2014 BENEFITS SUMMARY COMPARISON

See the Plan Document for a full description of benefits. You can access the Plan Document through Lawson Employee Self Service, Employee Connect or FBC Website. In the event any benefit summary contained herein differs from the official text of the Plan, the official text shall prevail. (NOTE: HEALTH CARE BENEFITS ARE SUBJECT TO CHANGE AS THE RESULT OF THE HEALTH CARE REFORM LEGISLATION IN 2010. CHANGES TO THE BELOW MAY OCCUR IN ORDER TO BECOME COMPLIANT WITH THE REFORM ACTS.)

New Employees: Benefits are effective the 1st of the month following 58 days of continuous Active Service.
Late Entrants: Benefits are effective the 1st of the month following 58 days after receipt and approval of Late Entrant application.

MEDICAL PLAN:	*FBC Employee Benefit Plan Option A (PPO)*		*FBC Employee Benefit Plan Option B (PPO)*	
	PARTICIPANT'S COINSURANCE PERCENTAGE SHOWN UNLESS OTHERWISE NOTED			
	In Network	Out of Network	In Network	Out of Network
Calendar Year Deductible* - Per Participant	$250.00	$700.00	$750.00	$1,000.00
Calendar Year Deductible* - Annual Family Limit	$250.00 X 5 = $1,250.00	$700.00 X 5 = $3,500.00	$750.00 X 3 = $2,250.00	$1,000.00 X 3 = $3,000.00
Participant's Coinsurance**	20%	50%****	20%	50%****
Plan Pays 100% When Qualified & Eligible Expenses Reach	$15,000.00	$20,000.00	$10,000.00	$15,000.00
Office Visit Copay (Physician's Charges Only)**	$25.00	50%	$25.00	50%
Annual Wellness Benefit*****	$750	None	$750.00	None
Annual Vision Benefit** Not Covered: Refraction Fee, Glasses, Contacts, and Other Exclusions	20%***	50%	20%***	50%
Hospitalization - Inpatient**	20%	50% Plus $250.00 Per Hospital Confinement	20%	50% Plus $500.00 Per Hospital Confinement
Hospitalization - Outpatient**	20%	50%	20%	50%
Surgery - Inpatient**	20%	50%	20%	50%
Surgery - Outpatient**	20%	30%	20%	30%
Emergency Room	20%	50%	20%	50%
Emergency Room** (Non-Emergency Visit)	20%	50%	20%	50%
Networks	Preferred Provider Organization (PPO) Network	N/A	Preferred Provider Organization (PPO) Network	N/A
PREMIUMS	**FBCEB Plan A - 24 Payroll Deductions Per Year**		**FBCEB Plan B - 24 Payroll Deductions Per Year**	
Employee Only	$24.98		-0-	
EE and Child(ren)	$77.80		$25.33	
EE and Spouse	$130.61		$50.63	
EE and Family	$183.43		$75.96	

* Calendar Year Deductible (CYD) ** Subject to Calendar Year Deductible *** Subject to Office Visit Copay **** See Plan Document for Exception(s)
***** Over Maximum is Processed under Medical, Subject to CYD and Coinsurance

PRESCRIPTION CO-PAYS (Plan Option A and Plan Option B)	RETAIL PHARMACY (30 Day Supply or Less)	MAIL ORDER PHARMACY (90 Day Supply)
Tier 1 Generic	$10.00	$20.00
Tier 2 Brand Name	$25.00	$50.00
Tier 3 Non-Formulary	$40.00	$80.00
Tier 4 Specialty	$100.00	$200.00

DENTAL PLAN:	*FBC Employee Benefit Plan*	*CompDent (DHMO)*	
	Any Licensed Dentist in the U.S.A.	In Network	Out of Network
Calendar Year Deductible - Per Participant	$100.00	None	None
Calendar Year Deductible - Per Family	$300.00	None	None
Co-Insurance	Type I Benefit Must Be Used First / Type II and V Services Plan Pays 80% / Type III and IV Services Plan Pays 50%	See Plan Schedule in Benefit Booklet for Co-Pays	None
Preventative Benefit	Type I Services 100% / Required Every 180 Days	See Plan Schedule in Benefit Booklet	None
Calendar Year Maximum Per Person	$1,500.00	See Plan Schedule in Benefit Booklet	None
Lifetime Maximum	None	Unlimited	None
PREMIUMS	**FBCEB Dental Plan - 24 Payroll Deductions Per Year**	**CompDent - 24 Payroll Deductions Per Year**	
Employee Only	-0-	-0-	
EE and Child(ren)	$17.93	$10.66	
EE and Spouse	$11.16	$10.00	
EE and Family	$29.09	$14.92	

VISION PLAN:	*VisionCare*
	See the Plan Summary for benefits.
PREMIUMS	**VisionCare - 24 Payroll Deductions Per Year**
Employee Only	$3.46
EE and Child(ren)	$6.55
EE and Spouse	$6.90
EE and Family	$11.59