XGB

2026

X GROUP BENEFITS

a proposal for:

ADVANTAGES OF XGB

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.

Lower Administration Costs
With BHPI TPA self-funded, level funding, or fully-funded plans underwritten by Benefits Re, 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.

The Attached Plans are Fully-Funded, Employer Sponsored Medical Plans
Besides the attached, we can help you to decide which benefits, if any, should be self-funded, level funded, or fully-funded plans underwritten by Benefits Re, 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.

PLAN ELIGIBILITY RULES

GROUP SIZE 5 - 100

50% Participation:
Group must have at least 5 Full Time Eligible employees after valid waivers (Medicare, Medicaid, Tricare, Spouse Employer Coverage, Parents Plan, Tribal Plans) with 50% enrolling in a medical plan.
3 enrolling of 5 Eligible is the smallest group size accepted. Not 3 of 4, or 3 of 3.
If a group falls below participation eligibility, they will be subject to termination of plan at that time.

The **Standard Rates** contained in this proposal are applicable for all virgin groups without prior group coverage in place and groups with current Like Plan coverage within 14% of the Standard Rates in the proposal.

Like Plan Rules:

- Within $500 of deductible either way.
- Cannot Exceed 14% of Standard rates
- Equal networks: PPO-PPO, EPO-EPO.
- All plans that fall outside the above rules will be submitted to the carrier for Re-Rates.

For groups that have existing coverage with plan rates above 14% of the Standard Rates, Re-Rates will be determined after reviewing current and renewal rates. Please request Re-Rates 30 days prior to effective date.

Employer Contribution Requirement– Must be at least 50% of the Employee Only Premium of the lowest MM plan offered (excluding VL plans).

Calendar Year Plans- All Plan deductibles and requirements reset on Jan 1st.

Benefit Health Plan, Inc
ADMINISTRATORS

What role does a network play in Health Insurance?

Networks do not provide medical or health benefits. Most PPO Networks are not insurance companies; they do not sell insurance and do not pay claims. That is the role of the Benefit Plan Administrator found on your ID Card.

A PPO Health Network offers access to healthcare provider networks, like First Health, 1st Choice, HealthSmart, United Healthcare, Aetna, Humana, and Blue Cross Blue Shield, and they all have branded networks. This can be separate from the traditional insurance you may know as the "insurance company", which provides the private insurance of your catastrophic claims. A network offers clients (and you, our member) access to healthcare providers who have agreed to participate in your chosen network, and they in turn offer their services at a discounted rate. We receive the claims directly from the providers and reprice and pay the providers directly. Your responsibility, such as you Co-Pay, Deductible, or Coinsurance is lowered because of these networks.

If you have questions about your specific benefit plan or claims payment, please contact your Benefit Plan Administrator.

Contact information can be found in your Human Resources Department, Employee Enrollment Packet, Welcome Kit, or on your ID Card.

Sometimes people misunderstand Networks, so it's important that you know what they do. Here is a high-level summary to help explain:

What Role Does a Network Play in Health Insurance *Continued*

Benefit Plan Administrator **(First Health, 1st Choice, PHCS, etc)**	**Member**	**Network**	**Providers**
Examples: Benefit Health Plan, MBA TPA, TPA exchange, etc. (TPA's) Insurance companies Employers and more.	Example: Members are individuals who have a benefit plan through their Benefit Plan Administrator.	Examples: First Health PPO, An Aetna Company Private Health Care Services (PHCS) Other PPO Networks	Doctors, specialists, hospitals and related professionals who provide health care.

