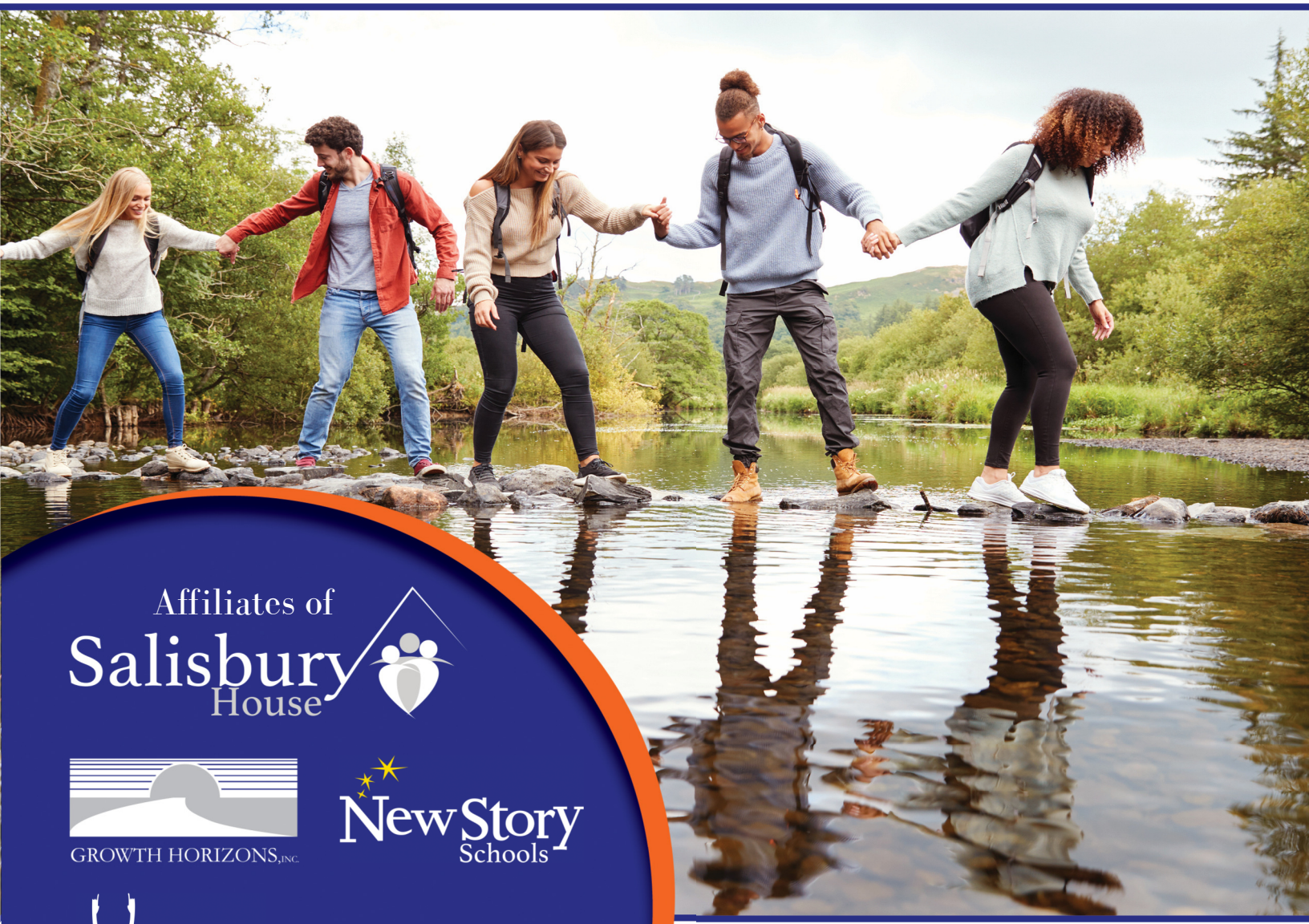
2020 Benefits

With you every step of the way



Affiliates of Salisbury House

GROWTH HORIZONS, INC.

