ASBURY
Anticipate More

2019-2020

Guide to your Benefits

Part-time and PRN ACA Associates

August 1, 2019–July 31, 2020

WHAT'S INSIDE

Have questions?

Client Advocates at Health Advocate can help you and your eligible family members with your benefit needs, such as:

- Questions regarding eligibility and benefits
- Claims questions and issue resolution
- Enrollment support during Open Enrollment and for new hires
- Change-in-status events

Call 1-866-799-2728. email answers@healthadvocate.com. or visit HealthAdvocate.com/asburycommunitiesinc
Available Monday through Friday, 8 a.m. to 12 a.m. (Eastern Time).

Associates are the reason for Asbury's success, and we are dedicated to providing a competitive compensation and benefits package, a safe workplace, and other programs to assist you and your family on and off the job.

We understand that each individual has different needs. As an associate, you have the ability to choose plans for you and your family that are cost-effective and comprehensive in design. Please take the time to review all of the information in this guide. This guide was designed to help you make educated and sound decisions regarding your benefits.

Get the tools and information you need to participate in Asbury's Benefits program by going to the Associate Resources webpage at www.asbury.org/associate-resources or on the Associate app.

ENROLLING IN YOUR BENEFITS

Enroll online at https://e13.ultipro.com/login.aspx

Want to take a quick tour to learn how you can use UltiPro to review, elect, and submit your benefit choices?

Visit http://bit.ly/UltiProQuickTour-LifeEvents.

When you're ready to enroll:

UltiPro® by ULTIMATE SOFTWARE

1. Visit https://e13.ultipro.com/login.aspx.
2. Once logged in, click on the Menu button in the upper left, hover over the "Myself" tab, and navigate to "Open Enrollment."
3. For new hires, select "Open Enrollment (ACA 2019)"
4. The system will prompt you to add your dependents and beneficiary information, and will then walk you through the steps to enroll in each benefit.
5. Once you are finished with your elections, the last page will show a summary of the changes you are about to make. Please verify your changes carefully and review any outstanding actions or errors. You must take care of these action items prior to submitting your final elections. When you are satisfied with your changes, please print a copy of this page for your records and click the Submit button to submit your elections.

Before you enroll:

- Familiarize yourself with your options by reading this ***2019–2020 Guide to your Benefits***.
- Have the following information handy:
  - Social Security Numbers for you and your eligible dependents
  - Dates of Birth for you and your eligible dependents

The benefits Plan Year runs August 1, 2019 through July 31, 2020. You will not be able to make changes to your elections during the plan year, unless you are a new hire, or you or one of your dependents experience a qualified change-in-status event. See page 5 of the ***2019-2020 Guide to your Benefits*** for details regarding change-in-status events.

As a benefits-eligible Asbury Associate, you and your dependents can participate in the benefits described in this 2019-2020 Guide to your Benefits.

BENEFITS ELIGIBILITY

Employees

Part-time or PRN Associates that meet the average of 60 hours worked bi-weekly over the "look-back" measurement period are eligible to participate in the medical plan.

Eligible Dependents

In addition to enrolling yourself, you may also enroll any eligible dependents. Eligible dependents are defined below:

- **Spouse:** a person to whom you are legally married by ceremony up to age 26 regardless of student, financial, and marital status
- **Domestic Partner** (same sex or opposite sex) who has signed a notarized Domestic Partner Affidavit with you
- **Child(ren):** Your biological, adopted, or legal dependents
- **Disabled Child**
  - A child who is unmarried and is dependent on you and your spouse as a result of a mental or physical incapacity.
  - A child who is disabled prior to reaching the maximum age allowed under the plan.

Are you a new associate?

If you are a new associate eligible to receive benefits, **you must go online and enroll within 30 days** from your date of hire. If you do not complete your enrollment within this time frame, you will not have benefit coverage and will not be able to enroll until the next Benefits Open Enrollment period, unless you have a qualified change-in-status event.

Dependent coverage terminates on the last day of the month in which the dependent ceases to meet the definition of an eligible dependent.

