ASBURY
Anticipate More

2019-2020

Guide to your Benefits

Asbury Communities, Asbury Methodist Village, Asbury Solomons, Bethany Village, Inverness Village, Springhill

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 "Life Events."
3. For new hires, select "New employee or newly eligible 2019-2020"
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

Associates whose work status is at least 60 hours per pay period (excluding seasonal, interns, and temporary workers) are eligible for benefits. Benefits for newly hired associates are effective on the first of the month following or coincident with 30 days of employment.

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
- **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
  - Medical, Dental, Vision, Critical Illness Insurance, Hospital Indemnity, and Accident Insurance: eligible up to age 26 regardless of student, financial, and marital status
  - Supplemental Life Insurance: eligible age 6 months up to age 25
- **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

WORKING ON WELLNESS PROGRAM

Asbury's mission involves a strong commitment to doing all the good we can by enabling personal fulfillment and enriching the lives of those we serve and associates. As part of that mission, we encourage residents and associates to live a healthy lifestyle. The WOW! Working on Wellness program is a wellness and healthy living program designed or associates that provides fitness activities, health risk evaluation, and healthy lifestyle coaching.

Earn a total of 175 incentive points by completing a Biometric Screening (50 points, Personal Health Profile (50 points), and earning 75 additional points in the Wellness program.

Benefits-eligible associates will be eligible to pay a lower medical plan payroll deduction for the 2019-20 plan year by completing all of the steps in the wellness program. To earn your wellness incentive for the 2019-20 plan year, you (and your spouse, if you elected employee + spouse or family coverage) will need to **complete the steps below by June 30, 2019, for a total of 175 points**. For those Associates not covered by an Asbury medical plan, you are eligible to earn a $100 wellness incentive if you complete all of steps in the wellness program.

Step 1: Biometric Screening (50 points)
Complete a Biometric Screening (50 points) by using a Physician Form. This form can be taken to your doctor during a routine visit. Your doctor will complete the bottom portion of the form and send it to Health Advocate. The form can be located on ShareLink in the documents section.

Step 2: Personal Health Profile (PHP) (50 points)
Associates (and your spouse if you elected employee + spouse or family coverage) complete the PHP, which is a series of questions designed to help identify your potential health risks. To complete your PHP, log on to the secure website hosted by Health Advocate at www.HealthAdvocate.com/asburycommunitiesinc.

> **New Hires:** If you were hired after August 1, 2019, you are considered a new hire and will only need to complete a PHP within 30 days of your date of hire in order to receive the incentive for 2019-20. If you were hired between January 1, 2019 and July 31, 2019, you will only need to complete the PHP in order to qualify for the incentive for the 2019-20 and 2020-21 plan years.

Step 3: Earn an additional 75 points
In addition to your Biometric Screening and PHP, you will also need to earnan additional 75 points by completing items o your choosing: Healthy Challenges, Workshops, Healthy Trackers, Wellness Coaching, and more. You can also earn points for completing Preventive Care exams if you are covered by an Asbury medical plan. Please note that these exams can take up to three months to process, so it is recommended you have your exams early in order to get your incentive paid out in time.

How to access your Health Advocate account, and complete your PHP

1. Go to the secure website hosted by Health Advocate at www.HealthAdvocate.com/asburycommunitiesinc.
2. Enter the organization name: Asbury Communities.
3. Register as a new user, and sign in with your username and password.

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.

Staying on top of your health can be challenging.

Once you are logged into your Health Advocate account (see page 6 for details on how to log in), you will have access to many health and wellness features for you to use anytime to help you meet your health goals at your own pace. The member website provides you with all of the necessary tools to help get and stay healthy.

To access all of the wellness specific tools available to you, hover over the Well-Being tab at the top of the screen, and then click on Wellness Programs. Here you will have access to the ollowing items and more:

- Personal Health Profile to assess your health risks.
- Self-guided wellness workshops and programs.
- Health trackers compatible with a wide range of fitness devices and apps.
- Monthly newsletters full of healthy tips as well as a health and wellness blog.
- Secure web messaging system to communicate with a personal Wellness Coach.

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

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

You have three medical plan choices for 2019 administered by CareFirst BlueCross BlueShield (BCBS). All options include prescription drug coverage. None of the plans 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.

How do I choose the right plan for me?

The plans differ in terms of how much you will pay up front (deductible) for certain services, the cost you will have to pay (coinsurance and copays), and the maximum amount you pay per year (out-of-pocket maximum).

- ***Exclusive Provider Organization (EPO) Plan:*** The EPO plan features the lowest deductible and out-of-pocket maximum of the three plans, and is also the most costly. This plan provides coverage for services **received in-network only**; there is no coverage for services received out-of-network. Some services, such as office visits, are not subject to the deductible and you will pay a copay at the time of service. Emergency care and hospitalization are subject to the deductible, and a copay will apply after you meet your deductible. Each plan member is only responsible for the Individual deductible amount.
- ***Preferred Provider Organization (PPO) Plan:*** The PPO plan provides coverage in-network and out-of-network. After you meet your deductible, in-network, the plan pays 70% for most covered services, and you pay 30%. Some services, such as office visits, are not subject to the deductible and you will pay a copay at the time of service. Each plan member is only responsible for the Individual deductible amount.
- ***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 under all 3 plans 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	EPO Plan	PPO Plan		HSA-qualified Plan	
	In-Network Only YOU PAY	In-Network YOU PAY	Out-of-Network YOU PAY	In-Network YOU PAY	Out-of-Network YOU PAY
Network	BluePreferred (PPO)	BluePreferred (PPO)	N/A	BluePreferred (PPO)	N/A
Annual Deductible (Per Plan Year)	$500 Individual $1,000 Family embedded	$1,000 Individual $2,000 Family embedded	$2,000 Individual $5,000 Family embedded	$3,000 Individual $6,000 Family non-embedded	$6,000 Individual $12,000 Family non-embedded
Out-of-Pocket Maximum (Per Plan Year)	$5,500 Individual $11,000 Family embedded	$7,000 Individual $14,000 Family embedded	$9,000 Individual $18,000 Family embedded	$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	No charge	50% after deductible	No charge	50% after deductible
Office Visits, Labs, and Testing					
PCP/Specialist Office Visits	$20/$40 copay	$20/$40 copay	50% after deductible	10% after deductible	50% after deductible
Lab/Pathology Routine Imaging Complex Imaging	$20 copay $40 copay $80 copay	30% after deductible	50% after deductible	10% after deductible	50% after deductible
Inpatient & Outpatient Services					
Inpatient Hospital Pre-certification required	$300/day after deductible; max $1,500/stay	30% after deductible	50% after deductible	10% after deductible	50% after deductible
Outpatient—Hospital	$200 after deductible	30% after deductible	50% after deductible	10% after deductible	50% after deductible
Outpatient—Facility	$100 copay	30% after deductible	50% after deductible	10% after deductible	50% after deductible
Urgent & Emergency Care					
Urgent Care Facility	$60 copay	$75 copay	50% after deductible	10% after deductible	50% after deductible
Hospital Emergency Room (Copay waived if admitted)	$200 after deductible	30% after $200 copay	30% after $200 copay	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	 $5 copay $40 copay $100 copay $100 copay $150 copay	 $5 copay 20% up to $50 50% up to $100 $250 copay $500 copay		**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	 $15 copay $120 copay $300 copay $300 copay $450 copay	 $15 copay 20% up to $150 50% up to $300 $750 copay $1,500 copay		**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

