Estep & Co. Inc.

SUBWAY

FIVE GUYS

SERVICE MY RESTAURANTS SMR

DAVE'S HOT CHICKEN

MONTANA MIKE'S STEAKHOUSE

Employee BENEFITS GUIDE

2027

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Eligibility Criteria

As a full-time employee working at least 30 hours per week, you are eligible to participate in the Estep & Company, Inc. benefits plan following a 60-day waiting period. Benefits are effective on the 61st day of your full-time employment.

As a variable hour employee, your work hours are reviewed over a 12-month measurement period starting on your hire date. You must average at least 30 hours per week during the measurement period to be considered eligible for benefits. If determined eligible, benefits will begin 14 months from your hire date and will remain in place for a one year stability period.

The plan eligibility requirements apply to:

- Medical & Rx
- Dental
- Vision
- Basic Life
- Voluntary Life
- Short Term Disability
- Long Term Disability
- Accident
- Hospital Indemnity
- Critical Illness

→ The Estep & Company, Inc. Employee Benefits Plan is a Section 125 plan and is governed by the Internal Revenue Service. Some premiums are deducted on a pre-tax basis and as a result, your benefit elections are **binding and cannot be changed** in the absence of a Qualifying Life Event or during the annual benefit enrollment period. Refer to the Qualifying Life Events page in this guide for more information.

→ The Estep & Company, Inc. Medical Plan has a spousal carve-out provision. If your spouse is eligible for medical coverage with their employer, then he/she cannot enroll in the Estep & Company, Inc. Medical Plan. There is a spousal carve-out form that may require verification from your spouse's employer.

→ Pre-existing conditions exclusions may apply to non-medical coverages.

→ Your plan contains specific rules around dependent eligibility. Proof of eligibility may be required by the Plan. In terms of the Estep & Company, Inc. Medical Plan, a dependent is defined as:

1. An Employee's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way, who is a resident of the same country as you.
2. An Employee's Child (including step-children, adopted children, qualified medical dependents as ordered by the court, and grandchildren if grandparent has legal custody) who is less than 26 years of age.
   NOTE: Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.
3. An Employee's Child, regardless of age, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

IMPORTANT NOTE: This booklet provides a summary of the benefits offered by the Estep & Company, Inc. plan. This benefits guide is not an exhaustive list of all the plan's features and rules. For comprehensive details about the plan, including all terms, benefits, exclusions, requirements, and parameters, refer to the relevant plan certificate. The plan certificate is the authoritative document that governs the benefits and conditions of the plan.

Qualifying Life Events

Reasons You May Be Eligible to Change Your Benefits

Changing Your Benefits Outside the Annual Enrollment Period

A qualifying life event is a change in your situation that may allow you to alter your benefit elections.

→ Benefit changes must correspond with your specific life event.

For example: If you get married, you may add your spouse to the benefit plan, but you may not drop coverages you have already elected.

→ When you experience a qualifying life event, you must complete benefit changes within 30 days of the event.

For example: If you have a baby on September 1, your newborn must be added to the plan by September 30.

If you have questions about qualifying life events or you need to make changes to your benefits, contact your employer's Human Resources Department or Benefits Manager.

Following are some examples of common life events; this is not a complete list.

- Involuntary loss of coverage
- A change in your marital status, such as marriage, divorce, or death of a spouse
- A change with your dependents, such as birth, adoption, or death of a dependent
- A change in employment status for you, your spouse, or your dependent
- Your dependent gaining or losing eligibility as a dependent on the plan
- A change in residence for you, your spouse, or your dependent that affects your healthcare options
- Losing or gaining eligibility for Medicare, Medicaid, or CHIP
- A court order, judgement, or decree, including QMCSO
- A severe curtailment in coverage available under this plan or a dependent's plan
- A change your dependent's coverage under a plan sponsored by the dependent's employer
- A HIPPA special enrollment event
- Any other change permitted under IRS rules

Visit www.benefiti.com/life-events for more information on qualifying life events.

Exceptions cannot be made to the plan's enrollment rules.

Changes to your benefits can only be made during the annual enrollment period or within 30-days of a qualifying life event or status change. Special enrollment and status change rules were established by the Internal Revenue Service and are governed by the IRS and Department of Health and Human Services.

Medical Plan Options

CHOOSE THE PLAN THAT WORKS BEST FOR YOU!

Everyone's healthcare needs and financial priorities are different. Estep & Company, Inc. is happy to offer different medical plan options so you can choose the coverage that best fits your personal needs and budget.

Medical Plan Options
Co-Pay Plan
A reference based pricing medical plan with predictable costs. → Fixed co-pays for most office visits and prescriptions → Ideal if you prefer knowing your cost upfront when you visit a provider → Works well for those who expect regular doctor visits or ongoing medications
High Deductible Health Plan
A reference based pricing plan offering HSA eligibility. → Lower per-paycheck cost compared to the Co-Pay Plan → Requires that you meet the deductible before the plan begins paying benefits → Works well if you want the lowest premium cost and typically don't use a lot of healthcare services

Direct Primary Care
DPCplus from Healthcare2U
More access. Fewer barriers. Our new Direct Primary Care plan gives you unlimited access to a dedicated primary care network at an affordable per paycheck cost. → Unlimited primary care, urgent care, and telehealth with $0, $10, or $25 co-pays → Unlimited treatment and maintenance support for certain chronic diseases → Longer appointments and more personalized care → Can be enrolled by itself (for those who only want primary care coverage) *or* paired with the HDHP or Co-Pay Plan for broader protection **Important:** *DPCplus is not a major medical plan. If you want full health insurance coverage, enroll in DPCplus in addition to the HDHP or Co-Pay Plan.*

Which Option is Right for You?		
Consider the Co-Pay Plan if you:	**Consider the HDHP if you:**	**Consider DPCplus if you:**
✓ Prefer predictable out-of-pocket costs for care ✓ Expect to use healthcare regularly ✓ Want fixed co-pays for office visits and prescriptions	✓ Want the lowest payroll deduction ✓ Typically have low medical utilization ✓ Are okay paying out-of-pocket until your deductible is met	✓ Want easy, unlimited access to primary care and telehealth ✓ Like the idea of no surprise costs ✓ Want a low-cost way to maintain regular acute and chronic care

Medical Benefits

Diversified + ClaimDOC

Your Medical Plan Options		
	High Deductible Plan–*HSA Qualified*	Co-Pay Plan–*Non-HSA Qualified*
Individual Deductible	$3,500	$3,500
Family Deductible	$7,000	$7,000
Individual Out of Pocket	$6,650	$6,650
Family Out of Pocket	$13,300	$13,300
Coverage Level	Plan pays 100% after deductible	Plan pays 100% after deductible

Open Access Health Plan

This plan does not utilize a provider network.

This is an open-access health plan, which means you can choose any provider you wish. Benefits are paid at the same level, regardless of the provider you visit. You are not responsible for balance bills issued by providers.

Pave the Way

Whenever possible, submit a Provider Nomination form to ClaimDOC's *Pave the Way Program* before your appointments. This allows ClaimDOC to engage with your provider ahead of time for a more seamless experience at your visit and fewer questions at the time of billing.

	High Deductible Health Plan	Co-Pay Plan
General Office Visit	Deductible	$30 Co-Pay
Specialist Office Visit	Deductible	$50 Co-Pay
Wellness-Preventive	No Charge	No Charge
Urgent Care	Deductible, then $75 Co-Pay	$250 Co-Pay
Teladoc Virtual Care	No charge	No charge
New! Labs at a Freestanding	Deductible, then no charge	No Charge
Emergency Room	Deductible, then $200 Co-Pay	$500 Co-Pay
New! Facility Services	Deductible + $500 Co-Pay	$500 Co-Pay
Regenexx	Deductible, then no charge	No Charge

Prescription Co-Pays				
	High Deductible Health Plan		Co-Pay Plan	
	30 Day Fill	*90 Day Fill*	*30 Day Fill*	*90 Day Fill*
Generic Drugs	Deductible, then $10	Deductible, then	$10	$25
Preferred Drugs	Deductible, then $35	Deductible, then	$35	$105
Non-Preferred Drugs	Deductible, then $75	Deductible, then	$75	$225

*__Specialty drugs are not covered by the Rx benefit.__ You must obtain specialty drugs through the plan's sourcing

Your Cost per Paycheck (26 pays per year)						
	High Deductible Health Plan			Co-Pay Plan		
Your Annual Salary	Under $30K	$30K - $50K	Above $50K	Under $30K	$30K - $50K	Above $50K
Employee Only	$60	$81	$88	$67	$89	$98
Employee + Spouse	$210	$265	$291	$221	$275	$301
Employee + Children	$158	$195	$214	$168	$206	$224
Family	$368	$471	$522	$378	$482	$532

ATTENTION SMR TECHS–Contact Human Resources or your manager for a copy of the TECHNICIAN Benefits Guide.

This is an outline of benefits only; it is not a complete list of all plan parameters. The policy certificate is the official governing plan document.