• Designs and administers benefit plans (deductibles, co-insurance, co-pays, exclusions, etc.)
• Buys access to a Network, like First Health, so members can find and access healthcare at a discounted rate
• Sends claims to the Network so that the discounted rate with the in-network Provider can be applied
  ◦ Handles requirements, like pre-authorization/pre-certification
  ◦ Answers phone calls from members on a wide variety of topics
  ◦ Applies benefits for the plan
  ◦ Funds and pays finalized claims
	• Enrolls in a benefit plan through their employer or Benefit Plan Administrator
	• Seeks and receives care from healthcare providers in the Network
	  ◦ Funds any remaining payment to the healthcare provider, after benefits are applied by the Benefit Plan Administrator (if applicable)
		• Builds and maintains the actual network of healthcare providers
		• Provides a directory of providers, so the Member can find a doctor or hospital
		  ◦ Applies the contracted rate (the discounted rate) to the Member's claim and sends the claim back to the Benefit Plan Administrator
		  ◦ Answers calls from members who have specific questions regarding finding an in-network provider
		  ◦ Answers calls from their clients (the Benefit Plan Administrators)
		Networks are not necessarily insurance companies and do not sell insurance or pay finalized claims.
			• Participates in a network
			• Provides care
			• Submits claims for services rendered to the Benefit Plan Administrator
			• Receives final payment from the Benefit Plan Administrator and/or the Member

XGB PLAN INFORMATION

In today's challenging healthcare landscape, small to mid-sized businesses are increasingly seeking cost-effective solutions to manage employee health benefits. One approach gaining traction is self-funding under ERISA (a federal program designed to enable an employer to fund its own risk), which offers greater control over healthcare expenses and plan design. We have explored the key aspects of self-funded health plans, including group health insurance, self-funding plans, stop-loss insurance, self-funded vs. fully insured plans, partially self-funded medical plans, and fully-funded medical plan. We have determined that a fully-funded ERISA plan is best suited for you.

Group Health Insurance

Group health insurance refers to coverage provided to businesses to enable them to Recruit, Retain, and Reward employees and usually can be found in employers with a significant number of employees, typically over 10. These plans often benefit from economies of scale, resulting in lower per-employee costs and more comprehensive coverage options.

Fully-Insured Plans

Fully insured plans are most often offered by the lager Publicly Traded Insurance Carriers such as Blue Cross Blue Shield, United Healthcare, Aetna and Humana (BUCAH). However, for small to mid-sized businesses, accessing these small employer, state governed health plans can be challenging due to their smaller workforce. If they have an employee who needs insurance coverage and uses it, then the entire workforce is penalized through rate increases. Consequently, such businesses may face higher premiums and less favorable terms when opting for traditional large group health insurance plans.

Self-Funding Plans

Self-funding plans, also known as self-insured plans, involve employers directly funding their employees' healthcare expenses every month rather than purchasing a traditional insurance policy. This involves no cash flow forecasting and can sometimes be risky if an employer has larger than expected claims. In this arrangement, the employer assumes the financial risk for providing healthcare benefits but gains greater flexibility in plan design and potential cost savings. Employers can tailor benefits to meet the specific needs of their workforce, leading to more efficient use of healthcare dollars.

XGB PLAN INFORMATION CONTINUED

Partially Self-Funded Medical Plans

Partially self-funded medical plans present a middle ground between fully insured and fully self-funded options. In these arrangements, employers self-insure for a predetermined portion of claims and purchase insurance for claims that exceed this amount. This approach allows employers to benefit from the cost savings and flexibility of self-funding while limiting their financial exposure. Partially self-funded plans can be particularly advantageous for medium-sized organizations where claims are more unpredictable, offering a balance between risk and cost control. Implementing a self-funded or partially self-funded health plan requires careful planning and expertise and doesn't guarantee a predictable outcome.

Fully-Funded Medical Plans

Fully-funded Self Insured medical plans present a 12 month forecasted costing structure forself-funded options. In these arrangements, employers self-insure for the full cost of their liabilities for a 12 month period and purchase insurance for claims that exceed this amount. This approach allows employers to benefit from the stable cash flow forecasting, cost savings and flexibility of self-funding while limiting their financial exposure. Fully-funded ERISA plans can be particularly advantageous for all organizations where cash flow is important in determining their maximum liability of offering a Health Plan, again offering a balance between risk and cost control.