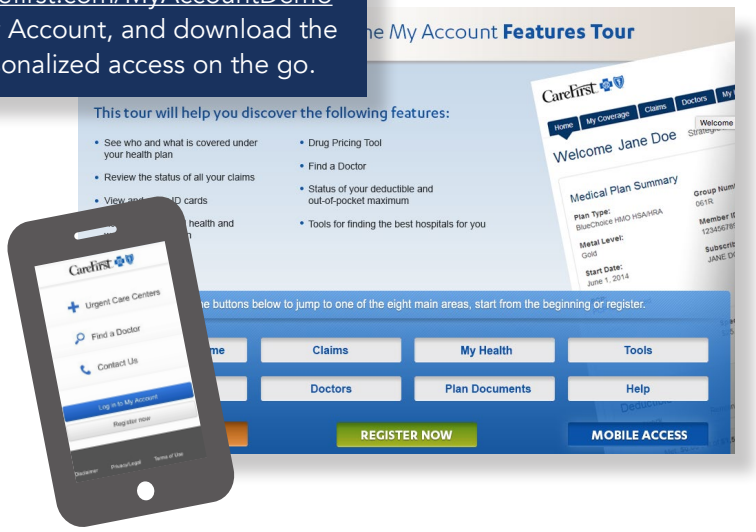
View personalized information on your claims and out-of-pocket costs online with My Account. You can also sign up for electronic Explanation of Benefits (EOB) from CareFirst and get your health care info quicker and more securely. Simply log on to www.carefirst.com/myaccount to get started. My Account 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, and they include contributions made by Asbury. Limits for the 2019 tax year are below:

	2019 HSA Limits Set by the IRS	Asbury HSA Contribution	Employee 2019 HSA Contribution Limit
Individual	$3,500	$500	$3,000
Family	$7,000	$1,000	$6,000

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.

ASBURY CONTRIBUTES TO YOUR HSA!

Asbury contributes $500 for individuals or $1,000 if you are enrolled with dependents. Asbury contributions will be deposited at the beginning of each quarter into your Discovery Benefits HSA.

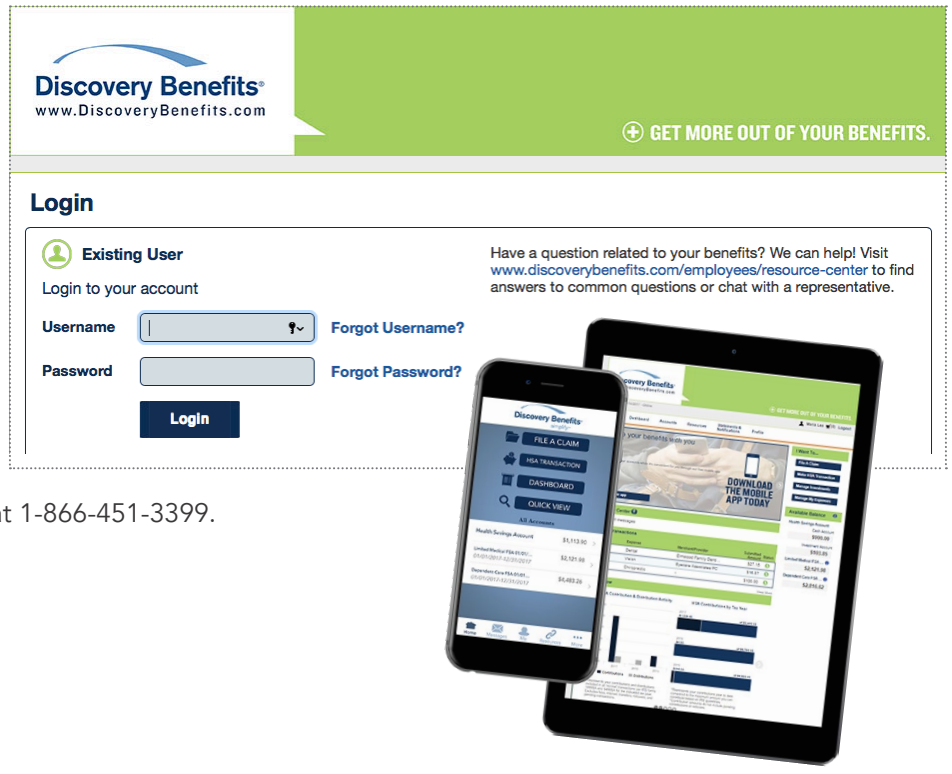
*Amount prorated for new hires.

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.

VISION

You have the option to enroll in a Vision plan administered by **VSP**. You may receive care from any provider you choose, but your benefits are greater when you see a participating, in-network provider. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form to VSP for reimbursement.

