

# McElroy Truck Lines, Inc.

## Schedule of Benefits for Plan Year 2012

Medical Insurance- United Healthcare; find doctors and hospitals- [www.myuhc.com](http://www.myuhc.com)

Dental Providers- [www.deltadentalins.com](http://www.deltadentalins.com)

MEDICAL INSURANCE	SILVER PLAN	GOLD PLAN	PLATINUM PLAN
<b>Plan Cost (Weekly)- before-tax</b>			
Emp/Emp+ch(ren)/Emp+spouse/Fam	\$20 / \$35 / \$42 / \$62	\$35 / \$65 / \$73 / \$107	\$53 / \$92 / \$100 / \$155
<b>Plan Coverage</b>			
<b>Deductible/Coinsurance/Out of Pocket Max (for 1 individual; family is x3)</b> PPO Non-PPO	out of pocket max= max co-insurance you have to pay in year \$2,000 / 70% / \$4,000 \$4,000/50%/\$5,000	Out of pocket max not inclusive of deductible \$1,000 / 80% / \$2,000 \$3,000 / 50% / \$4,000	Family deductible doesn't have to be met before one person is then subject to co-insurance \$500 / 90% / \$1,000 \$1,500 / 50% / \$2,000
<b>Office Visit (OV) Co-pay</b> Primary Care Specialist Care	None None <i>Subject to deductible and Coinsurance</i>	\$30.00 \$60.00	\$25.00 \$50.00
<b>Outpatient Diagnostic Services or with Office Visit (X-Ray and Lab)</b> PPO Non-PPO  <b>All Major Diagnostics (CT, PET, MRI, Nuclear Medicine, etc.) is subject to deductible- all 3 plans</b>	70% 50% <i>After applicable Deductible both PPO and Non-PPO</i>	100% 50% <i>After applicable Deductible only for Non-PPO</i>	100% 50% <i>After applicable Deductible only for Non-PPO</i>
<b>Hospital Services (IP and OP*)</b> PPO Non-PPO *IP= inpatient OP= outpatient	70% 50% <i>After applicable deductible</i>	80% 50% <i>After applicable Deductible</i>	90% 50% <i>After applicable Deductible</i>
<b>Hospital Services (ER)</b> PPO  Non-PPO	70% <i>After applicable deductible</i>  50% <i>After applicable deductible</i>	80% <i>After \$250 co-pay</i>  50% <i>After applicable Deductible</i>	90% <i>After \$150 co-pay</i>  50% <i>After applicable deductible</i>
<b>Preventative Care/Newborn Care</b> PPO  Non-PPO	Doctor's visit 100% <i>After \$35.00 co-pay</i> Lab and tests 70% Not Covered	Doctor's visit & lab/tests 100% <i>After \$30.00 co-pay</i>  Not Covered	Doctor's visit & lab/tests 100% <i>After \$25.00 co-pay</i>  Not Covered
<b>All Other</b> PPO Non-PPO	70% 50% <i>After applicable deductible</i>	80% 50% <i>After applicable deductible</i>	90% 50% <i>After applicable deductible</i>
<b>Prescription Drug Co-pay (30 day/90 day)</b> Generic Preferred Brand Non-Preferred	\$10 / \$20 Only generic covered <i>After \$50 annual deductible</i>	\$10 / \$20 \$40 / \$80 \$60 / \$120 <i>After \$50 annual deductible</i>	\$10 / \$20 \$30 / \$60 \$50 / \$100 <i>After \$50 annual deductible</i>