CHANGE-IN-STATUS EVENTS

Life is constantly changing. Sometimes these changes mean you may need to make updates to your current benefit elections. When one of these qualified change-in-status events happen, you can make certain changes to your benefit elections without waiting for the next annual Benefits Open Enrollment.

You must be employed for at least 30 days and you must notify your Human Resources Department within 30 days of the change-in-status event in order to make a change to your benefit elections. Documentation supporting the change will be required.

Benefit changes must be consistent with your change-in-status event. Some examples of change-in-status events are highlighted below:

Marriage or divorce

Birth, adoption, or death

Change in employment, or employment status for you, your spouse, or your dependent child

Eligibility for, or loss of other coverage, due to spouse's Benefits Open Enrollment period, or a loss or gain of benefit eligibility

The benefits plan year runs from August 1, 2019 through July 31, 2020. You will not be able to make changes to your elections during the plan year, unless you or one of your dependents experience a change-in-status event. If you do not experience a qualified change-in-status event, the elections you make will remain in effect through July 31, 2020.

Documentation is required to make changes.

For documentation to be valid, it must be a copy of an official document and include the impacted member's name and the date of the event.

Some examples of documentation are listed below:

Event	Documentation required
Marriage	Marriage certificate
Divorce	Divorce decree
Spouse starting or ending employment	Letter from spouse's employer
Spouse losing other coverage	Letter from spouse's employer
Birth or adoption of a child	Birth certificate or adoption certificate
Death of a spouse or child	Death certificate
Court order requiring you to cover a child	Court order

Summary of Benefits and Coverage (SBC)

Choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC), which summarizes important benefit information in a standard format, is available for each medical plan option.

The SBCs are located on the Associate Resources webpage at www.asbury.org/associate-resources, or on the Associate app in the Open Enrollment section.

A paper copy is also available by contacting the Human Resources Department.

MEDICAL & PRESCRIPTION DRUGS

Your medical plan for 2019 is administered by CareFirst BlueCross BlueShield (BCBS) and includes prescription drug coverage. The plan does not require you to select a Primary Care Physician (PCP), and you do not need a referral to see a Specialist. To locate a participating, in-network provider, visit www.carefirst.com/doctor.

- ***HSA-qualified Plan:*** The HSA-qualified plan features the highest deductible of the three plans, but the premium rates per pay are the least costly. This is an HSA-qualified plan, which means you are eligible to open a Health Savings Account (HSA) that allows you to contribute money pre-tax to pay for eligible health care expenses. Asbury also contributes to the HSA for you! After you meet your deductible, in-network, the plan pays 90% for most covered services, and you pay 10%. If you are enrolled with dependents, the entire family deductible must be met before the plan will pay for covered services. This can be met by one individual or a combination of all family members.

Preventive care services are covered in full if you visit an in-network provider.

Note: The amount the plan pays for covered services is based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that Preferred Providers have agreed to accept as payment for covered services. Out-of-network coinsurances are based on a percentage of the Allowed Benefit. When services are rendered by out-of-network providers, charges in excess of the Allowed Benefit are the member's responsibility. Some services require pre-certification. The medical carrier will not pay for these services unless approval is received. Examples include: hospitalization, surgery, home health care, hospice care, private duty nursing, and therapy services. In order to obtain pre-certification, your doctor should contact BlueCross BlueShield at 1-866-773-2884.