New Story Schools

PAHrtners DEAF SERVICES

SALISBURY BEHAVIORAL HEALTH, LLC
Healing and recovery through empowerment and self-discovery.

Salisbury MANAGEMENT, LLC
Supporting Operational Excellence

This bulletin is designed to provide a general overview of the benefit options available to eligible employees and should not be used in place of referring to the carrier certificate of coverage booklets available on the Employee SelfService Portal.

Welcome

Salisbury House, Inc. appreciates the role that employee benefits plays as a critical component of an employee's overall compensation. We continue to make every effort to acquire the best quality benefit plans for our valued employees and their families.

Enclosed is an overview of the available benefit options. Eligibility for most benefits is the first of the month following 60 days of full-time employment (*scheduled 30 hours or more per week*).

Please review the information in this guide as well as the insurance carrier booklets prior to making your benefit elections online.

Submit questions and forms to the Benefits Department at:

Salisbury Management, Inc.
1150 Wyoming Ave.
Wyoming, PA 18644
E-mail: benefits@salisburymgt.com
Phone: 888.879.8858
Fax: 888.714.4428

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What You Need to Know

ELIGIBILITY—NEW HIRE AND CHANGES IS STATUS

Employees are eligible for most benefits outlined in this guide on the first day of the month following 60 days of full time employment (as defined by the ACA, scheduled a minimum of 30 hours per week) unless otherwise noted.

SPECIAL ENROLLMENT

You are not eligible to enroll, terminate or make changes to your plan coverage during the year unless you experience a life event. Life events include: gaining or losing other coverage; overage dependent; death; divorce; gain a new dependent because of marriage; birth, adoption; or placement for adoption. In order to meet the eligibility requirements for special enrollment, you MUST notify the Benefits Department no later than 30 days from the date of the life event.

DEPENDENT & SPOUSE ELIGIBILITY

Dependent children can be covered under your healthcare plans to age 26. The Company offers coverage for spouses and domestic partners of employees provided that the spouse or domestic partner is not offered medical coverage through his or her employer. If enrolling a spouse or domestic partner on your medical plan, you are required to submit the spouse/domestic partner waiver form indicating that your spouse or domestic partner is not eligible for medical coverage through their employer. This form is available in the benefit section of the Employee Self-Service Portal under Forms and Documents.

TERMINATION OF COVERAGE

Healthcare benefits will terminate at the end of the month in which your employment terminates. Benefits available through UNUM (Life, LTD, Accident & Hospital plans) and Flexible Spending Accounts will terminate as of your last day of employment. Conversion/portability options may be available for UNUM plans. COBRA may be available for healthcare plans and healthcare Flexible Spending Account (FSA).

CHANGE IN EMPLOYMENT STATUS

If you have a change in employment status, i.e. full time to part time (as defined by the ACA, scheduled less than 30 hours per week), you may remain active in only the medical plan until the end of the applicable stability period. You will receive notification from the Company outlining this time period. All other benefits will terminate as outlined in the Termination of Coverage section above.

Glossary and Terms

Co-Insurance
The amount you pay your provider after you meet the deductible. Usually stated as a percentage.
Example: 20% after deductible.

Co-Pay
The amount you pay at the time you receive a service. Example, a family physician office visit or a prescription co-pay. Co-pays do not count towards the deductible. Co-pays do count towards the out of pocket maximum.

Deductible
The amount you pay to the provider before the insurance plan starts to pay. See pages 8 & 9 for more details.

Employee Payroll Contribution
The amount you pay per paycheck to purchase insurance under the employer's benefit plans. This amount is not applied towards deductibles, out of pocket maximums or towards the cost of services.

ESS (Online Employee Self-Service Portal)
Visit www.thesalisburyhouse.com to access the Online Employee Self-Service Portal. Here you can find additional details including coverage booklets, plan summaries, educational videos, forms, etc. Go to the benefits section.

Full Time Employee
Employees scheduled to work 30 or more hours per week are eligible to participate in the plans outlined in this guide unless otherwise noted.

