McElroy Truck Lines, Inc.

Schedule of Benefits for Plan Year 2018

HealthSCOPE- No network of hospitals; it's open access! All services must be pre-certified
Directory for in-network physicians and lab/medical equipment/imaging/physical therapy – visit www.multiplan.com/healthscope or call 877-952-7427 (this network is called PHCS)

	SILVER PLAN	GOLD PLAN
Plan Cost (Weekly)- *before-tax*		
Emp /Emp+child(ren) / Emp+spouse / Family	**No cost / $47.35 / $57.65/ $83.10**	**$50.00 / $92.30 / $105.00 / $151.85**
Plan Coverage		
Deductible/Coinsurance/Out of Pocket Max (for 1 individual; family is x3) PPO Non-PPO	Out of pocket max = max co-insurance you have to pay in year **$1,500 / 75% / $3,500** **$4,000/50%/$5,000**	Out of pocket max not inclusive of deductible **$1,000 / 80% / $2,000** **$3,000 / 50% / $4,000**
Office Visit (OV) Co-pay Primary Care Specialist Care	**None** **None** ***Subject to deductible and Coinsurance***	**$30.00** **$60.00**
Outpatient Diagnostic Services or with Office Visit (X-Ray and Lab) PPO Non-PPO **All <u>Major</u> Diagnostics (CT, PET, MRI, Nuclear Medicine, etc.) <u>is</u> subject to deductible- both plans**	**75%** **50%** ***After applicable Deductible both PPO and Non-PPO***	**100%** **50%** ***After applicable Deductible only for Non-PPO***
Hospital Services (IP and OP*) All hospitals are in network *IP= inpatient OP= outpatient	**75%** ***After applicable deductible***	**80%** ***After applicable Deductible***
Hospital Services (ER) All hospitals are in network	**75%** ***After applicable deductible***	**80%** **After $250 co-pay**
Preventative Care/Newborn Care PPO Non-PPO	**Doctor's visit 100%** ***After $35.00 co-pay*** ***Lab and tests 100%*** **Not Covered**	**Doctor's visit & lab/tests 100%** ***After $30.00 co-pay*** **Not Covered**
All Other PPO Non-PPO	**750%** **50%** ***After applicable deductible***	**80%** **50%** ***After applicable deductible***
Prescription Drug Co-pay (30 day/90 day) Generic Preferred Brand Non-Preferred	**$10 / $20** **$40 / $80** **$60 / $120** ***After $50 annual deductible***	**$10 / $20** **$40 / $80** **$60 / $120** ***After $50 annual deductible***

LIFE INSURANCE			
Plan Cost	All full-time can elect voluntary; Basic for all full-time employees		
Employee (Basic Coverage) Employee (Additional Coverage) Spouse Child(ren)	**No Charge** **Age-Based** **Age-Based** **Amount-Based**		
Plan Coverage			
Employee (Basic Coverage) Employee (Additional Coverage) Spouse Child(ren)	**$20,000** **$1,000 up to two-times salary $100,000 max)** **$1,000 up to two-times salary $100,000 max)** **$10,000 max**	**SPECIAL NOTE: $35,000 IS THE GUARANTEE ISSUE FOR SPOUSE; MEDICAL QUESTIONS HAVE TO BE ANSWERED FOR AMOUNT ABOVE THAT**	
SHORT-TERM DISABILITY			
Plan Cost	ALL FULL-TIME EMPLOYEES CAN ELECT		
Employee	**Salary-based $.60/$1,000 covered payroll**		
Plan Coverage			
Employee	**60% of Weekly Earnings; max $600.00/week**		
VISION INSURANCE	**Only one plan EyeMed**	**Only one plan EyeMed**	**Only one plan EyeMed**
Plan Cost *before-tax*			
Employee Employee + 1 Family	Available to every full-time employee, <u>regardless</u> if elect medical or not.	Available to every full-time employee, <u>regardless</u> if elect medical or not.	**Cost/week** **$1.62** **$3.09** **$4.53**
Plan Coverage			
Annual Exam- 1/year Lenses/Frames 1/year OR Contacts			
DENTAL INSURANCE		**GOLD PLAN**	**PLATINUM PLAN**
Plan Cost (Weekly)			
Employee/Employee + 1/Family		**$4.00 / $9.00 / $15.00**	**$7.00 / $14.00 / $22.00**
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 **(cleaning, exam 1/year bite-wing xray)**		**90%** ***No deductible***	**100%** ***No deductible***
Basic Services **(filling, root canal, oral surgery, etc.)**		**80%** ***After deductible***	**90%** ***After deductible***
Major Services **(dentures, crowns, TMJ treatment, caps, etc.)**		**50%** ***After deductible***	**60%** ***After deductible***
Orthodontic Services *Limited to dependent children*		**Not covered**	**50%** ***After deductible***