Medical and Prescription Plan Highlights

Summary of Services	HSA Qualified Plan	
	In-Network YOU PAY	Out-of-Network YOU PAY
Network	BluePreferred (PPO)	N/A
Annual Deductible (Per Plan Year)	$3,000 Individual $6,000 Family non-embedded	$6,000 Individual $12,000 Family non-embedded
Out-of-Pocket Maximum (Per Plan Year)	$6,650 Individual $13,300 Family embedded	$9,000 Individual $18,000 Family embedded
Preventive Services[1]		
Well Child visits and immunizations, routine annual GYN visit, mammography screening, prenatal office visits, annual adult physical	No charge	50% after deductible
Office Visits, Labs, and Testing		
PCP/Specialist Office Visits	10% after deductible	50% after deductible
Lab/Pathology Routine Imaging Complex Imaging	10% after deductible	50% after deductible
Inpatient & Outpatient Services		
Inpatient Hospital Pre-certification required	10% after deductible	50% after deductible
Outpatient—Hospital	10% after deductible	50% after deductible
Outpatient—Facility	10% after deductible	50% after deductible
Urgent & Emergency Care		
Urgent Care Facility	10% after deductible	50% after deductible
Hospital Emergency Room (Copay waived if admitted)	Deductible, then 20% after $200 copay	Deductible, then 20% after $200 copay
Prescription Drugs		
Retail (34-day supply) Generic Preferred Brand Non-Preferred Brand Preferred Specialty Non-Preferred Specialty	Subject to deductible $5 copay 20% up to $50 50% up to $100 $250 copay $500 copay	
Mail Order (90-day supply) Generic Preferred Brand Non-Preferred Brand Preferred Specialty Non-Preferred Specialty	Subject to deductible $15 copay 20% up to $150 50% up to $300 $750 copay $1,500 copay	

1 As defined by the U.S. Preventive Services Task Force based on your age and gender. For more information, please refer to https://www.healthcare.gov/coverage/preventive-care-benefits/.

This chart is intended for comparison purposes only. If there are any discrepancies, the Summary of Benefits and Coverage (SBC) will govern. The SBCs can be accessed on the Associate Resources webpage at www.asbury.org/associates or on the Associate app in the Open Enrollment section.

CAREFIRST MEMBER BENEFITS

Manage your benefits – and your health

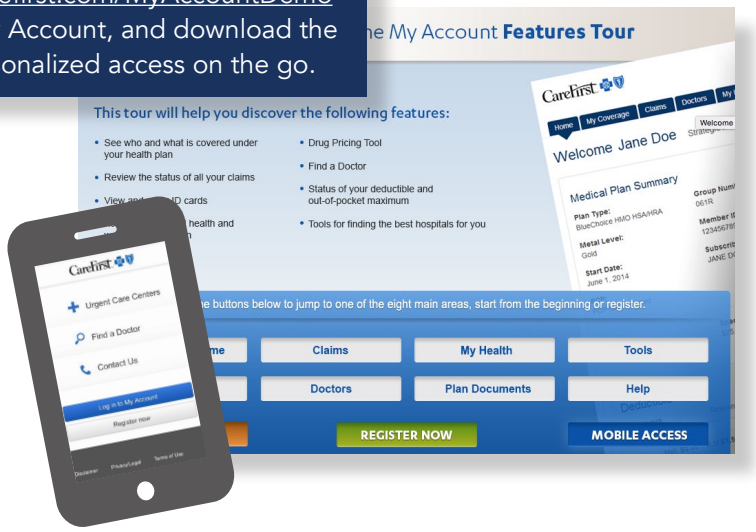
View personalized information on your claims and out-of-pocket costs online with My Account. You can also sign up for electronic Explanation of Benefits (EOB) from CareFirst and get your health care info quicker and more securely. Simply log on to www.carefirst.com/myaccount to get started. My Account puts you in charge of your health plan information and gives you tools to manage your plan — and your health.

- See who and what is covered under your health plan
- Review the status of all your claims
- View and order ID cards
- Access customized health and wellness information
- Research drug costs using the Drug Pricing tool
- Find a Doctor
- Check the status of your deductible and out-of-pocket maximum

You can also contact customer service toll-free at 1-800-628-8548.

New to CareFirst?

Visit http://www.carefirst.com/MyAccountDemo to take a tour of My Account, and download the mobile app for personalized access on the go.



Health and Wellness Resources

http://carefirst.staywellsolutionsonline.com

Take an active role in managing your health by visiting CareFirst's Health and Wellness Information website. The online wellness library has information on a variety of health topics, interactive tools, healthy recipes, and much more.

Choosing the right setting for care is key to getting the best treatment with the lowest out-of-pocket costs.

Knowing where to go when you need medical care is key to getting the best treatment with the lowest out-of-pocket costs. Except for emergencies, your first call should be to your primary care provider.