Stop-Loss Insurance

To mitigate the financial risk associated with self-funding, many employers purchase stop-loss insurance. This type of coverage protects against unexpectedly high claims by reimbursing the employer when claims exceed a predetermined threshold. There are two main types of stop-loss insurance: individual (specific) stop-loss, which covers claims exceeding a set amount for a single employee, and aggregate stop-loss, which covers total claims exceeding a specified amount for the entire group. By incorporating stop-loss insurance, employers can safeguard their financial stability while still reaping the benefits of self-funded plans.

Full Funded ERISA vs. Fully Insured State Plans

When comparing self-funded ERISA and fully insured health plans, several key differences emerge. In a fully insured plan, the employer pays fixed premiums to an insurance carrier, which then assumes the responsibility for paying claims. This arrangement offers predictability in budgeting but may include higher costs and less flexibility the following year, impacting your ability to Recruit, Retain, and Reward employees. Conversely, fully-funded ERISA plans allow employers to estimate and pay for actual claims incurred on a 12 month basis, potentially leading to cost savings the following year if claims are lower than expected. Fully-funded plans offer greater customization of benefits and improved cash flow management. They also require the employer to assume a 12 month premium liability, and mitigate their risk through stop-loss insurance.

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 Benefits Re 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.
- True emergency services are covered anywhere, even if out of network, so you are covered while you travel!
- $0 Copay Telemedicine visits for Our Live Doc.
- Broad Access to Primary, Specialists, and Imaging Facilities with Co-Pay assistance (With Supplemental Upgrade).

PHARMACY

COVERAGE LINE	PROVIDER	PLAN	FOR ASSISTANCE OR TO FIND PROVIDER
Pharmacy Specialty Pharmacy	MarPai Rx	Pharmacy Benefit Manager Specialty Rx Manager	

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/

One network allowed for groups under 100 enrolled employees

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

One network allowed for groups under 100 enrolled employees

HSA VL 1750 WITH $25/MONTH CONTRIBUTION TO HSA PLAN	MONTHLY RATES
EE (PHCS)	$334.00
EE SP (PHCS)	$639.00
EE CH (PHCS)	$629.00
Family (PHCS)	$889.00

VL 1000 DEDUCTIBLE PLAN (DED MUST BE MET PRIOR TO COPAYS)	MONTHLY RATES
EE (PHCS)	$374.00
EE SP (PHCS)	$679.00
EE CH (PHCS)	$669.00
Family (PHCS)	$959.00

One network allowed for groups under 100 enrolled employees

HSA CIGNA EPO 1750 WITH $25/MONTH CONTRIBUTION TO HSA PLAN	MONTHLY RATES
EE	$414.00
EE SP	$739.00
EE CH	$729.00
Family	$1,009.00

CIGNA EPO 1000 DEDUCTIBLE PLAN (DED MUST BE MET PRIOR TO COPAYS)	MONTHLY RATES
EE	$459.00
EE SP	$779.00
EE CH	$769.00
Family	$1,079.00

MEDICAL PLAN BENEFIT COVERAGE (INSURANCE PAYS 100% OF NETWORK ALLOWABLE MINUS MEMBERS DEDUCTIBLE COPAY/COINSURANCE/OOP)	**8300 HSA** (COMES WITH $25MO ON HSA CARD!) *This plan is for individuals and families who are healthy, take only generic medications (if any), and would like to take a tax deduction (like an IRA) to save for a medical emergency	**3500 HSA** *This plan is for generally healthy individuals and families who will participate in the sharing of costs up to a $7,000 max out of pocket. Tax advantages still apply.
Annual Deductible Individual (In/Out)* Family (In/Out)	$8,300 / $16,600 $16,600 / $33,200	$3,500 / $7,000 $7,000 / $14,000
Out-of-Pocket Maximum Individual (In/Out) Family (In/Out)	$8,300 / $16,600 $16,600 / $33,200	$7,000 / $14,000 $14,000 / $28,000
Co-Insurance: Members Pays (In/Out)	0% / 50%	30% / 50%
Physician Services - Schedule of Benefits Preventative Telemedicine (Only Our Live Doc) Office Services - Family Physician Office Services - Specialist	 $0 Copay Unlimited $0 Copay Deductible + 0% Deductible + 0%	 $0 Copay Unlimited $0 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)	Deductible + 0%	Deductible + 30%

