



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-PRESPLAN (1-800-773-7752) (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-PRESPLAN (1-800-773-7752) (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$1,500 individual/\$1,500 family Network deductible does not apply to office visits, preventive care services, emergency room visits, 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 drugs; office visit and emergency room 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 \$6,000 individual/\$12,000 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, non-preferred brand drugs, certain non-essential specialty pharmacy drugs, and healthcare expenses this plan	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters
	doesn't cover do not apply to your total maximum out-of-pocket limit .	
Will you pay less if you use a network provider?	Yes. See www.myghealthpcusa.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 . You will pay less if you use a provider in the plan's 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 (a balance bill).
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	\$30 copayment /visit	50% coinsurance	—————none—————
	Specialist visit	\$50 copayment /visit	50% coinsurance	—————none—————
	Preventive care/screening/immunization	No charge	50% coinsurance for office visit; no charge for screenings and immunizations	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	40% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification required
If you need drugs to treat your illness or condition More information about prescription drug coverage	Preventive generic drugs	\$5 copayment/prescription (retail, 30-day fill); \$15 copayment/prescription (retail, 90-day fill); \$12.50 copayment/prescription	Not covered	Prior authorization or step therapy program may apply.

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)	
is available at www.express-scripts.com/boardofpensions . You can also call 1-855-497-1237 for personalized assistance.		(mail, 90-day fill)		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)	Not covered	Prior authorization or step therapy program may apply
	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 covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Generic: \$25/\$75 copayment/prescription (retail, (30/90-day fill); \$62.50 copayment/prescription (mail, 90-day fill) Preferred brand: 25% coinsurance , \$200/\$600 max (retail, (30/90-day fill); 25% coinsurance , \$500 max (mail, 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)	
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	\$250 copayment	\$250 copayment	Precertification required within 48 hours if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	To nearest appropriate facility
	Urgent care	\$50 copayment /visit	40% coinsurance	————— none —————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————— none —————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copayment /office visit and 20% coinsurance for other outpatient services	40% coinsurance	Precertification required
	Inpatient services	20% coinsurance	40% coinsurance	Precertification 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—————
	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; Precertification required
	Rehabilitation services	\$50 copayment	40% coinsurance	—————none—————
	Habilitation services	\$50 copayment	40% coinsurance	See Guide to Your Healthcare Benefits.

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)	
	Skilled nursing care	20% coinsurance	40% coinsurance	180 days maximum annual limit for extended care facilities; Precertification required
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification required (all rentals and purchases over \$1,500)
	Hospice services	20% coinsurance	40% coinsurance	Precertification required
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 | • Long-term care | • Routine foot care |
| • Dental care | • Private-duty nursing | • Non-preferred brand drugs |
| • Experimental or investigational medical treatment | • Weight management drugs (certain requirements apply) | |

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 | • Infertility treatment | • Most coverage provided outside the United States |
| • Chiropractic care | • Hearing aids (and fittings) | |
| | • 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-PRESPLAN (1-800-773-7752) (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 1-855-497-1237 (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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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	\$1,500
■ Specialist copayment	\$50
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$2,240
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,740

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$50
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$450
Coinsurance	\$730
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,680

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$50
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$750
Coinsurance	\$110
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,360

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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Important Questions	Answers	Why This Matters
What is the overall deductible ?	\$4,000 individual/\$4,000 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 drugs ; office visit, emergency room visit, diagnostic test , and imaging 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 \$6,000 individual/\$12,000 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 1-855-497-1237 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	\$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)	\$80 copayment /visit	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	\$200 copayment /visit	Not covered	Precertification required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com/boardofpensions 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 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 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)	
	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)	Not covered	Prior authorization or step therapy program may apply.
	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 covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Generic: \$25/\$75 copayment/prescription (retail, (30/90-day fill); \$62.50 copayment/prescription (mail, 90-day fill) Preferred brand: 25% coinsurance , \$200/\$600 max (retail, (30/90-day fill); 25% coinsurance , \$500 max (mail, 90-day fill)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	_____ none _____
	Physician/surgeon fees	30% coinsurance	Not covered	_____ none _____
If you need immediate medical attention	Emergency room care	\$250 copayment	\$250 copayment	Precertification required within 48 hours if admitted
	Emergency medical transportation	30% coinsurance	30% 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)	
	Urgent care	\$60 copayment /visit	Not covered	_____ none _____
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Precertification required
	Physician/surgeon fees	30% coinsurance	Not covered	_____ none _____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copayment /office visit and 30% coinsurance for other outpatient services	Not covered	Precertification required
	Inpatient services	30% coinsurance	Not covered	Precertification required (within 48 hours of admission for mental health and substance abuse inpatient services)
If you are pregnant	Office visits	30% coinsurance	Not covered	_____ none _____
	Childbirth/delivery professional services	30% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
	Childbirth/delivery facility services	30% 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	30% coinsurance	Not covered	100 visits annually of up to 8 hours each; Precertification required
	Rehabilitation services	\$60 copayment /visit	40% coinsurance	_____ none _____
	Habilitation services	\$60 copayment	Not covered	See Guide to Your Healthcare Benefits.
	Skilled nursing care	30% coinsurance	Not covered	180 days maximum annual limit for extended care facilities; Precertification required
	Durable medical equipment	30% coinsurance	Not covered	Precertification required (all rentals and purchases over \$1,500)
	Hospice services	30% coinsurance	Not covered	Precertification required
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 | • Long-term care | • Routine foot care |
| • Dental care | • Private-duty nursing | • Non-preferred brand drugs |
| • Experimental or investigational medical treatment | • Weight management drugs (certain requirements apply) | |

