Benefit Health Plan, Inc
ADMINISTRATORS

A proposal for:

The content within is for broker-facing audiences only to be presented to the client. This information is customized for each employer. Rates are good for plans beginning by October 1, 2024. And are representative for groups without current benefits. Groups with benefits will be rated upon experience and medical questions. Misrepresenting or distributing this, or any, information contained herein is prohibited by law.

Advantages of Benefit Health Plan Inc Administrators, Inc (BHPI)

Self-Funded Assistance with Stop-Loss Protection
We can help you to decide which benefits, if any, should be self-funded, and we can assist you with determining the appropriate Stop-Loss protection. Traditionally, insurance companies consider premiums as a prepayment of future claims. However, sometimes companies would prefer to have better control over their funds. With self-funding benefits, this is possible, because employee claims are paid from the company's budget, instead of from the insurance company. Of course, this type of plan comes with an element of risk. If the amount of employee claims is within the company's budget, they are able to be paid, and the company will get to keep the surplus. But what if employee claims are higher than what is in the company's budget? This is where Stop-Loss comes in. It reduces this risk by referring claims over the predetermined limit to an insurance company for processing. In this case, the Stop-Loss limit is similar to a high deductible.

Lower Administration Costs With BHPI TPA self-funded and level-funded clients, expenses are reflected only as a percentage of claims. Clients pay for only paid claims rather than estimated premiums. There is no cash advance required, which is typically the case with other third-party administrators. On the other hand, if an insured person claims an amount that is over the Stop-Loss level, the company will not be billed, nor will there be an applicable fee (the Stop-Loss insurer will directly manage the following claims). Expenses are never charged for claims exceeding the chosen Stop-Loss level, making the competitive pricing structure of BHPI TPA advantageous over services provided by other TPAs.

Full-Service Administration BHPI TPA is a TPA providing group benefit services to over 1,000 businesses and 100,000 employees nationwide, with over 25 years of experience in administrative capabilities. Additionally, BHPI TPA can be combined with your online payroll, human resource and time management service to eliminate errors. Employees are provided with personalized booklets that describe the insurance programs and the administrative benefits. Clients are assigned an account representative who works directly with them to resolve issues.

8300 HSA	MONTHLY RATES
EE (PHCS / Cigna)	$499.01 / $549.01
EE SP (PHCS / Cigna)	$859.47 / $909.47
EE CH (PHCS / Cigna)	$969.62 / $1,019.62
Family (PHCS / Cigna)	$1,214.63 / $1,264.63

3500 HSA	MONTHLY RATES
EE (PHCS / Cigna)	$607.10 / $657.10
EE SP (PHCS / Cigna)	$1,252.62 / $1,302.62
EE CH (PHCS / Cigna)	$1,125.60 / $1,175.60
Family (PHCS / Cigna)	$1,759.61 / $1,809.61

$4500 COPAY	MONTHLY RATES
EE (PHCS / Cigna)	$649.80 / $699.80
EE SP (PHCS / Cigna)	$1,339.23 / $1,389.23
EE CH (PHCS / Cigna)	$1,213.73 / $1,263.73
Family (PHCS / Cigna)	$1,796.94 / $1,846.94

$3500 COPAY	MONTHLY RATES
EE (PHCS / Cigna)	$749.90 / $799.90
EE SP (PHCS / Cigna)	$1,415.49 / $1,465.49
EE CH (PHCS / Cigna)	$1,379.88 / $1,429.88
Family (PHCS / Cigna)	$2,071.67 / $2,121.67

For **PHCS** provider search to go: https://providersearch.multiplan.com/
Click: PHCS Extended PPO

For **Cigna** provider search go to: www.cigna.com
Click: Find a Doctor, Zip Code, Doctor, Guest
Select: PPO, Choice Fund PPO

