Crosby's marketplace

HENRY'S FINE FOODS and UNIQUE CATERING

Benefits Guide

Effective November 1, 2024 - October 31, 2025

PLAN DETAILS – BCBS Preferred Blue PPO With Benemax

Crosby's Markets, via Benemax offers you a choice of two PPO Plans. Each Benemax Health Plan® integrates a fully insured component from Blue Cross Blue Shield of Massachusetts (BCBS) and an employer-funded component from Crosby's Markets into a single benefit package. The BCBS plan has an annual deductible of $5,000 per individual ($10,000 family maximum) per plan year.

Advantage Plan	Economy Plan
BCBS Overall Deductible: $5,000/$10,000 **First $1,000 you pay $0 deductible /next $4,000 you pay 50%** Crosby's Markets Pays: Remaining deductible plus co-insurance and supplements co-payments	BCBS Overall Deductible: $5,000/$10,000 **You Pay: First $2,000 then next $3,000 you pay 50%** Crosby's Markets Pays: Remaining deductible plus co-insurance and supplements co-payments

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

Covered Services	Advantage Plan	Economy Plan
Deductible	1st 1k $0/ next $4k 50% co-ins	$2,000 / next $3k 50% co-ins
Routine office visits & tests	**No cost**	**No cost**
Routine eye exam (1 every 24 months)	**No cost**	**No cost**
Diabetic management services (first two clinic visits)	**No cost**	**No cost**
Office visits by your PCP, OBGYN, N/P, Telemedicine	$35 co-pay	$35 co-pay
Office visits performed by Specialist	$35 co-pay	$35 co-pay
Mental health or substance abuse treatment	$35 co-pay	$35 co-pay
Acupuncture visit (12 visits per year)	$35 co-pay	$35 co-pay
Chiropractic care	$35 co-pay	$35 co-pay
Short-term rehabilitation therapy (60 visits/Year)	$35 co-pay	$35 co-pay
Urgent care	$35 co-pay	$35 co-pay
Emergency room visits (co-pay waived if admitted)	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Diagnostic lab work	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Diagnostic x-rays	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Complex imaging (MRI/CT/PET)	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Day surgery in hospital, ambulatory day care facility	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Inpatient hospital services	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Durable medical equipment	*Deductible then 50% co-ins	*Deductible then 50% co-ins
Prescription drugs (approved by BCBS)	*Deductible then 50% co-ins	*Deductible then 50% co-ins

* Represents services supplemented by your employer, via Benemax.

Out-of-Network provides limited coverage. Out-of-network services are combined with in-network services for the first $5,000 of claims and will be paid the same as in-network claims, except for charges considered over usual and customary. Members are responsible for the remaining out-of-network deductible and co-insurance of 50% then 20% co-insurance thereafter.

For a listing of participating providers, visit www.bluecrossma.com/findadoctor or call the number on your BCBS ID card. You may also call Benemax at 800-528-1530 for assistance.

PRESCRIPTION DRUGS (RX)

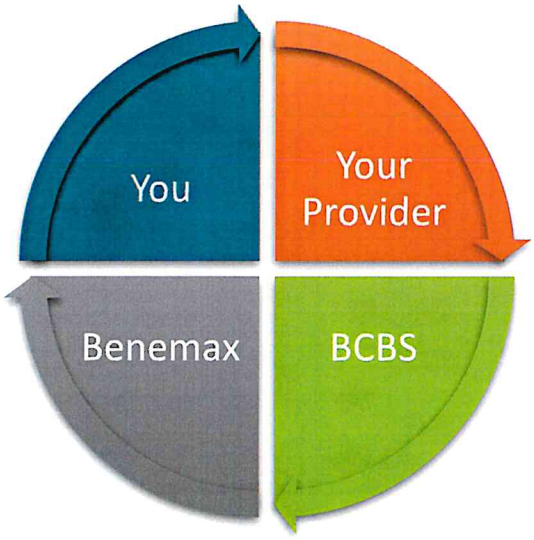
When purchasing approved prescription medications, members are responsible for the co-payments listed below. .

PillarRx Cost Share Assistance Program
Members who take an eligible medication can be eligible to get their medication for **$0-$35** by using manufacturer's coupons. If you are taking an eligible medication, you will receive a letter and a phone call asking you to join the program. ***Important!*** Make sur you enroll; if you decline to enroll, you will be require to pay 30% of the cost of the medication.

Prescription Drugs (RX)	Your cost
BCBS approved at retail participating pharmacy (retail up to 30 days supply)	Tier 1 - $15 Tier 2 - $30 Tier 3 –$50
BCBS approved at Mail order (Caremark/CVS) (Mail order up to 90-day supply)	Tier 1 - $30 Tier 2 - $60 Tier 3 - $100
BCBS approved Specialty drugs when obtained from designated specialty pharmacy (up to a 30-day formulary supply)	Tier 5 – 50% to a maximum of $350 Tier 6 – 50% to a maximum of $500

HOW YOUR HEALTH PLAN WORKS

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

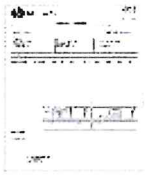


You or a member of your Family visits your provider (doctor/ hospital) and shows both their BCBS ID card and their Benemax Card. Click here to learn more about why showing your Benemax card is important.