- **Primary care provider (PCP):** Establishing a relationship with your PCP is important. Your PCP may be able to provide advice over the phone or fit you in for a visit right away.
- **FirstHelp - free 24-hour nurse advice line:** Call 1-800-535-9700 anytime to speak with a registered nurse. Nurses can provide you with medical advice and recommend the most appropriate care.

CareFirst Video Visit: See a doctor 24/7 without an appointment! You can consult with a board-certified doctor whenever you want on your smartphone, tablet, or computer. When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room.

Video Visit is perfect when your primary care provider (PCP) isn't available. The cost for a video visit is the same as a visit to your PCP, and will never exceed $49.

Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy. Get started by registering at www.carefirstvideovisit.com.

- **Convenience care centers (retail health clinics):** These are typically located inside a pharmacy or retail store (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic) and offer extended hours. Visit a convenience care center for help with minor concerns like cold symptoms and ear infections.
- **Urgent care centers:** (e.g., Patient First or ExpressCare) have doctors on staff for more severe illnesses or injuries when you need care after hours.
- **Emergency room (ER):** An ER provides treatment for acute illnesses and trauma. Call 911 or go straight to the ER if you have a life-threatening injury, illness, or emergency.

NOTE: The information provided herein regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.

Need to locate a participating, in-network provider?

To locate an in-network provider visit www.carefirst.com/doctor or call 1-800-810-2583.

HEALTH SAVINGS ACCOUNT (HSA)

Available only to employees who enroll in the HSA-qualified medical plan.

Reasons to Love a Health Savings Account (HSA)

- Triple Tax Savings
  - You can contribute to your HSA using tax-free dollars.
  - You can use the money in your HSA to pay for qualified expenses with tax-free money.
  - Money in the account accumulates year over year, and earns interest that is tax-free!
- You decide how and when to use the funds in your account; you can use the funds to pay for your qualified expenses or save them for future health care costs.
- The account may be used to build funds for retirement. Once you reach age 65, you can withdraw the money for non-medical reasons without a penalty.
- Your account is owned by you, which means you take it with you if you leave, resign, or retire from the company.
- Increased earning potential with investments—once your HSA balance reaches $1,000, you may invest your funds for increased earning potential that is also tax-free.

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used for qualified expenses today, or can help you save for future expenses.

An HSA can help you save money by allowing you to pay for qualified expenses with tax-free dollars. You can use the funds to pay for qualified expenses, such as medical and prescription drug expenses, as well as dental and vision expenses, for you and your tax dependents—even if they are not covered under your medical plan! Your HSA can be used to pay for eligible medical expenses of any family member who qualifies as a dependent on your tax return.

To contribute to an HSA, you must be covered by an HSA-qualified medical plan, and you cannot be eligible to make a claim for benefits under any other public or private health benefit arrangement. Health benefit arrangements include, but are not limited to, non-qualified commercial insurance, private employer arrangements such as Health Care Flexible Spending Accounts or Health Reimbursement Arrangements, and public options such as Medicare. **This would also include a Health Care FSA solely as a result of a carryover of unused amounts, until the end of the plan year when the Health Care FSA carryover balance is exhausted.**

Please note: If you use a Health Savings Account (HSA) you cannot enroll in the Medical FSA, but you can still enroll in the Dependent Care FSA.

Important Reminders:

- To pay for qualified expenses, your HSA must be opened prior to incurring those expenses.
- You may not have any other health insurance coverage, including through your spouse, Health Care FSA, Medicare, or Medicaid.
  - If you enroll in the HSA-qualified plan, but are not eligible to contribute to an HSA, you can choose to participate in the Health Care FSA.
- If your child is under the age of 26, but does not qualify as a dependent on your tax return s/he may be covered under your medical plan, but your HSA funds cannot be used for expenses for that dependent.
- If you have any questions about your HSA eligibility or eligible expenses, please consult a tax professional.

Funding your HSA

You can set up an automatic per pay deposit to fund your HSA on a regular basis without any hassle. Your contributions will be deducted pre-tax from each pay and deposited into your HSA.

The IRS establishes a limit that you can contribute per year. The limits are based on whether you have the Individual or Family coverage under the qualifying medical plan. Limits for the 2019 tax year are below:

	2019 HSA Limits Set by the IRS
Individual	$3,500
Family	$7,000

Individuals over age 55 may make an additional "catch-up" contribution of $1,000.