Plan Features	In-Network YOU PAY	Out-of-Network Plan Reimbursement
Network	Choice	N/A
Eye Exam Once every plan year	$10 copay	Up to $45
Eyeglass Frames Once every plan year	$25 copay; $150 allowance for a wide selection of frames, $170 allowance for featured frame brands, $80 Costco frame allowance	Up to $70
Lenses Once every plan year Single Vision Bifocal Trifocal	 $25 copay $25 copay $25 copay	 $30 $50 $65
Contact Lenses—in lieu of glasses Once every plan year	No copay; $200 allowance Fitting and evaluation: up to $60	Up to $105

This chart is intended for comparison purposes only. If there are any discrepancies, the plan description will govern. The plan description can be accessed on the Associate Resources webpage at www.asbury.org/associate-resources or on the Associate app in the Open Enrollment section.

Did you know your eyes can tell an eye care provider a lot about you?

Routine eye exams are essential to preserve your vision and safeguard your eye health. Vision insurance can make routine eye care more affordable, especially if you are among the majority of people who wear prescription eyeglasses or contact lenses.

In addition to a vision screening, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating, in-network provider?

To locate a provider, call VSP at 1-800-877-7195 or visit the VSP website at www.vsp.com. When researching providers online, choose the "Choice" network.

Enjoy Exclusive Member Extras from VSP.

View offers at www.vsp.com/specialoffers.

DENTAL

You have the choice between two dental plans administered by **Delta Dental**. You can see any dentist you want; however, using in-network dentists will save you money by allowing you to share in the pre-negotiated discounted fees charged by the network providers. If you receive services out-of-network, you will pay higher out-of-pocket costs and be balance billed by that provider.

Plan Features	Basic Option		High Option	
	In-Network YOU PAY	Out-of-Network YOU PAY*	In-Network YOU PAY	Out-of-Network YOU PAY*
Network	Delta Dental PPO	N/A	Delta Dental PPO	N/A
Annual Deductible (Per Plan Year) Applies to Basic & Major services only	$25 Individual/ $75 Family		$50 Individual/$150 Family	
Annual Benefit Maximum (Per Plan Year) Applies to Basic & Major services only	Plan pays $1,250 per person per plan year		Plan pays $2,000 per person per plan year	
Preventive Care Oral exams, cleanings, x-rays, fluoride treatment, sealants	No charge	10%	No charge	10%
Basic Services Fillings, simple extractions, and minor surgical procedures	30% after deductible	40% after deductible	20% after deductible	30% after deductible
Endodontics/Periodontal Endodontics (root canal), periodontal scaling and root planing	Not covered	Not covered	20% after deductible	30% after deductible
Major Services Crowns, inlays, onlays, dentures, bridges	Not covered	Not covered	50% after deductible	60% after deductible
Orthodontia Adults and children $2,000 lifetime maximum per person	Not covered	Not covered	50%	50%

This chart is intended for comparison purposes only. If there are any discrepancies, the plan description will govern. The plan description can be accessed on the Associate Resources webpage at www.asbury.org/associate-resources or on the Associate app in the Open Enrollment section.

*Non-participating (out-of-network) dentists may balance bill you for their charges that exceed the Delta Dental payment.

Prevention first!

Make sure you take advantage of your preventive dental visits. Preventive care services are not subject to the deductible, the plan covers 100% of the cost if you visit an in-network provider, and preventive visits do not accumulate toward your annual benefit maximum!

Need to locate a participating, in-network provider?

To locate a participating provider, visit www.deltadentalins.com or call 1-800-932-0783.

COSTS FOR COVERAGE

Per pay rates based on 26 pays per year

	Total Cost (Per Pay)	Standard		WOW! Incentive	
		Asbury Pays (Per Pay)	You Pay (Per Pay)	Asbury Pays (Per Pay)	You Pay (Per Pay)
EPO Plan					
Associate Only	$311.58	$229.01	**$82.57**	$249.36	**$62.22**
Associate + Spouse/Domestic Partner	$623.15	$364.54	**$258.61**	$405.26	**$217.88**
Associate + Child(ren)	$556.78	$341.31	**$215.47**	$361.72	**$195.06**
Family	$868.36	$523.62	**$344.74**	$564.39	**$303.97**
PPO Plan					
Associate Only	$243.42	$174.29	**$69.13**	$194.69	**$48.73**
Associate + Spouse/Domestic Partner	$486.84	$275.55	**$211.29**	$316.34	**$170.50**
Associate + Child(ren)	$434.99	$262.30	**$172.69**	$282.69	**$152.30**
Family	$678.40	$400.26	**$278.14**	$441.01	**$237.39**
HSA-qualified Plan					
Associate Only	$199.60	$139.32	**$60.28**	$159.70	**$39.90**
Associate + Spouse/Domestic Partner	$399.21	$218.77	**$180.44**	$259.52	**$139.69**
Associate + Child(ren)	$356.69	$211.52	**$145.17**	$231.89	**$124.80**
Family	$556.29	$320.98	**$235.31**	$361.72	**$194.57**

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.

	Total Cost (Per Pay)	Asbury Pays (Per Pay)	You Pay (Per Pay)
Dental—Basic Option			
Associate Only	$8.35	$6.64	**$1.71**
Associate + Spouse/Domestic Partner	$17.28	$11.60	**$5.68**
Associate + Child(ren)	$14.20	$8.52	**$5.68**
Family	$22.96	$13.78	**$9.18**
Dental—High Option			
Associate Only	$12.84	$10.21	**$2.63**
Associate + Spouse/Domestic Partner	$26.58	$17.59	**$8.99**
Associate + Child(ren)	$22.49	$13.50	**$8.99**
Family	$35.34	$21.20	**$14.14**
Vision			
Associate Only	$2.35	$1.40	**$0.95**
Associate + Spouse/Domestic Partner	$4.69	$2.81	**$1.88**
Associate + Child(ren)	$5.02	$3.01	**$2.01**
Family	$8.04	$4.83	**$3.21**

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

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars to pay for out-of-pocket health care and dependent care expenses for you and your family. There are two types of FSAs: Medical FSA and Dependent Care FSA. The plans are administered by **Discovery Benefits**.