Out of Pocket Maximum
The most you pay during the plan year for deductibles, co-pays, and co-insurance. If a covered family member meets the individual out of pocket maximum, then the insurance company will pay for 100% of that person's costs for the remainder of the calendar year.

Provider
Any healthcare system including hospitals, doctors, specialists, pharmacies, dentists, etc.

Provider Network
Providers who have agreed to provide services at discounted rates. You generally pay less out-of-pocket when you use in-network providers. Note: The Medical Plans require that you treat with an in-network provider and facility in order to receive coverage under the Plan.

Getting Started

- Go to **www.thesalisburyhouse.com**. You may be asked to enter your Office 365/Microsoft credentials.
- Enter on the Benefits Team located in the left-hand toolbar.
  Our Teams>Benefits department
- Click on the ADP Employee Self Service Link.
- Enter your ADP Portal login credentials.
  - If you have not registered for the ADP portal, enter on the registration icon and use registration code 0052N2M-1234
- Once you access the ADP Portal, enter on the Benefits tile in the left-hand toolbar.
- Make sure to visit the forms and documents section to access Summary Plan Descriptions, full carrier coverage booklets, plan descriptions and much more.
- Click on "Enroll Now" to make your benefit elections.
- In order to add any dependents to your benefit plans, you must add them to the dependent section.
- You must enter beneficiary information for any life insurance elections you make this includes the employer paid Basic Life section. You will not be able to complete enrollment without entering beneficiary data.

Ready To Enroll?

Visit our intranet site,
"The House", at:

www.thesalisburyhouse.com

Don't Forget:
Click on **Complete** to finish your enrollment and receive a **confirmation number**

If you have any questions or require assistance, please contact the Benefits Department.

Benefits@salisburymgt.com
Phone: **1.888.879.8858**
Fax: **1.888.714.4428**

Per Pay Employee Contributions/Wellness

PLANS	EMPLOYEE	EMPLOYEE & SPOUSE	EMPLOYEE & CHILDREN	FAMILY
Medical Option 1: High Deductible Health Plan	$23.08	$282.12	$159.55	$403.40
Cost After Wellness	$0.00	$259.04	$136.48	$380.32
Medical Option 2: HMO	$83.61	$483.22	$285.83	$658.05
Cost after Wellness	$60.54	$460.14	$262.75	$634.98
Vision Costs	$2.59	$7.15	$7.15	$7.15
Dental Costs	$12.67	$25.33	$27.15	$44.05
Group Hospital Indemnity	$10.27	$19.37	$14.04	$23.14
Group Accident	$7.52	$12.16	$14.04	$18.68

See Employee Self Service for Life and LTD Rates.

Live Well. Work Well.

Payroll Savings for Wellness

New participants have 90 days from benefit eligibility date to complete and submit the wellness requirements. Visit Employee Self-Service to review annual deadlines. Please do not submit results or scores with your submissions.

STEP 1 SCHEDULE YOUR WELL EXAM WITH YOUR FAMILY PHYSICIAN	STEP 2 COMPLETE THE ONLINE WELL-BEING PROFILE	STEP 3 SUBMIT TO BENEFITS
Screening results are completely confidential between you and your physician. Your physician must complete Section 1 of the Preventive Screening Notification form. Forms are available in the Benefits section (Forms and Plan Documents) of the Employee Self-Service Portal.	Go to www.ibx.com Log into your account or register as a member if first time. Click on: ▸ "Health and Wellness" tab ▸ "Achieve Well-Being" link ▸ "Well-Being Profile" tab ▸ "Start the Profile" OR "Re-take the Profile" if you have completed before. **Once complete, you will be able to view a PDF of your results. Print Page 1 ONLY. DO NOT SEND ANY RESULTS.**	Submit Section 1 of the Preventive Screening Notification form AND page 1 of the Wellness Profile to: Salisbury Management, Inc. Mail: 1150 Wyoming Avenue Wyoming, PA 18644 Fax: 888.714.4428 Email: Benefits@salisburymgt.com

Telemedicine

Independence Blue Cross

MDLIVE®

NEW Benefit — Telemedicine

You can now access telemedicine services through MDLive as part of your medical plan. Telemedicine is a convenient and low-cost option when you can't get to your doctor. You can see a board-certified doctor by secure video, phone or mobile app—anytime, anywhere. Telemedicine providers can prescribe medications and treat non-emergency medical conditions such as:

- Colds and flu
- Allergies
- Asthma
- Pink eye
- Ear infections
- Sinus problems
- Respiratory infections
- Joint aches and pains
- Vomiting and nausea
- And more!