Same Plan. **New Partners.**

Your medical plan design remains the same, but some of the partners supporting the plan have changed.

- New Plan Administrator (TPA): **Diversified** (*formerly Edison*)
- Same RBP Vendor: **ClaimDOC**
- New Pharmacy Benefits Manager (PBM): **ProAct** (*formerly US-Rx Care*)
- New Drug Sourcing Vendor: **UBACARE** (*formerly ScriptSourcing*)



How does the TPA change affect me?

Diversified will now handle all aspects of your medical plan administration, including answering your claims or coverage questions, processing claims, generating EOB's, and verifying, benefits with your providers. Instead of calling Edison for support, you and your providers will now contact Diversified.



What happens next?

You will receive a new ID card from Diversified. It is very important that you share the new card with your doctors and pharmacies.

You will also have access to a new member portal. Set up your new portal account at https://portal.dgb-online.com/Logon/Registration.aspx.



What about my prescriptions?

You will continue to fill your prescriptions like normal, but **you must present your new ID card to the pharcmacy and confirm your info is updated in their system**. Prescriptions processed under the old ID card will be denied.



What if a provider won't accept my plan? What about balance bills?

Your plan's Reference Based Pricing partner, ClaimDOC, is not changing. Continue contacting ClaimDOC for help securing appointments or if you receive a balance bill. If you have an open balance bill case, it will still be managed by ClaimDOC without interruption.

Understanding
Reference Based Pricing



What is Reference Based Pricing?

Reference based pricing (RBP) is a payment methodology that replaces a health plan's traditional pre-negotiated provider rates. RBP uses Medicare reimbursement rates as a benchmark and prices claims based on a multiple of that rate.

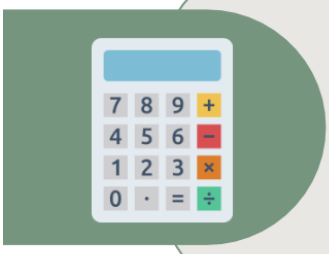
Reference based pricing helps you avoid overpaying for medical services and helps keep your medical premium costs down.



How does a Reference Based Pricing plan affect me?

Your RBP plan allows you to visit any medical provider of your choice. There is no network list. Sometimes providers may need help understanding how your plan works. **Don't be alarmed—this is normal**.

Simply ask your provider to call **ClaimDOC** at **888-330-7295**.



What is my financial responsibility?

Just like a traditional health plan, your RBP plan requires that you pay the plan deductible, co-pay, and/or co-insurance as shown on the Explanation of Benefits. **You are never required to pay balance bills.**

If you receive a balance bill, send it to ClaimDOC right away.



NEVER AVOID MEDICAL CARE BECAUSE YOU DON'T UNDERSTAND YOUR BENEFITS PLAN

If you need medical treatment but you don't know where to go or you're unsure how your plan works, **DO NOT DELAY.**

For help understanding your benefits, call **Diversified** at **888-322-2524**.
For guidance finding a provider, call **ClaimDOC** at **888-330-7295**.

Direct Primary Care

Healthcare2U

DPCplus is a Direct Primary Care plan that offers a simple, affordable way for you and your familly to access everyday healthcare needs. DPCplus gives members convenient access to primary care, urgent care, telehealth services, and preventive care.

While this is not a major medical insurance plan, DPCplus gives you reliable access to outpatient care and certain medications at a low cost—helping you and your family stay healthly.



Elect DPCplus as a standalone coverage or pair it with one of Estep & Company, Inc.'s medical plans for added access to care and predicable costs.

The DPCplus plan, provided by Healthcare2U, includes these valuable features:

Direct Primary Care	
In-Office Primary Care and Urgent Care	**Virtual Care – Online or Phone**
→ Unlimited Primary Care visits: **$10 per visit fee** → Unlimited Urgent Care visits: **$25 per visit fee** → Annual physical including four labs: **$0 visit fee**	→ Unlimited access to licensed medical providers online or by phone, available 24/7: **$0 visit fee**
Chronic Disease Management	**Concierge and Patient Advocacy**
Unlimited visits for 12 chronic conditions: **$10 per visit** *Covered conditions include:* ▪ *Diabetes* ▪ *Hypertension* ▪ CHF ▪ *Arthritis* ▪ *Depression* ▪ COPD ▪ *Asthma* ▪ *Fibromyalgia* ▪ GERD ▪ *Thyroid* ▪ *Anxiety* ▪ Gout	Healthcare2U acts as the member's personal concierge through our bilingual Patient Advocacy Line (PAL). PAL is staffed by certified medical professionals who navigate care options and book appointments for members and eligible participants.

Discounts on Services and Supplies		
Labs and Prescriptions	**Vision and Lasik**	**Speech and Hearing**
▪ 30%–70% savings on lab tests ▪ 15%–60% off retail price for most generic drugs	▪ 20%-40% off retail price of eyewear ▪ 20%–30% savings on Lasik	▪ 54%–69% discount on latest auditory technology ▪ Free speech screening

Your Cost per Paycheck (26 pays per year)	
Employee Only	$23.08
Employee + Spouse	$43.85
Employee + Child(ren)	$57.69
Family	$78.46

Get the Help You Need to Maximize Your Prescription Drug Benefits

ProAct facilitates the prescription benefit for your group health plan, administered through Diversified Group. This prescription benefit will replace your current prescription benefit program.

PROACT PHARMACY BENEFIT MANAGEMENT

Benefit Identification Card

Prior to your coverage effective date, you will receive a new Benefits Identification Card. This combined card can be used at both the pharmacy and your medical provider's office. Once received, please remember to destroy any old health identification or prescription cards.

Retail Pharmacy Benefit

In order to receive your prescription discount at the retail pharmacy, it is very important that you present your new benefit identification card to your pharmacist. In addition, many retail pharmacies offer automatic refill services via telephone or Internet access. Before utilizing this service on your next refill, you will need to:

- Call your local pharmacy to speak to a pharmacist so they can update your patient profile.
- Inform your local pharmacist that ProAct is your new prescription benefit manager (PBM), and
- Provide them with the prescription processing information located on the front of your new ID card.

Mail Order Pharmacy Benefit

Mail-Order is available for maintenance medications that you or your enrolled/ eligible dependents use on a regular basis. Please note that your prescriptions will not be transferred from your existing mail order pharmacy. To participate in the mail-order program with ProAct, on or after 3/1/2025, setup your Mail Order Profile online at www.proactrx.com/mail-order/1/#regsiter or call 866-287-9885 to speak to a Customer Service Representative. They will assist you in setting up a patient profile including payment method.

Prescription Formulary – Important Changes

The ProAct Formulary is available to you once you are enrolled by going to www.proactrx.com. If your medication is "non-preferred" or excluded, we encourage you to talk with your physician and ask if a preferred alternative is right for you. If s/he agrees, ask for a new written prescription. Please note that if you elect to continue taking a non-preferred medication, you may be subject to pay a higher cost share at the pharmacy based on your plan design.

IMPORTANT: Your prescription drug formulary with ProAct Rx may be subject to standard exclusions, quantity limits, day supply requirements, step therapy requirements and prior authorizations. Once enrolled, please call ProAct Customer Service at the number listed below for specific drug coverage information. Formulary changes can occur throughout the year due to continuous review of new and existing drugs in the marketplace.

Online Resources – www.proactrx.com

To set up your own personal account with a password after your effective date, visit www.proactrx.com. This website offers a variety of resources to help you with your prescription needs. The website allows you to check the status of your mail order prescriptions, view your claims, estimate your co-pay, research your medications, find in-network pharmacies, and much more!

If you have any questions, please contact Diversified Group or EmpiRx at the numbers below.

Diversified Group
1-888-322-25254 x412
cs@diversifiedgb.com
M-F 8:00 a.m. to 4:30 p.m. EST
www.dgb-online.com

ProAct Customer Service
1-877-635-9545
24 hours a day, 7 days a week

Health Plans that Benefit YOU!

DIVERSIFIED GROUP
Your Solution to Health Benefits

For further information, contact:
1-888-322-2524 ext. 412 | cs@diversifiedgb.com

OptiMed: Your Preferred Provider for Specialty Medications and Infusion Services!

Specialty/BioTech prescriptions are normally high-cost medications which require special handling and administration; they are most commonly injectable or infused, but in some limited situations can be oral. Some conditions that are treated with specialty medications include Multiple Sclerosis, Rheumatoid Arthritis, or Crohn's Disease.

These medications require pre-certification through your medical plan. Refer to the back of your new Diversified Group ID card for your health plans precertification requirements. If you are not sure if your drug is Specialty/ Biotech, please ask your doctor and/or you can call **Innovative Care Management** (ICM) at **1-800-862-3338.** Once the drug is authorized, the medication will be referred to **OptiMed Health Partners** for fulfillment.



Diversified Group is dedicated to offering members best-in-class support, as well as lower healthcare costs. This is why we have selected a preferred partner for specialty and infusion treatments, **OptiMed Health Partners**.

