The 2018 BB&N Employee Benefits Plan

BENEMAX

Introduction

Table of Contents

Welcome

On behalf of our entire team, we'd like to welcome Buckingham Browne & Nichols School (BB&N) employees to the Benemax family. We will be working closely with BB&N's staff to ensure everything runs smoothly not only during your enrollment period (June 1, 2018), but throughout the entire plan year, as well.

The BB&N Medical Plan is a custom designed high deductible plan which combines benefits insured by Blue Cross/Blue Shield of Massachusetts with funding of the plan deductible by BB&N. This plan design is known as a "Wrap Plan" and allows plan members to enjoy a high level of benefits at rates deeply discounted compared to market pricing. Similarly, the BB&N Dental and Ancillary Plans have been carefully crafted to meet the needs of the BB&N employees within favorable cost parameters.

In order to assist you with your plans, Benemax employs a team of HIPAA qualified Independent Member Advocates (IMAs), all of whom are trained in the specifics of The BB&N Benefits Plan.

For those of you who may be new to the plan, there may be a period of adjustment while you become comfortable with the administrative requirements of your plan. Our IMAs can help you understand and use your plan, plus they're experienced in working with insurance carriers, providers, and billing organizations on your behalf.

You can reach an IMA for immediate assistance from 8:30 AM to 5:00 PM daily by simply dialing 1-800-528-1530 or emailing service@benemax.com.

Eligibility

All BB&N employees who are regularly scheduled to work at least 20 hours or more per week are eligible to participate in The BB&N Employee 2018 Benefits Program.

Enrollment is permitted on the date of hire; annually during open enrollment; and/or within 30 days of a qualifying event such as the birth of a child, or loss of spousal coverage.

Benefit Highlights

Medical Plan: Blue Cross Blue Shield Access Blue New England

- Preventive: $0
- Office Visit: $25 co-pay
- Emergency Room: $150 co-pay
- Deductible: $250/$500

Dental Plan: Delta Dental Premier Voluntary Table Plan

- Plan Year: July 1st
- No Deductible
- Benefit Maximum: up to $1,500 per member per year

Vision: Blue 20/20 Insight Network

- Eye Exam: $10 co-pay
- Frames: $150 allowance
- Contacts: $150 allowance

Ancillary Plans: BCBS USAble

- Group Life Insurance
- Group Accidental Death & Dismemberment
- Long-Term Disability

Your Health Plan®

The Benemax Health Plan integrates a fully insured component from Blue Cross Blue Shield (BCBS) of Massachusetts with a self-funded component underwritten by your employer, into a single benefit package.

What is the Benemax Wrap®?
Your BCBS plan has an in-network plan deductible of $3,300 per individual/$6,450 per family. You are responsible for only the first $250 per individual/$500 per family. Your employer, via Benemax, pays the remaining $3,050/$5,950 deductible on your behalf, less applicable co-pays.

This unique structuring of your plan is what we call The Benemax Wrap®, and is a proprietary method for securing you the benefits you need, at highly competitive market costs.

Below are some examples of frequently used in-network services and your final cost after claims have been processed by both BCBS and Benemax. Complete plan details can be found in your carrier's Plan Document.