Register and activate your account at anytime using your IBC member ID.

Dependents on coverage can use MDLive as well. Children under age 18 must have parent present.

Access 24/7
Visit **mdlive.com/ibx**
Call **1.877.764.6605**
Mobile App available.

Medical Plan: Option 1 HDHP
(High Deductible Health Plan)

BENEFIT	IN-NETWORK
Annual Deductible	**Single Coverage:** $1,500; **Family:** $3,000
Out-of-Pocket Maximum	**Single Coverage:** $4,000; **Family:** $8,000
Lifetime Maximum	Unlimited
Preventive Care	
Adult and Child Preventive Care; Pediatric Immunizations; Mammograms	100%
Outpatient Care	
Primary Care Physician Office Visit	$25 copay after deductible
Specialist Office Visits	$50 copay after deductible
Telemedicine	$40 before deductible; $10 copay after deductible
Outpatient Facility Surgery	$500 copay after deductible
Chiropractic Care (20 visits per year)	$25 copay after deductible
Outpatient Mental Health	$25 copay after deductible
Inpatient Services	
Facility	$500 copay per day (max $2,500) after deductible
Physician/Surgeon	100% after deductible
Inpatient Mental Health	$500 copay per day (max $2,500) after deductible
Outpatient X-Ray/Radiology	
Routine Radiology/Diagnostic	$150 copay after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$150 copay after deductible
Emergency Care	
Ambulance	100% after deductible
Emergency Room	$200 copay after deductible
Urgent Care	$100 copay after deductible
Maternity Care	
First OB Visit	$25 copay after deductible
Hospital services	$500 copay per day (max $2,500) after deductible
Retail Pharmacy (30 day supply)	
Generic/Preferred Brand/Non-Preferred Brand	$10/$30/$50 after deductible
Mail Order (90 day supply)	
Generic/Preferred Brand/Non-Preferred Brand	$20/$60/$100 after deductible
Vision Rider	
Exam	$10 copay (no deductible)
Lenses	$25 copay (no deductible)
Frames or Contacts	$100 allowance (no deductible)
Frequency	Every two calendar years

Independence Blue Cross

Annual Deductible:
This amount needs to be paid by you before the insurance company pays for any service including prescriptions. For example, if you visit your family physician, you will pay the discounted rate of the visit, not an office visit co-pay. If you cover a dependent, you must pay the $3,000 family deductible before the insurance company will start to pay. There is no individual deductible when covering family on Option 1.

Network Access:
You have access to the Highmark National Blue Card PPO Physician Network. In-Network physicians/facilities. Visit www.ibx.com to review physician directory or contact your physician's office to ask if they participate.

FSA or HSA?
You can contribute to either a Flexible Spending Account OR a Health Savings Account (HSA) when enrolled in Option 1. Please see pages 12 and 13 for more details.

RX Drug Waiver
For drugs on the preventive and maintenance drug list, the deductible does not apply. Will pay the Co-Pay first.

This plan is a credible prescription drug plan for Medicare Part D eligible individuals.