MEDICAL PLAN BENEFIT COVERAGE (INSURANCE PAYS 100% OF NETWORK ALLOWABLE MINUS MEMBERS COPAY/COINSURANCE/OOP)	**8300 HSA** **(COMES WITH $25MO ON HSA CARD!)** BASE PLAN BENEFITS	**3500 HSA** BUY-UP #1 PLAN BENEFITS
Annual Deductible Individual (In/Out)* Family (In/Out)	$8,300 / $18,900 $16,600 / $37,800	$3,500 / $7,500 $7,000 / $15,000
Out-of-Pocket Maximum Individual (In/Out) Family (In/Out)	$9,450 / $24,000 $18,900 / $48,000	$7,000 / $17,500 $14,000 / $35,000
Co-Insurance: Member Pays (In/Out)	0% / 50%	30% / 50%
Physician Services - Preventative **Schedule of Benefits** Telemedicine Office Services - Value Choice DCP/PCP Office Services - Value Choice DCP/Specialist Office Services - Family Physician Office Services - Specialist	$0 Copay $0 Copay $0 Copay Deductible + 0% Deductible + 0%	$0 Copay $0 Copay $20 Copay Deductible + 30% Deductible + 30%
Inpatient Hospital Services	Deductible + 0%	Deductible + 30%
Outpatient Surgery	Deductible + 0%	Deductible + 30%
Emergency Room	Deductible + 0%	Deductible + 30%
Urgent Care	Deductible + 0%	Deductible + 30%
Labs & X-Rays (Quest Diagnostics/Lab Corp)	100% of covered charges up to $500 performed in DPC Office*	Deductible + 30%
Advanced Imaging	$200 Copay from DPC Referral	Deductible + 30%
Pharmacy Drugs Deductible Generic Drugs Preferred Brand Drugs Non-preferred Retail / Specialty Drugs	All prescriptions up to $200 covered, above $200 not covered. $20 $65 $95 / $200	In-Network Deductible Deductible + 30% Deductible + 30% Deductible + 30%
Employee Only (PHCS / Cigna) **Employee and Spouse (PHCS / Cigna)** **Employee and Child(ren) (PHCS / Cigna)** **Family (PHCS / Cigna)**	$499.01 / $549.01 $859.47 / $909.47 $969.62 / $1,019.62 $1,214.63 / $1,264.63	$607.10 / $657.10 $1,252.62 / $1,302.62 $1,125.60 / $1,175.60 $1,759.61 / $1,809.61

MEDICAL PLAN BENEFIT COVERAGE (INSURANCE PAYS 100% OF NETWORK ALLOWABLE MINUS MEMBERS COPAY/COINSURANCE/OOP)	**$4500 COPAY** BUY-UP #2 PLAN BENEFITS	**$3500 COPAY** BUY-UP #3 PLAN BENEFITS
Annual Deductible Individual (In/Out) Family (In/Out)	$4,500 / $8,500 $9,000 / $17,000	$3,500 / $7,500 $7,000 / $15,000
Out-of-Pocket Maximum Individual (In/Out) Family (In/Out)	$8,150 / $20,000 $16,300 / $40,000	$7,350 / $17,500 $14,700 / $35,000
Co-Insurance: Member Pays (In/Out)	30% / 50%	20% / 50%
Physician Services Telemedicine Office Services - Value Choice DCP/PCP Office Services - Value Choice DCP/Specialist Office Services - Family Physician Office Services - Specialist	$0 Copay $0 Copay $20 Copay $40 Copay $75 Copay	$0 Copay $0 Copay $20 Copay $40 Copay $75 Copay
Inpatient Hospital Services	Deductible + 30%	Deductible + 20%
Outpatient Surgery	Deductible + 30%	Deductible + 20%
Emergency Room	Deductible + 30%	Deductible + 20%
Urgent Care	$90 Copay	$90 Copay
Labs & X-Rays (Quest Diagnostics/Lab Corp)	100% of covered charges up to $500	100% of covered charges up to $500
Advanced Imaging	$300 Copay	$300 Copay
Pharmacy Drugs Deductible Generic Drugs Preferred Brand Drugs Non-preferred Retail / Specialty Drugs	N/A $20 $65 $95 / $200	N/A $20 $65 $95 / $200
Employee Only (PHCS / Cigna) **Employee and Spouse (PHCS / Cigna)** **Employee and Child(ren) (PHCS / Cigna)** **Family (PHCS / Cigna)**	$649.80 / $699.80 $1,339.23 / $1,389.23 $1,213.73 / $1,263.73 $1,796.94 / $1,846.94	$749.90 / $799.90 $1,415.49 / $1,465.49 $1,379.88 / $1,429.88 $2,071.67 / $2,121.67

Plan Highlights for Benefit Plans

Employees say: “We want to be compensated fairly, a way to save for retirement, affordable health insurance, a primary care provider (PCP) who cares about me and my family, open access to specialists, Life Insurance, Telemedicine, help with deductibles and out of pocket costs, and a way to save on taxes.”