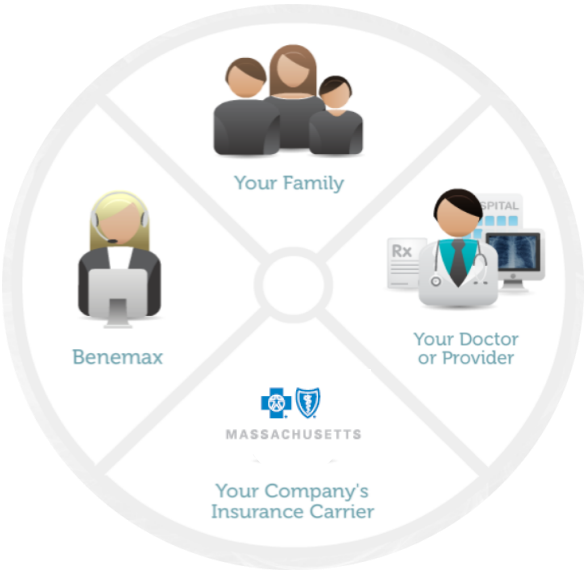
Covered Services (In-Network)	Your Cost In-Network
Routine adult physical exams, including relating tests (one per calendar year)	No cost
Routine GYN exams, including related tests (one per calendar year)	No cost
Well-child care visits	No cost
Routine eye exams (one every 24 months)	No cost
Routine hearing aids (up to $2,000 per ear every 36 months for a member age 21 and younger)	No cost
Non-routine office visits	*$25 co-pay
Specialist visits, other practitioner office visits	*$25 co-pay
Chiropractors' office visits	*$25 co-pay
Short-term rehab therapy (60 visits per calendar year)	*$25 co-pay
Speech, hearing, and language disorder treatment—speech therapy	*$25 co-pay
Mental health and substance abuse outpatient visits	*$25 co-pay
Emergency room visits (co-pay waived if admitted)	*$150 co-pay
Inpatient hospital services	*Deductible
Day surgery in hospital, ambulatory or surgical day care facility	*Deductible
Diagnostic lab work, X-rays (non-routine)	*Deductible
Complex imaging (MRI/CT/PET/Cardiac Imaging)	*Deductible
Durable medical equipment	*Deductible
Prescription drugs (retail)	$0 (with Benny WEX Card)
Prescription drugs (mail order)	$0 (with Benny WEX Card)

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

Using your Medical Plan

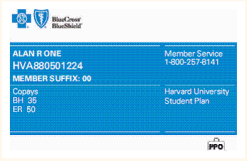
Understanding who pays for what and when can be summarized in the following 5-step process. If you'd like a brief tutorial, please click here or visit mybenemax.com and enter your company keyword: BBN.

1. You and/or your covered dependent visit your provider and show your BCBS Card (Provider Letter optional)
2. Your Doctor or Provider will bill BCBS directly
3. BCBS processes your claim, notifies your provider, and sends a Claims Summary to you and your provider detailing their payments. This BCBS Claims Summary is informational only
4. Benemax receives a report of your claims from BCBS, reviews it, and pays your provider the employer share
5. Benemax sends you a Benemax Explanation of Benefits (EOB) indicating your claims payment responsibility. You are responsible to pay the amount due to your provider as shown on your Benemax EOB.



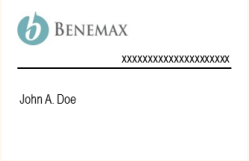
www.mybenemax.com, keyword: BBN

Your I.D. Cards

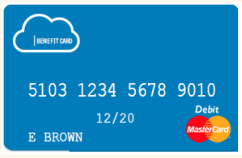


Blue Cross/Blue Shield Medical
Your primary health insurance card. Please show this card to all medical providers at the time of service, including pharmacists.

Delta Dental
Your dental insurance card. Please show this card to your dental provider at the time of service.



Benemax Card
Your medical supplemental payer card. This card is for your personal reference only and has no commercial value.



Debit Card
You may use this card to pay for all approved BCBS Rx medications and all qualified FSA and DCA expenses. Please allow 24-48 hours after activation before use.

Your Benemax EOB

When you receive your Benemax Explanation of Benefits (EOB), pay very close attention to it. Your Benemax EOB not only contains all the important information about your claims, it also serves as your bill. Any other documentation or invoice you may receive is informational only.

When it comes to what you should pay, your Benemax EOB is your guide.

If you have questions or need help understanding your Benemax EOB, please contact a Benemax Independent Member Advocate either by phone (800-528-1530) or via email (service@benemax.com).

1

Explains the type of service received and the date

2

This shows the amount allowed by your insurance

3

Outlines how much the insurance carrier paid.

