days maximum annual limit for extended care facilities
	Durable medical equipment	20% coinsurance	Not covered	———————— none ————————
	Hospice services	20% coinsurance	Not covered	———————— none ————————
If your child needs dental or eye care	Children's eye exam	$25 copayment (with VSP provider)	Not covered	Limited to one exam per year. Plan reimburses up to $45 if you use an out-of-network provider. Individuals enrolled in the HDHP will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.
	Children's glasses	Not covered	Not covered	
	Children's dental checkup	Not covered	Not covered	

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.)

- Cosmetic surgery
- Dental care
- Experimental or investigational medical treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture if provided by a physician or a state-licensed acupuncturist
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Hearing aids (and fittings)
- Most coverage provided outside the United States
- Routine eye exam through VSP

Your Rights to Continue Coverage: There is an agency that can help if you want to continue your coverage after it ends. The contact information for the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov. 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. For more information on your rights to continue coverage, contact Member Services at 1-800-773-7752 (1-800-PRESPLAN) (TTY: 711).

Your Grievance and Appeals Rights: The U.S. Department of Health and Human Services 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 on how 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 Quantum Health at 855-497-1237 (TTY: 711). You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565 or www.cciio.cms.gov.

Does this plan provide Minimum Essential Coverage? **Yes.**
This plan does provide minimum essential coverage.

Does this plan meet the Minimum Value Standards? **Yes.**
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-773-7752 (TTY: 711).

Korean (한국어): 한국어로 도움이 필요하시면, 1-800-773-7752 (TTY: 711) 로 전화하십시오.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-773-7752 (TTY: 711).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-773-7752 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-773-7752 (TTY: 711).

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.pensions.org.

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 prenatal care and a hospital delivery)

- **The plan's overall deductible** **$6,000**
- **Specialist copayment**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$6,000
Copayments	$0
Coinsurance	$1,340
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$7,340**

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$3,000
Copayments	$0
Coinsurance	$520
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,520**

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

- **The plan's overall deductible** **$6,000**
- **Specialist copayment**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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