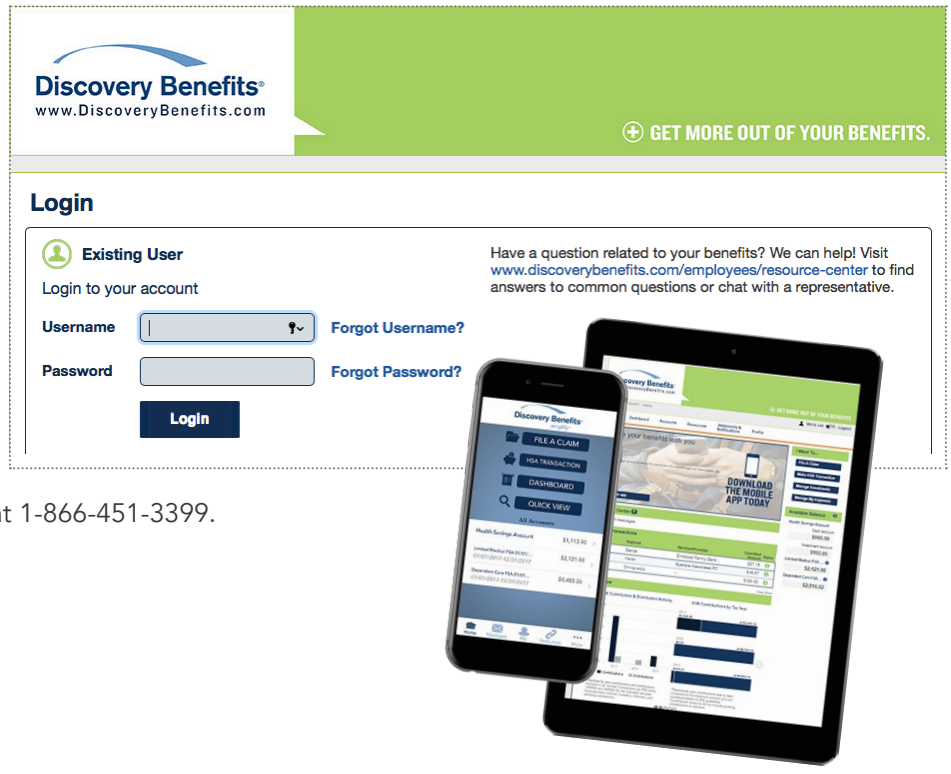
Please note the limits are based on a calendar year and subject to change each year based on IRS regulations. If you have questions regarding how your contributions will impact your individual tax situation, please consult a tax professional.

Access HSA Information!

Access account balances, HSA calculators, as well as log in for personalized access to manage your account at https://www.discoverybenefits.com.

Don't forget to download the free mobile app to manage your HSA on the go!

- Get instant status notifications on the status of your claims and upload documentation in seconds using your phone's camera
- Easily move funds from your HSA into your bank account to cover eligible expenses
- Check your balance and view account activity
- And more!



You can also call customer service toll-free at 1-866-451-3399.

How your medical plan and HSA work together

At the doctor's office...

1. Receive services. No copay is required at the time of service. Be sure to present your insurance ID card. If your health care provider requires a payment from you, it will be applied to your invoice.

Remember: In-network preventive care is covered at 100% with no deductible. You pay $0 out-of-pocket for your annual physical, well-woman visit, mammogram, colonoscopy, routine immunizations, preferred preventive drugs, and other age and gender appropriate services.

2. Provider bills the medical plan. Your provider will submit a claim to CareFirst for services rendered. CareFirst will review the claim and apply contracted rates. The amount you owe will:

- Be credited toward your deductible, or
- Paid to the provider per your benefit plan if you have already met your deductible

3. CareFirst sends you an EOB. You will receive an Explanation of Benefits (EOB) from CareFirst. Tip: Register on www.carefirst.com/myaccount to receive your EOBs electronically.