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 posts a Benemax Explanation of Benefits (EOB) on your **Claims Connection** portal. You are responsible to pay the amount due to your provider as shown on the Benemax EOB.

When you receive your BCBS claims summary or a provider bill, log in to Claims Connection to view your member responsibility as stated on the Benemax EOB before making a final payment to your provider.

How do I read and understand my Benemax Explanation of Benefit (EOB)? Click here.

ONEDIGITAL BENEMAX

Dear Provider,

Please be advised that your patient is a member of the Crosby's Markets Medical Plan underwritten by Blue Cross Blue Shield of Massachusetts (BCBSMA). This is a fully insured – dual option PPO plan. The deductibles are partially funded by Crosby's Markets (the Employer). The plan is administered by Benemax, a OneDigital Company. Please enter Benemax into your billing system as a supplemental payer.

Claims payment responsibility in this plan is as follows:

Crosby's Markets Benefits Plan Member				
In-Network Co-Pays and Deductibles				
BCBS PPO Advantage Plan	**Office Visit:** $35 co-pay	**Emergency:** Deductible then 20%-30% Co-Insurance	**RX:** $15/$30/$50 to $350/50% to $500 co-pay	**Deductible:** $0 of 1st $1,000 / $2,000, then 50% of next $4,000 / $8,000, then 20%-30% co-insurance
BCBS PPO Economy Plan	**Office Visit:** $35 co-pay	**Emergency:** Deductible then 20%-30% Co-Insurance	**RX:** $15/$30/$50 to $350 /50% to $500 co-pay	**Deductible:** 1st $2,000 / $4,000, then 50% of the next $3,000 / $6,000, then 20%-30% co-insurance
Crosby's Markets				
Pays the plan deductible and co-insurance, less the employee amounts above.				
Blue Cross Blue Shield of Massachusetts				
Pays the remaining balance of incurred claims after the amounts above are met.				

Benemax will administer Crosby's Markets claims payment responsibility and has been authorized to pay these charges directly to you, the provider, weekly as directed by Blue Cross Blue Shield of Massachusetts.

Please note that plan members have been advised that this plan requires no point of service payments, other than co-payments, and that prompt provider payments are assured.

If you have any questions regarding this letter or the payment procedures detailed above, please contact a Benemax Independent Member Advocate at 1-800-528-1530.

One Digital/Benemax, Inc.
7 West Mill Street
P.O. Box 950
Medfield, MA 02052

NEED HELP?

Questions

Benemax Independent Member Advocates can handle your benefit questions and claims issues. Best of all, our advocates work for you— not the insurance company—so your interests are our only priority.

- **800-528-1530**
- **benemax.service@onedigital.com**
- **Information Hub**

Claim Submission

Benemax receives an auto-crossover on claims from your health insurance carrier. If you do not see your claim listed on Claims Connection, you/your provider(s) may submit claims using any method below. Send us an EOB or Claims Summary and a copy of the Provider Bill.

- Electronic Upload
- Email: **benemax.claims@onedigital.com**
- Fax: 508-242-6198
- Mail: PO Box 950, Medfield, MA 02052

TELEHEALTH SERVICES

Your BCBS plan includes coverage for medical and behavioral health services via telehealth online video visits. You can consult with medical professionals, 24/7/365, and schedule visits right from your mobile device or home computer. For conditions such as bronchitis, sinus infections, pinkeye, or for behavioral health issues such as depression, anxiety, and sleep difficulties.
https://member.bluecrossma.com/login

*Telehealth visits are charged at time of service. Benemax will automatically reimburse the cost of a BCBS approved telehealth visit to the extent that it exceeds the member's cost shown on your benefit page.

ONLINE RESOURCES

Information Hub

MyBenemax.com offers online customer service, member education, and helpful tools and resources to assist with all your benefit questions. Visit our links below to learn more.

Interactive: Click on the video & link icons below to learn more!
If you are accessing via printed paper, visit mybenemax.com for more information.

Claims Connection™

Claims Connection allows you to monitor your own individual claims, and ensure you are making the appropriate payment to your provider.

Want to learn more? Need help accessing the portal?

Your Benemax EOB

Your Benemax Explanation of Benefit (EOB) contains all the important information about your claim(s) and should be your guide in determining what balance you owe to your providers.

How do I read and understand my Benemax Explanation of Benefit (EOB)?

Contact Center

Access our contact directory to learn about our departments and what questions we can help answer.

Your Benedent® Summary of Benefits

Crosby's Markets

WHAT IS MY COVERAGE?

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

DENTAL BENEFITS	
First $250 per year	Payable at 100%
Next $1,000 per year	Payable at 75%
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 side. If your provider has any questions, please have them call 800-528-1530 to speak with a Benemax IMA.