Note: you are not eligible to enroll in the Medical FSA if you elect the HSA-qualified medical plan option.

Medical FSA

Even though your benefits cover many of your health care expenses, you may need to pay some costs out-of-pocket. You can contribute up to **$2,700** each year to the Medical FSA to pay for copays, deductibles, and coinsurance related to your or your dependents' out-of-pocket medical, dental, vision, or prescription drug costs. The money can be used for your expenses or for expenses for your tax dependents — even if they are not enrolled in the Asbury medical, dental, or vision plans.

The full amount you elect to contribute to your Medical FSA is available in your account on the first day of the plan year. Your contributions will be deducted from your paycheck evenly over the plan year.

Eligible expenses include: Your out-of-pocket costs for doctor visit copays, prescription drugs, prescription eyeglasses, dental copays and deductibles, braces, contacts, hearing aids, and much more. For a list of eligible expenses, please visit the Discovery Benefits website at https://www.discoverybenefits.com/employees/eligible-expenses.

The Discovery Benefits Debit Card — a quick, easy way to pay
We encourage you to use your Discovery Benefits Debit Card to pay for expenses and services at eligible locations, such as the doctor's office or pharmacy. As always, save itemized receipts, bills, or statements any time the debit card is used.

Do I need to enroll each year?

In order to participate in the FSA, you ***must enroll each plan year***. Your annual contribution stays in effect during the entire plan year (August 1 through July 31). The only time you can change your election is during Benefits Open Enrollment or if you experience a qualified change-in-status event.

Will I lose my money if I don't use it in a year?

When you choose how much to contribute to an FSA, be sure to estimate your expenses carefully. These elections are subject to the IRS "use it or lose it" rule.

The Medical FSA has a grace period until October 15 for you to incur claims for the plan year. You have until October 31 to submit any claims. Any funds remaining in your Medical FSA as of October 31 will be forfeited. There is no grace period on the Dependent Care FSA.

Dependent Care FSA

Contributing to a Dependent Care FSA allows you to use tax-free money to pay for dependent care expenses so that you and your spouse can work, look for work, or attend school full-time. You may set aside up to **$5,000** annually in pre-tax dollars, or $2,500 if you are married and file taxes separately from your spouse. When submitting a claim, you can only be reimbursed up to the amount you have contributed to date, less any previous reimbursements.

Eligible expenses include: Daycare, day summer camp, after school care, and preschool expenses, for children 12 years old and younger (or disabled dependents of any age.) Sleep-away or overnight camps are not covered. You may also use this account to pay for adult daycare services for an elderly parent who is your tax dependent.

For a list of eligible expenses, please visit the Discovery Benefits website at https://www.discoverybenefits.com/employees/eligible-expenses.

The debit card may also be used at day care providers that accept credit cards and have a valid merchant category code signifying they are a day care provider. The debit card may not be used if you pre-pay day care expenses since the IRS requires the expense must be incurred before reimbursement can be made from your Dependent Care FSA. An expense is incurred when a service is received, not when a bill is paid. Even though your service provider may require payment at the beginning of the service period, you cannot request reimbursement until after the service is provided.

What is the difference between the Dependent Care FSA and the dependent care tax credit?

When considering funding a Dependent Care FSA, you need to weigh your potential savings from the spending account versus your savings through the dependent care tax credit. The money reimbursed through a Dependent Care FSA will reduce the amount of eligible expenses you can use for the tax credit on a dollar-for-dollar basis.

Tax savings with a Dependent Care FSA become more valuable as your income increases. Generally, if your family's adjusted gross income is less than $39,000 a year, it may be best for you to take the tax credit rather than participating in the FSA.

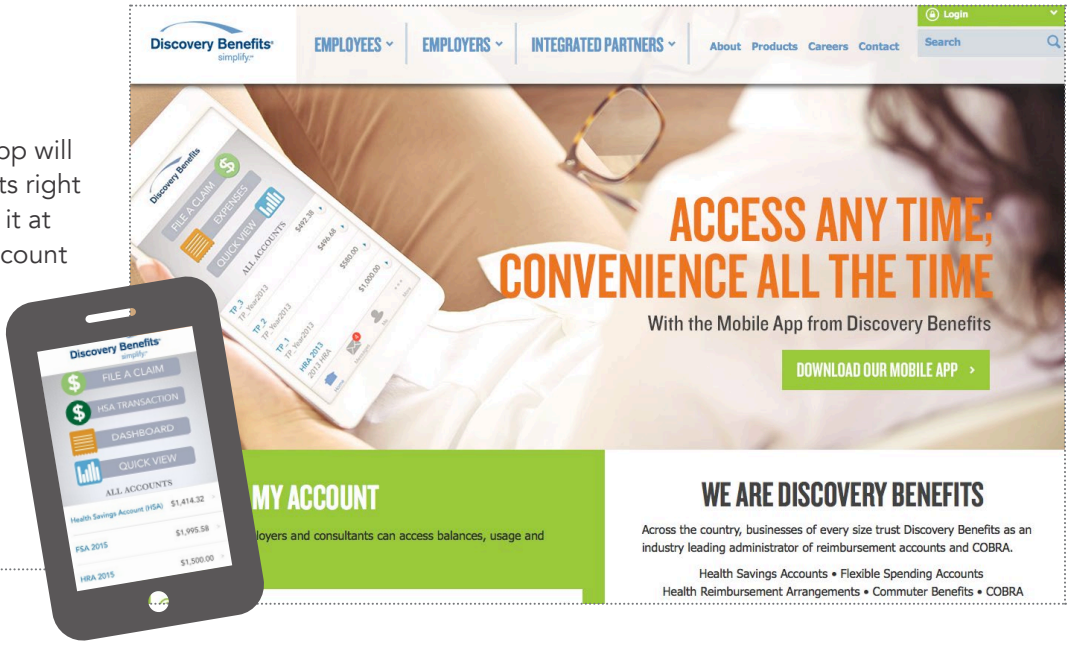
For tax advice specific to your situation, please contact your tax advisor.

Tools to manage your account on the go

Manage your FSA online at www.discoverybenefits.com.