- Once Precertification is established, OptiMed will work with you and your provider for proper delivery of your medication.
- To keep good communication between the member and OptiMed, be sure to supply your email and phone number to OptiMed.
- **For delivery and medication status updates, call OptiMed directly at 877-884-0998**

With licensed & certified clinicians and experienced support staff, OptiMed ensures 24/7 access to caring professionals and much more...

- **FREE delivery of all medications & supplies**
- **Proactive REFILL calls & care coordination**
- **A consistent care team throughout treatment**
- **Site of care treatment options**
- **Specialty trained clinical staff**

OptiMed
HEALTH PARTNERS
SPECIALTY PHARMACY
INFUSION SERVICES
PHARMACY

urac ACCREDITED
Specialty Pharmacy
Expires 12/01/2021

Questions? Contact:
Diversified Group: 888.322.2524.
Innovative Care Management (ICM): 800.862.3338
OptiMed: 877-884-0998

Health Plans that Benefit YOU!

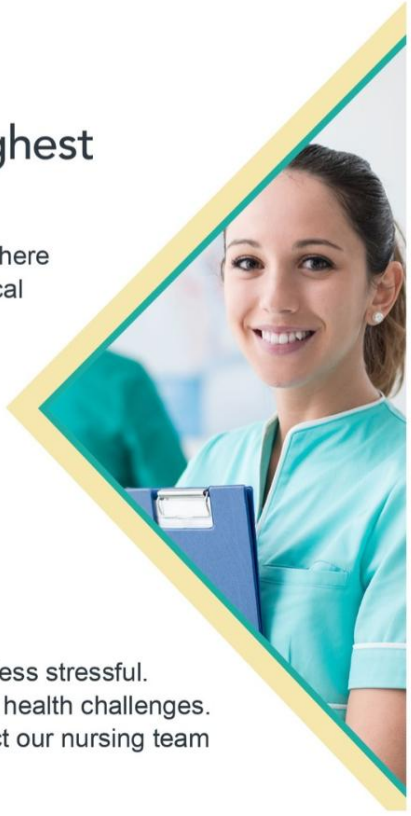
Get Extra Help with Your Healthcare

Innovative Care Management

Case Management

Support you can trust during life's toughest health moments

When health challenges feel overwhelming, our Case Management program is here to help. If you or a loved one is facing a serious injury, illness, or complex medical situation, you'll be paired with a dedicated Registered Nurse who will support you every step of the way.



Your nurse will:

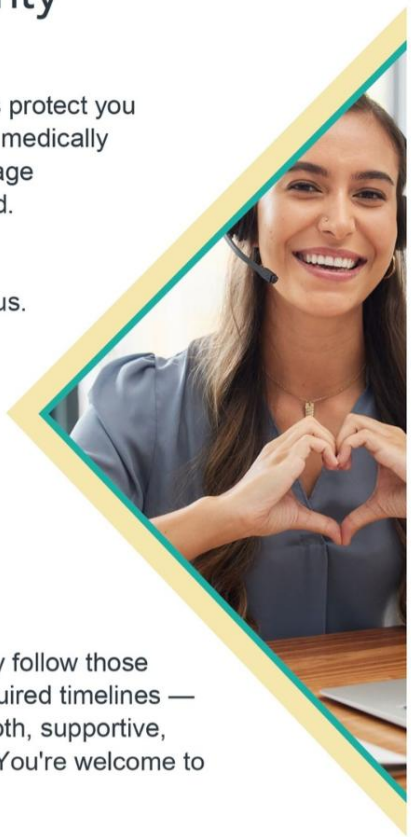
- → Get to know you and what matters most to you
- → Explain your treatment options in clear, simple terms
- → Help you navigate the healthcare system
- → Coordinate care with your doctors and specialists
- → Advocate for your needs so you never feel alone in the process

Our goal is to make your healthcare journey easier, more understandable, and less stressful. Case Management is a free, voluntary program designed to support you during health challenges. If you feel you might benefit from additional guidance, you're welcome to contact our nursing team at **nurse@innovativecare.com** to get started.

Preauthorization & Utilization Management

Helping you get the right care with clarity and confidence

Preauthorization (also called prior authorization) is a way your health plan helps protect you from unexpected costs and ensures the care you receive is safe, effective, and medically necessary. By reviewing certain services ahead of time, we help prevent coverage issues after care is provided — giving you peace of mind before moving forward.



How we support you:

- → **Clear, timely communication** so you understand your authorization status.
- → **Protection from unnecessary or unproven interventions,** helping ensure the care you receive is appropriate and evidence-based.
- → **Connections to helpful programs** like Case Management, Chronic Condition Management, and Healthy Mother Baby/Maternity Management when appropriate.
- → **Straightforward guidance** if a service isn't approved, including your appeal options.

Behind the Scenes

Your health plan determines which services require preauthorization. We simply follow those rules, working directly with your providers and completing all reviews within required timelines — no extra hoops or unnecessary steps. Our goal is to make the process as smooth, supportive, and transparent as possible, so you can focus on your health with confidence. You're welcome to contact our Preauthorization team at 1-800-862-3338, or visit our web page at www.innovativecare.com.

This is an outline of benefits only; it is not a complete list of all plan parameters. The policy certificate is the official governing plan document.

866-506-7953
regenexxbenefits.com/estep-co/oe

WHAT IS REGENEXX?

Regenexx is an innovative treatment for orthopedic injuries that enhances your body's natural healing processes. To treat damaged tendons, ligaments, muscle, bone, and cartilage, the physicians draw your blood platelets and bone marrow aspirate and process them using **Regenexx** lab processing techniques. They then inject them precisely at the site of your injury using image guidance. **Regenexx** treatments provide a lower-risk, lower-cost, minimally invasive alternative for up to 70 percent of elective orthopedic surgeries.

THE REGENEXX DIFFERENCE

Regenexx is a nonsurgical outpatient therapy performed either in a single day or in a series of three treatments over two weeks. Most patients are encouraged to return to activity within a week of their procedure. Patients with health factors such as heart issues or risk of stroke can find a lower-risk alternative to surgery with **Regenexx** treatments.

YOUR REGENEXX BENEFIT

Regenexx is covered as an in-network benefit within the Estep & Co. health plans. The copay plan will pay 100% with the participant only responsible for upfront imaging. On the HDHP, the participant will have 100% coverage after the deductible for the **Regenexx** procedure. **Non-Regenexx** services may fall under a different benefit level and may or may not be treated as in-network. Charges depend on your specific plan details and your current deductible and out-of-pocket status.

CONDITIONS TREATED

Ankle/Foot
- Achilles tendinopathy
- Arthritis
- Bunions
- Instability
- Ligament sprain or tear
- Plantar fasciitis

Hand/Wrist/Elbow
- Arthritis
- Carpal tunnel
- CMC joint arthritis (thumb)
- Tennis elbow
- Trigger finger
- Ulnar nerve entrapment

Hip
- Arthritis
- Bursitis Labral/labrum tear
- Joint-replacement alternative
- Osteonecrosis
- Tendinopathy

Knee
- Arthritis
- Joint-replacement alternative
- Meniscus tear
- Sprain or tear of ACL/PCL
- Sprain or tear of the MCL/LCL
- Tendinopathy

Shoulder
- Arthritis
- Joint-replacement alternative
- Labral tear
- Rotator cuff tear
- Rotator cuff tendinosis

Spine
- Back or neck nerve pain
- Bulging, collapsed, or herniated disc
- Ruptured or torn disc
- Degenerative disc disease
- Disc extrusion
- Disc protrusion

LEARN MORE

To find out more about your Regenexx benefit and whether Regenexx is an option for you, contact our education center.
Call 866-506-7953 or visit regenexxbenefits.com/estep-co/oe.

Register for a webinar at regenexxbenefits.com/estep-co/oeweb.

This is an outline of benefits only; it is not a complete list of all plan parameters. The policy certificate is the official governing plan document.

TELADOC®

Talk to a doctor anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.



MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- **Cold & flu symptoms**
- **Allergies**
- **Sinus problems**
- **Sore Throat**
- **Respiratory infection**
- **Skin problems**
- **And more!**

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary physician it is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Talk to a doctor anytime for **free!**

Teladoc.com

1-800-TELADOC (835-2362)

Available on the iPhone App Store

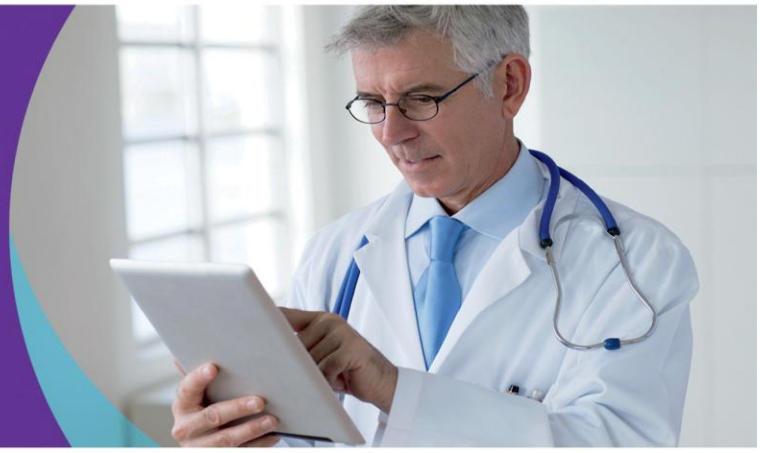
ANDROID APP ON Google play

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TELADOC®

So many reasons to use Teladoc®



Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits.
It's an affordable option for quality medical care.

