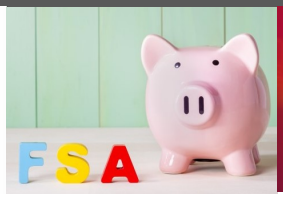
BENEMAX®

EMPLOYEE BENEFITS GUIDE

EFFECTIVE 1/1/2020

HEALTH DENTAL VISION FSA DISABILITY



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Introduction

Success in today's business environment begins with a creative and productive team of individuals, all dedicated to a set of common objectives.

We recognize that for each of us to be as creative and productive as possible, all of us need the peace of mind that comes from knowing that our most basic needs have been secured. This booklet outlines the features of our employee benefit plan. We hope you will find it a helpful reference.

Our primary goal is to ensure that every employee and his or her immediate family have access to great medical care. We supplement this fundamental commitment by also providing high level dental, vision, life, disability and long term care coverage plus flexible spending accounts.

Unfortunately, in today's economy, it is not enough for a company to design a top-notch benefit package; we also have to find a way to make it affordable for our employees and for the company. To accomplish this, we have elected to self-insure a portion of our benefits through our company, Benemax. We have contracted with Blue Cross Blue Shield of Massachusetts (BCBS) to be our health benefit carrier. We self-insure our dental benefits through Benedent®. Our medical, dental and vision benefits offer you the option to stretch your healthcare dollars further by utilizing preferred providers, but you still have the freedom to use any provider you choose.

Benemax is responsible for making our plan work for our employees.

Call Benemax First!
For all benefit related questions call:
800-528-1530 or
Visit our Virtual Benefit Manager® (VBM) for on-line help at www.mybenemax.com. Enter VBM keyword, BMAX, in the My Company box on the front page of the website.

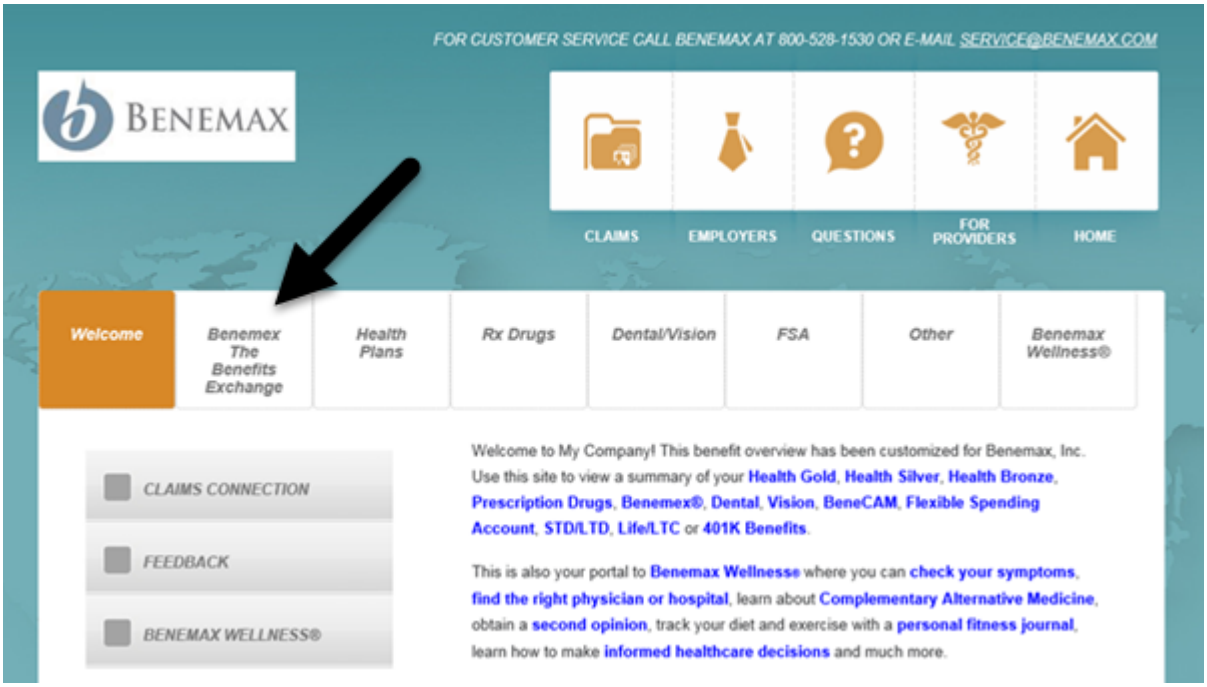
How To Enroll In Your Benefits

All employees are required to go through the Benemex® Online Enrollment system, even if you wish to waive coverage.

You will enroll or waive medical, dental, vision and flexible spending account coverages.

Before you begin, make sure you have all pertinent information on your dependents (social security numbers, date of birth, and alternate addresses). If joining one of the HMO plans you will also need the name of you and your dependent's primary care provider (PCP). A form to declare your PCP will be available under the plan choice. You are required to print and send that form to enrollment@benemax.com who will add your PCP information to your enrollment at BCBS.

1. Go to www.mybenemax.com, keyword BMAX
2. Select the "Online Enrollment" tab
3. Complete the required fields for yourself and any eligible dependents.
4. Print and save your confirmation page



ELIGIBILITY

Eligibility

Benemax offers all employees who work 35 hours or more per week the opportunity to participate in our benefit plans, which include group medical, dental, vision and flexible spending accounts (FSA). Newly hired employees (and their qualified dependents) are eligible to participate in our plans after a 30-day waiting period. After 30 days employees will be enrolled in the company paid life insurance, short and long term disability plans and long term care insurance. They are also eligible to purchase the additional voluntary coverages described in this guide. Dependent children remain eligible for all coverage until the last day of the month following their 26th birthday.

Open Enrollment

Open Enrollment for medical, dental, vision and FSA occurs each year in December for 1/1 effective dates. Employees will be notified of any changes to the plan and the dates they will be required to have any plan election changes communicated through the open enrollment process.

Employees that do not enroll after their waiting period are not eligible to enroll again until the next open enrollment period unless they experience a qualifying event (QE).

Changes to your plans

Changes to health plans outside of open enrollment can only be made if an employee or an employee's spouse experience a qualified change in status event (QE).

Qualified changes in status include:

- Change in employee's legal marital status
- Change in number of tax dependents (birth, adoption, death)
- Change in employment status that affects eligibility
- Dependent ceases to satisfy eligibility requirements
- Judgment, decree, or court order dictating provision of coverage
- Entitlement to Medicare or Medicaid
- Change in cost of the benefit
- Change in coverage
    - Addition or elimination of benefit option
    - Change in coverage of spouse or dependent under his/her employer's plan
    - Significant curtailment of coverage.

Changes to your health plan can be made at open enrollment or when you experience a qualified change in status event. Notify Human Resources within 30 days of a change.

Employees have 30 days from the qualifying event to notify Human Resources. Any change will be effective on the date of the qualifying event.