The free Discovery Benefits app will help you manage your benefits right from your mobile device. Use it at your convenience to check account balances, upload photos of receipts, file claims, view account activity and contact customer service.

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



Hospital Indemnity Insurance

can pay benefits that help you with the costs of a covered hospital visit.

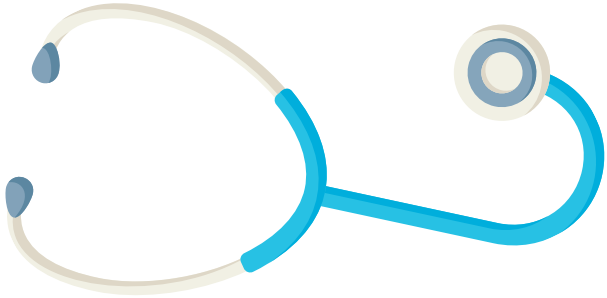
How does it work?

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you – not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.

What's included?

- $1,000 for each covered hospital admission - once per year
- $100 for each day of your covered hospital stay, up to 60 days - once per year

UNUM
1 (866) 679-3054
www.unum.com



The plan does not include a pre-existing condition limitation. You are covered from day one.

Why is this coverage so valuable?

- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.
- Wellness Benefit: Based on your plan, this benefit can pay $50 per calendar year per insured individual if a covered health screening test is performed, including: blood tests chest X-rays, stress tests, mammograms, and colonoscopies.
- A full list of covered tests will be provided in your certificate of coverage.

Who can get coverage?

You	If you're actively at work
Your spouse	ages 17 and up
Your children	Dependent children until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. Spouses and dependent children must reside in the United States to receive coverage.

Bi-Weekly Premium (includes wellness incentive)

	Bi-Weekly Premium
Associate Only	$8.41
Associate + Spouse/Domestic Partner	$15.19
Associate +Child(ren)	$10.70
Family	$17.48

Financial protection for you and your family in the event of your death. Some coverage is provided to you automatically at no cost; additional voluntary coverage is available to purchase based on your needs.

LIFE AND AD&D INSURANCE

Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. Accidental Death & Dismemberment (AD&D) insurance provides an additional benefit if you lose your life, sight, hearing, speech, or your limbs in an accident. Coverage is provided through **The Hartford** (toll-free phone 1-888-563-1124).

Don't Forget to Designate a Beneficiary!

Choosing who will receive your life insurance benefits is an important decision. During your benefits enrollment, make sure you've designated a beneficiary. Open Enrollment is a good time to check your beneficiary information to keep it up-to-date as your life status changes (e.g. you get married).

Core Life and AD&D Insurance — Company-Paid Benefit

- Class 1 (Associates whose work status is at least 60 hours per pay period): 1 times your base salary (rounded to the nearest $1,000), up to a maximum of $500,000. (Please note that coverage over $50,000 is considered taxable imputed income.)
- Class 2 (Associates whose work status is between 30 and 59 hours per pay period): $10,000 benefit.

Evidence of good health is not required. Benefits are subject to a reduction schedule, and reduce by 35% at age 70 and 50% at age 75 due to insurance company guidelines.

Not sure how much life insurance is right for you and your family?

Compare your beneficiaries' assets and expenses to estimate how much insurance you might want to buy. Insurance may be needed to help pay expenses for several years.

Consider these factors:

- Expenses
  - Regular expenses such as food, clothing and other recurring expenses
  - Debts, including car loans, mortgage or credit cards
  - Education costs for your children
  - Funeral expenses
- Resources
  - Savings, spouse's earnings, or other insurance you may have

Associate-Paid Supplemental Life Insurance

For associates whose work status is at least 60 hours per pay period.

Supplemental Life Insurance coverage is available through **The Hartford** (toll-free phone 1-888-563-1124); participation is voluntary, and **you pay 100% of the cost**.

You must elect coverage for yourself in order to purchase coverage for your spouse and/or dependent children.

- **For Associate:**
  - Increments of $10,000, up to a maximum of $500,000 or 5 times your annual salary, whichever is less.
  - This year, The Hartford is offering a true open enrollment, so if you waived coverage when you were first eligible, you will now be able to elect coverage up to the the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). The GI amount has also increased to $200,000 so you will be able to elect up to this amount without EOI.
- **For your spouse:**
  - Increments of $5,000, up to 50% of your elected Voluntary Life amount. The amount of Spousal Life Insurance cannot exceed $250,000.
    You must elect Voluntary Life Insurance for yourself in order to elect coverage for your eligible spouse.
  - This year, The Hartford is offering a true open enrollment, so if you waived coverage when you were first eligible, you will now be able to elect coverage up to the the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). The spouse GI amount has also increased to $150,000 so you will be able to elect up to this amount without EOI.

Benefits for you and your spouse are subject to a reduction schedule, and reduce by 35% at age 70 and 50% at age 75 due to insurance company guidelines.

- **For your children:**
  - $10,000 benefit (If death occurs before age 14 days there is no benefit. If death occurs age 14 days to 6 months, the maximum benefit received is $100.)
  - Eligible dependent children must be age 6 months to 18 years (up to age 23 if unmarried and a full-time student). You must elect Voluntary Life Insurance for yourself in order to elect coverage for your eligible dependent children.
  - Evidence of Insurability is not required for child life insurance.

Age	Supplemental Life Insurance Rates Per Pay per $1,000
<35	$0.0415
35-39	$0.0600
40-44	$0.0969
45-49	$0.1523
50-54	$0.2585
55-59	$0.4662
60-64	$1.0615
65-69	$1.8231
70+	$3.3646
Child ($10,000 benefit)	$0.9231

A note about Evidence of Insurability (EOI)...

The Hartford requires you to show that you are in good health before they will agree to provide certain levels of coverage. This is referred to as "Evidence of Insurability (EOI)".

EOI will be required for:

- Any Voluntary Life insurance amount you elect for yourself and/or spouse after this true open enrollment.
- Any Voluntary Life insurance amount that exceeds the Guarantee Issue Limit.

Coverage that requires EOI will not be in effect until you receive approval from The Hartford.

Asbury offers short-term and long-term disability options that help provide financial security for you and your family if you become sick or injured and unable to work.