THE GUARDIAN NETWORK CHOICE

With Benedent, you are not required to use a network provider. However, if you choose, you can utilize the Guardian network of providers and enjoy discounts of up to 35% on covered services. By using the Guardian network, you can maximize your dental benefits. To find a provider, go to **www.guardiananytime.com,** then click on "Find A Dentist" at the very top of the web page. On the next webpage, scroll down to the bottom of the page. On the third bullet down, choose **DentalGuard Preferred Select network**.

WHAT IS NOT COVERED?

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

This information is a summary only. Please refer to Benemax for specific plan details.

NEED HELP?

Questions

Our Independent Member Advocate (IMAs) can handle your benefit and claims questions. Call 800-528-1530 and press prompt 3, or email benemax.service@onedigital.com.

Benemax Claims Connection™

Members can access Benemax Claims Connection to view/print a Benemax Explanation of Benefit (EOB) or a benefit report. **Click here** to access the site. **As of 2023, EOBs are no longer mailed to members.**

Your Benemax EOB

Your Benemax Explanation of Benefits (EOB) contains all the important information about your claim(s) and should be your guide in determining what balance you owe to your providers.

How to read and understand my Benemax EOB

Need help accessing the Claims Connection portal?

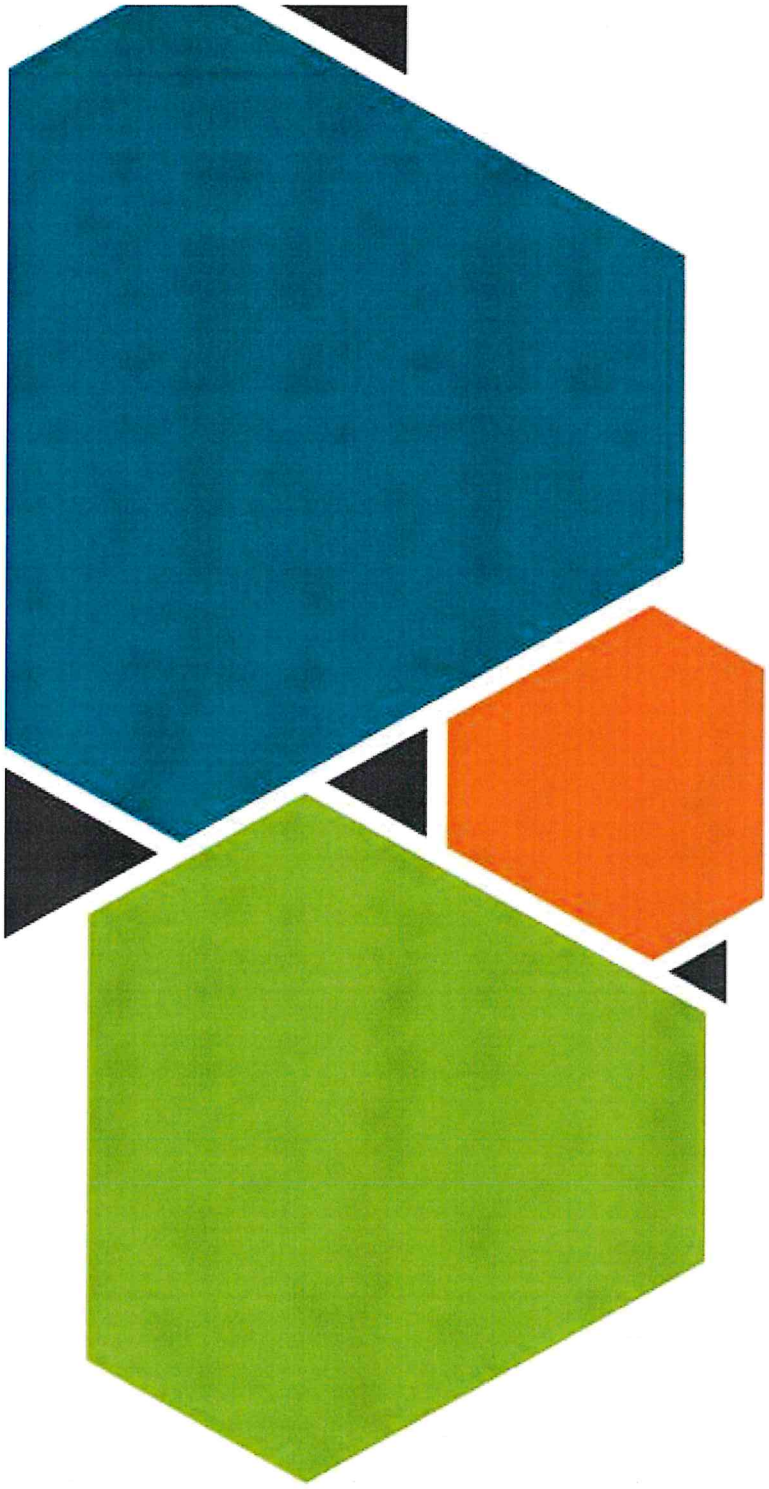
USER-FRIENDLY CLAIMS PROCESS

Present your Benedent® ID card when visiting your dental provider. In most cases, your dentist will bill Benemax directly for your services. There is no network. No claim form is required. Benemax will process the claim according to the benefit schedule described above and make payment directly to your dentist. The dental provider will receive an explanation of benefits on 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 an itemized bill or receipt that shows name of patient, the date of service, the service provided, and the amount charged. Please indicate on your bill that you have already paid the dentist and that payment should be made directly to you.