4

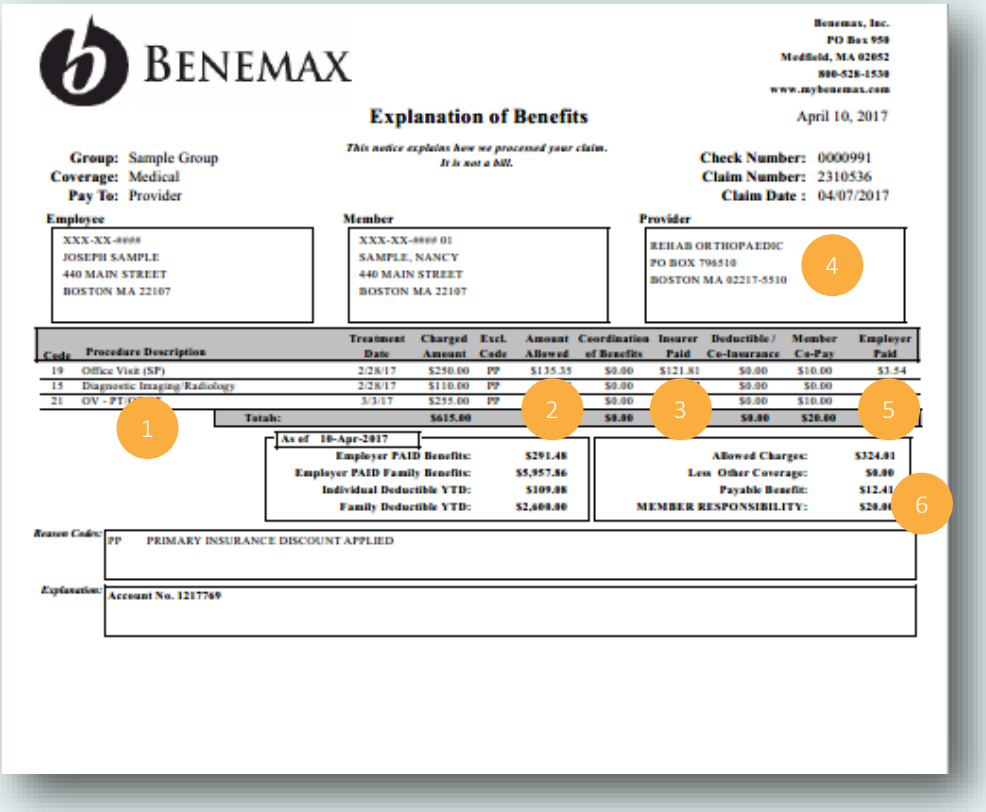
Contains your provider's billing address. Send your payment here.

5

Covers how much your employer paid on your behalf.

6

This amount is your responsibility. Pay this directly to your provider.



BENEMAX

Benemax, Inc.
PO Box 950
Medfield, MA 02052
800-528-1530
www.mybenemax.com

Explanation of Benefits

April 10, 2017

This notice explains how we processed your claim. It is not a bill.

Group: Sample Group
Coverage: Medical
Pay To: Provider

Check Number: 0000991
Claim Number: 2310536
Claim Date : 04/07/2017

Employee
XXX-XX-####
JOSEPH SAMPLE
440 MAIN STREET
BOSTON MA 22107

Member
XXX-XX-#### 01
SAMPLE, NANCY
440 MAIN STREET
BOSTON MA 22107

Provider
REHAB ORTHOPAEDIC
PO BOX 796510
BOSTON MA 02217-5510

Code	Procedure Description	Treatment Date	Charged Amount	Excl. Code	Amount Allowed	Coordination of Benefits	Insurer Paid	Deductible / Co-Insurance	Member Co-Pay	Employer Paid
19	Office Visit (SP)	2/28/17	$250.00	PP	$135.35	$0.00	$121.81	$0.00	$10.00	$3.54
15	Diagnostic Imaging/Radiology	2/28/17	$110.00	PP		$0.00		$0.00	$0.00	
21	OV - PT/	3/3/17	$255.00	PP		$0.00		$0.00	$10.00	
	Totals:		**$615.00**			**$0.00**		**$0.00**	**$20.00**	

1 2 3 4 5 6

As of 10-Apr-2017

Employer PAID Benefits:	$291.48
Employer PAID Family Benefits:	$5,957.86
Individual Deductible YTD:	$109.88
Family Deductible YTD:	$2,600.00

Allowed Charges:	$324.01
Less Other Coverage:	$0.00
Payable Benefit:	$12.41
MEMBER RESPONSIBILITY:	$20.00

Reason Codes: PP PRIMARY INSURANCE DISCOUNT APPLIED

Explanation: Account No. 1217769

Your Dental Plan

The Delta Dental Premier Voluntary Enhanced Table Plan is easy to use and understand. There are no deductibles, and each member is eligible to receive up to $1,500 in benefits each calendar year.