COVERAGE CONTINUED:

Advanced Imaging	Deductible + 0%	Deductible + 30%
Pharmacy Drugs Deductible Preventative Drugs (Generic Only. See Formulary) Generic Drugs Preferred Brand Drugs Non-Preferred Retail / Specialty Drugs **HSA Plans are allowed to have Copays for certain preventative medications such as flu shots, birth control, etc. All others are subject to the deductible.*	 $0 Copay* Deductible + 0% Deductible + 0% Deductible + 0%	 In-Network Deductible $0 Copay* 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

**Prescription Drug Coverage (HSA-Qualified Plan)

- This plan is designed as a High Deductible Health Plan (HDHP) compatible with a Health Savings Account (HSA)
- Except for certain preventive medications permitted under IRS guidance, prescription drugs are subject to the deductible and no benefits are payable before the deductible is met.
- Certain IRS-approved preventive medications may be covered prior to the deductible and may be subject to copayments or coinsurance.
- After the deductible is met, prescription drugs are covered according to the plan's applicable cost-sharing.

*** Example: Greg takes blood pressure and cholesterol medications. His blood pressure medication isn't included in the formulary list and is $300, meaning it's subject to deductible then subject to copay. His cholesterol medication is $58 and is listed on the formulary, meaning it's covered with a $0 Copay.

MEDICAL PLAN BENEFIT COVERAGE (INSURANCE PAYS 100% OF NETWORK ALLOWABLE MINUS MEMBERS DEDUCTIBLE COPAY/COINSURANCE/OOP)	**$4500 COPAY** *This plan is for individuals and families who want the protection of a low deductible and protection from catastrophic loss, as well as the convenience of copays.	**$3500 COPAY** *This plan is for individuals and families who may frequent the doctor more often, have a chronic condition, are on multiple medications, and want the convenience of copays.
Annual Deductible Individual (In/Out) Family (In/Out)	 $4,500 / $9,000 $9,000 / $18,000	 $3,500 / $7,000 $7,000 / $14,000
Out-of-Pocket Maximum Individual (In/Out) Family (In/Out)	 $9,000 / $18,000 $18,000 / $36,000	 $7,000 / $14,000 $14,000 / $28,000
Co-Insurance: Members Pays (In/Out)	30% / 50%	20% / 50%
Physician Services Telemedicine (Only Our Live Doc) Office Services - Family Physician Office Services - Specialist	 Unlimited $0 Copay $40 Copay $75 Copay	 Unlimited $0 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)	$25 Copay after Deductible	$25 Copay after Deductible
Advanced Imaging	$200 Copay after Deductible	$200 Copay after Deductible
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