- **Mail**: Benemax, P.O. Box 950, Medfield, MA 02052
- **Email**: Benemax.claims@onedigital.com
- **Fax**: 508-359-3601
- **Electronic upload: mybenemax.com**

ONEDIGITAL BENEMAX



Your Flexible Spending Account Participant Handbook

Effective 1/1/25

INTRODUCTION

Benemax is pleased to be your Flexible Spending Account (FSA) administrator. We are committed to providing you with superior service. Benemax is available 8:30 to 5PM EST at 800-528-1530 or via email at benemax.service@onedigital.com

You have two types of FSAs available to you: A **Healthcare FSA (HFSA)** and a **Dependent Care FSA (DCA).** You may participate in one or both FSAs. At the beginning of each plan year, you elect a specific dollar amount from your paycheck that you wish to direct to each FSA. You may not transfer money between your healthcare and your dependent care accounts. Participation in one or both FSAs reduces your taxable income because taxes (state, local, federal & FICA) are calculated *after* the elected amount is deducted from your salary. Please note that your taxable income will be reduced for Social Security purposes as well; therefore, it is possible that there could be a slight reduction in your Social Security benefits.

Any person with two percent or more ownership in an S corporation, LLC, LLP, PC, sole proprietorship, or partnership may **NOT** participate. C corporation owners and their families are eligible to participate in FSAs.

To meet the qualifications for tax-favored status, an FSA plan cannot discriminate in favor of key or highly compensated employees. These employees are defined as:

- Any employee with more than 5% ownership in the business in the current or prior plan year
- A 1% owner with a salary of $150,000 or more
- Any officer of the company in the prior plan year and/or any officer earning $185,000 or more annually
- Any employee with gross annual compensation of $130,000 or more in the prior plan year
- Any employee whose salary is in the top 20% of all employees in the current plan year.

If the percent of benefits elected by key and or highly compensated employees is more than 25% of the total benefits, those elections must be reduced pro-rata to meet the 25% test.

A **HFSA** allows you to use pre-tax dollars to pay for insurance deductibles, co-insurance and co-payments; you also may use these funds to pay for other qualified healthcare expenses such as eye glasses, contact lenses, orthodontia and complementary alternative medicine. Funds from your healthcare account are available up to your election amount throughout the year. This means you can use funds 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 **$3,300** per HFSA plan year. You may not participate in a HFSA Plan if you or your covered dependent are actively contributing to a health savings account (HSA).

HFSA Maximum $3,300

A **DCA** 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. You set aside pre-tax dollars to help fund the cost of such care. Dependent care funds are available only as the funds are deposited in your account. However, you can claim up to your full election, and you will be paid automatically each time a payroll deduction reaches your account. If using a debit card, you will need to make sure there are enough funds in the account for the card to process the payment.

DCA Maximum $5,000

The DCA contributions during a single calendar year may not exceed the lesser of the following:

- $5,000.00 or $2,500.00, if married but filing separate tax returns, or
- Participant's earned income (after participant's pre-tax contributions have been deducted under the Plan), or if married, the lesser of the participant's earned income and the spouse's earned income (after pre-tax contributions have been deducted) unless that spouse is disabled, in school or actively looking for work.

ELIGIBLE AND INELIGIBLE EXPENSES

Eligible Expenses	Ineligible Expenses
Artificial limbs and reconstructive breast implants	Counseling that is not medically related (counseling, etc,)
Counseling, if related to a medical condition	Dietary supplements that are beneficial to general health
Dental care (examinations, cleanings, fillings, crowns, etc.)	Drugs, prescribed OTC for cosmetic reasons without script
Diabetic supplies (blood sugar monitor, syringes, etc.)	Elective cosmetic surgery/procedure
Drugs, legally obtained by prescription (insulin or medicines)	Anti-aging treatments (chemical peels, laser therapy, etc.)
Fertility Enhancement (in vitro fertilization, reverse vasectomy)	Breast implants (non-reconstructive)
Guide/leader or hearing-assisting animal	Cosmetic dental veneers/teeth whitening
Hearing devices (hearing aids, batteries and repair)	Electrolysis/hair transplants
Insurance co-payments and deductibles	Funeral expenses
Menstrual products, includes tampons, pads, etc.	Health club membership fees
Nursing care	Household help
Orthodontia	Maternity clothing
Over-the-counter drugs (antacids, allergy, cold medicine)	Medical insurance premiums
Oxygen equipment	Toiletries and person care items (shampoo, deodorant, etc.)
Rental if medical equipment	Weight loss foods that substitute for nutritional needs
Service fees for medical care (consultations, lab work)	
Smoking cessation programs, aids, devices and medications	
Support or corrective devices (crutches, braces, etc.)	
Medically prescribed therapy treatments	
Vision care (eye exams, prescription eyeglasses, contacts)	
Vision corrective surgery (including RK and Lasik)	
Weight loss programs (when prescribed by a physician)	