Benefit coverage levels are listed on the Table of Allowance on your Dental Summary of Benefits. When you visit the dentist, Delta Dental will provide reimbursement up to the amount listed.

If you click on the icon to the right, you will be brought to the Dental Tab on your VBM site. Please refer to your carrier Plan Summary for complete plan details.

Your dental plan runs July 1st through June 30th of each year. Benefits are calculated on a calendar-year basis.

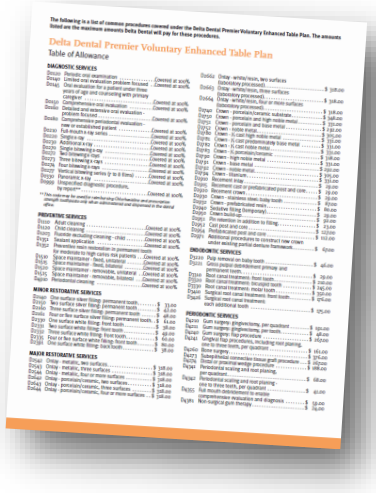

Delta Dental Premier Voluntary Enhanced Table Plan

Table of Allowance

Your Vision Plan

Vision benefits are provided by Blue 20/20 and available to all benefit eligible employees. This plan provides both in-network and out-of-network coverage. Below is a brief reference of frequently used in-network services and respective coverage levels. Refer to your carrier Plan Summary for complete plan details.

Covered Services (In-Network)	Coverage Level
Comprehensive Eye Exam (once every 12 months)	$10 Co-pay
Contact Lens Fit & Follow-Up	Standard: Up to $55
Frames (once every 24 months)	$150 allowance then 20% off balance
Lenses (once every 12 months)	$25 Co-pay (single, bifocal, trifocal)
Contact Lenses (once every 12 months)	$150 allowance then 15% off balance

Additional Insurance

These coverages through Indigo BCBS are automatically granted once an employee becomes benefit eligible. These benefits are paid in full by BB&N on the employee's behalf.

Life and Accidental Death & Dismemberment (AD&D)	
Benefit	1x salary to $100,000
Benefit Reduction	67% at age 70
Participation	Non-Voluntary
Long-Term Disability	
Benefit	60% to $6,500/month
Elimination Period	90 days
Participation	Non-Voluntary

Employee Participation Rates

Listed below are the 2018 Employee Benefits Plan Participation Costs. Please note that these rates are expressed per pay period (26 payrolls per year).

Coverage Tier	Medical			Dental	Vision
	F/T 100%	P/T 80-99%	P/T 50-79%		
Individual	$16	$138	$257	$14.77	$4.00
Dual	$204	$298	$600	N/A	$7.50
Family	$250	$369	$783	$36.46	$11.50

Member Extras

We encourage plan members to get the most out of their health plan by taking advantage of an extensive suite of tools and resources that can help make you a healthier and smarter consumer.

Your BCBS E-Kit provides more in-depth information on plan information and cost saving programs and resources. Access your BCBS E-Kit by visiting your company's VBM page at www.mybenemax.com.

- Mail Service Pharmacy
- Emergency Room Alternatives
- Telehealth Services
- BCBS' ahealthyme program
- 24/7 Nurse Hotline
- Pregnancy and Baby
- Fitness and Weight Loss Participation Program
- MyBlue Member App

Retirement Plan

https://www.tiaa.org/public/tcm/bbn—800-842-2252
The School offers a 403(b) Retirement Plan under the Teachers Insurance and Annuity Association (TIAA). This plan is open to all benefit eligible employees upon date of hire. The School contributes eight percent (8%) of an employee's regular gross salary to the retirement plan. The School will also match the first 2% of an employee's contribution to the retirement savings plan offered through TIAA. Enrollment in this plan must be completed prior to making employee contributions or receiving employer matching contributions.