Through membership in our Benefit Logistics program, you can now offer exactly what employees want. We have created a specific employee benefit plan that contains:

- A dedicated assigned Primary Care or Urgent Care physician for some plans, yet they can go to any in-network primary care or specialist physician for care.
- Authorizations are required for inpatient and/or outpatient services and diagnostic tests.
- Emergency services are covered anywhere, even if out of network, so you are covered while you travel!
- $0 Co-Pay for Primary Care (assigned PCP) and $0 Telemedicine visits.
- Open Access to Primary, Specialists, and Imaging Facilities with Co-Pay assistance.

Pharmacy

COVERAGE LINE	PROVIDER	PLAN	FOR ASSISTANCE OR TO FIND PROVIDER
Pharmacy Specialty Pharmacy	ScriptClaim ServeYouRx	Pharmacy Benefit Manager Specialty Rx Manager	844-580-BHPI

VIRTUAL PRIMARY CARE

Top primary care physicians to provide personalized care through message-based and video interactions, no matter your location or circumstance.

PRODUCT HIGHLIGHTS

COMPREHENSIVE	CONVENIENT	PREVENTATIVE
An integrated care team with board-certified primary care physicians enables whole-person care with a personal touch.	Market-leading patient access means no long appointment waits or barriers to accessing care.	A proactive approach that includes risk stratification enables early intervention to improve patient experience and outcomes.

- Dedicated Physician
- Primary Care Services
- Electronic Prescription Ordering
- Health Risk Assessment
- Integrated Urgent Care
- Chronic Care Management

DOWNLOAD THE MEMBER APP

APP Member App: https://benefithealthplan.com/

BENEFIT LOGISTICS Captive Insurance Company

Benefit Health Plan, Inc
ADMINISTRATORS

HSA VL 1650 WITH $25/MONTH CONTRIBUTION TO HSA PLAN	MONTHLY RATES
EE (PHCS / Anthem)	$334.00 / $414.00
EE SP (PHCS / Anthem)	$639.00 / $739.00
EE CH (PHCS / Anthem)	$629.00 / $729.000
Family (PHCS / Anthem)	$889.00 / 1,009.00

VL 1000 DEDUCTIBLE PLAN (DED MUST BE MET PRIOR TO COPAYS)	MONTHLY RATES
EE (PHCS / Anthem)	$374.00 / $459.00
EE SP (PHCS / Anthem)	$679.00 / $779.00
EE CH (PHCS / Anthem)	$669.00 / $769.00
Family (PHCS / Anthem)	$959.00 / $1,079.00

Benefit Health Plan, Inc
ADMINISTRATORS

Summary of Benefits & Coverage

VL $1,000 / $2,000 Deductible

Network Options:
Anthem PPO or PHCS PPO

Summary of Benefits & Coverage

VL $1,000/$2,000 Deductible

Benefit Health Plan, Inc

NETWORK	INN
Payment for Services	
In-network Provider: The provider network is shown on your I.D. card.	_____
Maximum Annual Benefit	See Services Performed
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	 $1,000 $2,000
Out-of-Pocket Maximum (For member accumulated deductible and copays (Individual/Family) Out of Pocket – Maximum for services beyond the plan visit limits	$9,200 $18,400 Unlimited

Copays: Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Annual Lab/X-Ray Tests • Annual Pap Smear/Mammogram • Cancer Screenings • Colonoscopies	• Diabetic Supply • Immunizations • Other Preventative Screenings • Precision Rx (Prescriptions)	• Telemedicine • Urgent Care and Office Visits • Well Baby Care • Wellness Visits

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture • Children's Dental Check-Up • Children's Glasses	• Children's Eye Exam • Dialysis • Biofeedback Organ • Transplant Services

Services may require preauthorization. Failure to obtain preauthorization will result in denial of benefits.

Precertification

Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan.

Emergencies are covered but do require authorization/certification within 48 hours.

This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.

The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan, and it is not to be considered a policy of insurance.

