Employee Benefit Guide

Plan Year: January 1, 2022 – December 31, 2022

Revised 11/18/2020

CONTENTS

Southern Precision Staffing strives to provide you with a comprehensive employee benefits program as part of your overall compensation package.

We put together this guide to help you understand your benefits and to help you get the most out of them. We encourage you to review it thoroughly so you can identify which offerings are best for you and your family.

If you have questions about your benefits, reach out to Human Resources or use the contact information included in this guide to get the answers you need.

MEDICAL INSURANCE

You may choose from two medical plans through BCBS of Alabama. When selecting your medical plan consider:

- The premium you'll pay (your payroll deduction)
- What you'll pay when accessing care (copays, deductible, coinsurance)
- What medications are covered
- Which providers are In-Network

SOME INSURANCE TERMS

Copay – a fixed amount you pay when seeking care for certain services.

Deductible – the amount you pay for certain health care services in a calendar year before the plan begins paying any portion of those services.

Coinsurance – the percentage you pay for certain services after meeting your deductible and before you meet your Out of Pocket Maximum.

Out of Pocket Maximum – the most you will pay in a calendar year for covered services. This includes copays, deductibles, coinsurance, and prescriptions. Once the Out of Pocket Maximum has been met, the plan will pay 100% of covered services for the remainder of that calendar year.

Balance Billing – the amount you are billed by out-of-network providers to make up the difference between the amount they charge and what the insurance reimburses. This amount is in addition to and does not count toward your Out of Pocket Maximum.

Medical Weekly (52) Payroll Deductions		
	Blue Saver Bronze	**Blue Secure Silver**
Employee	$86.22	$114.44
Employee + Spouse	$172.43	$228.88
Employee + Child(ren)	$159.50	$211.71
Employee + Family	$245.71	$326.15

MEDICAL INSURANCE

BlueCross BlueShield of Alabama

We cover what matters.

All benefits are shown as In Network. You are encouraged to call Blue Cross and Blue Shield with any and all questions about benefits.

Bronze

In Network Deductible $7,850 individual $15,700 family
In Network Out of pocket max $7,850 ind or $15,700 family

In Net Physician Copay 100% of allowed amount after $40 copay for first three illness related office visits per member. Thereafter subject to deductible

Silver

In Network Deductible $4000 individual $8,000 family
In Network Out of pocket max $8,550 ind or $17,100 family

In Net Physician Copay 100% of allowed amount after $40 copay for primary $70 for specialist

Prescription Drugs Bronze

Tier 1	$20
Tier 2	$35
Tier 3	Subject to deductible
Tier 4	Subject to deductible
Tier 5	Subject to deductible
Tier 6	Subject to deductible
Formulary	Source +RX 1.0
Pharmacy Network	Value One
Out of network	Not covered

Prescription Drugs Silver

Tier 1	$15
Tier 2	$30
Tier 3	$75
Tier 4	$100
Tier 5	$250
Tier 6	covered at 60% you will owe 40%
Formulary	Source +RX 1.0
Pharmacy Network	Value One
Out of network	Not covered

DENTAL

Benefit Summary	UNUM PPO	
	In Network	Out of Network
Fee Reimbursement	Fee Schedule	MAC
Preventive Expenses Benefit	100%	100%
Basic Expenses Benefit	80%	80%
Major Expenses Benefit	50%	50%
Orthodontia	Not Included	
Annual Deductible (single/family)	$50 / $150	
Deductible Amount Applies To	Basic & Major Services	
Endodontic & Periodontic Services	Major Service	
Annual Maximum Benefit	$1,000	
Rollover?	Yes	

Dental Weekly (52) Payroll Deductions	
	UNUM PPO
Employee	$7.11
Employee + Spouse	$13.87
Employee + Child(ren)	$18.09
Employee + Family	$26.88

VISION

SuperiorVision™

Benefit Summary	In Network	Out of Network
Vision Exam		
Frequency	Once a plan year	
Routine Eye Exam	$10 copay	Ophthalmologist: up to $40 (less $10 copay) Optometrist: up to $40 (less $10 copay)
Material Lenses		
Frequency	Once a plan year	
Single Vision Lenses (pair)	$25 copay	Up to $20 (less $25 copay)
Bifocal Lenses (pair)		Up to $40 (less $25 copay)
Trifocal Lenses (pair)		Up to $60 (less $25 copay)
Lenticular Lenses (pair)		Up to $100 (less $25 copay)
Frames		
Frequency	Once a plan year	
Frame	$25 copay $130 retail allowance	Up to $52 (less $25 copay)
Contact Lenses	**In Lieu of Frame & Lenses**	
Frequency	Once a plan year	
Medically Necessary	$250 retail allowance	Up to $250
Elective Contact Lenses	$130 retail allowance	Up to $78

Vision Weekly (52) Payroll Deductions	
	Vision Plan
Employee	$2.38
Employee + Spouse	$4.47
Employee + Child(ren)	$5.07
Employee + Family	$7.39

Revised: 11/11/2021