1. Talk to a doctor anytime, anywhere you happen to be
2. Receive quality care via phone, video or mobile app
3. Prompt treatment, talk to a doctor in minutes
4. A network of doctors that can treat every member of the family
5. Prescriptions sent to pharmacy of choice if medically necessary
6. Teladoc is less expensive than the ER or urgent care

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink Eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician

Talk to a doctor anytime for **free!**

Teladoc.com
1-800-TELADOC (835-2362)

Available on the iPhone App Store
ANDROID APP ON Google play

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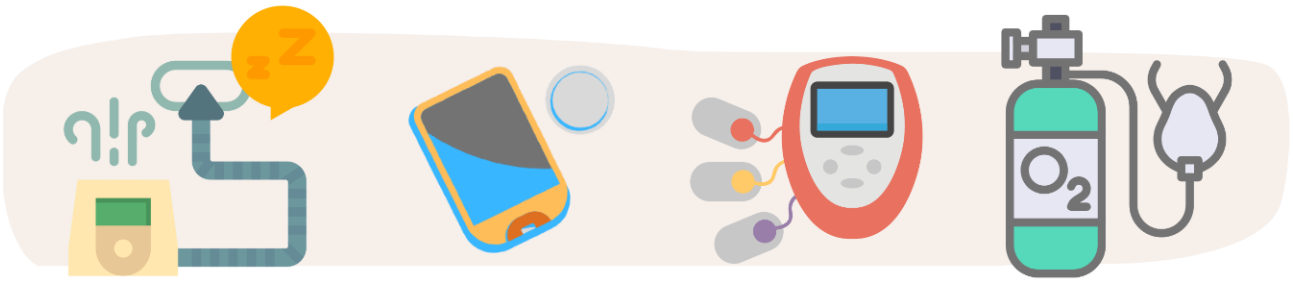
Need **Medical Equipment** or **Supplies**?

Get what you need from **Connect DME**

No **hassle**. No **stress**.

Supplies mailed to your home!

Connect DME carries C-PAP machines and supplies, insulin pumps, continuous glucose monitors, nebulizers, oxygen, mobility aids, and a variety of other equipment, often at **significantly lower prices** than your current supplier.



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CONNECT DME

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Health Savings Account

A Health Savings Account (HSA) is an account to which you can contribute pre-tax dollars to pay for eligible healthcare expenses. The money you contribute is tax-free, grows tax-free, and can be used tax-free for qualified expenses like doctor visits, prescriptions, and medical supplies.

HSA's give you more control over your healthcare spending and can also help you save for future medical costs.

The Health Savings Account is available only to those who elect the High Deductible Health Plan (HDHP).

Co-Pay Plans are not eligible to contribute to a Health Savings Account.

IRS Health Savings Account Contribution Limits	
Bank fees may also apply	
Individual	$4,500
Family	$9,000
Catch Up – Age 55 & Over	Additional $1,000

Important Information About Your HSA
You should carefully consider your HSA election as the maximum is for a calendar year
HSA funds are not "use it or lose it." Unused funds roll over from year-to-year and earn tax-deferred interest. In the event you leave the employment of Estep & Company, Inc., unused HSA funds will still be available to you.
You can use your HSA funds to pay for many everyday healthcare costs, like doctor visits, prescriptions, certain over-the-counter items, and menstrual products. It can also help cover things like copays, deductibles, and other out-of-pocket expenses.
You will find a list of eligible HSA expenses here: www.irs.gov/pub/irs-pdf/p502.pdf
Keep receipts on all withdrawals with tax return to provide proof of eligible withdrawals.
There is a 10% tax penalty prior to age 65, plus income tax on the gain for non-eligible withdrawals.
Spouses over age 55 need to set up separate HSA account for Catch Up deposits.
You will need to file Form 8889 with your tax return to verify eligible and non-eligible withdrawals.
You may not make contributions to an HSA if covered by another health plan, or enrolled in Medicare, or received health benefits in last 3 months from Veterans Administration.

IMPORTANT INFORMATION ABOUT YOUR HEALTH SAVINGS ACCOUNT

If you have an existing HSA and have not yet provided the banking details to Estep & Company, Inc.'s Human Resources team, you must do so as soon as possible. Failure to provide your bank details may result in your payroll contributions not being deposited appropriately.

If you need help establishing a health savings account, contact the Human Resources team.



Estep & Company, Inc.

The Help You Need,
One Phone Call Away

ClaimDOC®
Fair Payment Solutions for Health Plans

888-330-7295

portal.claim-doc.com

Monday – Friday
7 AM – 6 PM CST

membersupport@claim-doc.com

Your medical plan provides you with member advocacy support through ClaimDOC. Member advocates can help you navigate your medical plan and assist you with:

- Finding a provider in your area.
- Submitting nominations and explaining the plan to your provider.
- Understanding your medical bills and submitting balance bills.
- Getting access to affordable healthcare.

Your plan administrator provides you with the following services on behalf of your medical plan:

- Quoting benefits and eligibility, including how much is left of your deductible.
- Determining which health services are covered under your plan.
- Processing medical claims and issuing payment to your providers.
- Processing your medical claim forms and issuing your reimbursements.

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Member Portal
Scan the QR code

Estep & Company, Inc.

How Your Plan Works

Extraordinary member advocacy means you have an expert to help you navigate the complex healthcare system.

1 Before Your Appointment

ClaimDOC explains the plan and claim submissions to providers.
Mutually beneficial patient agreements for specific procedures or periods of time are available if needed. Members should nominate providers through Pave the Way.® Providers can contact ClaimDOC at 888-330-7295 with questions.





2 At Your Appointment

Present your medical plan ID card.

The back of the ID card has information providers will need, including the claims submission address and electronic payor ID for the plan administrator, Edison Health Solutions (Edison).

3 After Your Appointment

Review your explanation of benefits.

Members are only responsible for applicable copays, coinsurance and deductible up to the out-of-pocket maximum for the plan year. Remember, if you have any questions about the plan or what to pay, call a member advocate at 888-330-7295.



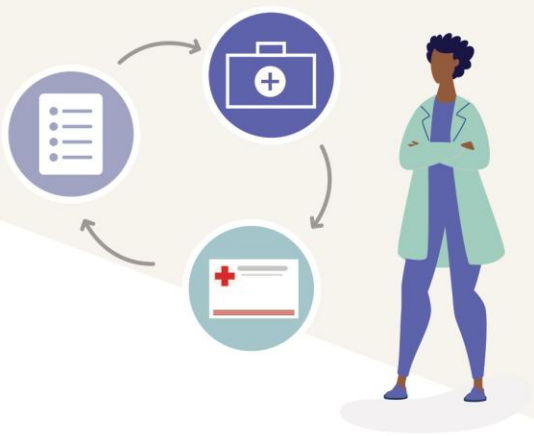


4 Only Pay Your Patient Responsibility

Don't forget to open your mail and compare the EOB to the bill.

If you receive a bill for more than the patient responsibility stated on the EOB, call 888-330-7295 to speak to a ClaimDOC member advocate for next steps. Member advocates are here to support you!

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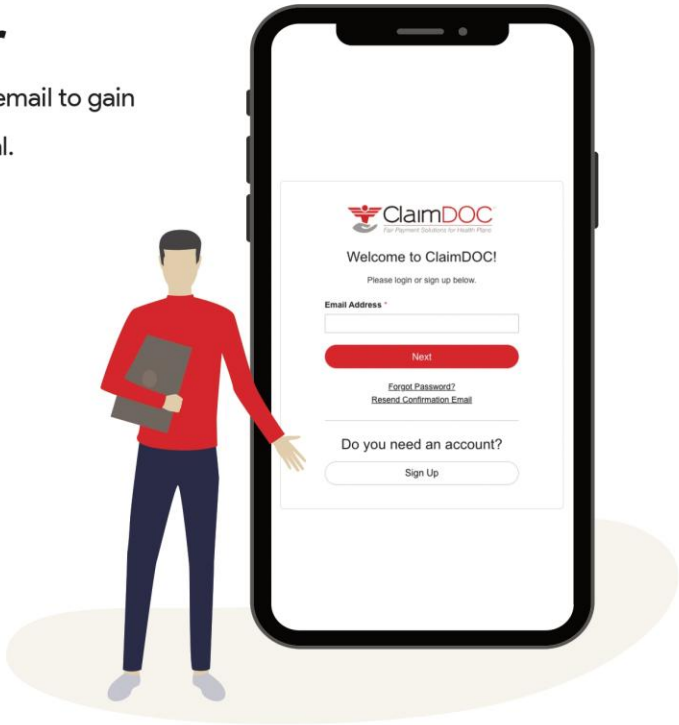
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ClaimDOC Portal

The portal offers easy access to medical plan tools, ensuring members receive reasonably priced care from the provider of their choice. It allows members to nominate providers, search the provider directory, submit a bill and review their plan's educational materials.