Summary of Benefits & Coverage

VL $1,000/$2,000 Deductible

Benefit Health Plan, Inc

NETWORK	INN
Covered Services - Illness or Injury	
Physician Office Services 10 visits per benefit year maximum is combined for PCP office visits, Specialist Office visits, and Urgent Care visits. 12 visits per benefit year maximum for Chiropractic Care. • Primary Care Physician • Specialist Office Visit • Urgent Care Visit • Spinal Manipulation Chiropractic • Surgery Performed in the Office (See Outpatient Surgery)	$50 Copay After Deductible
Telemedicine- through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay

Emergency Services
• Emergency Room Care
  ◦ 2-visit limit per benefit year for accident-related visits
  ◦ 2-visit limit per benefit year for sickness-related visits
• Emergency Medical Transportation
  ◦ Ground/Air Ambulance: 2 per benefit year
Please note that for a true medical emergency, any provider may be used.
	$250 Copay After Deductible

Diagnostic Testing/Imaging (Precertification Required) 3 per benefit year	$200 Copay After Deductible
Labs (3 per Benefit Plan Year)	$25 Copay
X-rays (3 per Benefit Plan Year)	$50 Copay

Outpatient Facility Services (Precertification Required)
• Infusions/Injections
  ◦ 10-visit limit per benefit year; maximum combined with chemotherapy/radiation
• Surgical Services (Outpatient hospital, Surgery Center of Office)
  ◦ 3 surgeries per benefit year (includes surgeon, anesthesia and any other incurred services associated with outpatient surgery)
• Outpatient Chemotherapy and Radiotherapy
  ◦ 10-visit limit per benefit year; maximum combined with infusion/injection drugs
• Dialysis
	$100 Copay/Visit After Deductible
	$250 Copay/Service After Deductible
	$100 Copay/Visit After Deductible
	Not Covered

Inpatient Services (Precertification Required) Stays Limited To: 2 ICU hospitalizations per benefit period and 2 Non-ICU hospitalizations per benefit period. (5-day limit per ICU hospitalization, 5-day limit per Non-ICU hospitalization) Associated/Incidental Inpatient Services (Included Anesthesia, Pathology, Physician Services, and any other incurred services)	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible

Summary of Benefits & Coverage

VL $1,000/$2,000 Deductible

Benefit Health Plan, Inc

NETWORK Inpatient Services (Precertification Required)	**INN**
Inpatient Hospital Surgical Services, All Fees 2 surgeries per plan year	$1,000 Copay/Surgery After Deductible
Inpatient Rehabilitation Facility 10-day limit per benefit year	$50 Copay/Day After Deductible
Preventive Services Preventive Care/Screening/Immunization	
• Annual Adult Physical • Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria • Mammogram • Gynecological Services • Routine Colonoscopy • Well Child Care/Newborn Care	$0 Copay
Other Covered Services	
Therapy 16 visits per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	$50 Copay After Deductible
Pregnancy/Maternity • Routine Vaginal Delivery • Routine C-section Delivery • All Other Maternity Service (Other maternity services included: office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded: Genetic testing, unless medically necessary.)	$250 Copay After Deductible $500 Copay After Deductible 100% Covered
Home Health Care (Precertification Required) 10-day limit per benefit year	$50 Copay After Deductible
Hospice Care 30-day limit per lifetime	$0 Copay After Deductible
Inpatient Skilled Nursing Facility (Precertification Required) 10-day visit limit per benefit year	$50 Copay/Day After Deductible
Durable Medical Equipment (DME) (Precertification Required) Copayment is applied per item received. 5 items/benefit period.	$50 Copay/Item After Deductible
Prosthetics (Precertification Required) 1 item per benefit year	$50 Copay/Item After Deductible
Organ Transplant	Not Covered

Summary of Benefits & Coverage

VL $1,000/$2,000 Deductible

Benefit Health Plan, Inc

NETWORK		INN
Diabetic Nutritional Counseling 1 visit per benefit year		$0 Copay After Deductible
Allergies • Shots (24 visits per benefit year) • Visits/Testing (2 visits per benefit year)		$25 Copay After Deductible $50 Copay After Deductible
Prescription Drugs		
Retail Pharmacy Copayments 30-day supply at retail pharmacies. Mail order required for maintenance medication after initial 30-day supply.	**Generic** Maintenance Rx	$0 Copay
	Generic Urgently Needed Care Rx	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments 90-day supply	**Generic** **Preferred Brand Name Drugs**	$0 Copay
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available
		Patient Assistance Plans Available
RX Benefit Highlights		
Rx Company		ScriptClaims
Phone 24/7/365		1-800-970-5821
Website		https://www.script-claim.com/
Formulary		Click Here