Medical Plan: Option 2 HMO Plan

BENEFIT	IN-NETWORK
Annual Deductible	**Single Coverage:** $2,500; **Family:** $5,000
Out-of-Pocket Maximum	**Single Coverage:** $6,350; **Family:** $12,700
Lifetime Maximum	Unlimited
Preventive Care	
Adult and Child Preventive Care; Pediatric Immunizations; Mammogram	100%
Outpatient Care	
Primary Care Physician Office Visit	$25 copay
Specialist Office Visits	$25 copay
Telemedicine	$30 copay
Outpatient Facility Surgery	20% after deductible
Chiropractic Care (20 visits per year)	$25 copay
Outpatient Mental Health	$25 copay
Inpatient Services	
Facility	20% after deductible
Physician/Surgeon	20% after deductible
Inpatient Mental Health	20% after deductible
Outpatient X-Ray/Radiology	
Routine Radiology/Diagnostic	$50 copay
MRI/MRA, CT/CTA Scan, PET Scan	$100 copay
Emergency Care	
Ambulance	20% after deductible
Emergency Room	$200 copay
Urgent Care	$50 copay
Maternity Care	
First OB Visit	$25 copay
Hospital services	20% after deductible
Retail Pharmacy (30 day supply)	
Generic/Preferred Brand/Non-Preferred Brand	$15/$35/$50
Mail Order (90 day supply)	
Generic/Preferred Brand/Non-Preferred Brand	$30/$70/$100
Vision Rider	
Exam	$25
Lenses	No cost
Frames	$65 allowance
Contacts	$100 allowance
Frequency	Every two calendar years

Independence Blue Cross

Eligibility

You must live in one of the following counties to be eligible for the HMO Option: DE: (New Castle), NJ: (Burlington, Camden, Gloucester, Hunterdon, Mercer, Salem, Warren), PA: (Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northampton, Philadelphia).

Annual Deductible:

The deductible on Option 2 only applies to certain services as outlined below. This amount must be paid before the insurance company pays. If you cover a dependent and a family member meets the individual $2,500 deductible, then the insurance company will start to pay for 80% (coinsurance) of that person's costs. The family max is met once 2 people in the family meet the individual $2,500 deductible.

Network Access:

You must visit In-Network physicians/facilities. Visit **www.ibx.com** to review physician directory or contact your physician's office to ask if they participate. You will have access to the Keystone East HMO physician network.

FSA or HSA?

You can contribute to enroll in a Healthcare Flexible Spending Account (FSA) if you choose Medical Plan Option 2. See pages 12 and 13 for more details.

This plan is a credible prescription drug plan for Medicare Part D eligible individuals.

Vision Benefits/Hearing Aid Program

VISION BENEFITS

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Eye Exam	Focus on your eyes and wellness	$10	Every 12 months
Frames	$130 allowance $150 allowance (featured frames) 20% discount on amounts over allowance $70 Costco frame allowance	Included	Every 24 months
Lenses	Single vision, lined biofocal/trifocal Polycarbonate lenses for dependent children	Included	Every 12 months
Lens Enhancements	Progressive lenses Scratch-resistance coating	Included	Every 12 months
Contacts	$130 allowance for contacts Contact lens exam	Up to $60	Every 12 months

TRUHearing Hearing Aid Discount Program

VSP Vision Care members can save up to 60% on the latest brand-name hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

More Than just Great Pricing
TruHearing also provides members with:

- Three provider visits for fitting & adjustments.
- A 45-day trial.
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement.
- 48 free batteries per hearing aid.

Plus, members get:

- Access to a national network of more that 3,800 hearing healthcare providers.
- Straight-forward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids.
- Deep Discounts on batteries shipped directly.

Learn more about this VSP exclusive member extra at:
truhearing.com/vsp or call 877.396.7194

Dental Benefits

DELTA DENTAL®

DENTAL PPO AND PREMIER NETWORK

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	**Individual:** $50 **Family:** $150	**Individual:** $50 **Family:** $150
Benefit Maximums Annual Orthodontic Lifetime	$1,500 $1,000	
Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants	100%	100%
Basic Services Fillings, space maintainers, denture repair, endodontics, periodontics, oral surgery	80% after deductible	80% after deductible
Major Services Crowns, inlays, onlays, cast restorations, bridges, dentures, implants	60% after deductible	60% after deductible
Orthodontic Services (Dependents to age 26)	50%	50%

Orthodontic Coverage to age 26

Dependent Eligibility

Dependent children are now eligible to be covered under the dental plan up to age 26.

