

McElroy Truck Lines, Inc.

Schedule of Benefits for Plan Year 2010

Medical Insurance- United Healthcare; find doctors and hospital- www.myuhc.com

Dental Providers- www.deltadentalins.com

MEDICAL INSURANCE	SILVER PLAN	GOLD PLAN	PLATINUM PLAN
Plan Cost (Weekly)- pre-tax			
Employee/Employee+1/Family	\$20.00 / \$40.00 / \$60.00	\$35.00 / \$70.00 / \$104.00	\$53.00 / \$97.00 / \$152.00
Plan Coverage			
Deductible/Coinsurance/Out of Pocket Max (for 1 individual; family is x3)			
PPO	\$2,000 / 70% / \$4,000	\$1,000 / 80% / \$2,000	\$500 / 90% / \$1,000
Non-PPO	\$4,000/50%/\$5,000	\$3,000 / 50% / \$4,000	\$1,500 / 50% / \$2,000
Office Visit Co-pay			
Primary Care	None	\$30.00	\$25.00
Specialist Care	None	\$60.00	\$50.00
	<i>Subject to deductible and Coinsurance</i>		
Diagnostic Services (X-Ray and Lab)			
PPO	70%	80%	80%
Non-PPO	50%	50%	50%
	<i>After applicable deductible</i>	<i>After applicable Deductible</i>	<i>IP/OP- After applicable deductible</i>
		<i>With OV- No deductible</i>	<i>With OV- No deductible</i>
Hospital Services (IP and OP)			
PPO	70%	80%	90%
Non-PPO	50%	50%	50%
	<i>After applicable deductible</i>	<i>After applicable Deductible</i>	<i>After applicable Deductible</i>
Hospital Services (ER)			
PPO	70%	80%	90%
	<i>After applicable deductible</i>	<i>After \$250 co-pay</i>	<i>After \$150 co-pay</i>
Non-PPO	50%	50%	50%
	<i>After applicable deductible</i>	<i>After applicable Deductible</i>	<i>After applicable deductible</i>
Preventative Care/Newborn Care			
PPO	100% / Not Covered	100% / 80%	100%
Non-PPO	Not Covered	Not Covered	Not Covered
	\$35 Co-pay	\$30 Co-pay	\$25 Co-pay
All Other			
PPO	70%	80%	90%
Non-PPO	50%	50%	50%
	<i>After applicable deductible</i>	<i>After applicable deductible</i>	<i>After applicable deductible</i>
Prescription Drug Co-pay (30 day/90 day)			
Generic	\$10 / \$20	\$10 / \$20	\$10 / \$20
Preferred Brand	Not Covered	\$40 / \$80	\$30 / \$60
Non-Preferred	Not Covered	\$60 / \$120	\$50 / \$100
	<i>After \$50 annual deductible</i>	<i>After \$50 annual deductible</i>	<i>After \$50 annual deductible</i>

LIFE INSURANCE		SILVER PLAN	GOLD PLAN	PLATINUM PLAN
Plan Cost	ALL FULL-TIME EMPLOYEES CAN ELECT	ALL FULL-TIME EMPLOYEES CAN ELECT	ALL FULL-TIME EMPLOYEES CAN ELECT	ALL FULL-TIME EMPLOYEES CAN ELECT
Employee (Basic Coverage) Employee (Additional Coverage) Spouse Child(ren)	No Charge Age-Based Age-Based Amount-Based	No Charge Age-Based Age-Based Amount-Based	No Charge Age-Based Age-Based Amount-Based	No Charge Age-Based Age-Based Amount-Based
Plan Coverage				
Employee (Basic Coverage) Employee (Additional Coverage) Spouse Child(ren)	\$10,000 1 or 2 Times Earnings 1 or 2 Times Earnings \$5,000 or \$10,000	\$10,000 1 or 2 Times Earnings 1 or 2 Times Earnings \$5,000 or \$10,000	\$10,000 1 or 2 Times Earnings 1 or 2 Times Earnings \$5,000 or \$10,000	\$10,000 1 or 2 Times Earnings 1 or 2 Times Earnings \$5,000 or \$10,000
SHORT-TERM DISABILITY		SILVER PLAN	GOLD PLAN	PLATINUM PLAN
Plan Cost	ALL FULL-TIME EMPLOYEES CAN ELECT	ALL FULL-TIME EMPLOYEES CAN ELECT	ALL FULL-TIME EMPLOYEES CAN ELECT	ALL FULL-TIME EMPLOYEES CAN ELECT
Employee	Salary-based \$.40/\$10 covered payroll	Salary-based \$.40/\$10 covered payroll	Salary-based \$.40/\$10 covered payroll	No Charge for \$750.00/week
Plan Coverage				
Employee	60% of Weekly Earnings; max \$500.00/week	60% of Weekly Earnings; max \$500.00/week	60% of Weekly Earnings; max \$500.00/week	60% of Weekly Earnings; max \$750.00/week
VISION INSURANCE		SILVER PLAN	GOLD PLAN	PLATINUM PLAN
Plan Cost				
Employee Employee + 1 Family	See rate sheet for pre-tax monthly premiums	See rate sheet for pre-tax monthly premiums	See rate sheet for pre-tax monthly premiums	See rate sheet for pre-tax monthly premiums
Plan Coverage				
Available to every full-time employee, <u>regardless</u> if elect medical or not.	Annual Exam- 1/year Lenses- Every 2 years Frames- Every 2 years	Annual Exam- 1/year Lenses- 1/year Frames- Every 2 years	Annual Exam- 1/year Lenses- 1/year Frames- Every 2 years	Annual Exam- 1/year Lenses- 1/year Frames- 1/year
DENTAL INSURANCE		GOLD PLAN	PLATINUM PLAN	
Plan Cost (Weekly)				
Employee/Employee + 1/Family		\$4.00 / \$9.00 / \$14.00	\$6.00 / \$12.00 / \$20.00	
Plan Coverage				
Deductible Individual Family (3 Individuals) Orthodontic (Lifetime) Annual Plan Maximums Individual Orthodontic (Lifetime)		\$50 \$150 Not covered \$1,000 Not covered	\$50 \$150 \$50 \$1,500 \$1,500	
Preventative Services		90% <i>No deductible</i>	100% <i>No deductible</i>	
Basic Services		80% <i>After deductible</i>	90% <i>After deductible</i>	
Major Services		50% <i>After deductible</i>	60% <i>After deductible</i>	
Orthodontic Services <i>Limited to dependent children</i>		Not covered	50% <i>After deductible</i>	