This list is merely a brief summary of eligible and ineligible expenses. Please visit our website at:

www.mybenemax.com

for a more descriptive list.

ELIGIBLE DCA EXPENSES & QUALIFYING INDIVIDUALS

- **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).
- **Home daycare providers:** Expenses incurred for services provided by home daycare providers. Provider must supply SS# for claim purposes and claim compensation as income.
- **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/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.

Note that full day kindergarten **is not** a covered expense under the FSA daycare assistance program.

YOUR FSA DEBIT CARD

A FSA Debit 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 FSA Debit 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 FSA Debit 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 amount has been exhausted, the card will reject any further charges. Do not discard the FSA Debit card at that time. It will be used for the next year's FSA plan; the card is good for 5 years.

BENEFIT PERIOD & INCURRED EXPENSES

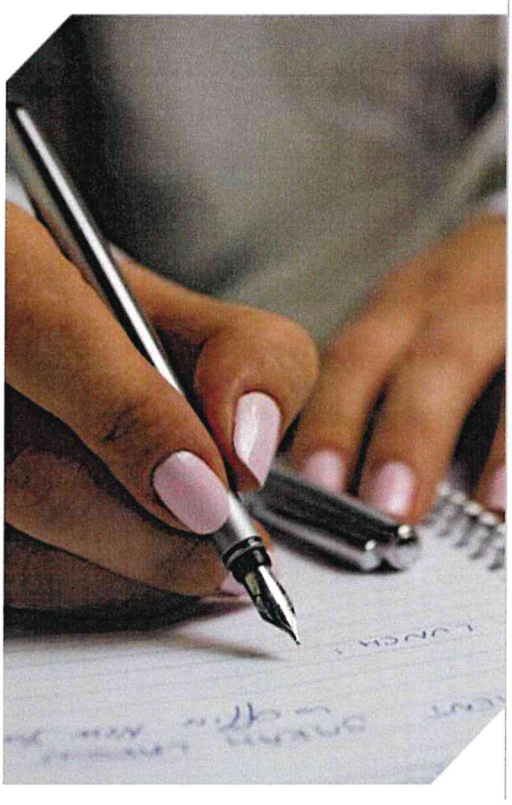
The benefit period is shown on your HFSA election form. Any money that you elect to set aside in the benefit period only may be used for eligible expenses you or your eligible dependents incur within that benefit period or grace period if applicable. You may only claim reimbursement from the HFSA account after the covered service has been performed. Eligible expenses are based on the dates the service was incurred, not when you pay for the service. Therefore you may submit your claims before you have paid them in full. IRS regulations require a date of service on all documentation submitted for reimbursement. Cancelled checks or bills that do not indicate a date of service or only show balance forward information are insufficient.

Orthodontia exception: You may submit and be reimbursed up to your annual election amount if you pre-pay orthodontia expenses, and the services are incurred within the benefit period. Proof of payment and a completed claim form are required. Initial evaluation fees for orthodontia, such as molding, diagnostic records fees, or appliances are reimbursable when incurred if the expenses are separated from the contracted treatment. A down payment is not eligible for reimbursement as it does not represent any incurred services.

USE-IT-OR-LOSE-IT RULE

It is important for you carefully to estimate your out-of-pocket healthcare and dependent care expenses for the upcoming year due to the IRS Use-It-or-Lose-It Rule. This rule requires that:

- Any amount of money in excess of $660 remaining in your **HFSA** after the end of the run-out period will be forfeited.
- Any amount of **DCA** money remaining after the end of the run-out and grace periods will be forfeited.



CARRYOVER - HEALTHCARE HFSA

On a Healthcare FSA, the IRS will allow an employee to carryover up to $660 of a previous plan years' balance for use in the next plan year. Carryover funds may be used to pay for or reimburse qualified healthcare expenses incurred at any time during the subsequent plan year. The carryover does not reduce the subsequent year's max annual contributions.

HFSA
Carryover
$660

In year two, if an employee doesn't make an election, they are allowed to carryover up to $660 to be used within that plan year. The carryover will not roll to subsequent years (year three and beyond) without an active election.