Benefit Health Plan, Inc
ADMINISTRATORS

Summary of Benefits & Coverage

HSA VL $1,650 / $3,300 Deductible

Network Options:

Anthem PPO or PHCS PPO

Summary of Benefits & Coverage

HSA VL $1,650/$3,300 Deductible

Benefit Health Plan, Inc

NETWORK	INN
Payment for Services	
In-network Provider: The provider network is shown on your I.D. card. For help in locating in-network providers, click here.	
Maximum Annual Benefit	See Services Performed
Deductible (The amount the Covered Person pays each benefit year for Covered Services before the Coinsurance is payable.) • Individual • Family	 $1,650 $3,300
Out-of-Pocket Maximum (For member accumulated deductible and copays (Individual/Family) Out of Pocket – Maximum for services beyond the plan visit limits **Copays:** Please note that after your deductible has been met, you will still be responsible for paying copayments for your medical services.	$9,200 $18,400 Unlimited
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Annual Lab/X-Ray Tests • Annual Pap Smear/Mammogram • Cancer Screenings • Colonoscopies	• Diabetic Supply • Immunizations • Other Preventative Screenings • Precision Rx (Prescriptions)
• Telemedicine • Urgent Care and Office Visits • Well Baby Care • Wellness Visits	
Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Acupuncture • Children's Dental Check-Up • Children's Glasses	• Children's Eye Exam • Dialysis • Biofeedback Organ • Transplant Services
Services may require preauthorization. Failure to obtain preauthorization will result in denial of benefits.	
Precertification Precertification is required for all in-hospital admissions, imaging (CT/PET/MRI/MRA), home health, skilled nursing, hospice, DME (over $500), chemotherapy/radiation, sleep studies, prosthetics/orthotics, therapies (chiropractic, cardiac, PT/OT/ST), and outpatient surgery. Please refer to the plan document for a complete list of all services that require precertification under your plan. Emergencies are covered but do require authorization/certification within 48 hours.	
This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.	
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Summary of Benefits & Coverage

HSA VL $1,650/$3,300 Deductible

Benefit Health Plan, Inc

NETWORK	INN
Covered Services - Illness or Injury	
Physician Office Services 10 visits per benefit year maximum is combined for PCP office visits, Specialist Office visits, and Urgent Care visits. 12 visits per benefit year maximum for Chiropractic Care. • Primary Care Physician • Specialist Office Visit • Urgent Care Visit • Spinal Manipulation Chiropractic • Surgery Performed in the Office (See Outpatient Surgery)	$50 Copay After Deductible
Telemedicine- through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay

Emergency Services
• Emergency Room Care
  ◦ 2-visit limit per benefit year for accident-related visits
  ◦ 2-visit limit per benefit year for sickness-related visits
• Emergency Medical Transportation
  ◦ Ground/Air Ambulance: 2 per benefit year
Please note that for a true medical emergency, any provider may be used.
	$250 Copay After Deductible

Diagnostic Testing/Imaging (Precertification Required) 3 per benefit year	$200 Copay After Deductible
Labs (3 per Benefit Plan Year)	$25 Copay
X-rays (3 per Benefit Plan Year)	$50 Copay

Outpatient Facility Services (Precertification Required)
• Infusions/Injections
  ◦ 10-visit limit per benefit year; maximum combined with chemotherapy/radiation
• Surgical Services (Outpatient hospital, Surgery Center of Office)
  ◦ 3 surgeries per benefit year (includes surgeon, anesthesia and any other incurred services associated with outpatient surgery)
• Outpatient Chemotherapy and Radiotherapy
  ◦ 10-visit limit per benefit year; maximum combined with infusion/injection drugs
• Dialysis
	$100 Copay/Visit After Deductible
	$250 Copay/Service After Deductible
	$100 Copay/Visit After Deductible
	Not Covered