DISABILITY INSURANCE

Asbury offers short-term and long-term disability options that help provide financial security for you and your family if you become sick or injured and unable to work. If you are an eligible associate, disability benefits are provided at **no cost to you** through **The Hartford** (toll-free phone 1-800-549-6514).

Core Short-Term Disability (STD) — Company-Paid Benefit

Exempt Associates and positions of RN and LPN whose work status is at least 60 hours per pay period.

- 66.67% of your base salary up to a maximum of $4,500 per week.
- Benefit payments begin on the 1st day of an accident or after 7 days due to an illness and can last for up to 180 days.

Core Long-Term Disability (LTD) — Company-Paid Benefit

Exempt Associates whose work status is at least 60 hours per pay period.

- 60% of your base salary up to a maximum of $15,000 per month.
- Benefits begin after you have been continuously disabled for 180 days.
- As long as you remain disabled, benefits will continue up to the later of your Social Security Normal Retirement Age or the duration schedule found in the Certificate of Coverage.
- Pre-existing condition limitations apply.

Short-Term and Long-Term Disability benefits are taxed as ordinary income. Taxes will not be withheld from your benefit payment. You will receive a 1099 from The Hartford for use when preparing your annual tax return.

If you receive benefits from other sources, such as Workers Compensation, Social Security, or other group and government disability benefits, they will be subtracted from the benefit amount you receive under the STD or LTD plan. Please refer to the Certificate of Insurance for more information.

Long-Term Disability payments are not payable or a disability caused by a pre-existing condition, which is an injury or illness or which you have consulted a doctor or received treatment during 90 consecutive days prior to the effective date of coverage. If you have a pre-existing condition, there is a 12-month waiting period before benefits for that condition will become payable. A condition will no longer be considered pre-existing if it causes a disability after you have been enrolled in the Long-Term Disability plan for at least 12 consecutive months.

Associate-Paid Disability Insurance

For Associates not eligible for the company-paid Disability Insurance, and whose work status is at least 60 hours per pay period.

If you are not eligible for the company-paid Disability Insurance, you have the option to purchase voluntary Short-Term and Long-Term Disability coverage through **The Hartford** (toll-free phone 1-800-549-6514). If you do not enroll when you are first eligible, Evidence of Insurability will be required.

Voluntary Short-Term Disability (STD)

- 60% of your weekly earnings up to a maximum of $1,000 per week to cover you in the event you are unable to work due to a qualified injury or illness.
- Benefit payments begin on the 1st day of an accident or after 7 days due to an illness, and can last for up to 180 days.
- The Voluntary STD has a pre-existing condition limitation that applies to conditions for which an employee receives medical services within 6 months of the effective date of coverage. For any disability that results from, or is caused or contributed to by, a pre-existing condition, benefits will only be payable for up to 4 weeks. A condition will no longer be considered pre-existing if it causes a disability after you have been enrolled in the STD plan for at least 12 consecutive months or until the employee has been covered for 6 consecutive months with no medical care for the condition.
- Please note this has changed to a flat percentage from the $100 increments between $100-$1,000.

Age	Voluntary STD Rates Per Pay Period per $10
< 40	$0.3508
40-49	$0.3092
50-59	$0.3969
60+	$0.5585

Voluntary Long-Term Disability (LTD)

- 50% of your monthly salary up to a maximum of $6,000 per month.
- Benefit payments begin after 180 days of continuous disability, and benefits will continue for a maximum of 5 years as long as you are disabled prior to age 61.
- If you become disabled after age 61, the duration of the benefit is dependent on your age at the time of disability. For more information, please refer to the Schedule of Insurance section in the Certificate.
- The Voluntary LTD pre-existing condition limitation applies to conditions for which an employee receives medical services within 6 months of the effective date of coverage. No benefits are payable for a disability resulting from such a condition until the employee has been covered for 6 consecutive months with no medical care for the condition, or until the employee has been covered for 12 consecutive months.

If you receive benefits from other sources, such as Workers Compensation, Social Security or other group and government disability benefits, they will be subtracted from the benefit amount you receive under the STD or LTD plan. Please refer to the Certificate of Insurance for more information.

A note about pre-existing conditions

Voluntary Short-Term and Long-Term Disability benefits are subject to a pre-existing condition exclusion. A pre-existing condition is a sickness or injury for which you received medical treatment, consultation, care, or services, including diagnostic measures or taken prescribed drugs or medicines.

Age	Voluntary LTD Rates Per Pay Period per $100 of Covered Payroll
< 25	$0.0559
25-29	$0.0598
30-34	$0.1327
35-39	$0.1709
40-44	$0.2053
45-49	$0.3075
50-54	$0.4179
55-59	$0.6038
60-65	$0.7107
65+	$0.8458

Could your bank account survive a serious illness?

Get protection with Critical Illness Insurance from The Hartford.

A major illness – such as cancer, a heart attack, or stroke – can leave you emotionally, physically, and financially overwhelmed. Critical Illness insurance can help relieve the financial impact of an illness so you can focus on recovery.

Critical Illness Insurance can enhance your traditional medical plan. When combined with accident or disability insurance, it can also help ensure that you'll be better prepared to cover out-of-pocket expenses in the event of a serious illness.

Examples of covered conditions include:

- Cancer
- Bone Marrow Transplant
- Heart Attack
- Stroke
- Heart Transplant
- Kidney Failure
- Major Organ Transplant
- Loss of Hearing, Speech, and Sight
- Paralysis
- Occupational HIV infection
- Coma

The Critical Illness Insurance plan also includes a $50 wellness benefit, payable each year for a covered person who has a health screening test performed.

CRITICAL ILLNESS INSURANCE

With Critical Illness Insurance, you will receive a lump-sum payment when a covered illness is diagnosed. You can use the payment any way you choose, to help cover day-to-day living expenses or any other expenses not covered by your medical plan. Pre-existing condition limitations will apply.
The Hartford toll-free phone: 1-866-547-4205.