Access Online Services:

Get information about your plan anytime, anywhere by signing up for an Online Services account at **deltadentalins.com**. This free service lets you check benefits and eligibility information, find a network dentist and more.

Check in With Ease:

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your name, birth date and enrollee or social security number.

Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

HSA or FSA?

WageWorks everyone benefits

	HEALTH SAVINGS ACCOUNT (HSA)	HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)
Do I need to be enrolled in a medical plan to participate?	Yes, you must be enrolled in the HDHP.	No
How much can I save?	Self Only—Up to $3,550 Family—Up to $7,100	Any amount between $500 and $2,700
When will my money become available?	Funds are only available as you contribute from your pay. You cannot use what you do not have available in the account.	Your entire balance is available immediately. The Company pre-loads funds to the debit card and you pay back from payroll deductions.
What expenses qualify?	Medical, Dental, Vision, Prescription and other medical expenses not covered by insurance visit **https://www.irs.gov/pub/irs-pdf/p502.pdf**	
Who can I use my account for?	You can use your account for yourself and taxable dependents even if they are not enrolled on your medical plan.	
Can I change my contribution?	Yes, anytime	No, not unless you experience a life event.
Is a debit card available?	Yes	Yes
Do I need to save receipts?	Yes, in case you are audited.	Yes, to prove your expense is eligible.
Can I take funds with me if I leave the company?	Yes	No, however you may be eligible for COBRA.
Can I carryover money into the next year?	Yes, all unused money carries over from year to year.	Yes, up to $500 can be carried over into the next year.
Is there a time limit to use the money in the account?	No	Yes, you must use the money before 12/31.
Is there a deadline for submitting receipts and filing claims?	Not applicable	Yes, you must submit all receipts and claims for expenses prior to 3/31 of the following year.
Can I contribute if I am enrolled in Medicare?	You can no longer contribute once however you can withdraw available funds.	Yes
How do I access my account?	**Myspendingaccount.wageworks.com** UMB Bank: **866.520.4472**	**Myspendingaccount.wageworks.com** Wageworks: **888.557.3156**

HSA & FSA

Download the EZ Receipts App!

Company Contribution

Contribute at least $1.00/pay to a Health Savings Account (HSA) and receive a Company contribution of $15.38/pay to your HSA account.

WageWorks
everyone benefits

Contributing to a Health Savings Account (HSA) or Healthcare Flexible Spending Account (FSA) allows you to save money from your paychecks to help pay for medical expenses that your insurance plan may not cover, like co-pays, deductibles and certain over the counter medical supplies. The money that you put into these accounts is deducted from your paycheck before taxes, allowing you to save money at tax time. This money is transferred onto a debit card that you can use at time of purchase or when paying an invoice from services already received.

Key Points

- You must be enrolled in the HDHP medical plan and no other medical plans, including Medicare, in order to contribute pre-tax dollars to a HSA.
- You can contribute to a Limited Purpose FSA and still contribute to a HSA.
- You cannot contribute to a HSA and a healthcare FSA at the same time.
- If you have a balance in a healthcare FSA, including carryover, you cannot contribute to a HSA without transferring the carryover to a Limited Purpose FSA.

OTHER ACCOUNTS	DEPENDENT CARE FSA	LIMITED PURPOSE FSA
Eligible Expenses	Qualified dependent daycare, Pre K or elder care	Qualified dental and vision expenses only.
Min / Max Annual Contribution	$500 / $5,000	$100 / $2,700
Carry Over	Not eligible	Up to $500

Additional Protection

Visit Employee Self Service Portal to calculate Life & LTD rates.

Better benefits at work.

Life Insurance

The company pays for a Basic Life and AD&D policy. The benefit amount is equal to one times the employee's salary, up to a maximum of $50,000. The employee has the option of purchasing additional life insurance coverage in increments of $10,000; as well as spouse and child life coverage at group rates. Employees must purchase coverage for themselves in order to purchase dependent coverage.

Long Term Disability

Eligible employees have the option of purchasing Long Term Disability Insurance (LTD) at group rates. Deductions are on an after-tax basis. Participants are eligible to receive 60% of their monthly earnings to a maximum of $5,000 per month when absent from work for more than 90 consecutive days for a qualified disability.