<b>LIFE INSURANCE</b>		<b>SILVER PLAN</b>	<b>GOLD PLAN</b>	<b>PLATINUM PLAN</b>
<b>Plan Cost</b>	All full-time can elect voluntary; Basic only for medically-insured	All full-time can elect voluntary; Basic only for medically-insured	All full-time can elect voluntary; Basic only for medically-insured	All full-time can elect voluntary; Basic only for medically-insured
Employee (Basic Coverage) Employee (Additional Coverage) Spouse Child(ren)	<b>No Charge</b> <b>Age-Based</b> <b>Age-Based</b> <b>Amount-Based</b>	<b>No Charge</b> <b>Age-Based</b> <b>Age-Based</b> <b>Amount-Based</b>	<b>No Charge</b> <b>Age-Based</b> <b>Age-Based</b> <b>Amount-Based</b>	<b>No Charge</b> <b>Age-Based</b> <b>Age-Based</b> <b>Amount-Based</b>
<b>Plan Coverage</b>				
Employee (Basic Coverage) Employee (Additional Coverage) Spouse Child(ren)	<b>\$20,000</b> <b>1 or 2 Times Earnings</b> <b>1 or 2 Times Earnings</b> <b>\$5,000 or \$10,000</b>	<b>\$20,000</b> <b>1 or 2 Times Earnings</b> <b>1 or 2 Times Earnings</b> <b>\$5,000 or \$10,000</b>	<b>\$20,000</b> <b>1 or 2 Times Earnings</b> <b>1 or 2 Times Earnings</b> <b>\$5,000 or \$10,000</b>	<b>\$20,000</b> <b>1 or 2 Times Earnings</b> <b>1 or 2 Times Earnings</b> <b>\$5,000 or \$10,000</b>
<b>SHORT-TERM DISABILITY</b>				<b>PLATINUM PLAN</b>
<b>Plan Cost</b>	ALL FULL-TIME EMPLOYEES CAN ELECT			
Employee	<b>Salary-based</b> <b>\$.60/\$1,000 covered</b> <b>payroll</b>			<b>No Charge for \$750.00/week</b> <b>when have Platinum medical</b> <b>insurance</b>
<b>Plan Coverage</b>				
Employee	<b>60% of Weekly</b> <b>Earnings; max</b> <b>\$500.00/week</b>			<b>60% of Weekly Earnings; max</b> <b>\$750.00/week</b>
<b>VISION INSURANCE</b>				<b>PLATINUM PLAN</b>
<b>Plan Cost <i>before-tax</i></b>				
Employee Employee + 1 Family	Available to every full- time employee, <u>regardless</u> if elect medical or not.			<b>Cost/week</b> <b>\$1.58</b> <b>\$3.00</b> <b>\$4.40</b>
<b>Plan Coverage</b>				
<b>Annual Exam- 1/year</b> <b>Lenses/Frames 1/year OR</b> <b>Contacts</b>				
<b>DENTAL INSURANCE</b>			<b>GOLD PLAN</b>	<b>PLATINUM PLAN</b>
<b>Plan Cost (Weekly)</b>				
Employee/Employee + 1/Family			<b>\$3.00 / \$8.00 / \$14.00</b>	<b>\$6.00 / \$12.00 / \$20.00</b>
<b>Plan Coverage</b>				
Deductible Individual Family (3 Individuals) Orthodontic (Lifetime) Annual Plan Maximums Individual Orthodontic (Lifetime)			<b>\$50</b> <b>\$150</b> <b>Not covered</b> <b>\$1,000</b> <b>Not covered</b>	<b>\$50</b> <b>\$150</b> <b>\$50</b> <b>\$1,500</b> <b>\$1,500</b>
<b>Preventative Services</b> (cleaning, exam 1/year bite-wing xray)			<b>90%</b> <i>No deductible</i>	<b>100%</b> <i>No deductible</i>
<b>Basic Services</b> (filling, root canal, oral surgery, etc.)			<b>80%</b> <i>After deductible</i>	<b>90%</b> <i>After deductible</i>
<b>Major Services</b> (dentures, crowns, TMJ treatment, caps, etc.)			<b>50%</b> <i>After deductible</i>	<b>60%</b> <i>After deductible</i>
<b>Orthodontic Services</b> <i>Limited to dependent children</i>			<b>Not covered</b>	<b>50%</b> <i>After deductible</i>