Cigna EPO	1,000 Deductible	1,750 HSA
Annual Deductible Individual (In/Out)* Family (In/Out)	 $1,000 $2,000	 $1,750 $3,500
Out-of-Pocket Maximum Individual (In/Out) Family (In/Out)	 $8,500 $17,000	 $8,500 $17,000
Physician Services - Schedule of Benefits Preventive Telemedicine (Only Our Live Doc) Office Services - Family Physician Office Services - Specialist	 $0 Copay, $0 Deductible $0 Copay for Unlimited Visits $50 Copay (After Deductible) $50 Copay (After Deductible)	 $0 Copay, $0 Deductible $0 Copay for Unlimited Visits $50 Copay (After Deductible) $50 Copay (After Deductible)
Inpatient Hospital Services	$2,500 Copay/Admission (After Deductible)	$2,500 Copay/Admission (After Deductible)
Outpatient Surgical Services	$2,500 Copay/Surgery (After Deductible)	$2,500 Copay/Surgery (After Deductible)
Emergency Room	$1,000 Copay (After Deductible)	$1,000 Copay (After Deductible)
Urgent Care	$50 Copay (After Deductible)	$50 Copay (After Deductible)
Labs **X-Rays**	$25 Copay (After Deductible) $50 Copay (After Deductible)	$25 Copay (After Deductible) $50 Copay (After Deductible)
Diagnostic Testing & Advanced Imaging	$200 Copay (After Deductible)	$200 Copay (After Deductible)
Pharmacy Drugs - Retail Preventive Rx Generic Drugs Preferred Brand Drugs Non-Preferred Retail / Specialty Drugs	 $0 Copay $0 Copay PAP Available PAP Available	 $0 Copay $0 Copay PAP Available PAP Available
Pharmacy Drugs - Mail Order Generic Drugs Preferred Brand Drugs Non-Preferred Retail	 $0 Copay PAP Available PAP Available	 $0 Copay PAP Available PAP Available
Employee Only (Cigna) **Employee and Spouse (Cigna)** **Employee and Child(ren) (Cigna)** **Family (Cigna)**	$459.00 $779.00 $769.00 $1,079.00	$414.00 $739.00 $729.00 $1,009.00

**Prescription Drug Coverage (HSA-Qualified Plan)

- This plan is designed as a High Deductible Health Plan (HDHP) compatible with a Health Savings Account (HSA.
- Except for certain preventive medications permitted under IRS guidance, prescription drugs are subject to the deductible and no benefits are payable before the deductible is met.
- Certain IRS-approved preventive medications may be covered prior to the deductible and may be subject to copayments or coinsurance.
- After the deductible is met, prescription drugs are covered according to the plan's applicable cost-sharing.

VL Plans	1,000 Deductible	1,750 HSA
Annual Deductible Individual (In/Out)* Family (In/Out)	 $1,000 $2,000	 $1,750 $3,500
Out-of-Pocket Maximum Individual (In/Out) Family (In/Out)	 $8,500 $17,000	 $8,500 $17,000
Physician Services *10 visits/Yr Combined Urgent Care Visit Office Services - Family Physician Office Services - Specialist	$50 Copay (After Deductible)	$50 Copay (After Deductible)
Inpatient Services *2 ICU/Yr, 2 Non-ICU/Yr	$1,000 Copay/Admission (After Deductible)	$1,000 Copay/Admission (After Deductible)
Outpatient Surgical Services *3 Surgeries/Yr	$250 Copay/Service (After Deductible)	$250 Copay/Service (After Deductible)
Emergency Room *2 visits/Yr Accident-related & 2 visits/Yr Sickness-related	$250 Copay (After Deductible)	$250 Copay (After Deductible)
Telemedicine (Only OurLiveDoc)	$0 Copay	$0 Copay
Labs *3/Yr **X-Rays** *3/Yr	$25 Copay (After Deductible) $50 Copay (After Deductible)	$25 Copay (After Deductible) $50 Copay (After Deductible)
Diagnostic Testing & Advanced Imaging *3/Yr	$200 Copay (After Deductible)	$200 Copay (After Deductible)
Pharmacy Drugs - Retail Generic Drugs Preferred Brand Drugs Non-Preferred Retail	 $0 Copay PAP Available PAP Available	 $0 Copay PAP Available PAP Available
Pharmacy Drugs - Mail Order Generic Drugs Preferred Brand Drugs Non-Preferred Retail	 $0 Copay PAP Available PAP Available	 $0 Copay PAP Available PAP Available
Employee Only (PHCS) **Employee and Spouse (PHCS)** **Employee and Child(ren) (PHCS)** **Family (PHCS)**	$374.00 $679.00 $669.00 $959.00	$334.00 $639.00 $629.00 $889.00

**Prescription Drug Coverage (HSA-Qualified Plan)

- This plan is designed as a High Deductible Health Plan (HDHP) compatible with a Health Savings Account (HSA.
- Except for certain preventive medications permitted under IRS guidance, prescription drugs are subject to the deductible and no benefits are payable before the deductible is met.
- Certain IRS-approved preventive medications may be covered prior to the deductible and may be subject to copayments or coinsurance.
- After the deductible is met, prescription drugs are covered according to the plan's applicable cost-sharing.

