



# **EMPLOYEE BENEFITS GUIDE**

Plan Year: 2024-2025

Shop Concepts LLC

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This guide is an overview of your health benefits and does not provide a complete description of all the benefit provisions. Please refer to the summary plan descriptions for more detailed information.

The information provided by the carriers supersedes the contents of this booklet provided by Endeavor Risk Advisors.

# Welcome to Open Enrollment

Dear Employee:

We are committed to supporting the health and wellness of our team of employees. Our annual employee benefits insurance is renewing effective **12/01/2024** and will be effective through **11/30/2025**.

This benefits guide is designed to help you understand the available benefit options so you can make the best benefit elections for you and your family. It provides a comprehensive overview of your benefits package, including eligibility, election periods, and costs. In addition, the guide offers descriptions and detailed explanations of each medical plan design.

Our goal is to, as a group, be efficient consumers of healthcare. This will help keep you from wasting money when consuming services and help make the process more efficient as well.

If you have any questions about any of the benefits mentioned in this guide or need assistance please reach out to our benefits consultant, Lisa Burkham with Endeavor Risk Advisors, at [lisa@endeavorrisk.com](mailto:lisa@endeavorrisk.com).

Sincerely, \_\_\_\_\_

Your Benefits Team

# Eligibility and Mid-Year Changes

## Who is Eligible?

All regular full-time employees working at least 30 hours per week in an active payroll status are eligible for the benefits listed. The following family members are also eligible for coverage:

- Your spouse (the person to whom you are legally married under state law)
- Your children under age 26 unless incapacitated due to a disability and primarily dependent on you for support

## Who is Not Eligible?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, siblings
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside of the United States

## When does Coverage Begin for New Hires?

The date you are eligible to participate in these health benefits is the **first of the month after date of hire**. Employees must make elections during the first 30 days of employment to ensure you receive your ID cards in a timely manner.

## Enrollment Periods

After your initial hire date, Open Enrollment is the only time during the year employees can make changes to their benefit elections without a qualifying event.

## How to make changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period.

Notify Human Resources within 30 days if you experience one of the following qualifying events and would like to make changes to your coverage.

Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

# Contacts



972-559-0461

[clientservice@endeavorrisk.com](mailto:clientservice@endeavorrisk.com)

Enrollment Questions: Lisa Burkham, Benefits Consultant

[lisa@endeavorrisk.com](mailto:lisa@endeavorrisk.com)

	Carrier / TPA	Contact	Policy Number
Medical	Blue Cross Blue Shield	800-521-2227	331147
Dental	Blue Cross Blue Shield	800-521-2227	331147
Vision	Blue Cross Blue Shield	877-442-4207	VF027849
Voluntary Life	Blue Cross Blue Shield	877-442-4207	VF027849
Flexible Spending	ABY Benefits	877-731-3532	

# BCBS Plan MTBCP310H – HDHP (HSA)

Plan Features	PPO Plan	
	In-Network	Out-of-Network*
Deductible (per calendar year)	Individual: \$4,500 Family: \$9,000	Individual: \$9,000 Family: \$20,000
Coinsurance	80%	60%
Out-Of-Pocket Max (includes deductible, coinsurance, & copays)	Individual: \$6,900 Family: \$13,800	Individual: Unlimited Family: Unlimited
Preventive Care	\$0 Copay	Pay Full Cost
Virtual Visits (Call BCBSTX)	20% after Deductible	40% after Deductible
Primary Office Visit (general practice, internal medicine, pediatrics, OB-GYN)	20% after Deductible	40% after Deductible
Specialist Office Visit	20% after Deductible	40% after Deductible
Urgent Care Facility	20% after Deductible	40% after Deductible
Emergency Services	20% after Deductible	40% after Deductible
Diagnostic Lab & X-rays	20% after Deductible	40% after Deductible
Hospitalization	20% after Deductible	40% after Deductible
Prescription Costs		
Tier 1	90% after Deductible	50% allowable amount minus copay after Deductible
Tier 2	90% after Deductible	50% allowable amount minus copay after Deductible
Tier 3	80% after Deductible	50% allowable amount minus copay after Deductible
Tier 4	70% after Deductible	50% allowable amount minus copay after Deductible

\* Out-of-Network providers can balance bill members for any services incurred out of the network. These costs are in addition to the benefits listed.

