McElroy Truck Lines, Inc.

Schedule of Benefits for Plan Year 2019

Medical Insurer- UMR (UnitedHealthcare)

You can view the provider directory at www.umr.com, select "Find a Provider", then select UHC Choice Plus network.

SAME NETWORK WE HAD FROM 2008 – 2017!!!

	SILVER PLAN	GOLD PLAN
Plan Cost (Weekly*)- before-tax*		
Emp /Emp+spouse / Emp+ch(ren) / Family	**No cost / $67.02 / $54.54/ $95.78**	**$57.33 / $121.62 / $107.28 / $174.64**
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*) PPO Non-PPO *IP= inpatient OP= outpatient	 **75%** **50%** ***After applicable deductible***	 **80%** **50%** ***After applicable Deductible***
Hospital Services (ER) PPO Non-PPO	 **75%** ***After applicable deductible*** **50%** ***After applicable deductible***	 **80%** **After $250 co-pay** **50%** ***After applicable Deductible***
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	 **75%** **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 **Cigna**			
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: $35,000 IS THE GUARANTEE ISSUE FOR SPOUSE; MEDICAL QUESTIONS HAVE TO BE ANSWERED FOR AMOUNT ABOVE THAT**	
SHORT-TERM DISABILITY **Cigna**			
Plan Cost	ALL FULL-TIME EMPLOYEES CAN ELECT		
Employee	**Salary-based** **$.60/$1,000 covered payroll; capped at $6/week**		
Plan Coverage			
Employee	**60% of Weekly Earnings; max $600.00/week**		
VISION INSURANCE **EyeMed**	**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, regardless if elect medical or not.	Available to every full-time employee, regardless if elect medical or not.	**Cost/week** **$1.63** **$3.09** **$4.53**
Plan Coverage			
Annual Exam- 1/year **Lenses/Frames 1/year OR Contacts**			
DENTAL INSURANCE **Delta Dental**		**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***