Medical Plan - HMO or PPO

The Benemax Health Plans integrates fully insured base plans from Blue Cross Blue Shield of Massachusetts (BCBS) plan with a employer-funded supplement known as Benemax Wrap®. Employees have the choice of 3 PPO plans or 3 HMO plans. The level of coverage you choose is related to the amount of premium you pay via your payroll deductions.

The Benemax health plans run on a calendar year, beginning January 1 of each year.

PPO members have access to BCBS network of "preferred providers". Preferred providers are also referred to as "in-network providers". Whenever a member voluntarily uses a "preferred provider", that provider accepts an "allowed amount" set forth by BCBS. A preferred provider will cost you less than an out-of-network provider.

HMO members are required to designate a primary care provider (PCP) from the BCBS HMO Blue New England network. For children, you may choose a participating network pediatrician as the PCP. **When seeking care from a specialist a referral from your PCP is required**. Your PCP is likely to refer you to their affiliated hospital group or medical practice. You do not need a referral to see an OB/GYN.

To find PPO preferred, in-network provider or an HMO New England provider, visit www.bluecrossma.com/findadoctor or call BCBSMA at 800-821-1388 for a list of providers.

Emergency services on both PPO and HMO are covered anywhere. If traveling outside the HMO service area you can go to the nearest appropriate health care facility. Under the HMO, you are covered for an urgent or emergency care visit and one follow-up visit while outside the service area.

Pre-Approval and Utilization Review Requirements include pre-admission review, pre-service approval for certain out-patient services, concurrent review, discharge planning and individual case management. If you need non-emergency or non-maternity hospitalization, you or someone (often your provider if in-network) on your behalf must call the number on your ID card for pre-approval. This is the members responsibility. If you do not notify BCBS and receive pre-approval, your benefits may be reduced or denied.

Did you know?

That an independent MRI provider could cost 25% to 50% less than a hospital based MRI provider? Independent MRI providers, like Shields MRI are covered by BCBS and will cost far less than hospital based MRI facilities. If you choose a deductible plan knowing this will save you and your company a significant amount of money.

Use Emergency Rooms Wisely

Employees are encouraged to use Emergency Rooms for true emergencies only. Deciding whether your situation is a true emergency can be a tough call when you feel sick or are in pain. If you thought you were having a heart attack or realized that your child swallowed a bottle of medicine, you would go to the closest hospital as quickly as possible. For other situations that are less clear, call your primary care physician, they will often see you within a 24 hour period or advise you on the best options for urgent care. Urgent Care will always cost less then Emergency Room care. Learn where you local, low cost network Urgent Care Center is located.

In an emergency, you're covered at any facility and the services are considered in-network. When possible, contact BCBS via the telephone number on the BCBS ID card to notify them of the emergency.

Medical Plans - PPO

Employees have three PPO plan options. All plans include a BCBS base plan with an annual, in-network deductible of $3,350 per individual plan or $6,550 per family plan. The plan also included additional co-pays and co-insurance after the deductible. Benemax pays a portion of this deductible depending on which plan you choose. In addition, some after deductible co-pays are paid by Benemax. On the Silver and Bronze plans, an individual in a family plan must meet the family plan deductible before benefits are paid. The Silver and Bronze plans are Health Savings Account (HSA) qualified.

Gold Plan: Members have no deductible. Office visits are a $20 co-pay and covered prescriptions drugs are covered in full.

Silver Plan: Members are responsible for the first $1,500 (individual coverage)/$3,000 (family coverage). Once the deductible is met, co-pays apply for office visits and emergency room, and prescriptions drugs are covered in full.

Bronze Plan: Members are responsible for the first $2,800 (individual coverage)/$5,600 (family coverage). Once the deductible is met, co-pays apply for emergency room only. After deductible, covered prescription drugs are covered in full.

Below is a brief reference of frequently used in-network services and your final cost after your claims have been processed by both BCBS and Benemax.

Covered Services (In-Network)	GOLD PLAN	SILVER PLAN	BRONZE PLAN
In-Network Deductible	No Deductible	$1,500 individual / $3,000 family	$2,800 individual/ $5,600 family
Routine office visits & tests	No cost	No cost	No cost
Routine eye exam (1 every 24 months)	No cost	No cost	No cost
Diabetic office visit (first 2 visits of each year)	No cost	No cost	No cost
Non-routine office visits - PCP, specialist, mental health and substance abuse, chiropractor	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Short-term rehab therapy (60 visits per year)	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Acupuncture visits (up to 12 visits per year)	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Telehealth visits	$0 co-pay via Teladoc	⊙$59 - $99 via BCBS	⊙$59 - $99 via BCBS
Urgent care visit	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Emergency room visits (co-pay waived if admitted)	*$0	*$150 co-pay after ded.	*$150 co-pay after ded.
Day surgery in hospital	*$0	*Deductible	*Deductible
Inpatient hospital services	*$0	*Deductible	*Deductible
Diagnostic lab work, X-rays (non-routine)	*$0	*Deductible	*Deductible
Complex imaging (MRI/CT/PET/Cardiac Imaging)	*$0	*Deductible	*Deductible
Durable medical equipment	*20% co-insurance	*20% co-ins. after ded.	*20% co-ins. after ded.
Prescription drugs (retail)	*$0 with Rx Card	*$0 after deductible with Rx Card	*Deductible then $0
Prescription drugs (mail order)			
Out-of-Network Deductible	$3,000 per individual	$4,650 per individual	$5,800 per individual
Co-insurance after out-of-network deductible	20% to 40%	20% to 40%	20% to 40%

Out-of-Network: If you go to an out-of-network provider, your provider may ask you to pay the actual charge for your care at the time of your visit. The out-of-network deductible shown above. Members are also responsible for charges considered over usual and customary by BCBS.

* Represents services that are supplemented by your employer, via Benemax.

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⊙Silver and Bronze plans use Well Connections from BCBS, see page 9. Once deductible is met members can use Teladoc at zero co-pay.

Medical Plans - HMO

Employees have three HMO plan options. All plans include a BCBS base plan with an annual, in-network deductible of $3,350 per individual plan or $6,550 per family plan. The plan also included additional co-pays and co-insurance after the deductible. Benemax pays a portion of this deductible depending on which plan you choose. In addition, some after deductible co-pays are paid by Benemax. On the Silver and Bronze plans, an individual in a family plan must meet the family plan deductible before benefits are paid. The Silver and Bronze plans are Health Savings Account (HSA) qualified.

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Below is a brief reference of frequently used in-network services and your final cost after your claims have been processed by both BCBS and Benemax.