Inpatient Services (Precertification Required) Stays Limited To: 2 ICU hospitalizations per benefit period and 2 Non-ICU hospitalizations per benefit period. (5-day limit per ICU hospitalization, 5-day limit per Non-ICU hospitalization) Associated/Incidental Inpatient Services (Included Anesthesia, Pathology, Physician Services, and any other incurred services)	$1,000 Copay/Admission After Deductible $250 Copay/Service After Deductible

Summary of Benefits & Coverage

HSA VL $1,650/$3,300 Deductible

Benefit Health Plan, Inc

NETWORK Inpatient Services (Precertification Required)	**INN**
Inpatient Hospital Surgical Services, All Fees 2 surgeries per plan year	$1,000 Copay/Surgery After Deductible
Inpatient Rehabilitation Facility 10-day limit per benefit year	$50 Copay/Day After Deductible
Preventive Services Preventive Care/Screening/Immunization	
• Annual Adult Physical • Adult Immunizations: Flu Vaccine, Pneumonia Vaccine, Tetanus/Diphtheria • Mammogram • Gynecological Services • Routine Colonoscopy • Well Child Care/Newborn Care	$0 Copay
Other Covered Services	
Therapy 16 visits per benefit year maximum combined • Physical & Occupational Therapies • Speech Therapy • Cardiac Rehabilitation Therapy	$50 Copay After Deductible
Pregnancy/Maternity • Routine Vaginal Delivery • Routine C-section Delivery • All Other Maternity Service (Other maternity services included: office visits, lab work, radiology, prenatal/postnatal care, etc. Excluded: Genetic testing, unless medically necessary.)	$250 Copay After Deductible $500 Copay After Deductible 100% Covered
Home Health Care (Precertification Required) 10-day limit per benefit year	$50 Copay After Deductible
Hospice Care 30-day limit per lifetime	$0 Copay After Deductible
Inpatient Skilled Nursing Facility (Precertification Required) 10-day visit limit per benefit year	$50 Copay/Day After Deductible
Durable Medical Equipment (DME) (Precertification Required) Copayment is applied per item received. 5 items/benefit period.	$50 Copay/Item After Deductible
Prosthetics (Precertification Required) 1 item per benefit year	$50 Copay/Item After Deductible
Organ Transplant	Not Covered

Summary of Benefits & Coverage

HSA VL $1,650/$3,300 Deductible

Benefit Health Plan, Inc

NETWORK		INN
Diabetic Nutritional Counseling 1 visit per benefit year		$0 Copay After Deductible
Allergies • Shots (24 visits per benefit year) • Visits/Testing (2 visits per benefit year)		$25 Copay After Deductible $50 Copay After Deductible
Prescription Drugs		
Retail Pharmacy Copayments 30-day supply at retail pharmacies. Mail order required for maintenance medication after initial 30-day supply.	**Generic** Maintenance Rx	$0 Copay
	Generic Urgently Needed Care Rx	$0 Copay
	Preferred Brand Name Drugs	Patient Assistance Plans Available
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available
Mail Order or Retail Pharmacy Copayments 90-day supply	**Generic** **Preferred Brand Name Drugs**	$0 Copay
	Non-Preferred Brand Name Drugs	Patient Assistance Plans Available
		Patient Assistance Plans Available
RX Benefit Highlights		
Rx Company		ScriptClaims
Phone 24/7/365		1-800-970-5821
Website		https://www.script-claim.com/
Formulary		Click Here

Dental Plans

(Open CIGNA PPO DENTAL Network)

OPEN ACCESS PPO! All dentists who bill BHPI TPA directly are considered in-network. Dental health means much more than healthy teeth — it is integral to your overall health and well-being. Diseases and conditions are often a sign of other health problems so taking preventive measures is best!