Register

Use your personal email to gain access to the portal.



- Submit a Provider Nomination
- Submit a Bill for Review
- Save Your Member ID Card
- Access Plan Education
- Search the Provider Directory

ClaimDOC Is Here for You!

888-330-7295

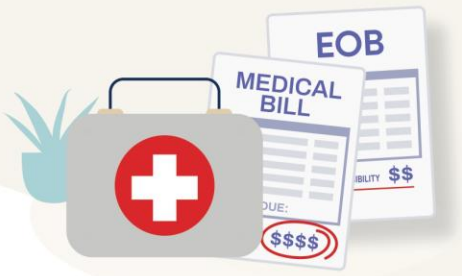
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Estep & Company, Inc.

Understanding Your Bill

Your Estep & Company, Inc. medical plan utilizes a claim review and audit program that determines the fair and reasonable cost for the medical services you receive. For a variety of reasons, your bill may not match your explanation of benefits, such as a balance bill. When you receive a bill, follow the following guidelines.

1. Do NOT pay the bill until you receive an EOB from Edison Health Solutions (Edison).
2. Compare your EOB to your provider bill.
3. Verify the payment from insurance was applied and the total amount due matches your patient responsibility.
4. If the bill and EOB do not match, contact ClaimDOC, who will work directly with providers to resolve any discrepancies.

Example

Your wrist is injured during a pickleball game so you visit a local urgent care clinic.
You're treated by an urgent care doctor and the office submits the claim to your medical plan.

EXPLANATION OF BENEFITS

Urgent Care Visit		$300
Insurance Reduction	-$162	
Plan Payment	-$118	
Patient Responsibility		**$20**

URGENT CARE INVOICE

Billed		$300
Insurance Reduction	$0	
Plan Payment	$118	
Amount You Owe		**$182**

The patient responsibility is $20 but the provider's bill is $182; this is a balance bill. You are not liable for any amount over your patient responsibility. You should only pay the $20 patient responsibility, NOT the provider's invoice. If the provider continues to send bills or other communication regarding the balance bill, immediately inform ClaimDOC.

ClaimDOC Is Here to Help!

888-330-7295 | balancebills@claim-doc.com | portal.claim-doc.com | Monday - Friday 7 AM - 6 PM CST

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ClaimDOC
Fair Payment Solutions for Health Plans

Estep & Company, Inc.

Know Your Patient Responsibility

When you receive a bill from a medical provider, always compare the bill to the explanation of benefits received from your third-party administrator. You are only responsible to pay the patient responsibility provided on the EOB. Your healthcare provider may send a bill stating you owe more than your patient responsibility. This is known as a balance bill, and you need to follow the steps below to ensure you receive the full benefits of your plan.

1 Determine Your Patient Responsibility

Ensure you have paid the amount shown as patient responsibility on your EOB. If you receive a bill that is more than your EOB, contact ClaimDOC to begin the balance bill process.

2 Inform a ClaimDOC Member Advocate

Upload the balance bill to the portal or contact ClaimDOC immediately.

You can reach us Monday through Friday 7 AM – 6 PM CST

balancebills@claim-doc.com | 888-330-7295 | 888-974-1264 | portal.claim-doc.com

3 Complete the Authorization Form and Initiate Balance Bill Process

Sign and return the ClaimDOC member authorization agreement, so ClaimDOC can work with the provider and initiate the dispute process. ClaimDOC will vigorously defend you against collection activity related to a balance bill. **You are not responsible for the amount over your patient responsibility.**

You are also protected by federal and state laws addressing the improper collection of medical debt. The length of time to resolve a balance bill dispute is dependent on the responsiveness of the provider, federal- and/or state-mandated timelines, and other factors. This process requires patience on your part, but your plan protection will continue for the life of the dispute.

4 What Are Your Next Steps?

If you receive subsequent bills even after ClaimDOC sends the initial dispute, send them to your member advocate or ClaimDOC balance bill team immediately. Remember, do not pay any amount above the stated patient responsibility amount identified on your EOB.

Never Pay a Balance Bill

ClaimDOC®
Fair Payment Solutions for Health Plans

Open Your Mail & Communicate

Your medical plan uses a claim review and audit program to determine the fair and reasonable reimbursement for the medical services you receive. ClaimDOC works to reduce your healthcare costs.

The audit performed may have resulted in a reduced payment to your healthcare provider. Most of the time, the payment is accepted. However, the provider may seek to bill you for the reduction.

You are not responsible for the reduction amount!
This is called a balance bill.

If you receive a balance bill from a provider or collection agency, please contact ClaimDOC immediately!

balancebills@claim-doc.com

888-330-7295

Monday – Friday
7 AM – 6 PM CST



Remember to open your mail AND check your provider's online patient portal for updated billing information.

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Estep & Company, Inc.

Collection Protection

888-330-7295 | balancebills@claim-doc.com

If a healthcare provider uses a third-party debt collector to recoup the disputed amount on a balance bill, they must still work with ClaimDOC as part of your plan's balance bill defense. If you receive a collection notice for a balance bill, send it to ClaimDOC immediately. A balance bill specialist will work with you through the process.

What happens if my bill is transferred to a collection agency?

The collection agency will notify you by mail and may also call to discuss the debt. The notification must be sent to ClaimDOC as soon as it is received. ClaimDOC will send the agency a cease-and-desist letter and demand they validate the debt is actually owed by you. Once the collection agency receives this letter, they are required to stop contacting you and provide validation of the disputed debt before resuming any collection activity.

How am I protected?

Before a collection agency can report a disputed debt to a credit bureau, they must complete a proper validation process, which is governed by the Fair Debt Collection Practices Act. ClaimDOC will dispute the balance bill until resolution even if a collection agency improperly reports debt. Resolution requires that any improper credit impairment be reversed and entirely removed from your credit report. If your credit was impaired by medical debt that was properly sent to and disputed by ClaimDOC at your request, formal documentation will be provided to you or other parties describing your plan, the balance bill process, and how the disputed debt is not your financial or legal responsibility.

What should I do if I receive a collection notice?

Notify ClaimDOC immediately. Ensure the patient responsibility amount on your explanation of benefits has been paid. Unpaid amounts of patient responsibility determined by your plan can be reported as a credit impairment. Make sure you have satisfied your patient responsibility as soon as possible.

Collection Notices

ClaimDOC is required by law to respond to collection notices within 30 days of the printed date. If ClaimDOC does not receive your notice in time, its defense may be limited.

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Estep & Company, Inc.

Understanding Your Rights



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Your health benefits are governed by ERISA and a summary plan description. ERISA is a federal law that provides regulations to protect you as a beneficiary and instruct your plan sponsor as to its obligations to protect you and the plan assets (e.g., your premiums). As part of this plan description, the proper reimbursements for medical services you or your family have received as beneficiaries under the plan are specifically defined. In order to meet its fiduciary responsibilities to you and your family, the plan will pay in accordance with the plan description.

If a healthcare provider disagrees with the plan-determined reimbursement amount, they have options to dispute the claim directly with your medical plan through ClaimDOC. Providers may attempt to bill you for this disputed amount. This is a balance bill, and it is not your responsibility. Contact ClaimDOC to discuss all available options before paying a balance bill. ClaimDOC and your medical plan will defend you against any unfounded collection activity related to a disputed balance bill.

Fair Debt Collection Practices Act

Under the Fair Debt Collection Practices Act a debt collector may not:

- Contact you once it receives notice that there is an authorized agent working on your behalf.
- Misrepresent the amount you owe.
- Claim legal action will be taken against you if it's not true.
- Harass you.
- File a report against your credit for a disputed debt without providing a validation of that debt.

The National Consumer Assistance Plan

The National Consumer Assistance Plan provides another layer of protection for consumers related to financial credit and medical debt. This is an agreement that was established between the U.S. attorney general and Equifax, Experian and TransUnion. The intent is to improve data accuracy and quality related to consumer debt. FICO 9 has stated that valid medical debt should not be weighed the same way other consumer debt is weighed in a credit score. NCAP's intent, in part, is to ensure the patient is removed from the middle in disputes between insurance and the provider. In the event NCAP is violated, a complaint to the attorney general in your state may be initiated.

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Balance Bill FAQ

How Do I Contact ClaimDOC?

