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Quantum Services High Deductible Health Plan

Schedule of Benefits

	In-Network	Out-of-Network
Calendar Year Deductible *(This is the amount you pay before the plan pays)*	Single: $2,300 Family: $4,600*	Single: $4,600 Family: $9,200*
Coshare Percentage *(This is the amount you pay after the deductible)* *Copay max doubles per family*	15% of 1st $7,500 THEN 0% FOR BALANCE OF YEAR	15% of 1st $15,000 THEN 0% FOR BALANCE OF YEAR
Hospital Charges: Inpatient/Outpatient	15% Plan Coshare	15% of Target Prices
Emergency Room Facility Charge	15% Plan Coshare	15% Plan Coshare
Sickness/Injury – Physician Charges – Office Visit	15% Plan Coshare 15% Plan Coshare	15% of Target Prices 15% of Target Prices
Preventive Care – Provider Services – Office Visit	0% Plan Coshare 0% Plan Coshare	15% of Target Prices 15% of Target Prices
Other Covered Expenses *Example: Supplies, lab & X-ray, Durable Medical Equipment, injections, etc.*	15% Plan Coshare	15% of Target Prices
Prescription Discount Card *Network provider for prescription services is Caremark*	15% Plan Coshare	15% Plan Coshare

- Lifetime Maximum for all Benefits paid under this Plan is unlimited.
- Chiropractic Services limited to a maximum benefit of $500.00 per year
- Deductible waived for Maternity Care (if treatment begins within 1st trimester)

** Family Deductible applies to all claims by the family, even if the claims are on one person.*

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Target Prices – are used as the maximum allowable payment for out-of-network (non-participating) providers. The Target Price fee schedule applies to provider procedure codes (called CPT-4's) and will cover most charges made by a Physician. The Target fee schedule is 115% of the Medicare reimbursement rate, which means that reimbursement is set at 15% more under this Plan than is paid for providing the same service to a Medicare patient. Any provider charge in excess of the Target Price will not be a covered expense under the terms of this Plan and will be the responsibility of the Covered Person.

If you choose to see an out-of-network Physician, you should ask prior to treatment if he or she will accept Target Price (115% of the Medicare reimbursement) as payment-in-full. If the Physician agrees you will not be responsible for any excess charge. Therefore, it is important that you obtain written verification. If not, you will be responsible for paying the balance of the charges.

Out-of-network provider charges that are not based upon CPT-4 codes, which include most Hospitals and other facilities and charges for which there are no Target Prices, will be paid at the in-network Coshare percentage minus twenty (20) percentage points.

Well Care covers:

- Routine Physicals
- Pap Smears
- Mammograms
- Prostate Exams
- Well Baby Care
- Immunizations
- Pre-Natal Care

Grandfathered Health Plan:

The Quantum Services Health & Welfare Benefits Plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to BAC (plan supervisor) at 1 (614) 863-8780, or toll-free 1 (800) 521-2654.

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Quantum Services Dental Plans

Schedule of Benefits:

All percentages shown are the employees responsibility. The plan covers the remaining balance up to the annual maximum.

Plus Plan A:	1st Year	2nd Year	Thereafter
Type I – Preventive/Diagnostic: Flouride Treatments, X-rays, Cleanings, Periodic Exams	No Deductible Covered in Full	No Deductible Covered in Full	No Deductible Covered in Full
Type II – Basic Restorative: Extractions, Fillings, Oral Surgery, Root Canals	$ 50 Deductible **20%**	$ 50 Deductible **20%**	$ 50 Deductible **20%**
Type III – Major Restorative: Bridges, Crowns, Dentures, Partials	Not Covered	$ 50 Deductible **50%**	$ 50 Deductible **50%**
Maximum Benefit Paid Per Year: For Type I, II, and III Services	**$ 750**	**$ 1,000**	**$ 1,500**
Type IV – Orthodontia: For Patients age 6-18	Not Covered	Not Covered	$ 50 Deductible 50% – $1,000 Max

Plus Plan A Employee Contributions: Single $13.38 | Single + 1 $25.38 | Family $36.92

Basic Plan B:	1st Year	2nd Year	Thereafter
Type I – Preventive/Diagnostic: Flouride Treatments, X-rays, Cleanings, Periodic Exams	No Deductible **20%**	No Deductible **20%**	No Deductible **20%**
Type II – Basic Restorative: Extractions, Fillings, Oral Surgery, Root Canals	$ 50 Deductible **40%**	$ 50 Deductible **40%**	$ 50 Deductible **40%**
Type III – Major Restorative: Bridges, Crowns, Dentures, Partials	Not Covered	$ 50 Deductible **60%**	$ 50 Deductible **60%**
Maximum Benefit Paid Per Year: For Type I, II, and III Services	**$ 500**	**$ 750**	**$ 1,000**
Type IV – Orthodontia: For Patients age 6-18	Not Covered	Not Covered	Not Covered

Basic Plan B Employee Contributions: Single $9.23 | Single + 1 $17.54 | Family $25.85

*** This is a summary in outline form of the Benefits. Eligible persons who choose to participate should review the SUMMARY PLAN DESCRIPTION and PLAN DOCUMENT (Benefit Booklet) for information about; participation, benefits, limitations, and exclusions. This is not a contract, policy or guarantee of coverage.***

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Quantum Services Vision Plan

Schedule of Benefits:

Covered Services and Supplies:

• Complete Eye Exam (per covered individual)	$35.00	Once every Calendar Year
• Frames (per covered individual)	$50.00	Once every 2 Cal. Years
• Lenses (per lens)		
Single Vision	$25.00	Once every Calendar Year
Bifocal	$35.00	Once every Calendar Year
Trifocal	$45.00	Once every Calendar Year
Lenticular	$50.00	Once every Calendar Year
Contact Lens	$75.00	Once every Calendar Year

Lens tinting, initialing and sunglasses are not eligible expenses. Benefits are available for either contact lenses or glasses (one or the other, but not both) once every Calendar Year.

Employee Contributions:	$3.34	Single
	$6.67	Employee + 1
	$10.23	Family