Group Hospital Indemnity Insurance

UNUM's Hospital Indemnity insurance is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization. Hospital Indemnity benefits are lump sum benefits and are paid directly to you, regardless of the actual cost of treatment.

Coverage includes:

- $1,000 for each covered hospital admission, once per year.
- $100 for each day of your covered hospital stay, up to 15 days once per year.
- $200 for each day spent in intensive care, up to 15 days, once per year.

Group Accident Insurance

Unum's Group Accident Insurance can pay a lump-sum amount for an injury that occurred because of an accident. This can include emergency-room care follow up treatment, surgery, etc. The benefit can help offset the out-of-pocket expenses that medical insurance does not pay, including deductibles and co-pays.

LIST OF COVERED INJURIES		EXAMPLE COVERED EXPENSES	
Broken Bones $75-$7,500	Burns $1,000-$10,000	ER Treatment $150	Occupational Therapy $25
Torn Ligaments up to $1,200	Eye Injuries $300	Outpatient Facility $300	Speech Therapy $25
Stitches $75-$600	Ruptured Discs $800	Pain Management $100	Chiropractor $25
Coma $10,000	Concussion $150	Hospitalization $200-$1,500	Physical Therapy $25

*Unum benefits are deducted on an after-tax basis.

Retirement Benefits

Once eligibility criteria is met, employees are automatically enrolled in the company's 401k plan and 1% will be deducted from your eligible earnings and contributed to a 401k account. Employees have the option of declining auto enrollment as well as electing to contribute a different amount.

Eligibility Criteria

- Employees must be age 21 and complete one year and 1000 hours of service.
- Entry date is the first day of the quarter (January, April, July, October) that either coincides with or next follows the date you complete the above requirements.
- The company will match 50% of your contribution up to the first 6%.
- The employer maximum contribution equals 3% if you contribute 6%.
- The total maximum contribution for the 2020 calendar year is $19,500. Those age 50 and above can contribute an additional $6,500 per calendar year as catch up contributions.

For free investment advice, contact UBS Financial at:

888.824.0336

401K

www.mykplan.com

Employee Assistance Plan

All employees and eligible dependents have access to the Employee Assistance Program (EAP) to help with many work and personal life issues. Your benefit provides face-to-face or telephone EAP consultations with a professional behavioral health clinician skilled in your area of concern. In certain types of needs, your Carebridge Counselor may refer you to additional appropriate sources of help.

The program will provide up to eight (8) consultations per event per every 12 months and counselors are available via phone 24 hours a day, 7 days a week.

COUNSELORS WILL HELP YOU WITH CONCERS SUCH AS:	LIFE MANAGEMENT & WORK-LIFE ASSISTANCE:
Marital and Relationship Issues	Child Care Resourcing and Information
Alcohol and Drug Abuse	Eldercare Assistance
Stress Management	Parenting Information
Family/Parenting Problems	Educational Guidance and Neighborhood Analysis
Depression or Anxiety	Time Management and Life Balance
Grief and Loss	Legal Assistance
Financial Pressures	Adoption Guidance
Spousal/Child/Parent Abuse	Travel and Expatriate Information
Legal Assistance	Consumer Information
Wellness information	Retirement Planning

Call 1.800.437.0911

For online services, logon to www.myliferesource.com, access code 9J9CR

Carebridge EAP Mobile App Now Available!

Specialized guidance is also available for the management of personal and family concerns. Helpful information and resources are provided to assist you in making the best decisions possible.