4. Provider sends you a bill. The provider will send you a bill reflecting the owed charges. Check to make sure that the amount matches the EOB sent to you by CareFirst. If not, contact CareFirst.

5. Use your HSA to pay. You can pay the bill with your HSA debit card. If the doctor's office doesn't accept credit cards, you can pay out-of-pocket using another method, and reimburse yourself from your HSA. Tip: Register on www.discoverybenefits.com and set up an electronic funds transfer to your bank account to make reimbursements easy.

At the pharmacy...

1. Obtain a prescription from your doctor. Obtain a prescription from your doctor for needed medication and submit it along with your insurance ID card to the pharmacy.

2. Pharmacy verifies insurance coverage. The pharmacy checks your insurance coverage on the spot to determine the amount you owe for the prescription.

3. Use your HSA to pay for your prescription. The pharmacy fills your prescription, and you pay the determined amount owed. The expense is automatically applied to your deductible. Use your HSA debit card to pay for your prescription.

Learn how to maximize your health savings with an HSA

There are a variety of resources on the Discovery Benefits website:

- How an HSA works and what to expect at the doctors office or pharmacy
- HSA member guide to maximizing your savings
- Contribution and balance calculators

Visit www.discoverybenefits.com/hsavideos

Eligible Expenses

Need a new pair of glasses? How about hearing aids? Due for a trip to the dentist? Those are just a few of the expenses an HSA covers. To view a full, searchable list of eligible expenses, go to www.DiscoveryBenefits.com/eligibleexpenses.

Tip: Unlike with an FSA, purchases made with HSA funds don't require documentation. However, it's a good idea to save all documentation in case you're ever the subject of an IRS audit.

COSTS FOR COVERAGE

Per pay rates based on 26 pays per year

	Total Cost (Per Pay)	Standard	
		Asbury Pays (Per Pay)	You Pay (Per Pay)
HSA-qualified Plan			
Associate Only	$199.60	$139.32	**$60.28**
Associate + Spouse/Domestic Partner	$399.21	$218.77	**$180.44**
Associate +Child(ren)	$356.69	$211.52	**$145.17**
Family	$556.29	$320.98	**$235.31**

The Wellness incentive is available to benefits-eligible associates and spouses. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources. You may also involve your personal physician in this process.

*Asbury's medical plans are self-insured, which means that when you visit a provider, Asbury pays all costs that are not paid by you.

EAP+WORK/LIFE PROGRAM

Struggling with a personal problem, concern, or emotional crisis? Balancing the needs of work, family, and personal responsibilities isn't always easy. The Health Advocate Employee Assistance Program (EAP)+Work/Life program gives you access to a Licensed Professional Counselor and Work/Life Specialist for help with personal, family, and work problems. All it takes is one phone call, available 24/7, at **no cost to you through Health Advocate**.

Your EAP gives you confidential access to a Licensed Professional Counselor who will provide short-term assistance with issues that are having an impact on your life and ability to focus on work. The program includes up to 6 in-person sessions per issue, per person, per year.

Your Licensed Professional Counselor can help address:

- Anger, grief, loss, depression
- Job stress, burnout, work conflicts
- Marital relationships, family/parenting issues
- Addiction, eating disorders, mental illness
- And more!

You can also reach out to a Work/Life Specialist for help with managing your time and locating resources for better balancing work and life. Your Work/Life Specialist can help with:

- Childcare centers, babysitter tips, preschools
- Assisted living, nursing homes, adult day care services
- Personal/family/elder law, identity theft
- Debt management, budgeting, credit issues

How does it work?

Call 1-866-799-2728, and the right professional will help you address your problem, assess the type of help you need, and either provide the required help or make the most appropriate, cost-effective referral for you.

For added support, log on to the EAP+Work/Life member website for information and to sign up for monthly webinars. www.HealthAdvocate.com/asburycommunitiesinc

ADDITIONAL BENEFITS

Paid Time Off (PTO)

The company provides an accrual of paid leave hours for associates based on scheduled hours and length of service. PTO hours may be used for short and extended periods of time off from work (when approved by management).

Please refer to the PTO Policy for accruals and Asbury-recognized holidays.