ClaimDOC®

Address

PO Box 42155
Urbandale, IA 50323

Email

balancebills@claim-doc.com

Phone Number

888- 330-7295

Fax

888-794-1264

What is a balance bill?

Your Estep & Company, Inc. medical plan uses a claim review and audit program that determines the fair and reasonable reimbursement for the medical services you receive. The audit uncovers overcharges and billing errors. As a result, the payment to the provider may be reduced. A balance bill occurs when the provider seeks to collect the reduction amount directly from you.

I received a balance bill from my provider, should I be concerned?

No. Balance bills, sometimes called "surprise bills," are common in the healthcare industry. With traditional plans, the patient is left to fend for themselves or pay the bill. However, your medical plan provides you with balance bill defense. ClaimDOC takes over the burden of reviewing the bill for errors and works directly with the provider so you don't have to. Balance bills are an expected part of the process, and ClaimDOC will guide you every step of the way.

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Am I responsible for paying this bill?

You are only responsible for the out-of-pocket expenses outlined by your medical plan. These expenses include deductibles, copays and coinsurance. The amount you are responsible for paying is listed on the explanation of benefits you receive once your claim is processed. Anything over that amount may be a balance bill.

What if I did not receive an EOB?

Contact your plan administrator or log onto your member portal to view the EOB.

What should I do if I get a balance bill?

Only pay for your patient responsibility as shown on your EOB. Upload your balance bill to the portal or call ClaimDOC as soon as possible. A member advocate will send you an authorization form requesting your signature so ClaimDOC can initiate your plan-sponsored balance bill defense benefit.

What happens once ClaimDOC takes over?

Once you sign the ClaimDOC member authorization agreement, a member advocate will contact the provider to begin discussing the matter and ensure your involvement is limited. Please note that after ClaimDOC starts working with the provider, they may still choose to send you billing statements or may not be able to stop sending them due to their systems autogenerating them. Therefore, you must continue to contact ClaimDOC via phone or mail regarding any communications you receive from your provider about your balance bill.

What if I receive a collection notice?

If you receive a collection notice for a bill that ClaimDOC is disputing, do not panic. ClaimDOC and your medical plan defend you throughout this process. It is important that you notify ClaimDOC as soon as you receive a call or letter from the collection agency. Ensure that you have paid the patient responsibility amount shown on your EOB as unpaid amounts of patient responsibility determined by your plan can be reported as a credit impairment. Please make sure that you have made arrangements with the provider to fulfill your patient responsibility as soon as possible. You are protected by the Fair Debt Collection Practices Act and the National Consumer Assistance Plan.

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Dental

Guardian Life Insurance Co

	Option 1: Low Plan	Option 2: High Plan
Maximum Benefit	$1,000 per year	$1,500 per year
Individual Deductible	$50 per year	$50 per year
Family Deductible	$150 per year	$150 per year
Deductible Waived	For Preventative Services	For Preventative Services
Carryover Benefit	$350 in network	$500 in network
Orthodontics	Not Covered	Not Covered
Provider Network	DentalGuard Preferred	DentalGuard Preferred

DentalGuard Preferred dentists have agreed to certain payment rates and cannot charge you higher rates. Out-of-network dentists can bill you for the difference between the amount paid by the plan and the billed amount. If you visit an out-of-network dentist, you will likely pay more out of pocket.

	Low Plan	High Plan
Coverage	100%	100%
Preventive	♦Oral Exams (twice/12 mos.) ♦Cleanings (twice/12 mos.) ♦X-Rays (Full-mouth series once/24 mos.) ♦Fluoride Treatment (to age 16, twice/12 mos.) ♦Sealants (to age 16, once/36 mos.) ♦Space Maintainers/Harmful Habit Appliances	
Coverage	60%	80%
Basic Care	♦Fillings (include posterior composites) ♦Perio Maintenance Procedure (once/3 mos.) ♦Combined Cleanings/Perio Maintenance (4 in a 12 consecutive months period) ♦Simple Extractions w General Anesthesia ♦X-Rays	
Coverage	40%	50%
Major Care	♦Bridges & Dentures ♦Endodontics ♦Root Canal ♦Implants ♦Crowns ♦Complex Extractions ♦Repair & Maintenance of Crowns, Bridges & Dentures ♦Periodontal Services (eg Scaling and Root Planing) ♦Periodontal Surgery ♦Inlays, Onlays & Veneers	

Frequency limits, age requirements, and other restrictions may apply to these benefits. Contact Guardian prior to receiving services to be sure you understand the benefits and your potential costs.

Find a Dentist and Manage Your Benefits

Find a DentalGuard Preferred dentist, access your ID card, manage your benefits, and check your claims by visiting www.guardianananytime.com and clicking "My Account".

Your Cost per Paycheck (26 pays per year)		
	Low Plan	High Plan
Employee Only	$8.16	$9.80
Employee + Spouse	$16.58	$19.90
Employee + Child(ren)	$22.14	$25.21
Family	$32.70	$37.68

Vision

Guardian Life Insurance Co

Plan Provisions	
Exam Co-Pay	$10
Standard Materials Co-Pay	$25
Provider Network	VSP – Full Feature

Service Frequencies	
Eye Exams	Once per calendar year
Lenses (for Glasses)	Once per calendar year
Contact Lenses	Once per calendar year
Frames	Once per calendar year

Amount You Pay *after applicable co-pay*		
	In Network	Out of Network
Eye Exam	$0	Charges that exceed $39
Single Vision Lenses	$25	Charges that exceed $23
Bifocal Lenses	$25	Charges that exceed $37
Trifocal Lenses	$25	Charges that exceed $49
Lenticular Lenses	$25	Charges that exceed $64
Frames	$130 + 20% discount on balance	Charges that exceed $46
Frames at Costco, Walmart, or Sam's Club	$70	N/A
Elective Contact Lenses (materials)	Charges that exceed $130	Charges that exceed $100
Elective Contact Lenses (eval and fitting)	$60	Included in materials allowance
Medically Necessary Contact Lenses	$0	Charges that exceed $210

Find an Eye Care Provider and Manage Your Benefits
Visit www.vsp.com/eye-doctor to find a VSP network participating provider. Access your ID card, manage your benefits, and check your claims by visiting www.guardianananytime.com and clicking "My Account".

Your Cost per Paycheck (26 pays per year)	
Employee Only	$2.76
Employee + Spouse	$5.52
Employee + Child(ren)	$6.24
Family	$9.73

Employee Basic Life and AD&D

Guardian Life Insurance Co

New!

ADDED BENEFITS

Estep & Company, Inc. is pleased to offer all eligible employees a Basic Life and AD&D policy. This policy provides financial protection in the event of death or qualifying accidental injury.

This is automatic coverage provided at NO COST TO YOU.

Plan Provisions		
Life Insurance Benefit	$10,000	
AD&D Benefit	$10,000	
Benefit Reduction Schedule *Occurs on the insured's birthday*	Age 65: Benefit is reduced by 35% Age 75: Benefit is reduced by 75%	Age 70: Benefit is reduced by 60% Age 80: Benefit is reduced by 85%

Converting Your Life Coverage

If your employment ends or you retire, you may have the option to continue your life insurance coverage by converting to an individual plan. This allows you to keep your coverage without answering medical questions or going through underwriting review. Coverage options and rates may differ from those available while employed.

In order to convert your coverage, you must submit an application and pay the relevant premiums within 30 days from the date you end your employment. Applications and premiums are submitted directly to the insurance carrier.

If you decide to convert your coverage or want to learn more about your options, contact Guardian Life Insurance Company at 800-627-4200 to request a Notice of Conversion Privilege form.

Note – Other plans in the Estep & Company, Inc. benefits package may also be eligible for conversion. Contact Guardian Life Insurance Company or Benefit Innovations for more information.

Voluntary Life and AD&D

Guardian Life Insurance Co

OPEN ENROLLMENT
Read the following provisions to learn how you can take advantage of this year's enrollment.

Electing Coverage
If you are a new employee, you may elect Voluntary Life coverage for yourself, your spouse, and/or your child(ren) up to the Guarantee Issue amount noted below. If you elect an amount that exceeds Guarantee Issue, you will be required to submit a health questionnaire and could be denied the excess coverage amount.
If you previously waived Voluntary Life coverage for yourself, your spouse, and/or your child(ren), this is your opportunity to enroll. You may elect coverage up to the Guarantee Issue amount noted below without completing a health questionnaire. If you elect an amount that exceeds Guarantee Issue, you will be required to submit a health questionnaire and could be denied the excess coverage amount.
If you have existing Employee coverage, you may increase your coverage amount up to the Guarantee Issue amount noted below. If you elect an amount that exceeds Guarantee Issue, you will be required to submit a health questionnaire and could be denied the excess coverage amount.
If you have existing Employee or Spouse coverage that already exceeds the Guarantee Issue amount noted below, you will be required to submit a medical questionnaire for any coverage increases, regardless of amount.
If you choose to waive Voluntary Life coverage now, you may be required to submit a medical questionnaire for any future enrollment.