## BCBS Plan MTBCP023 – Blue Choice PPO

Plan Features	PPO Plan	
	In-Network	Out-of-Network*
Deductible (per calendar year)	Individual: \$2,500 Family: \$7,500	Individual: \$5,000 Family: \$15,000
Coinsurance	80%	60%
Out-Of-Pocket Max (includes deductible, coinsurance, & copays)	Individual: \$5,500 Family: \$14,700	Individual: Unlimited Family: Unlimited
Preventive Care	\$0 Copay	Pay Full Cost
Virtual Visits (Call BCBSTX)	\$0 Copay	N/A
Primary Office Visit (general practice, internal medicine, pediatrics, OB-GYN)	\$30 Copay	40% after Deductible
Specialist Office Visit	\$60 Copay	40% after Deductible
Urgent Care Facility	\$75 Copay	40% after Deductible
Emergency Services	\$500 Copay, then 20% after Deductible	
Diagnostic Lab & X-rays	20% after Deductible	40% after Deductible
Hospitalization	20% after Deductible	40% after Deductible
Prescription Costs		
Preferred Pharmacy Prescription Costs	\$0/\$10/\$50/\$100	50% allowable amount minus copay after Deductible
Non-Preferred Pharmacy Prescription Costs	\$10/\$20/\$70/\$120	50% allowable amount minus copay after Deductible

\* Out-of-Network providers can balance bill members for any services incurred out of the network. These costs are in addition to the benefits listed.

## BCBS Plan MTBCP034 – Blue Choice PPO

Plan Features	PPO Plan	
	In-Network	Out-of-Network*
<b>Deductible</b> (per calendar year)	Individual: \$4,000 Family: \$12,000	Individual: \$10,000 Family: \$20,000
<b>Coinsurance</b>	80%	50%
<b>Out-Of-Pocket Max</b> (includes deductible, coinsurance, & copays)	Individual: \$7,900 Family: \$15,800	Individual: Unlimited Family: Unlimited
<b>Preventive Care</b>	\$0 Copay	Pay Full Cost
<b>Virtual Visits</b> (Call BCBSTX)	\$0 Copay	N/A
<b>Primary Office Visit</b> (general practice, internal medicine, pediatrics, OB-GYN)	\$35 Copay	50% after Deductible
<b>Specialist Office Visit</b>	\$70 Copay	50% after Deductible
<b>Urgent Care Facility</b>	\$75 Copay	50% after Deductible
<b>Emergency Services</b>	\$500 Copay, then 20% after Deductible	
<b>Diagnostic Lab &amp; X-rays</b>	20% after Deductible	50% after Deductible
<b>Hospitalization</b>	20% after Deductible	50% after Deductible
<b>Prescription Costs</b>		
Preferred Pharmacy Prescription Costs	\$0/\$10/\$50/\$100	50% allowable amount minus copay after Deductible
Non-Preferred Pharmacy Prescription Costs	\$10/\$20/\$70/\$120	50% allowable amount minus copay after Deductible

\* Out-of-Network providers can balance bill members for any services incurred out of the network. These costs are in addition to the benefits listed.