DENTAL PLANS OFFERED	SMART PREMIUM 100/80/60-1000C-MAC	SMART PREMIUM PLUS 100/80/50-2000
Annual Benefit Maximum Per insured person per calendar year	$1,000	$2,000
Annual Deductible Individual / Family	$50 / $150	$50 / $150
Deductible Waived for Diagnostic / Preventative Services	Yes	Yes
Diagnostic & Preventive Coverage Exams, cleanings, flouride, space maintainers, x-rays, and sealants	100%	100%
Basic Services Minor restorative (fillings), prosthetic maintenance (relines and repairs to bridges, implants, and dentures), and emergency palliative treatment (to temporarily relieve pain)	80%	80% Minor restorative (fillings), emergency palliative treatment (to temporarily relieve pain), endodontics (root canals), periodontics (to treat gum disease), oral surgery (extractions and dental surgery), and prosthetic maintenance (relines and repairs to bridges, implants, and dentures)
Major Services Major restorative (crowns, inlays, and onlays), endodontics (root canals), periodontics (to treat gum disease), prosthodontics (dentures), prosthetics (bridges), implants, and oral surgery (extractions and dental surgery)	50%	50% (Implants, major restorative (crowns, inlays, and onlays), prosthetics (bridges), and prosthodontics (dentures))
Coverage Level Monthly Rates Employee Only Employee & Spouse Employee & Child(ren) Family	Open Acess PPO $34.77 $69.54 $78.58 $113.34	Open Access PPO Orthodontic Included $60.22 $120.45 $131.73 $191.95

Vision Plan Offered

It is important to schedule regular eye exams for you and your family. A routine eye exam can detect a wide range of diseases that may otherwise go unnoticed. The vision plan provides coverage for routine eye exams, eyeglasses, and contact lenses.

To find a list of doctors covered under this plan, please visit www.vsp.com/eye-doctor.

Choice Network: 31,000 preferred providers and 57,000 access points

BENEFIT COVERAGE	VSP CHOICE PLAN #1 BENEFITS	
	IN-NETWORK	OUT-OF-NETWORK
	WHAT YOU WILL PAY	WHAT YOU MAY BE REIMBURSED
Eye Exam	$10 Copay	$10 Copay
Eyeglass Lenses Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses	 $25 Copay $25 Copay $25 Copay $25 Copay	 Up to $30 Up to $50 Up to $65 Up to $100
Eyeglass Frames	$150 Allowance	Up to $70
Contacts (In lieu of glasses) Necessary Elective	 $25 Copay $150 Allowance	 Up to $210 Up to $105
Contact Lens Fitting & Evaluation	15% off (Copay not to exceed $60)	
Coverage Level Monthly Rates Employee Only Employee and Spouse Employee and Child(ren) Family	 $9.52 $19.04 $20.78 $32.42	

VSP Network Value Added Programs

- Diabetic Eyecare Plus Program
- Hearing Aid Discounts
- Eye Health Management
- Diabetic Exam Reminder Letters

VSP Network Extra Discounts & Savings

- Lens Enhancements: Most popular are covered with a copay, saving 20-25%, average
- Additional Pairs of Glasses: 20% off
- Laster Vision Correction (LVC): Average 15% Discount

No one should leave a family member with grief and unexpected debts, so Group Term Life Insurance is included in one Plan but only cost $10/mo. in all others!

Group Life provides basic coverage to employees while giving them the opportunity to purchase voluntary term life. This is included in the 8300 HSA Plan at no cost but can be purchased for an additional $10 per month on all other plans.