Employee Assistance Program (EAP)

The New Directions Employee Assistance Program (EAP) (800-624-5544 or https://ndbh.com, login: SGE3F) gives you and your loved ones completely free and entirely confidential access to the programs, tools, and services you need to live a balanced and happy life. Whether you sense that a life challenge is just ahead, or you're already knee-deep in it, the EAP is here to help with top-notch providers, experts, and offerings in these areas:

- Relationships and family challenges
- Life-changing events
- Excessive worry
- Legal or financial challenges
- Stress
- Feeling sad/blue
- Substance dependence
- Addiction
- Workplace challenges

MBTA Monthly Pass Program

The School will arrange for employees to receive MBTA monthly passes at work. Benefits include the convenience of payroll deduction and up to $125 of the cost paid on a pre-tax basis. Enrollment in or changes to this plan must be made one month prior to the effective date of the change.

Be Better & Now Wellness Program

In an effort to promote health and well-being among BB&N employees and their families, we offer a variety of wellness-related programs, including:

- Onsite fitness classes and programs
- $150 fitness reimbursement by BCBS (per calendar year).
- Wellsteps Rewards (www.wellsteps.com) - an online program that gives points towards rewards for completing specific wellness-related activities.

Flexible Spending Accounts

Your Flexible Spending Account (FSA) plans year runs June 1st through May 31st of each year. You have two types of FSAs available: A Healthcare FSA (HFSA) and a Dependent Care FSA (DCA or DCAP). At the beginning of each plan year, you elect a specific dollar amount from your paycheck that you wish to direct to your FSA. Participation in an FSA 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.

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 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 $2,650.00 per HFSA plan year.

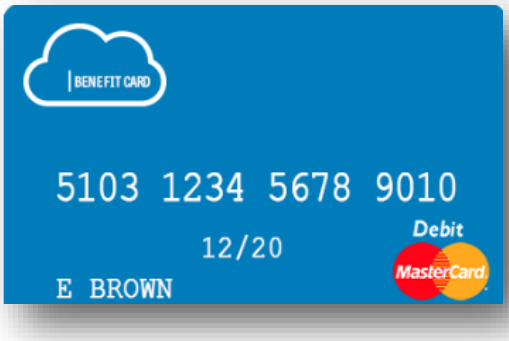
Annual Savings Example	With FSA	Without FSA
Orthodontia Expense	$1,500	$1,500
Tax Savings (approx. 30%)	$450	$0
Cost for $1,500 Orthodontia Expense	$1,050	$1,500

A **DCAP** 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 daycare 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 pay-roll deduction reaches your account.

Please note that Kindergarten tuition, or anything considered "educational" in nature, is not an eligible expense.

The DCAP contributions during a single calendar year may not exceed the least 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 participant's spouse's earned income (after pre-tax contributions have been deducted) unless that spouse is disabled, in school or actively looking for work.



Flexible Spending Accounts

What expenses are eligible and ineligible?

For a complete listing of eligible and ineligible expense, please click here or visit www.mybenemax.com, keyword BBN. The FSA Tab will provide helpful information regarding your Flexible Spending Account(s).

Benny™ WEX Debit Card

A Benny™ WEX Pre-paid Card is provided for your convenience for FSA-eligible item and service purchases. You'll have no claim forms to complete and you won't have to wait for a reimbursement check. Simply present your Benny™ WEX Card at participating locations that accept Debit MasterCard® and the amount for eligible purchases will be automatically deducted from your account.

Please save all your receipts, and ask your dental and vision providers for detailed receipts that show the members name, date of service and services provided. When necessary, you will receive a letter or e-mail from Benemax requesting this additional information.

Benefit Period & Incurred Expenses

The benefit period is shown on your FSA 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. You may only claim reimbursement from the FSA account after the 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.

Run-Out, Carryover and Grace Periods

On a Healthcare FSA, the IRS will allow an employee to carryover up to $500 of a previous plan years' balance for use in a new 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 is not included in the plan limit on annual contributions.

The IRS allows Dependent Day 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 (e.g., 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.).

Your plan allows a *run-out period* of 90 days from the end of the plan year (FSA) and 90 days from the end of the grace period (DCAP) to submit FSA expenses that were incurred during the prior plan year. Please note that your $500 carryover will not be available until the 90 day run-out period concludes.