Provisions	Employee	Spouse	Child
Increments	$10,000	$5,000	$10,000
Maximum	$300,000	$150,000 *to 100% of Employee benefit*	$10,000
Guarantee Issue	$200,000	$50,000	$10,000

Per Paycheck Rates per $1,000 of coverage (26 pays per year)										
Age*	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate	$0.027	$0.030	$0.039	$0.053	$0.078	$0.132	$0.207	$0.345	$0.685	$1.131

** Spouse rate is based on Employee's age*

Per Paycheck – Child Voluntary Life	
Benefit	Cost
$10,000	$0.733

Benefit Reduction Schedule			
Reduction occurs on the insured person's birthday			
Age 65: 35%	Age 70: 60%	Age 75: 75%	Age 80: 85%

Short Term Disability

Guardian Life Insurance Co

OPEN ENROLLMENT
Read the following provisions to learn how you can take advantage of this year's enrollment.

Electing Coverage
If you are a new employee, you may elect Short Term Disability without answering any medical questions.
If you previously waived Short Term Disability, you may elect coverage now without answering any medical questions.
If you choose to waive Short Term Disability and decide to elect the coverage during a later enrollment, you may be required to complete a medical questionnaire for underwriting review. Coverage will not be in effect until you are approved by underwriting.

Plan Provisions	
Benefit Amount	60% of weekly pre-disability earnings
Maximum Benefit	$1,000 per week
Elimination Period	Benefits begin on 8th day of injury or sickness
Maximum Benefit	12 weeks
Pre-Existing Exclusion	3 months prior / 12 months insured

Per Paycheck Rates per $10 of Weekly Benefit (26 pays per year)									
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
Rate	$0.127	$0.159	$0.270	$0.230	$0.151	$0.151	$0.183	$0.222	$0.318

Calculate Your Weekly Benefit and Per Paycheck Cost for Short Term Disability

	÷	52	=		×	0.60	=	
Your Annual Income				Weekly Income				Weekly Benefit ($1,000 max)

	÷	10	=		×		=	
Weekly Benefit ($1,000 max)						Your Rate		Your Cost per Paycheck

Long Term Disability

Guardian Life Insurance Co

OPEN ENROLLMENT
Read the following provisions to learn how you can take advantage of this year's enrollment.

Electing Coverage
If you are a new employee, you may elect Long Term Disability without answering any medical questions.
If you previously waived Long Term Disability, you may elect coverage now without answering any medical questions.
If you choose to waive Long Term Disability and decide to elect the coverage during a later enrollment, you may be required to complete a medical questionnaire for underwriting review. Coverage will not be in effect until you are approved by underwriting.

Plan Provisions	
Benefit Amount	60% of monthly pre-disability earnings
Maximum Benefit	$6,000 per month
Definition of Disability	24 months – own occupation
Elimination Period	90-days
Pre-Existing Exclusion	3 months prior / 12 months insured
Benefits Duration	Social Security normal retirement age – If over age 62, see plan document

Per Paycheck Rates per $100 of Covered Monthly Income (26 pays per year)									
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Rate	$0.038	$0.046	$0.092	$0.157	$0.230	$0.349	$0.452	$0.559	$0.521

Calculate Your Monthly Benefit and Per Paycheck Cost for Long Term Disability

	÷ 12	=		× 0.60	=			
Your Annual Income			Monthly Income ($10,000 max)			Your Monthly Benefit		
	÷ 100	=		×		=		
Monthly Income ($10,000 max)					Your Rate		Your Cost per Paycheck	

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Accident

Guardian Life Insurance Co

AD&D Benefits	
Accidental Death and Dismemberment	Employee: $50,000 | Spouse: $25,000 | Child: $12,500
Quadriplegia	100% of AD&D
Hemiplegia/Paraplegia	50% of AD&D
Common Carrier	200% of AD&D
Common Disaster	200% of Spouse AD&D
Loss of sight – both eyes	100% of AD&D
Loss of speech and hearing (both ears)	100% of AD&D
Loss of cognitive function	100% of AD&D

Accident Benefits	
Ambulance	Air: $1,000 / Ground:
Burns (2nd or 3rd degree)	Up to $6,000
Burn Skin Graft	50% of burn benefit
Coma	$10,000
Concussion	$200
Diagnostic Exam (major)	$200
Dislocations	Up to $4,000
Doctor Follow-Up Visits	$50–up to 6 visits
Emergency Room	$100
Eye Injury	$200
Fractures	Up to $4,000
Hospital Admission	$1,000

Accident Benefits	
Hospital Confinement	$250/day–up to 1 year
ICU Admission	$2,000
ICU Confinement	$500/day–up to 15 days
Initial Office Visit	$75
Laceration	Up to $400
Medical Appliance	Up to $300
Outpatient Therapies	$25/day–up to 10 days
Surgery (specific)	Up to $1,250
Surgery (exploratory)	$150
Tendon/Ligament	1: $100 / 2+: $200
X-Ray	$40
Child Organized Sports	25% increase to benefits

Plan Provisions	
Plan Exclusions	This is a summary of the Accident benefits that may be available to you. For details on coverage, benefits, and exclusion, refer to the official plan document.
Wellness Benefit	Per year benefit for completing certain routine wellness screenings. Employee $50 / Spouse $50 / Child $50

This page contains an abridged list of available benefits. Refer to the plan document for a complete list of benefits available to you, benefit amounts, requirements, and a complete list of plan exclusions.

Your Cost per Paycheck (26 pays per year)	
Employee Only	$3.87
Employee + Spouse	$5.96
Employee + Child(ren)	$6.55
Family	$8.64

Critical Illness

Guardian Life Insurance Co

Benefit Options		
Employee	Spouse	Child
$10,000 | $20,000 | $30,000	50% of Employee benefit	50% of Employee benefit

Critical Illnesses – % of Lump Sum Benefit		
Condition	1st occurrence	2nd occurrence
Cancer and Benign Tumors	Up to 100%	Up to 100%
Lung and Vascular disorders	Up to 100%	Up to 100%
Additional Disorders	Up to 100%	Up to 100%
Chronic Disorders	Up to 30%	N/A
Heart Disorders	Up to 100%	Up to 100%
Neurological Disorders	Up to 100%	N/A
Childhood Disorders	Up to 100%	N/A

Plan Provisions	
Plan Exclusions	This policy includes exclusions, limitations, reductions, and special requirements that may affect eligibility and benefits. Refer to the plan document or contact Guardian for complete details of your benefits and coverage.
Wellness Benefit	Per year benefit for completing certain routine wellness screenings. Employee $50 / Spouse $50 / Child $50

This page contains an abridged list of available benefits. Refer to the plan document for a complete list of benefits available to you, benefit amounts, requirements, and a complete list of plan exclusions.

Employee and Spouse Rates per Paycheck (52 pays per year)						
	Employee	*Spouse*	*Employee*	*Spouse*	*Employee*	*Spouse*
Benefit	$10,000	$5,00	$20,000	$10,000	$30,000	$15,000
Age <25	$1.02	$0.51	$2.03	$1.02	$3.05	$1.52
25-29	$1.43	$0.72	$2.86	$1.43	$4.29	$2.15
30-34	$2.22	$1.11	$4.43	$2.22	$6.65	$3.32
35-39	$2.58	$1.29	$5.17	$2.58	$7.75	$3.88
40-44	$3.60	$1.80	$7.20	$3.60	$10.80	$5.40
45-49	$5.17	$2.58	$10.34	$5.17	$15.51	$7.75
50-54	$7.62	$3.81	$15.23	$7.62	$22.85	$11.42
55-59	$10.66	$5.33	$21.32	$10.66	$31.98	$15.99
60-64	$15.42	$7.71	$30.83	$15.42	$46.25	$23.12
65-69	$21.83	$10.92	$43.66	$21.83	$65.49	$32.75
70+	$31.66	$15.83	$63.32	$31.66	$94.98	$47.49

**Spouse rate is based on Employee's age*

Hospital Indemnity

Guardian Life Insurance Co

Description	Benefit	Maximum Benefit
Hospital admission for covered condition	$1,000	Once per member per year
ICU admission for covered condition	$1,000	Once per member per year
Daily hospital stay	$100	30 days per member per calendar year
Daily ICU stay	$100	30 days per member per calendar year

Plan Provisions	
Plan Exclusions	This policy includes exclusions, limitations, reductions, and special requirements that may affect eligibility and benefits. Refer to the plan document or contact Guardian for complete details of your benefits and coverage.
Wellness Benefit	Per year benefit for completing certain routine wellness screenings. Employee $50 / Spouse $50 / Child $50



This page contains an abridged list of available benefits. Refer to the plan document for a complete list of benefits available to you, benefit amounts, requirements, and a complete list of plan exclusions.

Your Cost per Paycheck (26 pays per year)	
Employee Only	$6.41
Employee + Spouse	$15.12
Employee + Child(ren)	$12.66
Family	$20.70

GuidanceResources®

For Employees: What is the Employee Assistance Program?