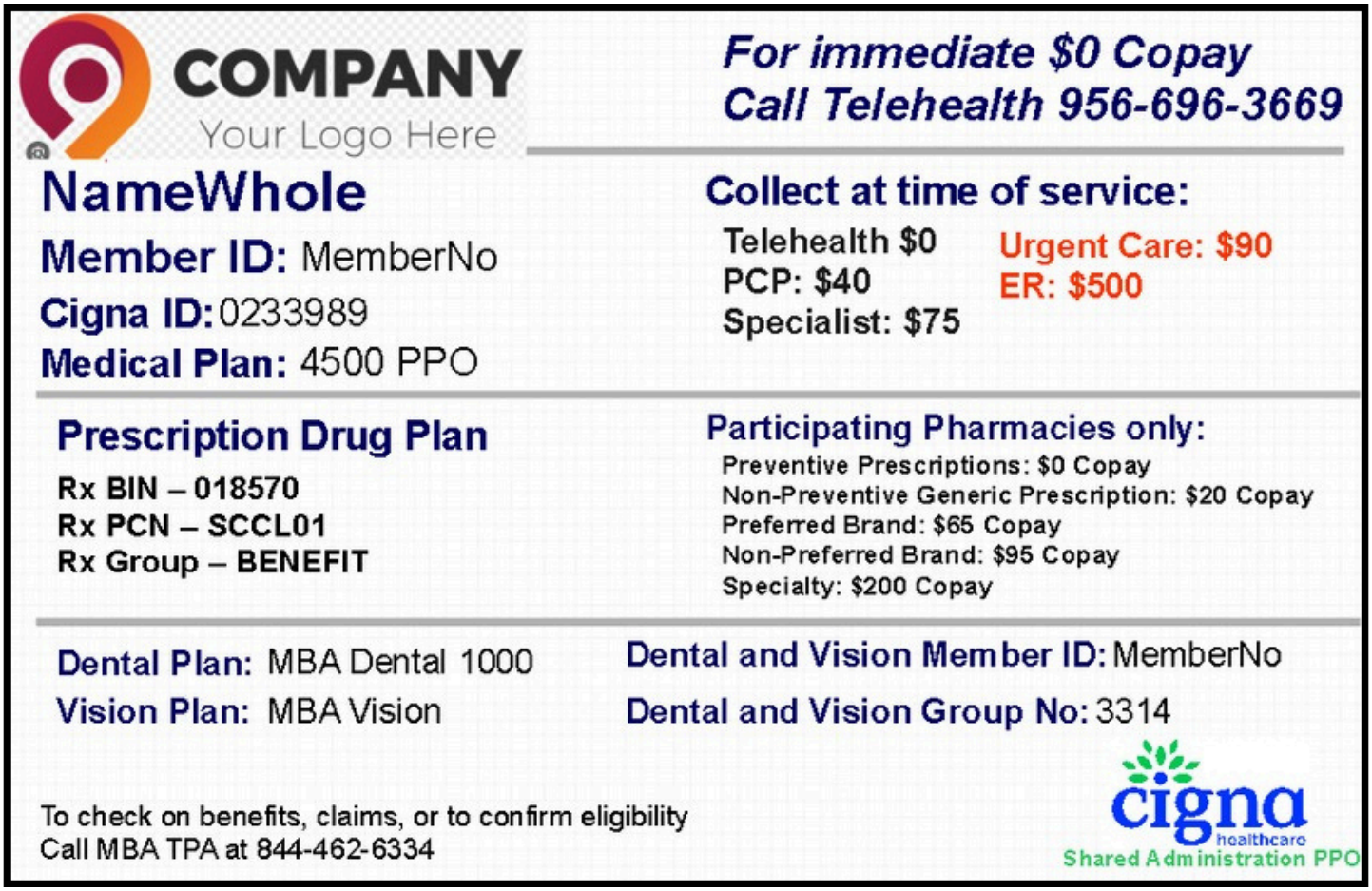
Our Life Plan Includes:

- Guaranteed issue amounts of $20,000.00 for Base Coverage and $200,000.00 buy up option: Eligible employees, spouses, and dependent children, will receive a specified amount of life coverage without medical underwriting
- Waiver of premium: Premiums for a covered person are waived after total disability for 6 months beginning before his/her 60th birthday (until age 65)
- Guaranteed conversion: If employee, spouse, or dependent loses coverage due to employee's loss of employment, loss of eligibility, or reduction for age, the coverage can be converted to an individual whole life insurance policy
- Accelerated benefit for terminal illness: 50% benefit of basic group term life insurance (not to exceed $200,000) payable upon proof of terminal illness
- Benefit for death of a spouse until age 65
- Benefit for death of a child ages 15 days to 26 years
- AD&D coverage at DOUBLE THE FACE VALUE: Provides double
- compensation in the event of certain disabling accidents or accidental loss of life

Additional Life Plan Options:

- Employee coverage: a flat amount of coverage, or a multiple of the employee's salary rounded to the next $1,000, or based on employee classification
- Spouse coverage: $5,000 to $20,000
- Dependent child coverage: $500 to $5,000
- Minimum coverage: $10,000 to $15,000
- Maximum coverage: Lesser of 7 times annual salary or $1 million, combined with Supplemental Life

ID Card Example



Contact Information

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COVERAGE LINE	PROVIDER	PLAN	FOR ASSISTANCE OR TO FIND A PROVIDER
Medical	PHCS Network	Extended PPO	MultiPlan Provider Search www.multiplan.com
Pharmacy Specialty Pharmacy	ScriptClaim ServeYouRx	Pharmacy Benefit Manager Specialty Rx Manager	844-580-BHPI
Telemedicine	Our Live Doc	Virtual Primary Care Provider	844-580-BHPI info@benefithealthplan.com