Flexible Spending Accounts

Use-It-or-Lose-It Rule

It is important for you carefully to estimate your out-of-pocket healthcare expenses for the upcoming year due to the IRS Use-It-or-Lose-It Rule. For your HFSA, any amount greater than $500 remaining after the end of the plan year and runout period, will be forfeited and not returned to you, per IRS rule. For your DCA, any amount of money remaining after the end of the run-out and grace period will be forfeited and not be returned to you, per IRS rule.

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 daycare only)
- Change in coverage (dependent daycare 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

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.

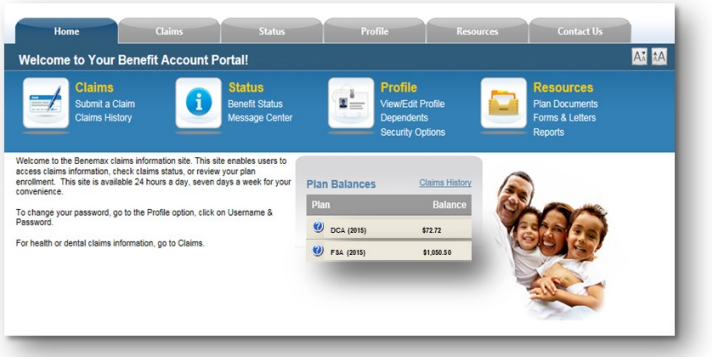
COBRA: COBRA, if elected, allows you to continue to participate in your healthcare account and receive reimbursement for medical expenses incurred after the termination of your employment. COBRA does not apply to dependent daycare accounts. Under COBRA, you must elect coverage within 60 days of notification, 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.

Flexible Spending Accounts

Personal Service and Online Lookup

We are here to help! Call a Benemax Independent Member Advocate (IMA) at 800-528-1530 or email service@benemax.com. You may also visit your company's VBM page at www.mybenemax.com and enter your company keyword: BBN. Select the Claims Connection link to view your elections, balances and claim information.



Letter of Medical Necessity

A 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 company's FSA page.

How to File Your Claim

1. Obtain a Claim Form
   - Go to www.mybenemax.com, and enter your company's keyword: BBN
   - Click on Flexible Spending Account (FSA)
   - Select applicable Claim Form, download or print and complete
   - Benemax also provides an electronic claim form through Claims Connection.

2. Complete the Claim Form
   - Attach legible receipt(s) from the service provider or an explanation of benefits from your insurance company 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 prescription or LOMN from your doctor and the register receipt showing the date of purchase
   - DCAP 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.

3. 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 claims@benemax.com
   - Fax to 508-242-6198 or 508-359-3601 Attn: FSA/BBN
   - Mail to Benemax, P.O. Box 950, Medfield, MA 02052 Attn: FSA

Help When You Need It

Independent Member Advocate (IMA)

Benemax understands today's group health insurance arrangements can be difficult to grasp, particularly when plan members visit providers infrequently, as is often the case. That's why Benemax employs a team of HIPAA-qualified IMAs trained in the specifics of your plan. Our IMAs have experience working with insurance carriers, providers, and billing organizations on behalf of plan members.

We are prepared to help you understand how to use your plan and are available from 8:30 AM to 5:00 PM daily. Simply dial 1-800-528-1530 and ask to speak to any member of our team. You may also contact our team by emailing service@benemax.com.

Virtual Benefit Manager®

This informational tool provides plan members with an easy source of information regarding the specifics of their plan.

- Review benefits and track claims activity
- Establish a personal wellness program
- Access healthy lifestyle links
- Review plan requirements

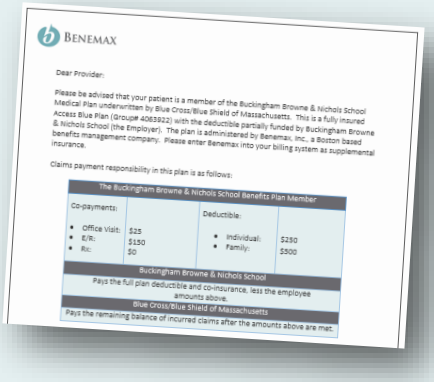
Access VBM by clicking here or visiting www.mybenemax.com, keyword BBN.