Tuition Reimbursement

After completing one year of service, associates whose work status is 60 hours or more may be eligible to receive tuition reimbursement at 90% of approved costs up to $2,000 per year.

If you have questions about any of these benefits, please contact your local Human Resources Department.

HUMAN RESOURCES CONTACTS

Contact Name/Community	Number	Email Address
Asbury Communities Ana Rivera, Analyst, Compensation and Benefits	301-250-2035	arivera@asbury.org
Asbury Methodist Village Tim Leiter, Human Resources Director	301-216-4318	tleiter@asbury.org
Asbury Solomons Tami Radisch, Human Resources Director	410-394-3033	tradisch@asbury.org
Bethany Village Faye Betsker, Human Resources Director	717-591-8040	fbetsker@asbury.org
Inverness Village Debbie Yoder, Human Resources Director	918-388-4216	dyoder@asbury.org
Springhill Linda Vestrand, Human Resources Director	814-860-7004	lvestrand@asbury.org
Asbury Place - Maryville Interim, Human Resources Director	865-738-2763	APM-HR@asburyplace.org
Asbury Place - Kingsport Tracy Williams, HR Generalist	423-245-0360	tlwilliams@asburyplace.org

CARRIER RESOURCES

Plan / Provider	Phone Number	Website
Employee Assistance Program Health Advocate	1-866-799-2728 Option 2	www.HealthAdvocate.com/asburycommunitiesinc
Medical BlueCross BlueShield Group # 5801257	Locate a Provider: 1-800-810-2583 Customer Service: 1-800-628-8548	www.carefirst.com
Prescription Drug Coverage CareFirst	1-800-241-3371	www.carefirst.com/rx
Health Savings Account Discovery Benefits	1-866-451-3399	www.discoverybenefits.com

GLOSSARY

Allowed Benefit "AB"—This is the amount that the insurance carrier has established for payment of covered services. When receiving services out-of-network, you are responsible or charges that exceed the allowed benefit.

BlueCard Worldwide—International access to doctors and hospitals in more than 200 countries and territories around the world.

Coinsurance—The percentage of the charges that the member is financially responsible or. Coinsurance is often applied after you have met the deductible.

Copay—The flat fee paid by the member when a medical service is received (such as $20 for a Primary Care doctor's visit or $5 or a generic prescription at a retail pharmacy). In most cases, you are responsible for payment when services are received. Copays do not apply to the deductible.

Deductible—The dollar amount you must pay each year out-of-pocket before the plan will pay for certain eligible benefits.

Embedded—Each plan member is only responsible for the Individual amount. *See also non-embedded.*

Health Savings Account (HSA)—A tax-advantaged savings account that you can use to pay for eligible expenses tax-free.

HSA-qualified health plan—The type of plan you need to enroll in to be eligible to contribute to a Health Savings Account (HSA).

In-Network—Preferred providers and facilities within the plan network that have agreed to negotiated rates. In-network providers generally charge you less than out-of-network providers.

Non-Embedded—The entire family together meets the Family amount. *See also embedded.*

Out-of-Pocket Maximum—The maximum amount the member would have to pay in a plan year for eligible medical expenses. After reaching the Out-of-Pocket maximum, the plan pays 100% of the allowable charges for covered services in-network for the remainder of the plan year.

Plan Year/Benefit Year vs Calendar Year— Plan Year/ Benefit Year is the annual period from August 1 through July 31. Calendar Year is the period of time from January 1 through December 31 of each year.

Pre-certification—Approval from your doctor to receive certain services. The medical carrier will not pay for these services unless approval is received. Examples include: hospitalization, surgery, home health care, hospice care, private duty nursing, and therapy services. In order to obtain pre-certification, your doctor should contact the insurance carrier.

Reasonable & Customary Charges—Reasonable & Customary (R&C) refers to the commonly charged or prevailing fees for services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charges fee for the particular service within that specific community.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

ASBURY COMMUNITIES, INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

Asbury Employee Welfare Plan*

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Asbury Communities, Inc. that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Asbury Communities, Inc.) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Carole Braithwaite
Director, Compensation and Benefits
301-250-2038

Effective Date: The effective date of this notice is: August 1, 2019.