Covered Services (HMO Blue NE)	GOLD PLAN	SILVER PLAN	BRONZE PLAN
In-Network Deductible	No Deductible	$1,500 individual / $3,000 family	$2,800 individual/ $5,600 family
Routine office visits & tests	No cost	No cost	No cost
Routine eye exam (1 every 24 months)	No cost	No cost	No cost
Diabetic office visit (first 2 visits of each year)	No cost	No cost	No cost
Non-routine office visits - PCP, specialist, mental health and substance abuse, chiropractor	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Short-term rehab therapy (60 visits per year)	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Acupuncture visits (up to 12 visits per year)	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Telehealth Visits	$0 co-pay via Teladoc	⊙$59 - $99 via BCBS	⊙$59 - $99 via BCBS
Urgent care visit	*$20 co-pay	*$20 co-pay after ded.	*Deductible
Emergency room visits (co-pay waived if admitted)	*$0	*$150 co-pay after ded.	*$150 co-pay after ded.
Day surgery in hospital	*$0	*Deductible	*Deductible
Inpatient hospital services	*$0	*Deductible	*Deductible
Diagnostic lab work, X-rays (non-routine)	*$0	*Deductible	*Deductible
Complex imaging (MRI/CT/PET/Cardiac Imaging)	*$0	*Deductible	*Deductible
Durable medical equipment	*20% co-insurance	*20% co-ins. after ded.	*20% co-ins. after ded.
Prescription drugs (retail)	*$0 with Rx Card	*$0 after deductible with Rx Card	*Deductible then $0
Prescription drugs (mail order)			

* Represents services supplemented by your employer, via Benemax.

Members are required to designate a Primary Care Provider (PCP) and to obtain a referral from their PCP when seeking care from a specialist. For a listing of participating providers, visit www.bluecrossma.com or call the number on your BCBS ID card. This plan does not allow for out-of-network services.

⊙Silver and Bronze plans use Well Connections from BCBS, see page 9. Once deductible is met members can use Teladoc at zero co-pay.

Medical Plans - Continued
Benemax Rx and Pediatric Dental

Prescription drugs (applies to all plans)

Without our Benemax Wrap, prescription drugs are subject to the BCBS plan deductibles. Under the Wrap plans, the Gold Plan BCBS approved Rx drugs are zero co-pay. Under the Silver and Bronze plans after the deductible is met, approved BCBS prescriptions are covered in full. You will be issued a Wex/Rx Card from Benemax; this card allows you to purchase prescription drugs (Rxs) that are approved by BCBS.

For first time RX Card users:

- activate the Rx card upon its arrival. Cards take 24-48 hours to align with the pharmacy manager. Rx refills ordered or charges made before allowing this activation time will result in card rejections.
- When purchasing a covered Rx at the pharmacy, present your BCBS ID card to ensure coverage, then use your Rx Card to pay for the balance due. The card functions as a credit card or you can set up a pin during activation.
- If you card rejects, ask the pharmacist if a coupon or other Rx program is used. Only Rx that is approved and exact cost share from BCBS will be authorized. Coupons may have to be removed. Pay for your Rx separately from other purchases. Your card will deny if other non-covered items are included.
- If, despite following the above instructions, your Rx Card does not work, purchase your prescription with another form of payment, and submit the pharmacy receipt (note that is attached to the bag) to Benemax for reimbursement. See the claims submission section under the Service and Support section of this booklet.

Bronze plan member do not receive a Wex Rx cards unless requested and after deductible is met.

Pediatric Dental Benefits (under BCBS plan)

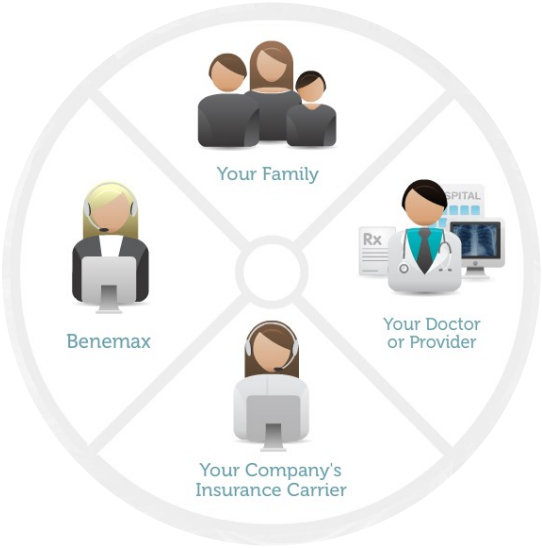
As a result of the Affordable Care Act, your BCBS health plan now includes coverage for **in-network** pediatric dental expenses. **BCBS is the primary dental payer for dependent children under the age of 19.** Show the dentist your BCBS ID card at the time of visit. The dentist sends the claim to BCBS. BCBS processes your claim, sends you an explanation of benefits (EOB) and pays the dentist the covered amount. If your dependent child is also enrolled in the Benedent® plan, send your BCBS EOB to Benemax, and Benemax will process the balance of your claim according to your Benedent® schedule of benefits.

Pediatric Dental Benefits (for members under age 19)	Your Cost In-Network
All dental services are limited to schedule and/or frequency limits, see your subscriber certificate for details. Medical plan deductible applies only to Groups 2 & 3 services.	
Group 1: Preventive & Diagnostic Services: Including oral exams, x-rays, & routine care	No cost
Group 2: Basic Restorative Services: See BCBS summary for more details	25% co-insurance
Group 3: Major Restorative Services: Including tooth replacement	50% co-insurance
Orthodontic Services: Medically necessary orthodontic care that has been pre-authorized	50% co-insurance

Using and Understanding Your Plan

How Does it Work

The chart below will help you understand who pays for what and when.



Your Family visits your provider (doctor/hospital) and shows both their BCBS ID card and their Benemax Card.

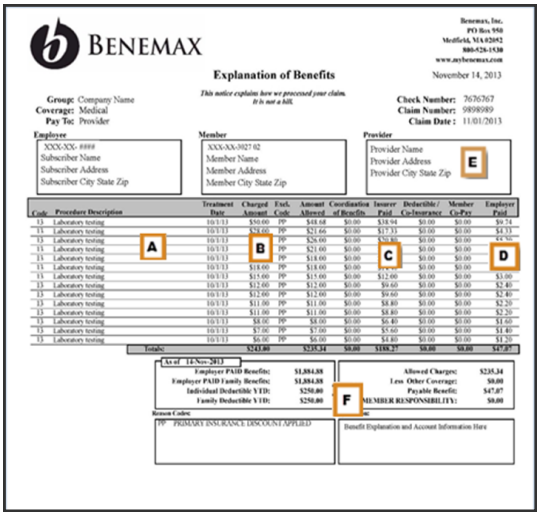
Your Doctor or Provider will bill BCBS

BCBS will process your claim, notify your provider, and send a Claims Summary to you and your provider.

Benemax receives a report of your claims from BCBS. Benemax reviews your claim and makes additional payments on behalf of your employer.

Benemax notifies you of payment via a Benemax Explanation of Benefits (EOB). You are responsible to pay the amount due to your provider as shown on your Benemax EOB (depiction below).

You can visit our website for a tutorial on how your plan works. Go to www.mybenemax.com and enter company keyword **BMAX**, visit the Health Tab and click on "Learn How Your Plan Works".



A. The service and date it occurred

B. BCBS allowed amount

C. How much BCBS paid

D. How much your employer paid on your behalf

E. Who Benemax paid

F. How much you need to pay

This is the document you need to confirm what you pay your provider.