Plan Contacts

Important Plan Contact Information

INDEPENDENCE BLUECROSS (IBC) www.ibx.com Phone: 1.800.253.3854 **High Deductible** National Blue Card Network Group# 10135996 **Keystone East HMO** HMO Network Group # 10135993	**ADP 401K:** www.mykplan.com Phone: 800.541.7705 UBS Financial – Investment Advice Phone: 888.824.0336
	UNUM www.unum.com **Life & LTD** 800.421.0344 **Accident & Hospital** 800.635.5597
DELTA DENTAL OF PA Group# 04930 www.deltadentalins.com 1.800.932.0783	**CAREBRIDGE EAP** 1.800.437.0911 www.myliferesource.com Carebridge EAP mobile app available
VSP VISION Group # 30078422 www.vsp.com 800.877.7195	**WAGEWORKS FSA & HSA** myspendingaccount.wageworks.com WageWorks Phone: 888.557.3156 EZreceipts mobile app available UMB—HSA Bank Phone: 866.520.4472

BENEFITS VIP www.benefitsVIP.com Phone: 866.293.9736 Fax: 856.996.2775 Email: solutions@benefitsvip.com	**VISIT EMPLOYEE SELF–SERVICE PORTAL** www.salisburyhouse.com **BENEFITS DEPARTMENT** Phone: 1.888.879.8858 Fax: 1.888.714.4428 Email: benefits@salisburymgt.com

Disclosures

SPECIAL ENROLLMENT RIGHTS (HIPAA)

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

NO GUARANTEE ON TAX CONSEQUENCES

Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of an Employee under any Plan will be excludable from the Employee's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Employee. An Employee shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or social security tax from such payments or reimbursements.

NEWBORNS & MOTHERS HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:
1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Federal law imposes certain requirements on employee benefit plans voluntarily established and maintained by employers. [29 USC §1001 et seq.; 29 CFR 2509 et. seq.] ERISA covers two (2) general types of plans: retirement plans, and welfare benefit plans designed to provide health benefits, scholarship funds, and other employee benefits. As a participant, you are entitled to certain rights & protections under ERISA.

- Examine, without charge, at the office of the Administrator and at other specified locations, such as worksites, all Plan documents and copies of all documents filed by the Plan with the US Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Obtain a statement telling you whether you have a right to receive a benefit at normal retirement age and, if so, what your benefit would be at normal retirement age if you stopped working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing, and no one is required to give such a statement more than once a year. The Administrator must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to run the Plan prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire your or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you may take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you win the suit, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – for example, if it finds that your claim is frivolous.

If you have any questions about the Plan, you should contact the plan administrator at your Human Resources Department. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Written notice stating whether or not the expected amount of paid claims under a group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard drug benefit under Medicare Part D. Must be sent to participants and beneficiaries eligible for Medicare Part D.

The notice must be provided by (1) October 15th each year; (2) prior to an individual's individual enrollment period for Part D; (3) prior to the effective date of coverage for any Part D eligible individual who enrolls in the employer's prescription drug coverage; (4) when the plan no longer provides drug coverage or when the coverage is no longer creditable; and (5) upon request.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

Disclosures

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

HIPAA INFORMATION NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health related information. The Notice of privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your local Human Resources Department.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CAN CHILDREN STAY ON A PARENT'S PLAN UNTIL AGE 26?

If a plan covers children, they can be added or kept on the health insurance policy until they turn 26 years old.

Children can join or remain on a plan even if they are:

- married
- not living with their parents
- attending school
- not financially dependent on their parents
- eligible to enroll in their employer's plan

HOW TO GET COVERAGE FOR ADULT CHILDREN

Adult child may be enrolled during a plan's open enrollment period or during other special enrollment opportunities. The employer or insurance company can provide details.

Under-26-year-olds can be signed up directly in new Marketplace plans. Be sure to include him or her on the list of people to be covered.

Questions? Call 1-800-318-2596, 24 hours a day, 7 days a week. (TTY: 1-855-889-4325)

Advocacy

WEBSITE

Stay informed with the latest health news, biometric tools, calculators and information at **benefitsvip.com**!

BLOG

HealthDiscovery.org is a lifestyle blog with wellness articles, tips, quizzes, recipes, and more!

BenefitsVIP®
Help starts here.

Help Starts Here

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues.

For service that's confidential and responsive, contact:

866.293.9736

Monday - Friday,
8:30am—8:00pm (ET)
Fax: 856.996.2775
solutions@benefitsvip.com

Questions Answered Here

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

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