A study of American cancer survivors showed that 65% of participants did not have sufficient income to cover out-of-pocket expenses for cancer treatment and other incurred debts related to the illness. Following treatment, 30% reported debt of $10,000 or more.[1]

- Coverage available for both you and your dependents*.
  - For you: $10,000
  - For your spouse: 50% of your elected amount
  - For your dependent children: $5,000
- The first time you're diagnosed with an illness from any of the three categories of covered conditions, you will be paid a lump-sum benefit that's 100% of your coverage amount.
- If you suffer from the same illness again later, or you're diagnosed with another illness in the same category, you will be paid a percentage of your benefit.

* Policy age limit is 80. The coverage amount for each covered person will decrease by 50% on the policy anniversary date following the date you attain age 70.

Premium Rates Per Pay

Rates are based on your age and tobacco status. You are considered a tobacco user if you use any tobacco or nicotine product.

Non-Tobacco User				
Issue Age	Employee	Employee & Spouse	Employee & Child	Family
18-24	$1.1169	$1.8646	$1.9292	$2.8292
25-29	$1.4585	$2.3815	$2.2938	$3.3785
30-34	$1.9985	$3.1985	$2.8477	$4.2092
35-39	$2.8662	$4.5092	$3.7108	$5.5246
40-44	$4.3246	$6.7569	$5.1600	$7.7492
45-49	$6.2169	$9.6831	$7.0292	$10.6477
50-54	$8.5246	$13.2646	$9.3231	$14.2062
55-59	$11.5154	$17.9077	$12.2908	$18.8169
60-64	$15.0969	$23.4185	$15.8446	$24.2908
65+	$17.0077	$26.3215	$17.7369	$27.1708

Tobacco User				
Issue Age	Employee	Employee & Spouse	Employee & Child	Family
18-24	$1.2508	$2.0723	$2.1000	$3.0877
25-29	$1.7585	$2.8477	$2.6446	$3.9138
30-34	$2.6215	$4.1723	$3.5215	$5.2523
35-39	$4.1169	$6.4708	$5.0123	$7.5462
40-44	$6.8769	$10.7538	$7.7446	$11.7923
45-49	$10.7677	$16.7954	$11.6077	$17.7923
50-54	$15.8077	$24.6000	$16.6246	$25.5600
55-59	$22.4585	$34.8923	$23.2431	$35.8154
60-64	$30.6554	$47.5338	$31.4031	$48.4062
65+	$35.1138	$54.3969	$35.8385	$55.2415

1 Insights From Survivors: Managing the Personal, Emotional and Financial Impact of Cancer, Washington National Institute for Wellness Solutions, 2014.

ACCIDENT INSURANCE

With Accident Insurance, you will receive a lump-sum payment for a covered injury and related services. You can use the payment any way you choose, to help cover day-to-day living expenses or any other expenses not covered by your medical plan. **No medical questions asked!** The Hartford toll-free phone: 1-866-547-4205.

In the U.S., a disabling injury occurs every second, and an accidental death occurs every 4 minutes.[1] And, more than 3.5 million children ages 14 and younger get hurt each year playing sports or participating in recreational activities.[2]

- Coverage available for both you and your dependents.
- Direct payment to you or to your beneficiary.
- If you experience one of the covered accidental injuries or related services, you will be paid a lump-sum benefit (varies based on service)—organized sports are included.

Premium Rates Per Pay

Rates are based on which coverage tier you select.

Employee	Employee + Spouse	Employee + Child(ren)	Family
$4.0846	$6.4246	$6.7385	$10.6292

1 Injury Facts. National Safety Council. 2014 Edition. P. 37. Print. Viewed on 06/18/2015
2 "Sports Injury Statistics." Health Library. Johns Hopkins Medicine, n.d. Web. 18 June. 2015. <http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/sports_injury_statistics_90,P02787>

If you have an accident, will it hurt your bank account, too? The Hartford's Accident Insurance gives you something to fall back on.

An accident can happen to anyone, and recovery can be costly. Your medical plan may pick up most of the tab, but leave you with out-of-pocket expenses that add up quickly. Accident insurance can help ease the unplanned financial burden by complementing other insurance you may have, including major medical and disability coverage. As medical costs continue to rise, this additional layer of financial protection may make a difference at a time when you and your family need it most.

Accident Insurance provides benefits for covered accidental injuries, related services, and treatments. Examples include:

- Dislocations, fractures, and lacerations
- Diagnostic exams, x-rays, and other emergency services
- Ambulance transportation, hospital admission and confinement
- Follow-up/recovery services, including physical therapy and chiropractic care