Telemedicine

Teladoc®

As part of our wellness initiative, we have partnered with Teladoc to help you and your immediate family members get the care you need quickly, easily, and cost-effectively. Bronze and Silver plan members must satisfy their deductibles before using Teladoc services. See Well Connections below for Telemedicine services before you meet your deductible.

Zero Co-pay Telemedicine Visit Anywhere, Anytime

- Don't take time out of your schedule to go to the doctor's office.
- Receive immediate advice on non-emergent symptoms 24/7 from any location, including on vacation locations.
- Get prescriptions/refills for common conditions based on medical history entered online

Telemedicine through BCBS Well Connection

MASSACHUSETTS

Well Connection works with the Silver and Bronze Plans while in deductible. In addition, Well Connections provides Behavioral health services, where Teledoc does not.

You are covered for certain medical and behavioral health services for conditions that can be treated through video visits.

The cost of a general medicine visit is $59 and for a behavioral health visit, $99.

This offers great savings for an MD visit while still in your deductible.

See licensed doctors using live video visits on your favorite device.

Download the app, or visit **wellconnection.com**

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.
183536M 55-1831 (04/18)

Once a member reaches the Silver or Bronze deductible they can use Teladoc for zero co-pay general medicine visits.

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Health Plan - Extras

From Benemax

Benemax Fitness Club Sponsorship

- $45/month toward Kingsbury Club membership fee

BeneCAM®

BeneCAM® is a Complementary Alternative Medicine group benefit plan sponsored by Benemax and administered by Benemax. BeneCAM covers certain alternative medicine procedures after a licensed physician completes a Letter of Medical Necessity (LOMN); all benefits are paid as follows;

- First $250/year @ 100%
- Next $1,000/year @ 50%
- $750 per patient maximum (January 1st plan year)

Bronze and Silver plan members must satisfy their deductibles before using BeneCAM services.

Blue Cross Blue Shield of Massachusetts offers you additional programs to promote wellness. Visit the Virtual Benefit Manager for the complete brochure of all of the value added extras from BCBS.

Healthy Actions – Earn up to $300 just for being healthy! Benemax sponsors this a program that pays you up to $300 for having a routine physical and being up to date with your health screening. If you are found to be healthy you will receive the $300 within two to three weeks after you or you doctor submits your results. If you need to improve your health, you will receive $100 Visa debit card once your completed form is received by Healthy Actions. Your doctor will set a goal for you to meet before your plan year ends. If your doctor confirms progress you will receive the additional $200. Look for your Healthy Actions letter about two weeks after the new plan year begins.

Fitness Benefit $150 reimbursement at any health club that includes cardiovascular and strength-training exercise equipment or (or 10 fitness classes). This is good for one membership per subscriber who has been active on BCBS medical plan for 4 months or more.

Weight loss benefit reimbursement is available up to $150 toward the cost of three months membership in Weight Watchers® or in another approved program.

Living Health® Smoke-free program – Online help at www.ahealthyme.com

Living Health Babies - Visit www.livinghealthybabies.com for information about BCBS's Maternity Care program. Expectant Mothers are eligible for reimbursement up to $90 for completing a childbirth course. New Mothers can get a cost-free manual or dual electric breast pump and call in maternity support.

Blue Care Line – answers health questions 24 hours a day: 800-247-BLUE (2583)
And much more. Visit www.bluecrossma.com/ahealthyme.

Members can access these resources from the Benemax Virtual Benefit Manager by clicking on the health tab, then the BCBS E-Kit icon on the left side of page.

Dental Plan

Benedent® - Your dental benefit will pay up to $1,500 per covered individual beginning January 1st of each year. There is no deductible for any services. There are no distinctions among preventive, basic and major services. There is no waiting period for major dental services. Orthodontia is a covered service under this plan for dependent children under the age of 19, and is paid under the same schedule of benefits. Dependent children who are enrolled on the plan are eligible for benefits to age 26.

Dental Benefits	
First $200 per year	Payable at 100%
Next $1,000 per year	Payable at 80%
Next $1,000 per year	Payable at 50%
Maximum Annual Benefit	$1,500 per individual per year

100% Freedom - With your Benedent Dental Plan, you may visit any dentist of your choice. Please make sure to show your provider your Benedent ID Card. This card includes a summary of benefits on the reverse. If your provider has any questions, please have them call 800-528-1530, prompt 3, to speak with a Benemax Independent Member Advocate.

The Guardian Network - With Benedent use of a network dentist is not required. However, if you choose to visit a Guardian network dentist, you will receive an average discount of 28% to 33% off of the cost of services provided. Using the Guardian network and help you maximize your dental benefits. To find a provider in this network, go to www.guardiananytime.com and click on "Find A Provider". Enter PPO for the plan and DentalGuard Preferred Select as the network.

Services that are not covered under your Benedent Dental Plan include: services covered under your employer's health benefit plan, procedures not approved by the American Dental Association (ADA), services for which the patient is not obligated to pay, services rendered in connection with TMJ, cosmetic services (e.g., teeth whitening and teeth bleaching), adult orthodontia, oral hygiene, and services that do not meet accepted dental practice standards.

The Benedent Wellness Initiative is a program that encourages dental utilization for members who have been diagnosed with diabetes or who are pregnant, as studies show that this can reduce medical expenses. For these individuals, a special schedule of benefits (below) applies.

All covered dental services	Payable @100%
Maximum Annual Benefit	$1,500 per individual per year

A Letter of Medical Necessity (LOMN) attesting to one of these diagnoses must be completed by your physician and sent to Benemax. To access your LOMN, visit www.mybenemax.com, enter keyword **BMAX**, click on the Dental tab, then select the LOMN.

User-friendly claim process - Present your Benedent ID card when visiting your dental provider. In most cases, your dentist will bill Benemax directly for your services. No claim form is required. Benemax will process the claim according to the benefit schedule described above and make payment directly to your dentist. Both you and the dental provider will receive an Explanation of Benefit for each claim.

If your dental provider declines to bill Benemax on your behalf and you are required to pay at the time of service, you may submit your claim to Benemax for reimbursement. Send Benemax an itemized bill and make note that you have paid your dentist. Follow the submit a claim or bill per directions on page 23.

Vision Plan

Your Vision Plan is through EyeMed and the Insight network. For a complete list of providers near you, visit www.eyemed.com or call 1-866-804-0982. Your claims payment responsibility or out-of-network reimbursement is listed on the below depiction.

Covered Vision Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with dilation as necessary (once every 12 months)	$10 co-pay	Up to $50
Standard contact lens fit & follow-up	Up to $55	N/A
Retinal imaging	Up to $39	N/A
Frames (once every 24 months)	$0 co-pay; $150 allowance; 80% of charge over $150	Up to $120
Standard lenses (single/bifocal/trifocal)	$25 co-pay	Up to $42/$78/$130
Standard lenses (standard progressive lens)	$25 co-pay	Up to $140
Standard lenses (premium progressive lenses)	$45-$70 co-pay	Up to $140
Contact lenses (once every 12 months) Conventional Disposable Medically Necessary	$0 co-pay; $150 allowance; 15% off retail price over $150 ($0 on Medical necessary)	Up to $150 $150 Up to Up to $210
Laser vision correction	15% off retail price	N/A

Please refer to your EyeMed Summary of Benefits available on the Virtual Benefit Manager at www.myBenemax.com, keyword BMAX for complete coverage details.