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 | • Infertility treatment | • Most coverage provided outside the United States |
| • Chiropractic care | • Hearing aids (and fittings) | |
| | • Routine eye exam through VSP | |

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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:

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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, kwijigo 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	\$4,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$0
Coinsurance	\$2,610
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$6,610

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$420
Coinsurance	\$480
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$4,900

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$4,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300

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-PRESPLAN (1-800-773-7752) (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-PRESPLAN (1-800-773-77) (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	\$5,000 individual/\$10,000 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 enroll any family members, 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 \$7,500 individual/\$15,000 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	0% coinsurance	Not covered	_____none_____
	Specialist visit	0% 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)	0% coinsurance	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	Precertification required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com/boardofpensions . 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		
	Generic drugs	\$10 copayment/prescription after deductible (retail, 30-day fill); \$30 copayment/prescription after	Not covered	Prior authorization or step therapy program may apply.

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)	
		deductible (retail, 90-day fill); \$25 copayment/prescription after deductible (mail, 90-day fill)		Prior authorization or step therapy program may apply.
	Preferred brand drugs	\$30 copayment/prescription after deductible (retail, 30-day fill) \$90 copayment/prescription after deductible (retail, 90-day fill) \$75 copayment/prescription after deductible (mail, 90-day fill)	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Generic: \$25/\$75 copayment/prescription after deductible (retail, (30/90-day fill); \$62.50 copayment/prescription after deductible (mail, 90-day fill) Preferred brand: 25% coinsurance after deductible, \$200/\$600 max (retail, (30/90-day fill); 25% coinsurance , \$500 max (mail, 90-day fill)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	_____ none _____
	Physician/surgeon fees	0% coinsurance	Not covered	_____ none _____
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Precertification required within 48 hours if admitted
	Emergency medical transportation	0% coinsurance	0% coinsurance	To nearest appropriate facility
	Urgent care	0% coinsurance	Not covered	_____ none _____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	Precertification required
	Physician/surgeon fees	0% coinsurance	Not covered	_____ none _____

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 need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not covered	Precertification required
	Inpatient services	0% coinsurance	Not covered	Precertification required (within 48 hours of admission for mental health and substance abuse inpatient services)
If you are pregnant	Office visits	0% coinsurance	Not covered	————— none —————
	Childbirth/delivery professional services	0% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following cesarean section
	Childbirth/delivery facility services	0% 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	0% coinsurance	Not covered	100 visits annually of up to 8 hours each; Precertification required
	Rehabilitation services	0% coinsurance	Not covered	————— none —————
	Habilitation services	0% coinsurance	Not covered	See Guide to Your Healthcare Benefits.
	Skilled nursing care	0% coinsurance	Not covered	180 days maximum annual limit for extended care facilities; Pre-certification required
	Durable medical equipment	0% coinsurance	Not covered	Precertification required (all rentals and purchases over \$1,500)
	Hospice services	0% coinsurance	Not covered	Precertification required
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
- Weight management drugs (certain requirements apply)
- Routine foot care
- Non-preferred brand drugs

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
- Chiropractic care
- Infertility treatment
- Hearing aids (and fittings)
- Routine eye exam through VSP
- Most coverage provided outside the United States

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-PRESPLAN (1-800-773-7752) (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 1-855-497-1237 (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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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	\$10,000 ¹
■ Specialist copayment	
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$10,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$10,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$5,000
■ Specialist copayment	
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$5,000

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■ The plan's overall deductible	\$5,000
■ Specialist copayment	
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

¹Member + Family coverage

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.