GRACE PERIODS - DEPENDENT CARE

The IRS allows Dependent Care Plans a grace period of two and one-half months after the end of the plan year, during which time participants may incur and submit claims for reimbursement against their prior year account balances. During this two and one-half month grace period, participants can draw from either the prior year's balance, the current year's balance or both. For example, if you have a $200 balance at the end of one plan year and you incur $300 of expenses during the grace period, $200 will be paid from the prior year's account balance and $100 will be paid from the current year's balance.

DCA Grace Period
2 1/2 Months

RUN-OUT

Runout
90 Days

Your plan allows a *run-out period* of 90 days from the end of the plan year to submit claims for **healthcare expenses** that were incurred during the prior plan year. As mentioned above, a carryover of $640 is allowed; any money in excess of that $660 will be forfeited if unclaimed after the end of the run-out period.

Your plan allows a *run-out period* of 90 days from the end of the grace period for you to submit **dependent care** claims incurred during the prior plan year and/or the grace period.

ELECTION IRREVOCABILITY

Once you have elected the plan year dollar amount that you wish to direct into your FSA(s), you may not change that election unless there is a qualifying change in your status that affects eligibility. Even if a change in status occurs, you only may make changes that are consistent with the qualifying event (or as otherwise specified by your Plan Document).

Qualified changes in status may include:

- Change in employee's legal marital status
- Change in number of tax dependents
- 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 (healthcare only)
- Change in cost of the benefit (dependent care only)
- Change in coverage (dependent care only)
    - Addition or elimination of benefit option
    - Change in coverage of spouse or dependent under his/her employer's plan
    - Significant curtailment of coverage.

TERMINATION OF EMPLOYMENT

FSA: 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.

DCA: 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 care accounts. Under COBRA, 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.

NEED HELP?

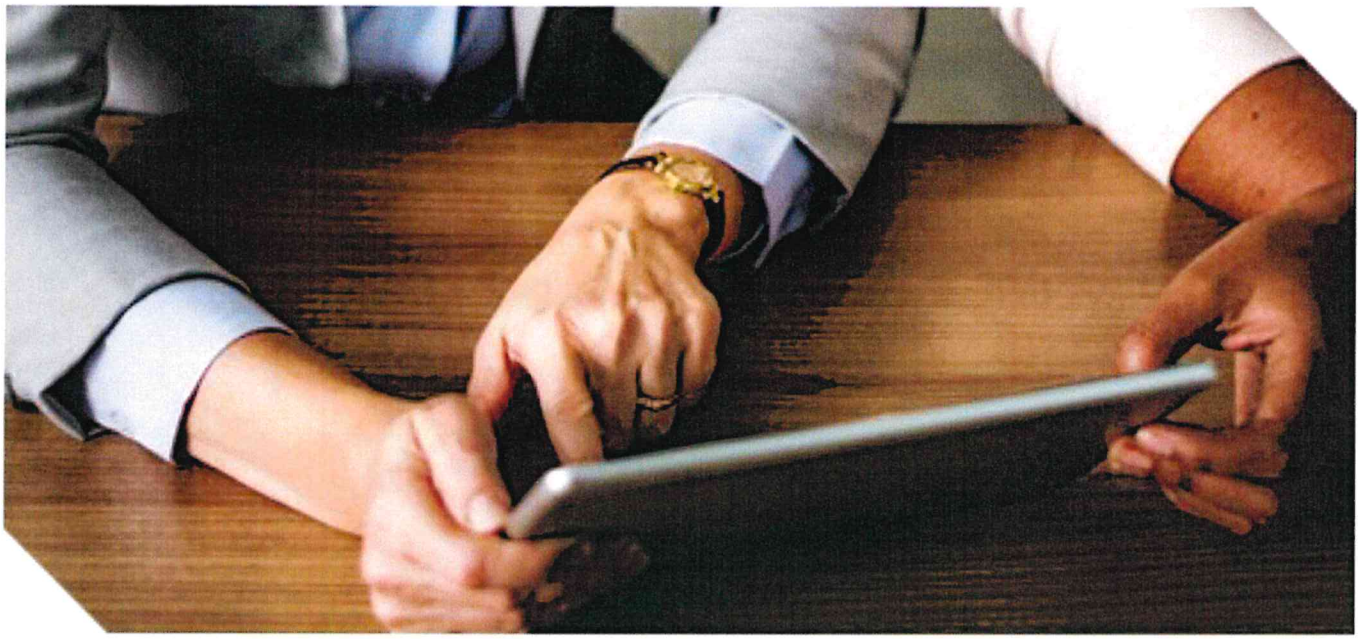
Call a Benemax IMA at 800-528-1530, prompt 3

Visit www.mybenemax.com

the Claims Connection™ link will allow you to view elections, balances and claim information.

A Letter of Medical Necessity (LOMN) or written prescription is required for reimbursement for certain services. A LOMN is available on VBM.

HOW TO FILE A CLAIM



OBTAIN A CLAIM FORM

- Go to **www.mybenemax.com**. Click on Flexible Spending Account (FSA), then select claim form, and download or print the form.
- Or, call us at 800-528-1530, prompt 3.
- Benemax also provides a electronic claim form through Benemax Claims Connection™.