Questions? Call 1-800-528-1530
For questions about your health benefits, call or visit our website at www.mybenemax.com, keyword: **BMAX**.

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Flexible Spending Account

A Flexible Spending Account is an IRS-qualified plan that allows plan members to set aside pre-tax dollars to pay for eligible healthcare or dependent care expenses. Participation in one or both FSAs avoid state, local, federal and FICA taxes. This saves you approximately 21-25% for eligible expenses for you and/or your eligible dependents.

Benemax offers three types of FSA, Healthcare, a Limited Purpose Healthcare and Dependent Daycare Assistance.

- Plan runs on a calendar year
- Employee cannot make a change to an election and/or enroll outside of open enrollment unless they experience a qualifying event.
- Open Enrollment for FSA is during the month of December.
- Funds from one account cannot be transferred to another account.

Healthcare FSA (HFSA) (Gold Plan)

- Annual Election: $2,750
- 75-day grace period allowed, extending the plan an additional 2 1/2 months
- Unused funds at the end of the grace period and runout are forfeited.
- HFSA allows you to use pre-tax dollars to pay for insurance co-pays, deductibles and co-insurance, dental, orthodontia, eye glasses/contact lenses, and complementary alternative medicine.
- HFSA funds can be used before they accumulate in members account. The full election amount is available to the member on the first day of the plan.
- A Letter of medical necessity (LOMN) or written prescription is required for reimbursement for over-the-counter drugs and/or complementary alternative medicine when used to treat an illness or injury. A LOMN is available on VBM, under your companies FSA page.

LP-HFSA (Silver and Bronze Plan)

- Allows pre-tax dollars to pay for dental and vision services only. **No medical** plan co-pays, deductibles, prescription drugs or alternative healthcare are eligible expenses through a LP-HFSA.
- The LP-HFSA is used when a member is part of a qualified Health Saving Account (HSA) program.
- The full election amount is available for eligible claims uniformly throughout the year. This means you can be paid for an eligible expense as soon as it has been incurred, even if that is before you have deposited sufficient funds to cover that expense.
- You may elect up to $2,750 per LP-HFSA plan year.

Dependent Care FSA (DCAP)

- Annual election: $5,000 (or $2,500 if married, but filing separately)
- 75-day grace period allowed
- Unused funds at the end of the grace period and runout are forfeited.
- Assists employees who need to provide custodial care (i.e., "daycare") for a qualified dependent (child under the age of 13, disabled adult or elderly parent) in order for you or your spouse to be able to work.
- Funds are available only as the funds are deposited into your account.
- Eligible daycare expenses include:
  - Daycare center: Expenses incurred for services provided by a licensed daycare center (i.e., a facility providing care for more than six individuals not residing at the facility.)
  - Payments to relatives: Expenses incurred for services provided by a relative who is not your dependent (even if he or she lives in your household). However, you may not claim any amounts paid to:
    - An individual for whom you or your spouse is entitled to receive a personal tax exemption as a dependent, or
    - Any of your children who are under age 19 at the end of the year in which the expenses were incurred (even if he or she is not your dependent).
- Summer day camp: Expenses incurred for a day camp that is primarily custodial in nature rather than educational. However, expenses for overnight camps are not considered work-related and are ineligible.

Flexible Spending Account

A new WEX card is provided for your convenience for FSA-eligible items and service purchases. You'll have no claim forms to complete, and you won't have to wait for a reimbursement check. Present your Wex card at participating locations that accept Debit MasterCard®, and the amount for eligible purchases will be deducted automatically from your account. You may check your WEX card balances or account details anytime – online or with a quick phone call to Benemax. Please save all your receipts; ask your dental and vision providers for detailed receipts that show the member's name, date of service and services provided. When necessary, you will receive a letter or e-mail from Benemax requesting this additional information.

Once your election has been reached, the card will be rejected. Do not discard the WEX card. It will be used for the next year's FSA plan. The card is good for 5 years.

Paper claims can be filed through Claims Connection via the Virtual Benefit Manager (VBM) or by obtaining a claim form from the FSA tab on the VBM. Receipts for eligible expenses must include name of person receiving service, date of service and charge for service. With the exception of eligible over the counter items, register receipts cannot be accepted. All DCAP claims must include dependent' name, dates of service, provider's tax id number or social security number.

Use-It or Lose-It Rule

It is important for you carefully to estimate your out-of-pocket healthcare and dependent daycare expenses for the upcoming year due to the IRS Use-It-or-Lose-It Rule. These rules require that:

- Any amount of **HFSA, LP-HFSA, DCAP** money remaining after the end of the run-out and grace periods will be forfeited and not be returned to you, per IRS rule. Grace period ends on March 15, run-out ends on June 15.

Termination of Employment

HFSA & LP-HFSA: Unless you elect COBRA, your participation in the plan ends when you terminate employment. You no longer will be able to incur expenses for reimbursement. Your contributions also will cease; however, you will have a 90-day runout period to file claims for services incurred before your termination.

DCAP: If, upon termination of employment, you have not yet claimed 100% of the contributions made to your account, you have a 90-day runout period to submit claims incurred from the beginning of the plan up to your termination date. Any funds remaining in your account after the run-out period will be subject to the Use-It-or-Lose-It rule.

COBRA: COBRA, if elected, allows you to continue to participate in your healthcare account and receive reimbursement for medical expenses incurred after the termination of your employment. COBRA does not apply to dependent daycare accounts. Under COBRA, you must elect coverage within 60 days of notification, and you must continue to submit contributions (now with after-tax dollars) to your employer. COBRA eligibility terminates at the end of the plan year in which your employment terminated.

If you are terminated, you may elect COBRA if (and only if):

- The plan sponsor (your employer) is subject to COBRA, and
- You have contributed more into your healthcare account than you have received in healthcare benefits as of your termination date.

Health Savings Account (HSA) (Silver & Bronze Plan)

Employee that participate in either the Silver or Bronze Health plan, are encouraged to open and contribute pre-tax funds from their wages to an Health Saving Account (HSA) of their choice. Benemax will assist you with setting up an HSA account from Optum HSA Bank, and will pay the monthly fee. Optum Bank offers state of the art HSA services, including a convenient debit card, online banking and HSA education. Long-term saving and investing options are available after your account reaches a balance of $2,500. All IRS qualified health care expenses, (deductibles, co-pays, dental and vision expenses) can be paid with HSA funds.

In order to contribute to a Health Saving Account, you must;

- Be covered with an HSA eligible high-deductible health plan (The Benemax Silver or Bronze plans)
- Not be enrolled in any other health coverage (spouse or VA benefits), Medicare, or Healthcare FSA plan
    - This does not include dental and vision coverage or limited purpose FSA
- You cannot be claimed as a dependent on someone else's tax return
- Other restrictions apply, please consult your tax, benefits or financial advisor.