DENTAL PLANS

(Open 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 Per insured person per calendar year	$50 / $150	$50 / $150
Deductible Waived for Diagnostic / Preventative Services	Yes	Yes
Diagnostic & Preventative 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%
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% Orthodontic Included
Coverage Level Monthly Rates Employee Only Employee & Spouse Employee & Child(ren) Family	Open Access PPO $34.77 $69.54 $78.58 $113.34	Open Access PPO $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

When using VSP at an ophthalmologist or optometrist your SSN is your Member Number

No one should leave a family member with grief and unexpected debts, so Group Term Life Insurance is included in the 8300 HSA 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 medical plan elections.

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

Plan	$20K Coverage	$200K Coverage
8300 HSA	Included in Premium	$75/mo
3500 HSA	$10/mo	$75/mo
4500 Copay	$10/mo	$75/mo
3500 Copay	$10/mo	$75/mo
1750 HSA VL	$10/mo	$75/mo
1000 VL	$10/mo	$75/mo
1750 HSA EPO	$10/mo	$75/mo
1000 EPO	$10/mo	$75/mo

CONTACT INFORMATION

	CONTACT	CUSTOMER SERVICE
Enrollments Contact	Group@themvpplans.com	
Group Sales, Underwriting, and Enrollment Contact	Bill Morrissey Wmorrissey@themvpplans.com	844-580-BHPI

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

ADVANTAGES OF OUR XGB ADMINISTRATORS

There are many advantages to using third party administration for benefit packages.

Access to Top Insurance Companies
Third party administrators help you get access to the top insurance companies in the market, making it easy to place your benefit packages with the insurer best suited to your needs. Maximum Benefits will obtain quotes for your various benefits from the leading insurance companies.

Choose the Best Insurer for Each Benefit
If you offer group health, life, dental, short-term or long-term disability insurance, using a third-party administrator such as the BHPI TPA allows companies to pick and choose the best insurer for each individual benefit. With easy access to the market, they can identify the best company that provides the “maximum benefit” for each insurance program, with only one enrollment form needed. You can also add additional benefits such as Critical Illness, Prescription Drug and Best Doctors Plans.

No Need to Re-Enroll Employees
Shopping for group plans can be a daunting task when different companies require different application forms. Employers can become frazzled when it comes to getting all the various forms back from employees. However, with BHPI TPA, you only need one enrollment form for your employees, and there is no need to re-enroll when switching carriers. This is a huge time-saver for the employer, alleviating the burden of distributing, collecting and submitting all of the various forms. With BHPI TPAs’ third-party administration, it becomes possible to adjust your plan as needed without completing more paperwork.

Peace of Mind with our ERISA Plans with Stop-Loss Indemnity Protection
We can help you to decide which benefits, if any, should be offered, and we can assist you with determining the appropriate deductible levels to offer your employees. Many insurance companies consider premiums as a prepayment of future claims. However, sometimes companies would prefer to have better control over their funds and choose a level premium amount to pay for their employees. With ERISA plans, this is possible through Level Funded ICHRA, HSA, and HRA plans. If the amount of total premiums for each employee is within the company's budget, and they are able to be paid to us as premiums, the company's liability is limited to ONLY the premiums paid. But what if employee claims are higher than what is in the company's budget and has been paid for? This is where Benefits Re Stop-Loss comes in. They pay all of the claims over the total amount of the premiums collected from the employer each month, thus limiting the employer liability.

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.