## BCBS Plan MTBCP043 – Blue Choice PPO

Plan Features	PPO Plan	
	In-Network	Out-of-Network*
Deductible (per calendar year)	Individual: \$6,000 Family: \$15,800	Individual: \$10,000 Family: \$20,000
Coinsurance	100%	50%
Out-Of-Pocket Max (includes deductible, coinsurance, & copays)	Individual: \$7,900 Family: \$15,800	Individual: Unlimited Family: Unlimited
Preventive Care	\$0 Copay	Pay Full Cost
Virtual Visits (Call BCBSTX)	\$0 Copay	N/A
Primary Office Visit (general practice, internal medicine, pediatrics, OB-GYN)	\$40 Copay	50% after Deductible
Specialist Office Visit	\$80 Copay	50% after Deductible
Urgent Care Facility	\$75 Copay	50% after Deductible
Emergency Services	\$500 Copay, then 0% after Deductible	
Diagnostic Lab & X-rays	0% after Deductible	50% after Deductible
Hospitalization	0% after Deductible	50% after Deductible
Prescription Costs		
Preferred Pharmacy Prescription Costs	\$0/\$10/\$50/\$100	50% allowable amount minus copay after Deductible
Non-Preferred Pharmacy Prescription Costs	\$10/\$20/\$70/\$120	50% allowable amount minus copay after Deductible

\* Out-of-Network providers can balance bill members for any services incurred out of the network. These costs are in addition to the benefits listed.



## BCBS Dental DTNLM38 - Base Plan

Calendar Year Deductible: \$50 Individual / \$150 Family		
Coverage	Network	Non-Network
<b>Diagnostic</b> <ul style="list-style-type: none"> <li>○ Periodic Oral Evaluations</li> <li>○ X-rays, Bitewing</li> <li>○ Comprehensive Oral Evaluations</li> </ul>	100%	100%
<b>Preventive</b> <ul style="list-style-type: none"> <li>○ Cleanings</li> <li>○ Topical Fluoride applications</li> </ul>	100%	100%
<b>Basic</b> <ul style="list-style-type: none"> <li>○ Amalgams</li> <li>○ Resin based composite restorations</li> <li>○ Non-surgical extractions</li> <li>○ Non-surgical Periodontal services</li> <li>○ General anesthesia</li> </ul>	80%	80%
<b>Major</b> <ul style="list-style-type: none"> <li>○ Endodontic Services</li> <li>○ Oral Surgery Services</li> <li>○ Surgical Periodontal Services</li> <li>○ Major Restorative Services</li> <li>○ Prosthodontic Services</li> </ul>	50%	50%
<b>Calendar Year Maximum</b>	\$1,500 per covered person	
<b>Orthodontics (Adult &amp; Dependent children)</b>	50%	
<b>Orthodontics Lifetime Maximum</b>	\$1,000 per covered person	

Dental implants are not covered.

The above is a listing of common services available through your network of Contracting Dentists.

The Member's share of the cost is determined by whether care is received from a Contracting or Non-Contracting Dentist.

Out of Network Reimbursement is MAC.

# BCBS Dental DTNHR33 - Buy Up Plan

Calendar Year Deductible: \$50 Individual / \$150 Family		
Coverage	Network	Non-Network
<b>Diagnostic</b> <ul style="list-style-type: none"> <li>○ Periodic Oral Evaluations</li> <li>○ X-rays, Bitewing</li> <li>○ Comprehensive Oral Evaluations</li> </ul>	100%	100%
<b>Preventive</b> <ul style="list-style-type: none"> <li>○ Cleanings</li> <li>○ Topical Fluoride applications</li> </ul>	100%	100%
<b>Basic</b> <ul style="list-style-type: none"> <li>○ Amalgams</li> <li>○ Resin based composite restorations</li> <li>○ Non-surgical extractions</li> <li>○ Non-surgical Periodontal services</li> <li>○ General anesthesia</li> <li>○ Endodontic Services</li> <li>○ Oral Surgery Services</li> <li>○ Surgical Periodontal Services</li> </ul>	80%	80%
<b>Major</b> <ul style="list-style-type: none"> <li>○ Major Restorative Services</li> <li>○ Prosthodontic Services</li> <li>○ Implants</li> </ul>	50%	50%
<b>Calendar Year Maximum</b>	\$1,500 per covered person	
<b>Orthodontics (Adult &amp; Dependent children)</b>	50%	
<b>Orthodontics Lifetime Maximum</b>	\$1,500 per covered person	

The above is a listing of common services available through your network of Contracting Dentists.

The Member's share of the cost is determined by whether care is received from a Contracting or Non-Contracting Dentist.