Contributions limits are determined by the IRS each year.

- Maximum contribution for 2020
    - Individual coverage is $3,550
    - Family coverage $7,100
- If age 55 or older, a annual catch-up deposit of $1,000 is allowed.

HSA funds are different from health FSA's.

- You can only use your debit card or on-line bill pay for qualified expenses when you have enough money in your account.
- While you are growing you HSA savings, you may pay for a qualified medical expense out of your pocket. You can reimburse yourself from your HSA later via ATM or other banking methods, after you have enough money you in your account.
- There is no use-it-or-lose-it rule
- In addition to all of the Healthcare FSA eligible expenses, you can pay for other kinds of health insurance, such as COBRA, long-term care and any health plan coverage you have while receiving unemployment compensation.
    - When you turn 65, you can use HSA savings to pay for any tax deductible health insurance, except Medicare supplement insurance.
- If HSA funds are used for eligible expenses your contribution and any gains from investments remain tax free.

Funds withdrawn for other purposes or not in accordance with IRS rules will be subject to ordinary taxation and a penalty tax (consult your tax advisor for details). All HSA accounts are fully owned by the employee and funds from this account will remain with you in the event you leave Benemax.

Please see the additional materials, Optum Bank enrollment form and a video that is available on the Benemax Virtual Benefit Manager under the Silver and Bronze plan tabs.

Know Your Healthcare FSA & HSA Eligible and Ineligible Expenses

Eligible Expenses (Services that are used to treat an illness or injury)

BABY/CHILD TO AGE 13
Lactation Consultant*
Lead-Based Paint Removal
Special Formula*
Tuition: Special School/Teacher for Disability or Learning Disability*
Well Baby /Well Child Care

DENTAL
Dental X-Rays
Dentures and Bridges
Exams and Teeth Cleaning
Extractions and Fillings
Oral Surgery
Orthodontia
Periodontal Services

EYES
Eye Exams
Eyeglasses and Contact Lenses
Laser Eye Surgeries
Prescription Sunglasses
Radial Keratotomy

HEARING
Hearing Aids and Batteries
Hearing Exams

LAB EXAMS/TESTS
Blood Tests and Metabolism Tests
Body Scans
Cardiograms
Laboratory Fees
X-Rays

MEDICAL EQUIPMENT/SUPPLIES
Air Purification Equipment*
Arches and Orthotic Inserts
Contraceptive Devices
Crutches, Walkers, Wheel Chairs
Exercise Equipment*
Hospital Beds*
Mattresses*
Medic Alert Bracelet or Necklace
Nebulizers
Orthopedic Shoes*
Oxygen*
Post-Mastectomy Clothing
Prosthetics
Syringes
Wigs*

MEDICAL PROCEDURES/SERVICES
Acupuncture
Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
Ambulance
Fertility Enhancement and Treatment
Hair Loss Treatment*
Hospital Services
Immunization
In Vitro Fertilization
Physical Examination (not employment-related)
Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
Service Animals
Sterilization/Sterilization Reversal
Transplants (including organ donor)
Transportation*

MEDICATIONS
Insulin
Prescription Drugs

OBSTETRICS
Breast Pumps and Lactation Supplies
Doulas*
Lamaze Class
OB/GYN Exams
OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
Pre- and Postnatal Treatments

PRACTITIONERS
Allergist
Chiropractor
Christian Science Practitioner
Dermatologist
Homeopath
Naturopath*
Optometrist
Osteopath
Physician
Psychiatrist or Psychologist

THERAPY
Alcohol and Drug Addiction Counseling (not marital or career)
Exercise Programs*
Hypnosis
Massage*
Occupational
Physical
Smoking Cessation Programs*
Speech
Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, call Benemax, at 800-528-1530, prompt 3 or via email at service@benemax.com.

The IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs or HRAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

Contact Lens or Eyeglass **Insurance** Cosmetic Surgery/Procedures Electrolysis	Insurance Premiums and Interest (FSA Ineligible Only) Long Term Care Premiums (FSA Ineligible Only) Marriage or Career Counseling	Personal Trainers Sunscreen **(spf less than 30)** Swimming Lessons

Note: This list is not meant to be all-inclusive.

Please Note: The IRS does not allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care FSA or HRA funds unless accompanied by a prescription and the prescription is filled by a pharmacist.

Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

Acid controllers Acne medications Allergy & sinus Antibiotic products Antifungal (Foot) Antiparasitic treatments Antiseptics & wound cleansers Anti-diarrheals Anti-gas Anti-itch & insect bite Baby rash ointments & creams Baby teething pain Cold sore remedies Contraceptives	Cough, cold & flu Denture pain relief Digestive aids Ear care Eye care Feminine antifungal & anti-itch Fiber laxatives (bulk forming) First aid burn remedies Foot care treatment Hemorrhoidal preps Homeopathic remedies Incontinence protection & treatment products Laxatives (non-fiber)	Medicated nasal sprays, drops, & inhalers Medicated respiratory treatments & vapor products Motion sickness Oral remedies or treatments Pain relief (includes aspirin) Skin treatments Sleep aids & sedatives Smoking deterrents Stomach remedies Unmedicated nasal sprays, drops & inhalers Unmedicated vapor products

OTC items that **are not** medicines or drugs remain eligible for purchase with FSAs.

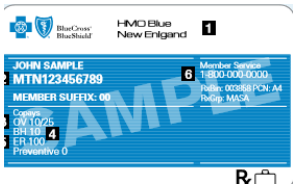
Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

Baby Electrolytes and Dehydration Pedialyte, Enfalyte **Contraceptives** Unmedicated condoms **Denture Adhesives, Repair, and Cleansers** PoliGrip, Benzodent, Plate Weld, Efferdent **Diabetes Testing and Aids** Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products **Diagnostic Products** Thermometers, blood pressure monitors, cholesterol testing **Ear Care** Unmedicated ear drops, syringes, ear wax removal	**Elastics/Athletic Treatments** ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts **Eye Care** Contact lens care **Family Planning** Pregnancy and ovulation kits **First Aid Dressings and Supplies** Band Aid, 3M Nexcare, non-sport tapes **Foot Care Treatment** Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles **Glucosamine &/or Chondroitin** Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements	**Hearing Aid/Medical Batteries** **Home Health Care (limited segments)** Ostomy, walking aids, decubitis/ pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs **Incontinence Products** Attends, Depend, GoodNites for juvenile incontinence, Prevail **Prenatal Vitamins** Stuart Prenatal, Nature's Bounty Prenatal Vitamins **Reading Glasses and Maintenance Accessories**

Your Identification Cards

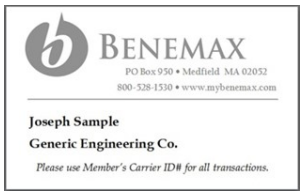
Blue Cross Blue Shield Card

This is your primary insurance card. Please show this card to all medical providers at the time of service, along with your Benemax Card (below).