EMPLOYEE CALL CENTER & ADVOCACY PROGRAM

Members who have issues with their insurance carriers can have lower productivity and morale. Resolving issues with insurance carriers can be a daunting task.Having a trained professional who understands the intricacies of the healthcare system and how to navigate through it can truly be a life saver. For those employees who need help, they can access the BHPI TPA Employee Advocacy program.

Personalized Employee Support
• Benefit Assistance • Eligibility issues and resolution

BHPI TPA Advocates help sort out and solve claims and related paperwork problems. We work on coverage issues and help members understand their benefits.

Examples of Services Include
• Helping with Retirement Savings tools, such as target date funds • Researching a member's outstanding out-of-pocket responsibilities and resolving errors with providers and/or their health plan. • Correcting balance-billing problems. • Resolving eligibility problems and benefit and claim denials. • Correcting charges incorrectly applied to the member’s deductible. • Resolving incorrect plan procedure interpretations such as emergency room claims denied for a lack of precertification. • Assuring correct application of provider network status. • Providing payers with additional information required to correctly pay a claim or apply a benefit. • Resolve coordination of benefits disputes between multiple carriers. • Resolving errors in the application of deductibles and co-payments.

24x7x365 access via web and mobile device app available at www.benefithealthplan.com

HEALTH SAVINGS ACCOUNT (HSA)

What is a Health Savings Account?

A Health Savings Account (HSA) is a tax-advantaged account for individuals who are covered by a high-deductible health plan (HDHP). Contributions are made to the HSA account. These contributions can be used to pay for qualified medical expenses, such as medical, dental and vision care, as well as prescription drugs. You HSA plan has a maximum out of pocket amount of $8050 for individual in 2024.

An HSA is like a personal savings account with investment options for health care. The employee owns the HSA account and funds the account with TAX-FREE dollars. Investment options are available once a minimum balance of $500 is reached.

You can start, stop, or change your payroll contributions at any time during the plan year. Please check with the Human Resources Department for additional information. HSA funds can be used for any eligible HSA expense. Regular medical, dental, and vision expenses are most common.

For example, if you are going in for an annual eye exam, and you do not have vision coverage, you can use your HSA funds to pay for that exam.

Advantages of an HSA	**You may not be eligible for an HSA plan if:**
• HSA contributions are pre-tax deductions. • Withdrawals for health care expenses are tax-free. • You earn tax-free interest on the money in your account. • Your HSA balance rolls over from year to year; you do not forfeit any unused balance. • It is always yours to spend on eligible health care expenses. You can also save and invest for future use. • At age 65, you can start using your HSA dollars for any purpose, not just health care expenses and your health care withdrawals are tax-free.	• You are covered by an FSA (unless $0 balance) • You are covered by an HRA (unless $0 balance) • You are covered by another health plan (unless it is another HSA-qualified plan) • You are enrolled in Medicare A • You are a dependent of another taxpayer
HSA Contribution Limits and Uses	**HSA Contribution Limits for 2025**
Your HSA deferrals are deposited into your HSA account through payroll deductions. You can defer up to the annual contribution limit amounts shown below. Those age 55 and older can contribute an additional $1,000 annually.	• Individual - $4,150 • Family - $8,300 • Catch-up (55+) - $1,000

PRE-TAX HEALTH BENEFIT

GROSS	$1,000
DEDUCT MEDICAL	$250
FEDERAL TAX	$27.31
STATE TAX	$20.35
FICA	$57.38
TOTAL TAKE HOME	**$644.96**

POST-TAX HEALTH BENEFIT

GROSS	$1,000
FEDERAL TAX	$55.17
STATE TAX	$34.72
FICA	$76.5
DEDUCT MEDICAL	$250
TOTAL TAKE HOME	**$584.61**

OUR HSA PLANS HAVE NO FEE TRADING WITH THE SCHWAB PLATFORM SO YOU CAN INVEST YOUR TAX FREE MONEY!

What if you invested $8,300 per year in your HSA Account for 10 years? The result: $27,390 more in your take home pay, and $145,508.69 in your HSA Account to spend!