MEDICAL BENEFIT OFFERING EFFECTIVE June 1, 2022

QUEST SERVICE GROUP LLC

NATIONAL NETWORK: *AETNA SIGNATURE ADMINISTRATORS - PPO*	PREMIUM OPTION PPO	ENHANCED OPTION EPO	BASIC OPTION EPO
IN-NETWORK BENEFITS:			
Specialist Referral Required	No	No	No
Calendar Year Deductible (Single/Family)	$375/$750	$375/$750	$500/$1,250
Coinsurance	100%	100%	90%
Out-of-Pocket Maximum Per Year Per Person (2x family limit)	$6,600	$6,600	$6,600
Office Visit Copay (Primary Doctor/Specialist)	$25/$50 (deductible waived)	$35/$60 (deductible waived)	$35/$60 (deductible & coinsurance waived)
Diagnostic Lab & X-ray	No Charge	No Charge	All lab, x-ray and imaging subject to deductible and coinsurance(waived if part of office visit)
In-Patient Hospital Copay	Deductible then 100%	Deductible then 100%	$250 then deductible and coinsurance
Out-Patient Facility Copay	Deductible then 100%	Deductible then 100%	$100 then coinsurance (deductible waived)
Emergency Room Copay (waived if admitted)	$200 (deductible waived)	$200 (deductible waived)	$100 then 90% (deductible waived)
Retail Prescriptions (generic/preferred brand/non-preferred brand)	$50 deductible/person/year (3x family limit) then $15/$40/$75	$50 deductible/person/year (3x family limit) then $15/$40/$75	$50 deductible/person/year (3x family limit) then $15/$40/$75
Mail-Order Prescriptions (90 day supply)	$50 deductible/person/year (3x family limit) combined with retail deductible then $30/$80/$150	$50 deductible/person/year (3x family limit) combined with retail deductible then $30/$80/$150	$50 deductible/person/year (3x family limit) combined with retail deductible then $30/$80/$150
Maintenance Prescriptions	A 30-day supply may be filled at the retail pharmacy for the first 3 months subject to retail plan provisions. If, after the first 3 months, member does not fill the maintenance drug through the mail-order program, all retail copays will be doubled.		
OUT-OF-NETWORK BENEFITS:			
Deductible Single/Family	$1,000/$2,500	IN NETWORK ONLY	IN NETWORK ONLY
Coinsurance	70%		
Out-of-Pocket Maximum Per Year Per Person (2x family limit)	$6,600		
Reasonable & Customary Allowance Percentile	80th		
EMPLOYEE WITH PRIOR YEAR W-2 EARNINGS OF $80K OR MORE ANNUALLY COST PER BI-WEEKLY PAYCHECK:			
Employee Only	**$188.99**	**$136.16**	**$100.95**
Employee & Spouse	**$347.47**	**$303.45**	**$182.48**
Employee & Child(ren)	**$303.45**	**$250.62**	**$162.58**
Full Family	**$558.77**	**$497.15**	**$285.84**

NOTES:

1 - MANDATORY GENERIC RX - If a person purchases a brand name drug when the physician has indicated a generic drug can be dispensed, the covered person will be required to pay the difference between the cost of the generic drug and the brand name requested, plus the usual copay.

2 - Eligible In-Network preventive care will be paid at 100% - all copays, deductible and coinsurance will be waived.

This is merely a brief summary of the current medical plan offerings. Benefits are subject to the terms, conditions, and limitations of the certificate booklet which can be obtained through the Human Resource Department.