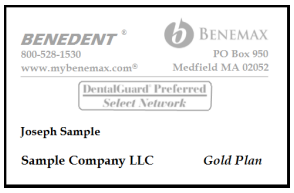
Benemax Card

This is your supplemental payer card. This card is used to help explain your cost responsibility when using BCBS and Benemax. Please have the providers use your BCBS insurance ID number as your Benemax ID number.



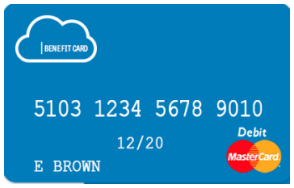
Benedent with Guardian Dental Card

This is your dental insurance card. Please show this card to all dental providers at the time of service.



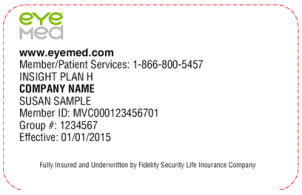
WexHealth Card

This is your Wex Health Card. If enrolled in either the Gold or Silver plan, this card is used to pay for BCBS approved Rx once your deductible is met. It is also used for Flexible Spending Account (FSA).



Eye Med

If you enroll in vision coverage, this is your vision ID card. Please show this card to all vision providers at the time of service.



OPTUM Bank HSA Card (Silver & Bronze Only)

If you enroll in the Silver or Bronze Plan and enroll in the OPTUM Bank HSA, you will receive this debit card to use to pay eligible healthcare expenses.

Life & Disability Plans

Your Life, Accidental Death and Dismemberment, Long-Term Disability and Short-Term Disability Benefits are offered through UNUM. All full-time employees working 35 hours or more automatically receive these benefits after the 30 day waiting period.

Covered Services	Your Coverage
Group Term Life and AD&D	Description
Eligibility	All employees working 35 hours or more
Coverage	1 x base salary, minimum benefit $50,000
Group Short-Term Disability	Description
Coverage Amounts	60% of your weekly earnings to a maximum of $2,000
Elimination Period	14 days
Benefit Duration	Maximum of 11 weeks
Group Long-Term Disability	Description
Coverage Amounts	60% of your monthly earnings to a maximum of $10,000
Elimination Period	90 days
Benefit Duration	Social Security Normal Retirement Age
Long-Term Care	Description
Assisted Living Home Health Care	$3,000 per month $1,500 per month

*** Please refer to your UNUM Summary of Benefits for complete coverage details. Additional summary info is available on the Virtual Benefit Manager.**

Questions? Call 1-800-528-1530

For questions about your benefits, call 1-800-528-1530, or visit our website at www.mybenemax.com, keyword: **BMAX**.

BENEMAX®

VOLUNTARY INSURANCE BENEFITS

Transamerica

Employees have the option to purchase additional Voluntary Insurance products designed to provide personalized financial protection for your family.

- Transamerica Critical Illness: Guarantee issue up to $20K for newly hired employees.
  - Cash upon the diagnosis of stroke, heart attack, cancer

- Transamerica Accident: Protects you and your dependents from costs associated with accidental injury.

See the details and cost on these coverages on the Virtual Benefit Manager.

UNUM Long Term Care

Employees have the opportunity to purchase additional long term care insurance.
Benemax provides a benefit of:
Assisted Living $3,000 per month
Home Health Care $1,500 per month

To read more and/or apply for additional coverage on your long term care coverage visit, http://unuminfo.com/Benemax

UNUM Additional Life

Supplemental life insurance up to 3x annual compensation is available—coverage is portable. Some guaranteed issue is available. See pricing on the VBM.

Employee Assistance Program

Benemax though UNUM offers an Employee Assistance Program.

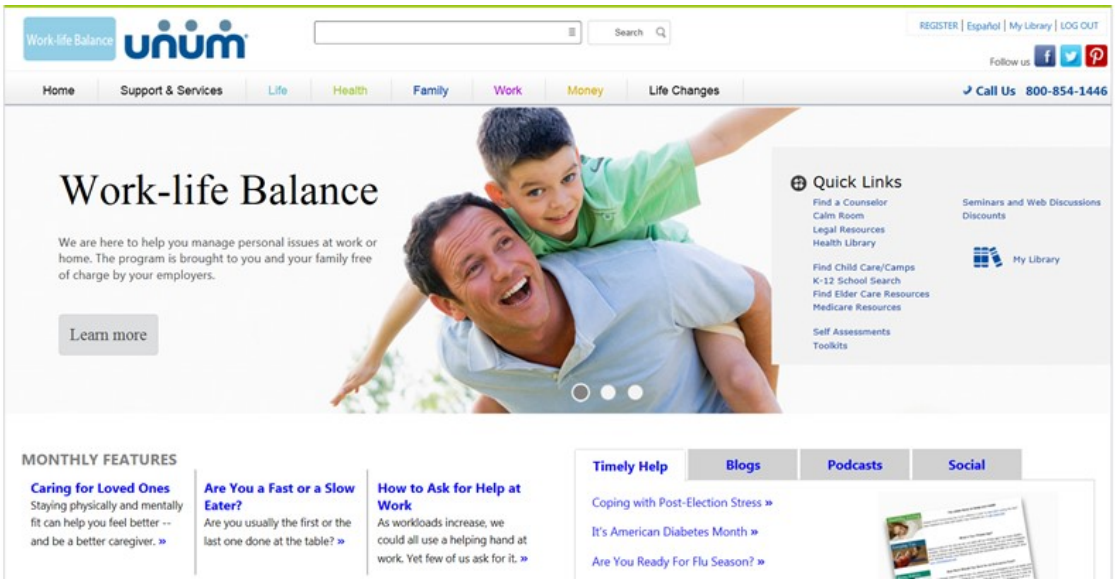
Your work-life balance employee assistance program is provided at no charge through your company's Life/LTD/STD insurance benefit plans. The EAP can help you find solutions for the everyday challenges of work and home as well as for more serious issues involving emotional and physical well-being.

* Childcare and/or eldercare referrals
* Personal relationship information
* Health information and online tools
* Legal consultations with licensed attorneys
* Financial planning assistance
* Stress management
* Career development

Help is easy to access

* Telephone consultations: Speak confidentially with a master's level consultant to clarify your need, evaluate options and create an action plan.
* Face-to-face meeting: meet with a local consultant up to three times per issue for short-term problem resolutions.
* Educational materials: Receive information through our online library of downloadable materials and interactive tools.

Toll-free, 24-hour access
1-800-854-1446: English
1-877-858-2147: Spanish
Online access
www.lifebalance.net; user ID and password: lifebalance



Employee Contributions

Listed below are your per pay period contribution amounts. Health, dental and vision amounts are taken from your payroll pre-tax.