PET INSURANCE

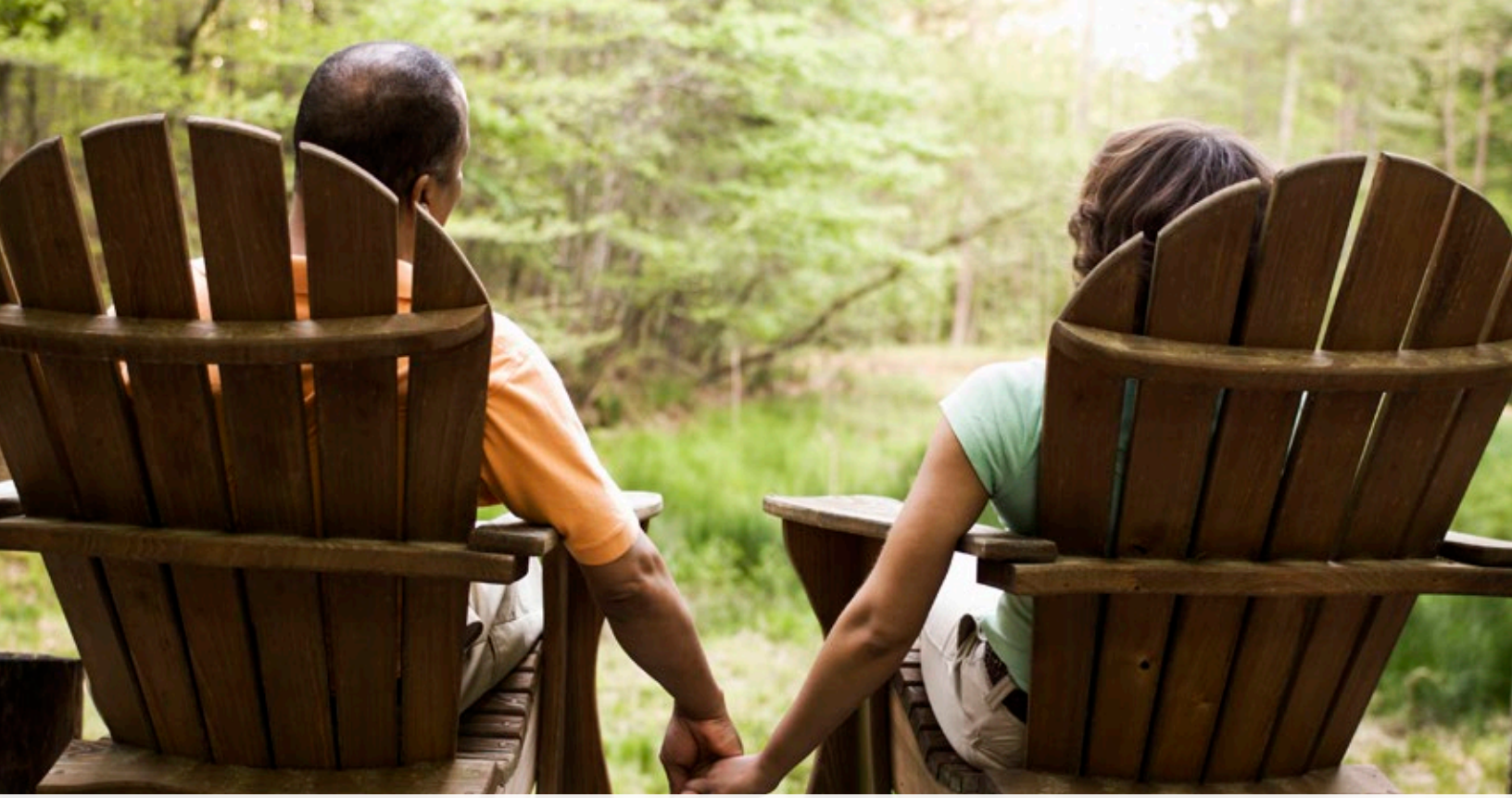
Your pet is part of the family too!

Save up to 90% on your dog and/or cat's medical care with Healthy Paws Pet Insurance. If your dog or cat needs treatment for any accident or illness (except pre-existing conditions), you're covered. It's that simple. Enroll your pet anytime between 8 weeks and before 14 years old.

- Unlimited lifetime benefits for your dogs and cats, no caps.
- Mobile app for easy claim submission and quick claim reimbursements.
- Pay Healthy Paws directly via debit or credit card.

Special discounts available for Asbury Associates!

For a free quote and to enroll, visit www.tinyurl.com/AsburyCommunities or call 1-855-898-8991.



Plan for your long-term financial future with the 401(k) Retirement Savings Plan.

401(K) PLAN

The 401(k) Retirement Savings Plan allows eligible associates to plan or their long-term financial future. By participating in the 401(k) plan through Prudential, you are saving for your retirement by contributing a percentage of your pay to the Plan on a pre-tax basis. This means that the amount contributed to the Plan from your pay will not be taxed as income until it is ultimately distributed to you from the Plan.

You are eligible to participate on the first day of the payroll period following your date of employment. You may contribute any percentage of your pay. Asbury makes a nonelective contribution equaling 3% of your total earnings into your account. Asbury will also make a matching contribution of the first 2% you contribute. You must complete one year of service (working at least 1,000 hours during the year) to be eligible to receive Asbury's 3% contribution and the 2% matching contribution.

Once your contributions begin, they will continue unless you elect to make a change. You may increase of decrease your contribution percentage, stop your contributions, and/or resume your contribution at any point in time. To change the way your account is invested, call **1-800-547-7754** or visit the Plan's website at www.principal.com.

You may take a withdrawal from your 401(k) account upon normal retirement at age 65 or delayed retirement, total disability, death, or termination of employment.

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

CARRIER RESOURCES

Plan / Provider	Phone Number	Website
Wellness/Personal Health Profile Health Advocate	1-866-799-2728	www.HealthAdvocate.com/asburycommunitiesinc
Employee Assistance Program Health Advocate	1-866-799-2728 Option 2	www.HealthAdvocate.com/asburycommunitiesinc
Retirement Savings Plan Principal Account/Contract # 523614	1-800-547-7754	www.principal.com
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
Dental Delta Dental Group # 19326	1-800-932-0783	www.deltadentalins.com
Vision VSP Group # 30082941	1-800-877-7195	www.vsp.com
Flexible Spending Accounts Discovery Benefits	1-866-451-3399	www.discoverybenefits.com
Life and Disability Insurance The Hartford Group # 678024	Life and AD&D Insurance: 1-888-563-1124 Short-Term and Long-Term Disability: 1-800-549-6514	www.TheHartfordatWork.com
Critical Illness Insurance **Accident Insurance** The Hartford	1-866-547-4205	www.TheHartfordatWork.com
Hospital Indemnity Insurance UNUM	1-866-679-3054	www.unum.com
Pet Insurance Healthy Paws	1-855-898-8991	www.tinyurl.com/AsburyCommunities

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.*

EPO—stands for "Exclusive Provider Organization." As a member of an EPO, you can use the doctors and hospitals within the EPO network, but cannot go outside the network for care. There are no out-of-network benefits.

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.

PPO—PPO stands for "Preferred Provider Organization." It is a group of hospitals and physicians that are contracted with insurance companies to provide medical services. Out-of-pocket costs are lower when a provider is used within the PPO network (called in-network).

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:

Carol 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:

Carol 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:

EPO	In-Network	Out-of-Network
Individual Deductible	$500	N/A
Family Deductible	$1,000	N/A
Coinsurance	N/A	N/A

PPO	In-Network	Out-of-Network
Individual Deductible	$1,000	$2,500
Family Deductible	$2,000	$5,000
Coinsurance	30%	50%

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:

Carol 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

NOTES

NOTES

Asbury Communities
Asbury Methodist Village
Asbury Solomons
Bethany Village
Springhill
Inverness Village

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**