COMPLETE THE CLAIM FORM

- Attach legible receipt (s) from the service provider or an explanation of benefits from your insurance showing:
  - A description of the service or a list of supplies furnished
  - The charge (s) for each service
  - The date (s) of service
  - The name of the person (s) receiving the service.
- For prescriptions, submit non-register receipts that show the patient's name, date of service and amount paid.
- For OTC drugs, submit a register receipt showing the date of purchase.
- DCA receipts should include dependent's name, dates of service, and provider's TIN or social security number. Cancelled checks can be accepted if this information is included.

SUBMIT YOUR CLAIMS

- Upload on Claims Connection; fill out the electronic claim form and attach the receipts you have scanned and saved to your computer.
- Email scanned forms and receipts to **benemax.claims@onedigital.com**
- Fax to 508-242-6198 or 508-359-3601 Attn: FSA
- Mail to Benemax, PO Box 950, Medfield, MA 02052, Attn: FSA

Life and AD&D Insurance

Financial peace of mind.

Life insurance pays a benefit if you pass away while you're covered. Accidental Death and Dismemberment (AD&D) insurance pays an additional benefit if you pass away or are seriously injured due to an accident.

Basic life and AD&D insurance

Plan Documents

This coverage is no cost to you.

	Basic life	Basic AD&D
Coverage	1 x annual earnings	1 x annual earnings

What's AD&D?

Accidental death and dismemberment (AD&D) insurance may pay:

- **your beneficiary** if you pass away due to an accident
- **you** a partial benefit due to the loss, or the loss of use, of body parts or functions such as limbs, speech, eyesight, and hearing

How much life insurance do I need?

Questions about your benefits or claims?
Contact Benemax now!
800-528-1530
benemax.service@onedigital.com

Voluntary life and AD&D insurance

Plan Documents

Purchase additional coverage for you, your spouse, and your child(ren).

	Employee	Spouse	Child(ren)
Coverage increments	$10,000	$5,000	$2,000
Guarantee Issue	$10,000	$5,000	$2,000
Maximum	up to 5X your earnings; $500,000 Maximum	$250,000	$10,000

A beneficiary is the person, or organization who would receive your benefit in the event you lose you life. **Make sure your beneficiaries are up to date** – you can change them at any time!

You, the employee, must enroll/be approved for coverage for your spouse and/or child(ren) to also enroll.

Electing an amount over the Guarantee Issue (GI)? Are you a late enrollee (declined coverage when first eligible)?
If you answered yes to either or both questions, you must complete an Evidence of Insurability (EOI) form. If you are newly eligible and electing coverage over the GI, you will not be approved for coverage over the GI until your EOI form has been approved. If you are a late enrollee, the GI does not apply and any amount you apply for will not go into effect until your EOI is approved.

EOI Form

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

Whole Life Insurance

Colonial Life

Advantages of Whole Life Insurance

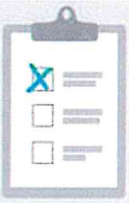
- Permanent coverage that stays the same throughout the life of the policy
- Guaranteed level premiums that do not increase because of changes in health or age
- Access to the policy's cash value through a policy loan for emergencies
- Benefit for the beneficiary that is typically tax-free

Benefits and Features

- Two plan options to choose at the age your premium payment will end
  - Paid up to age 70
  - Paid up to age 100
- Stand-alone spouse policy available whether you buy a policy for yourself
- Flexibility to keep the policy if you change jobs or retire
  - Built-in terminal illness accelerated death benefit that provides up to 75% of the policy's death benefit (up to $150,000) if you're diagnosed with terminal illness
- Immediate $3,000 claim payment that can help you designate beneficiary pay for funeral costs or other expenses
- Pays cash surrender value at age 100 (when the policy endows)

In the U.S., medical spending in the last 12 months of life is nearly $80,000 per person.

HealthAffairs.org, End-Of-Life Medical Spending In Last twelve Months Of Life Is Lower Than Previously Reported, July 2017.



Your cost will vary based on the level of coverage you select.

Talk with your benefits counselor for information about what level of coverage would work best for you.

Questions about your benefits or claims? **Contact Benemax now!**
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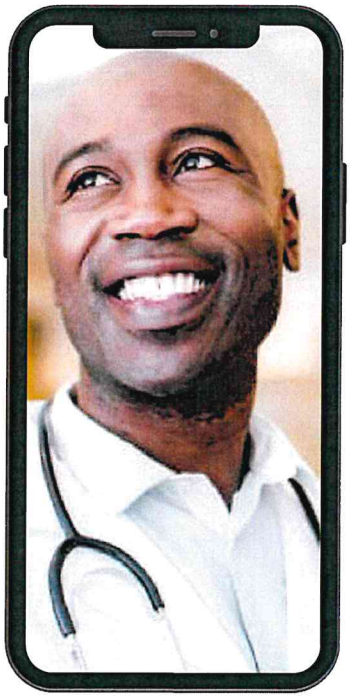
First Stop Health

Your partner in health and wellbeing

Get convenient care for your body and mind – all via phone or video, at no cost to you. Interactions provides First Stop Health to all employees and their immediate family members. We are here to support you!