Vision – 8-12/12/24 \$130 600V		
Coverage	Network	Non-Network
<b>Eye Examination</b> <ul style="list-style-type: none"> <li>Comprehensive exam of visual functions &amp; prescription of corrective eyewear</li> </ul>	\$10 Copay	Up to \$30
<b>Materials / Eyewear</b> <b>Standard Corrective Lenses</b> <ul style="list-style-type: none"> <li>Single Vision</li> <li>Lined Bifocal</li> <li>Lined Trifocal</li> <li>Lenticular</li> </ul>	\$25 copay	Up to \$25 Up to \$40 Up to \$55 Up to \$55
<b>Frame Allowance</b> (You will receive 20% off any amount over your allowance.)	\$130 allowance	Up to \$65
<b>Contact Lenses (in lieu of glasses)</b> <ul style="list-style-type: none"> <li>Contact Fitting &amp; Evaluation</li> <li>Elective Lenses (You will receive 15% off any amount over your allowance.)</li> <li>Necessary</li> </ul>	Up to \$40 Standard  \$130 allowance  Covered in full	N/A  Up to \$104  Up to \$210
<b>Frequency</b> <ul style="list-style-type: none"> <li>Examinations</li> <li>Standard Corrective Lenses</li> <li>Frames</li> <li>Contact Lenses</li> </ul>	1 per 12 months 1 per 12 months 1 per 24 months 1 per 12 months	



# Voluntary Life Insurance and AD&D

When you enroll yourself or yourself and your dependents in this Voluntary Life/AD&D, you pay the full cost through payroll deductions. You must enroll to enroll your dependents.

	<b>Employee</b>	<b>Spouse</b>	<b>Child</b>
<b>Life Coverage: provides a benefit in the event of death Schedules:</b>	Increments of \$10,000	Increments of \$5,000	Flat Amount: \$1,000, \$2,000, \$4,000, \$5,000, or \$10,000
<b>Non Medical Maximum</b>	\$100,000	\$25,000	\$10,000
<b>Overall Benefit Maximum</b>	The lesser of 5 times Your Basic Annual Earnings, or \$500,000	Not to exceed 50% of Employees coverage	\$10,000
<b>AD&amp;D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident Schedules:</b>	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)
<b>AD&amp;D Maximum</b>	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage
<b>Employee Contribution</b>	100%	100%	100%

Any Purchase or increase in benefits, which does not take place within 31 days of employee's or dependent's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of BCBS.

Due to rounding, your actual payroll deduction amount may vary slightly.

## Your Semi-Monthly Cost

MEDICAL				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
MTBCP310H	\$0.00	\$330.18	\$301.89	\$631.15
MTBCP023	\$113.12	\$605.82	\$563.49	\$1,056.22
MTBCP034	\$108.78	\$595.16	\$553.37	\$1,039.78
MTBCP043	\$89.82	\$548.59	\$509.16	\$967.96

DENTAL				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
BASE PLAN	\$16.17	\$32.34	\$41.52	\$63.82
BUY UP PLAN	\$23.72	\$47.43	\$58.14	\$89.76

VISION				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
BASE PLAN	\$3.40	\$6.45	\$6.79	\$9.98

Voluntary Life				
Age Band	EE & SP Life Rates per \$1,000	EE & SP AD&D Rates per \$1,000	EE & SP Total Semi-Monthly Rates per \$1,000	Child Total Rates per \$1,000
>20 – 29	0.035	0.015	0.050	0.2405
30-34	0.050	0.015	0.065	0.2405
35-39	0.060	0.015	0.075	0.2405
40-44	0.075	0.015	0.090	0.2405
45-49	0.105	0.015	0.120	0.2405
50-54	0.195	0.015	0.210	0.2405
55-59	0.325	0.015	0.340	0.2405
60-64	0.490	0.015	0.505	0.2405
65-69	0.785	0.015	0.800	0.2405
70 +	1.485	0.015	1.500	0.2405

***The insurance carrier and published plans take precedence as the correct information in the event of any conflicting information. Endeavor Risk Advisors is not responsible for any errors or omissions in this book.***