The Employee Assistance Program is provided by ComPsych® GuidanceResources® and offers counseling, legal and financial consultation, work-life assistance and crisis intervention services to you and your household family members.

Why is your employer providing access to an EAP?

Because your employer cares about you and your dependents. The EAP can be used free of charge as needed when you or your dependents are facing emotional, financial, legal or other concerns.

Are the services confidential?

Yes, the EAP is strictly confidential. No information about your participation in the program is provided to your employer.

Why might my family or I use the services?

There are many reasons to use these services. You may wish to contact the EAP if you:

- Are feeling overwhelmed by the demands of balancing work and family
- Are experiencing stress, anxiety or depression
- Are dealing with grief and loss
- Need assistance with child or elder care concerns
- Have legal or financial questions
- Have concerns about substance abuse for yourself or a dependent

What happens when I call?

When you call, you will speak with a GuidanceConsultant℠, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant℠ will provide the name of a counselor who can assist you. You can then set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit.

What counseling services does the EAP provide?

3 face-to-face or virtual sessions per person, per issue, per year

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

Can my children use the EAP?

Yes. The EAP is a confidential benefit for employees and their household family members.

ComPsych® GuidanceResources® Worldwide | Guardian®

24/7 Live Assistance:
Call: (855) 239.0743
TRS: Dial 711

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: Guardian

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GuidanceResources®

Guide to Using GuidanceResources® Online

First-time users, follow these simple instructions and start exploring the resources offered to you on GuidanceResources® Online.

- Go to **guidanceresources.com** to reach the website.
- Once on the guidanceresources.com home page, click the **Register** tab.
- Enter your **Organization Web ID (web ID: Guardian)** and click the Register button.
- You will then be asked to enter a **User Name** and **Password**. Both can be anything you would like them to be but should be something you will remember. The **User Name** (often your name) must be at least six characters long and should have no spaces (for example: joesmith). The **Security Questions** are meant to prompt you if you forget your password. You must select the button verifying that you are at least 13 years of age, as required by federal law. Be sure to read the **Terms of Use** and click inside the check box to indicate your agreement to those terms. Make sure that you complete all fields that have red asterisks, as these are required fields. When you've finished, click the **Submit** button at the bottom of the page. You should now be on the website.

For Future Logins

You will only need to remember your **User Name** and **Password**. When you get to step 2 above, instead of clicking on the **Register** tab, use the **Login** section and enter your **User Name** and **Password** and click the **Login** button. This will take you directly to GuidanceResources® Online.

If you have any problems registering or logging into GuidanceResources® Online, email Member Services at **memberservices@compsych.com**.



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24/7 Live Assistance:
Call: (855) 239.0743
TRS: Dial 711

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: Guardian

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Guardian® is a registered trademark of The Guardian Life Insurance Company of America, New York, NY. 2023-160441 (8/25) Legal/financial assistance and resources services are not available in the state of New York. The Employee Assistance Program is a suite of services solely created and offered by ComPsych. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and ComPsych reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or any action against Guardian, ComPsych, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.

Required Notices

The Estep & Company, Inc. group benefit plan is obligated to make certain notices and materials available to you.

→ You may obtain a copy of these notices at any time by logging in to your Employee Navigator account at www.employeenavigator.com/benefits/account/login and clicking *Document Library*

→ You may also request digital and/or hardcopies of these notices by contacting Estep & Company, Inc.'s Human Resources Manager, Jeni Moffatt at jmoffatt@estep-co.com or 812-378-7158

Following is a summary of the notices available to you.

Notice of Non-Grandfathered Status
This notice describes the ACA guidelines that apply to your plan because it is considered non-grandfathered.

Medicare Part D Non-Creditable Coverage Notice
This notice informs you that your plan is considered *non-creditable* according to Medicare Part D requirements. This information is important when you are considering joining a Medicare drug plan.

Notice of Privacy Practices
The Notice of Privacy Practices describes how your health plan may use and share your information and describes your health privacy rights under the plan.

Notice to Employees of Marketplace Coverage Options
The purpose of this notice is to make you aware of the Health Insurance Marketplace and to confirm the Estep & Company, Inc. medical plan meets the minimum value standard and is considered affordable.

COBRA – Continuation of Coverage Notice
This notice outlines how you or your family members may elect to continue your coverage when you have lost coverage because of certain qualifying events.

Medicaid and the Children's Health Insurance Program (CHIP)
The CHIP Notice provides information about health plan premium assistance for individuals and their dependents who are eligible for their employer's health plan but are unable to afford the premium.

Women's Health and Cancer Rights Act Notice (WHCRA)
This notice outlines the benefits and coverage available under the health plan for mastectomies and/or breast reconstruction services and the patient's rights following such surgeries.

Newborns and Mothers Health Protection Act (NMHPA)
The NMHPA notice outlines the protections in place for mothers and their newborn children with regard to the length of the hospital stay following childbirth.

Your Right to Appeal
This notice describes your right to appeal if your plan refuses to pay a claim or ends your coverage.

No Surprises Billing Act
This notice describes your rights and protections again surprise medical bills.

Summary of Benefits and Coverage (SBC)
The SBC is a snapshot of the plan's benefits, covered services, and other important information.

Summary Plan Description (SPD)
The SPD outlines what the plan does and does not cover and how the plan operates.

COMPLETE YOUR ENROLLMENT IN EMPLOYEE NAVIGATOR

Already have an Employee Navigator account? Visit www.employeenavigator.com/benefits/account/login to complete your benefits enrollment.

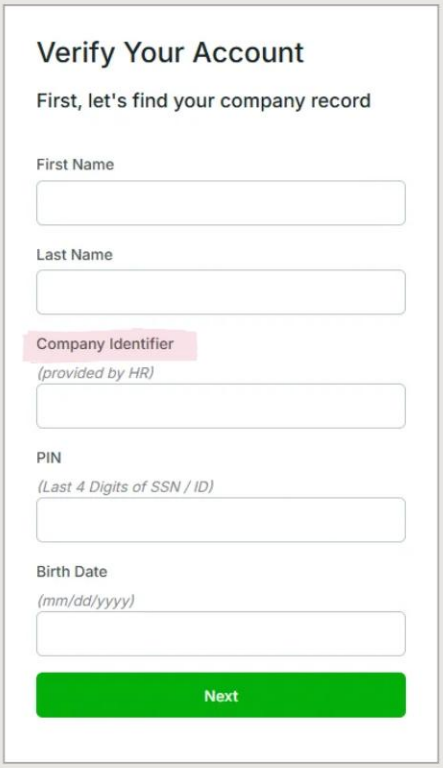
New to Employee Navigator? Follow the steps below to create an account and complete your enrollment.

1. Visit: www.employeenavigator.com/benefits/account/register

2. Enter your personal details.

* *Your **Company Identifier** is: **EstepandCo***

3. Click **Next** to finish your account setup and begin your benefits enrollment.



? **Need help?**

Contact your Human Resources team or reach out to Benefit Innovations.

Contacts

Diversified Group		Medical Plan Administrator
ID cards, coverage info, check claims	888-322-2524	www.dgb-online.com

Innovative Care Management		Pre-Certification – Case Management
Call prior to any medical procedures or admissions	800-862-3338	nurse@innovativecare.com

ClaimDoc		Provider and Balance Bill Support
Nominate providers and submit balance bills	888-330-7295	membersupport@claim-doc.com

Teladoc		Virtual Care
No cost virtual care online or by phone	800-835-2362	www.teladoc.com

ProAct		Pharmacy Benefits Manager
Filling prescriptions at a pharmacy or by mail order	866-287-9885	www.proactrx.com

OptiMed		Specialty and High-Cost Drug Sourcing
Obtain high-cost prescriptions for $0	877-884-0998	www.optimedhp.com/specialty-pharmacy

Regenexx		Alternative Orthopedic Treatment
Contact Regenexx before an orthopedic procedure	866-506-7953	regenexxbenefits.com/estep-co

Healthcare2U		Direct Primary Care
DPCplus primary care, urgent care, and virtual care	800-496-2805	*Call to request care or book appointments*

Guardian Dental – *Group ID# 00105988*		Dental Benefits
DentalGuard Preferred	888-400-9304	www.guardiananytime.com

Guardian Vision – *Group ID# 00105988*		Vision Benefits
VSP Network	866-939-3633	www.vsp.com/eye-doctor

Guardian Life Insurance Co – *Group ID#'s 00105988 & 01105988*		Other Benefits
Basic and Voluntary Life, STD, LTD, Term Disability, Accident, Critical Illness, Hospital Indemnity	866-679-3054	www.guardiananytime.com

Benefit Innovations			Benefit Advisor Partners
Hannah Pipes	Client Services Consultant	317-663-4046	hannahp@benefiti.com
Amber Blevins	Director of Client Services	317-663-4044	amberb@benefiti.com
Wanza Schweiger	Managing Partner	317-663-4041	wanzas@benefiti.com

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