Claims Connection

Plan members can track their claims history through the Claims Connection link on the VBM page. It's a secure portal that lets you track both activity and spending.

Provider Letter

From time to time, providers may need help adjusting to your plan's requirements. That's why we include a Provider Letter that helps clarify the plan and procedure. A copy of this letter can be found in your open enrollment materials, as well as VBM.


BENEMAX

Dear Provider:

Please be advised that your patient is a member of the Buckingham Browne & Nichols School Medical Plan underwritten by Blue Cross/Blue Shield of Massachusetts. This is a fully insured Access Blue Plan (Group# 4083922) with the deductible partially funded by Buckingham Browne & Nichols School (the Employer). The plan is administered by Benemax, Inc., a Boston based benefits management company. Please enter Benemax into your billing system as supplemental insurance.

Claims payment responsibility in this plan is as follows:

The Buckingham Browne & Nichols School Benefits Plan Member	
Co-payments:	Deductible:
Office Visit: $25 ER: $150 Rx: $0	Individual: $250 Family: $500
Buckingham Browne & Nichols School	
Pays the full 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.	

Member Central

Your online destination to better understand your plan, manage health care costs, and embrace a healthier lifestyle. Create an account and view your personal information, access claims, and take advantage of programs and resources available through BCBS.

MYBLUE Member App

Plan members can look up their personal health care information quickly and easily from the convenience of their mobile device. Simply download the app, and register your account using your BCBS member ID card.

Health Insurance Terms To Know

ABCDEFGHIJKLMNOPQRSTUVWXYZ

Allowable Charge: The dollar amount a health insurance company considers to be a reasonable charge for services or supplies based on the rates in your area.

Benefit: The amount payable by the insurance company for medical costs.

Benefit Level: The maximum amount an insurance company has agreed to pay for a covered benefit.

Benefit Year: The 12-month period for which health insurance benefits are calculated.

Claim: Request by a plan member, or their care provider, for the insurance company to pay for medical services.

Co-insurance: The share of the cost of covered services after your deductible has been paid. For example, if the insurance company pays 80% of the claim, the remaining co-insurance balance would be 20%.

Co-payment: The flat fee you pay for certain medical expenses.

Deductible: Amount of money you must pay each year before medical expenses are paid by your employer and insurance company.

Dependent: Any individual, either spouse or child, that is covered by the primary insured member's plan.

Dependent Care Account (DCA or DCAP): IRS qualified plan that allows you to designate pre-tax dollars to pay for eligible dependent care expenses.

Drug Formulary: List of prescription medications covered by your plan.

Effective Date: The date on which a policyholder's coverage begins.

Exclusion: Any specific situation, condition, or treatment a health plan does not cover.

Explanation of Benefits (EOB): A written explanation of how a medical claim was paid, with detailed information about what the company paid and what portion you are responsible for. With Benemax, the EOB also doubles as your bill.

Flexible Spending Account (FSA): IRS qualified plan that allows you to designate pre-tax dollars to pay for eligible healthcare expenses.

Independent Member Advocate (IMA): HIPAA trained Benemax professionals who can assist plan members with navigating their health care.

In-Network Provider: Health care professional, hospital or pharmacy that is part of a health plan's network of preferred providers.

Network: A group of doctor's, hospitals and other health care providers that insurance companies contract with to provide services at discounted rates.

Out-of-Network Provider: A health care professional, hospital or pharmacy that is not part of a health plan's network of preferred providers.

Out-of-Pocket Maximum: The most money you will pay during a plan year for coverage. This usually includes deductibles, co-payments and co-insurance, but is separate from your regular premiums. Beyond this maximum, the insurance company will pay all expenses for the remainder of the plan year.

Preferred Provider Organization (PPO): Plan members of PPOs are free to receive care from both in-network and out-of-network providers, but will receive the most benefits when they use providers inside the PPO network. Under a PPO plan, plan members are not required to designate a primary care physician, and do not need referrals to see a specialist.

Premium: The amount you or your employer pays each month in exchange for insurance coverage.

Provider: Any healthcare professional or facility that provides medical, dental or vision care.

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