ASBURY COMMUNITIES, INC. EMPLOYEE HEALTH CARE PLAN
NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Carole Braithwaite
Director, Compensation and Benefits
301-250-2038

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Asbury Communities, Inc. Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Asbury Communities, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

HDHP	In-Network	Out-of-Network
Individual Deductible	$3,000	$6,000
Family Deductible	$6,000	$12,000
Coinsurance	90%	50%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Carole Braithwaite
Director, Compensation and Benefits
301-250-2038

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 **877-KIDSNOW** 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 **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 January 31, 2019. Contact your State for more information on eligibility:

ALABAMA-Medicaid	ALASKA-Medicaid	ARKANSAS-Medicaid	FLORIDA-Medicaid
Website: http://myalhipp.com/ Phone: 855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://myarhipp.com/ Phone: 855-MyARHIPP 855-692-7447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 877-357-3268
GEORGIA-Medicaid	**IOWA- Medicaid**	**INDIANA-Medicaid**	**KANSAS-Medicaid**
Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://dhs.iowa.gov/hawk-i Phone: 800-257-8563	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com	Website: http://www.kdheks.gov/hcf/ Phone: 785-296-3512
KENTUCKY-Medicaid	**LOUISIANA-Medicaid**	**MAINE-Medicaid**	**MASSACHUSETTS-Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 800-635-2570	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888-695-2447	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 800-442-6003 TTY: Maine relay 711	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800-862-4840
MINNESOTA-Medicaid	**MISSOURI-Medicaid**	**MONTANA-Medicaid**	**NEBRASKA-Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800-657-3739 or 651-431-2670	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA-Medicaid	**NEW HAMPSHIRE-Medicaid**	**NEW JERSEY-Medicaid and CHIP**	**NEW YORK-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 800-852-3345, ext. 5218	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: 800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800-541-2831
NORTH CAROLINA-Medicaid	**NORTH DAKOTA-Medicaid**	**OKLAHOMA-Medicaid and CHIP**	**OREGON-Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844-854-4825	Website: http://www.insureoklahoma.org Phone: 888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075
PENNSYLVANIA-Medicaid	**SOUTH CAROLINA-Medicaid**	**SOUTH DAKOTA - Medicaid**	**TEXAS-Medicaid**
Website: http://www.dhs.pa.gov/provider/medicalassistancehealthinsurancepremiumpaymenthippprogram/index.htm Phone: 800-692-7462	Website:https://www.scdhhs.gov Phone: 888-549-0820	Website: http://dss.sd.gov Phone: 888-828-0059	Website: http://gethipptexas.com/ Phone: 800-440-0493
UTAH-Medicaid and CHIP	**VERMONT-Medicaid**	**VIRGINIA-Medicaid and CHIP**	**WASHINGTON-Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 877-543-7669	Website:http://www.greenmountaincare.org/ Phone: 800-250-8427	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855-242-8282	Website: http://www.hca.wa.gov/free-or-Low-cost-health-care/program-administration/premium-payment-program Phone: 800-562-3022 ext. 15473
WEST VIRGINIA-Medicaid	**WISCONSIN-Medicaid and CHIP**	**WYOMING-Medicaid**	To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:
Website: http://mywvhipp.com/ Toll-free phone: 855-MyWVHIPP or 855-699-8447	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531	U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/agencies/ebsa** 866-444-EBSA (3272) U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 877-267-2323, Menu Option 4, Ext. 61565

Asbury Communities
Asbury Methodist Village
Asbury Solomons Bethany
Village Springhill
Inverness Village
Asbury Place - Kingsport
Asbury Place - Maryville

ASBURY SM
Anticipate More

MISSION

Doing all the good we can by providing exceptional lifestyle opportunities to those we serve.

VISION

As a nationally recognized leader in senior lifestyle opportunities, Asbury continually redefines the expectations of aging.

CORE VALUES

Asbury holds strong to a set of core values that drives our mission and reinforces our commitment to serving seniors.

- **Commitment to residents, associates, volunteers, and partners**
- **Stewardship and financial strength**
- **Quality and innovation**
- **Integrity**