Urgent Care Issues

Talk to a provider in minutes for sinus issues, UTI, cold, flu, rash and more. Available for all ages.

Prevention and Wellness

Check in on your current healht and make a personalized plan to stay healthy and strong.

Health Management

Support managing asthma, diabetes, high blood pressure, high cholesterol, COPD and more.

Referrals, Tests and More

Our providers can* order lab tests, screenings and provide referrals to in-network specialists.

Mental Healthcare

Ready to feel your best? Get confidential support from a therapist, mental health coach or primary care doctor.

Activate Your Account

Use your employee ID to claim your account! You can also log-in at fshealth.com or call 888-691-7867

First Stop Health

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*First Stop Health services are not intended to constitute a health plan. Those under 18 are welcome to use 24/7 virtual urgent care only. *First Stop Health doctors do not prescribe controlled substances. Costs according to your medical plan may apply for prescriptions, lab orders and other non-FSH services.*

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Additional Perks (BCBS)

BCBS E-Kit

Fitness Reimbursement

See plan details

Whether you prefer going to the gym or practicing yoga, we'll reimburse you for fees you pay toward a fitness facility or other qualified membership. You can even use your reimbursement toward a virtual fitness class subscription. Request Form

Weight-Loss Reimbursement

See plan details

Receive up to $150 annually when you participate in a qualified weight-loss program. Start by picking a qualified weight-loss program. Once you pay for the program, fill out the attached form, or sign in to MyBlue to submit online at member.bluecrossma.com/login.

Doctors On Call

See plan details

When you need convenient access to care, try Well Connection. A network of telehealth providers for medical and mental health needs, with easy access via your computer or mobile device.

Mental Health Resources

See plan details

Nothing should stand between you and your mental wellness, whether that means emotional, psychological, or social well-being. Our Mental Health Resource Center is the place to explore your care options, insightful information, and helpful wellness choices.

Emergency Room Alternatives

See plan details

Knowing your options for care could save you time and money. You have more ways than ever to expert medical opinions and advise. Right when you need them.

MyBlue

See plan details

With MyBlue, you can see all of your benefits, all in one place. Track your claims, view your digital member ID card, and get answers to your questions. Take advantage of your plan's tools and benefits, whenever and wherever.

Blue365

See plan details

Blue365 is an online destination that offers members exclusive health and wellness deals to keep them healthy and happy, every day of the year. Blue365 delivers great discounts from top retailers on fitness gear, gym memberships, family activities, healthy eating options and much more.

Maven Clinic

See plan details

Every pregnancy is different, and a helping hand goes a long way. That's why we're working with Maven Clinic, an independent company, to provide 24/7 virtual support personalized for your unique needs — and it's available to you at no additional cost.

Pet Insurance Discounts

Program details

Protect your furry best friend with Pet Insurance. If you are enrolled in the BCBSMA health plan, you have access to discounts for pet insurance through fetch. This is a discount program.

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Helpful terms

We've removed as much jargon as possible.
But you'll probably still encounter some terms as you enroll in and use your benefits, and we want you to be prepared!

In-network
Networks are groups of medical, dental, and vision providers, pharmacies, and facilities that agree to discount the cost of their care or service. In-network care is always your lowest-cost option. Out-of-network provider can charge you whatever amount they deem fair - typically much higher than in network.

Out-of-pocket maximum
The most you'll pay for covered medical and pharmacy care in a year. This includes your deductible and any coinsurance or copays. The out-of-pocket maximum does not include your premium (the amount you pay for coverage) and non-covered expenses.

Primary care physician
A primary care physician (PCP) is your main medical doctor – usually a general practitioner (GP), family doctor, internal medicine, or pediatrician (for children).

Deductible
The amount you're responsible for paying in care expenses before the medical or dental plan starts sharing in the cost of your medical and pharmacy (if applicable) expenses.

Coinsurance
After you've met your deductible, you're sometimes responsible for a percentage of the cost of the medical care, dental care, or prescription medication you received. This percentage is coinsurance.

Referral/pre-authorization
Some specialty medical providers/services and prescriptions require additional supporting information from your doctor. Examples include - but are not limited to - inpatient or outpatient surgical procedures, brand name medications, or specialty medications.

Copay
A flat fee you pay each time you receive a copay-eligible medical, dental, or vision service or prescription medication.

Balance billing
When you use an out-of-network provider, they may bill you the difference between what they charge and the amount your insurance pays.

Still Need Help?

Benemax Independent Member Advocates (IMAs) can handle all your benefit questions!

800-528-1530
benemax.service@onedigital.com
Information Hub

Annual Notices

We're required to tell you about certain rights and responsibilities you have as an employee

You can also request a paper copy to HR at no charge.

Download now