Plan	Your Cost Bi-Weekly					
	PPO			HMO		
Health Benefits	Gold	Silver	Bronze	Gold	Silver	Bronze
Employee only	$161.54	$103.85	$34.62	$92.31	$34.62	$13.85
Employee + Spouse	$323.08	$207.69	$69.23	$184.62	$69.23	$27.69
EE + Child(ren)	$300.00	$193.85	$64.62	$173.08	$64.62	$25.38
Family	$484.62	$311.54	$103.85	$276.92	$103.85	$41.54
Dental Benefits						
Single	$4.62					
Employee + one	$9.23					
Family	$13.85					
Vision Benefits						
Single	$4.07					
Employee + one	$7.71					
Family	$11.33					
Ancillary Benefits						
Life, AD&D Insurance	100% Employer Paid					
Short-Term Disability	100% Employer Paid					
Long-Term Disability	100% Employer Paid					
Long-Term Care	100% Employer Paid					

Questions? Call 1-800-528-1530
For questions about your benefits, call or visit our website at www.mybenemax.com, keyword: **BMAX**.

BENEMAX®

Service and Support

CUSTOMER SERVICE

We encourage all plan participants to **CALL BENEMAX FIRST** to:

800-528-1530, prompt 3
(email: service@benemax.com)

- Access our team of Independent Member Advocates (IMAs) dedicated to delivering concierge service to all plan members.
- Ask any benefit or claim question.
- Our IMAs work for you, and not the insurance company.
- Your employer's designated IMA is:

Tanya Knight
800-528-1530 x146
Tanya@Benemax.com

Claim Submission - Members and providers may submit claims using any method below. Send us an EOB or claims summary and a copy of the Provider Bill. You may also upload an electronic claims submission, email claims@benemax.com, fax 508-242-6198, or mail to Benemax, PO Box 950, Medfield, MA 02052.

ADDITIONAL SUPPORT TOOLS

www.mybenemax.com, keyword: BMAX

Manage your benefits online 24/7 with **Virtual Benefit Manager**, where you can ask a benefit question, learn how to use your plan, and access various healthcare tools including information libraries, hospital report cards and wellness information.

Check you FSA balance, track your individual claims, print explanation of benefit statements or a benefit report by logging into Claims Connection inside the Virtual Benefit Manager.

Benemax Wellness

This site puts everything you need to get fit, stay healthy and use healthcare wisely right at your fingertips:

www.mybenemax.com
Keyword: BMAX

GET A SECOND OPINION

Benemax members are entitled to a on-line second opinion from Harvard Medical School and Partners Healthcare. This is an easy secure way to receive a second opinion without having to visit another healthcare provider.
50% of 2nd Opinions recommend treatment changes, 20% challenge the diagnosis!

MANAGE MY MIGRAINES

Benemax partners with Curelator Headache™ to make available a non– invasive, non-pharmaceutical therapy for Migraine. There is no cost for Benemax plan members. You need to have an Apple I-Phone or I-Pad to participate.

FIND THE RIGHT DOCTOR OR HOSPITAL

Don't have a doctor? Use Zocdoc where you can find a doctor and make an appointment all on one website. Or use Healthgrades to compare quality rating of hospitals in your area by procedure...and by results.

STOP SMOKING

Do you wish you could stop smoking? There is lots of help out there. Check out the options from these free websites

CHECK MY SYMPTOMS

What symptom are you experiencing? What might be causing them? Should you seek treatment? If so, when and where?

TRACK DIET & EXERCISE

We found some free apps that help you track your efforts to eat healthy, lose weight and exercise.

BENEMAX 401K PLAN

Benemax contracts with Trilogy Financial for 401K & Retirement Services.

Tom Elkins is our representative and can be reached for any questions or concerns you may have about your 401K. His contact information is below. Tom visits Benemax a few times a year and we will notify you when he makes a visit. You can set up a private appointment to talk about your needs for retirement or just to get educated about retirement savings. It is never to early to start saving.

- Employee may put a percentage of salary into a tax-deferred investment account
  - ⇒ Contributions are capped at $19,500 for 2020
  - ⇒ For those over 50, a catch up contribution of $6,500 is allowed
  - ⇒ Additional rules apply, see Trilogy Financial or your tax accountant for details.

Trilogy Financial
Tom Elkins
781-933-6533 x2601

Visit http://www.trilogyfs.com
to learn more about 401K

NOTIFICATIONS

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid - Phone 1-800-403-0864 Website: http://www.indianamedicaid.com
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 / CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth adoption , or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Woman's Health and Cancer Rights (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. See medical section of this booklet for this information.

Mental Health Parity and Addition Equity Act

The Mental Health Parity Act of 1996 (MHPA) provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits. There are two disclosure provisions for group health plans.

1. The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.
2. The reason for any claim denial must be made available, upon request, to the participant or beneficiary. The regulations clarify that, in order for plans subject to ERISA to satisfy this requirement, disclosures must comply with the ERISA claims and appeals procedure regulations.

The regulations clarify that this disclosure must be made in the form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations.

Provider Choice (HMO Plans)

Benemax Inc. with Benemax Wrap HMO Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the HMO Blue New England network and who is available to accept you or your family members. For information on how to select a primary care provider, contact Benemax at service@benemax.com or 800-528-1530. For a list of the participating primary care providers, contact www.bluecrossma.com/findadoctor or call the number on your BCBS ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCBSMA or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact www.bluecrossma.com/findadoctor or call the number on your BCBS ID card.

NOTICE OF PRIVACY PRACTICE

Duties of Benemax, Inc. (the Plan) Regarding Your Protected Health Information

Your Information. Your Rights. Our Responsibilities. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights—You have the right to: Get a copy of your health and claims records;

- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices - You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

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Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: .

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of Notice 1/1/2020

If you need more information or if you would like to exercise one of your rights described here, please contact:

David Cowles
HIPAA Privacy Officer
Benemax, Inc.
P.O. Box 950 / 7 West Mill St.
Medfield, MA 02052

Important Notice from Benemax, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Benemax and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Benemax, Inc. has determined that the prescription drug coverage offered by the Benemax, Inc. PPO Gold & Silver with the Benemax Wrap plan, pays more than standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Prescription Drugs (Rx) & Plan	Your Cost In-Network
Gold Plans - HMO and PPO	$0 co-pay
Silver Plans - HMO and PPO	$0 co-pay after $1,500/$3,000 deductible
Bronze Plans—HMO and PPO	$0 co-pay after $2,800/$5,600 deductible

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Benemax, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Benemax, Inc. coverage, be aware that you and your dependents will be able to get this coverage back if you remain employed by Benemax, Inc.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Benemax, Inc., and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Benemax, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	1/1/2020
Name of Entity/Sender:	Benemax, Inc.
Contact--Position/Office:	David Cowles, Principle
Address:	P.O. Box 950, Medfield, MA 02052
Phone Number:	508-359-4107

New Health Insurance Marketplace Coverage Options and Your Health Coverage

A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for your and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance the meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact or HR department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

Notes

For Customer Service
800-528-1530, prompt 3
(email: service@benemax.com)
Or
Visit our Virtual Benefit Manager at,
www.mybenemax.com, keyword: BMAX

The information provided in this booklet is a summary of benefits only. Please refer to the Plan Documents, Subscriber Certificate and any amendments and/or riders for complete plan details.

Seven West Mill Street, PO Box 950, Medfield, MA 02052
Phone: 800-528-1530 - Fax: 508-359-3601 - Email: info@benemax.com
www.benemax.com