STEINMAN COMMUNICATIONS

BENEFITS GUIDE

PLAN YEAR 2022

January 1, 2022—December 31, 2022

MEDICAL | VISION | DENTAL | FSA | LIFE | DISABILITY | EAP | 401(K)

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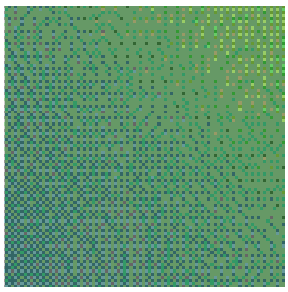
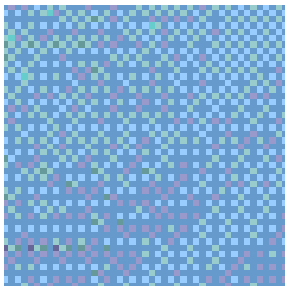




CONTACT INFORMATION

Steinman Communications, in partnership with the following carriers, strives to meet your benefit needs.

If you have any questions regarding your benefits, please contact the corresponding carrier listed below or Steinman Communications' Human Resources Department.

HEALTH ADVOCATE
1-866-695-8622
Email: answers@healthadvocate.com

MEDICAL
Capital Blue Cross (Group # 00525203)
1-800-962-2242
www.capbluecross.com

PRESCRIPTION
Express Scripts (Group # RXSTEIN)
1-877-884-3252
www.express-scripts.com

DENTAL
Delta Dental (Group # 5044)
1-800-932-0783
www.deltadentalins.com

VISION
NVA (Group # 478)
OptiVision (Group # 09980478)
1-866-468-2393
www.e-nva.com

FLEXIBLE SPENDING ACCOUNT
Discovery Benefits
1-866-451-3399
customerservice@discoverybenefits.com

WELLNESS PROGRAM
Wellworks For You
1-800-425-4657
www.wellworksforyoulogin.com

401(K) PLAN
The Newport Group
1-844-749-9981
www.newportgroup.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)
Carebridge
1-800-437-0911
www.myliferesource.com

CIGNA SHORT-TERM DISABILITY
1-800-362-4462
www.cigna.com

IMPORTANT INFORMATION

2022 ENROLLMENT PERIOD

Open enrollment will take place October 25, 2021 through November 19, 2021.

Active employees electing Long Term Disability or Supplemental Life will need to complete an Evidence of Insurability form if changing/increasing your enrollment option or adding coverage for the first time.

Online enrollment must be completed by close of business November 19, 2021.

Please contact Human Resources at 717-295-5067 with questions.

BENEFITS ELIGIBILITY

Who is Eligible?

Employees who are full-time working 30 hours or more per week and/or a New Hire or Newly Eligible employee may elect to participate in the benefit plans listed below:

- Medical and Prescription Drugs
- Dental
- Vision
- Basic Life
- Supplemental Life (for you)
- Short Term Disability (STD)**
- Long Term Disability
- Healthcare Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)
- 401(k)**

It is important to note as of January 1, 2019, the Federal individual mandate requiring you to have coverage is no longer in force. Individuals will not incur Federal penalties if they elect not to have medical coverage in place after this date.

However, some states have enacted state individual mandates requiring you to continue to have medical cover-age in place.

One example of this is the state of New Jersey. Before declining coverage, make sure that your state has not enacted such a law.

Note

A new hire or newly eligible employee is eligible for benefits the 1st of the month after date of hire or after the change in eligibility. **There is a 90 day waiting period to be eligible for 401(K) and STD benefits.

If dropping coverage, you must provide acknowledgement of your intention to purchase qualified health care coverage through another carrier or the State/Federal exchange.

SPOUSES & DEPENDENTS

Did you know?

An Employee's eligible dependent(s)—a legal spouse and/or dependent children up to age 26—may participate in medical/prescription, dental and vision plans. You may enroll your eligible dependents as long as you are enrolled too.

- If your spouse is eligible for medical and prescription plans under a group plan provided by his or her employer, the Steinman Communications medical / prescription plan will provide secondary coverage only.

- In addition, if you and your spouse are both employed and covered under the Steinman Plan, you may each be enrolled as an Employee or be covered as a dependent of the other person, but not both. If you and your spouse are both covered under the Plan, only one parent may enroll your child(ren) as a dependent.

CHANGES DURING THE YEAR

You can make changes to your life insurance beneficiaries or your address at any time, but the benefit coverage changes are governed by IRS guidelines. The health and welfare benefits you elect when hired or newly eligible must stay in effect until December 31, unless you report a qualified life event change (QLE) within 30 days of the event date to make changes to your benefits. If you do not initiate your QLE change, you must wait until the annual open enrollment period to add, drop or otherwise change your coverage.

Qualifying Life Events can be submitted through your Paycom Employee Self-Service. Please see the end of this guide for instructions or contact Human Resources.

COMMON QUALIFIED LIFE EVENTS

- **Marriage, Divorce**
- **Birth or Death of Dependent**
- **Adoption of / Placement for Adoption of your Child**
- **Qualified Medical Child Support Order (State or Federal)**
- **Termination or Commencement of Your Spouse's Employment**
- **Dependent Gaining Eligibility for Benefits**
- **Dependent Losing Eligibility for Benefits – Dependent Child reaches age 26**
- **Entitlement to Medicare or Medicaid**
- **Change in Employment Status (i.e. part-time to full-time, full-time to part-time)**

COST STRUCTURE

WHO PAYS FOR COVERAGE?

- Steinman Communications and employees share in the cost of the medical and dental insurance.
- Steinman Communications pays 100% of the cost for the Basic Life, the Employee Assistance Program (up to 3annual visits) and the Short Term Disability premium.
- Employees pay 100% of the cost of Supplemental Life Insurance, Long Term Disability, Critical Illness and Accidental Injury coverage.

Your dependents (legal spouse* and/or any dependent children up to age 26) may also participate in some benefits including:

- Medical Benefits
- Prescription Benefits
- Dental Benefits
- Vision Benefits
- Employee Assistance Program

Keep in mind that the benefit descriptions in this Benefit Guide are summaries only. If there is a discrepancy between these documents and formal summary plan documents (SPD) prepared by the insurance company, the official insurance policies will prevail. Benefit programs may also be subject to change or modification at any time. This benefit summary does not constitute a binding employee contract.

*If a spouse is offered coverage through their place of employment, their coverage will be primary and Steinman's coverage will be considered secondary.

BENEFIT	WHO PAYS FOR COST
MEDICAL COVERAGE	**Company/Employee**
DENTAL COVERAGE	**Company/Employee**
VISION COVERAGE	**Company/Employee**
BASIC LIFE	**Company****
LONG TERM DISABILITY	**Employee**
SHORT TERM DISABILITY	**Company**
SUPPLEMENTAL LIFE	**Employee**

** 1 X Base Salary *** See 401k Plan Document

BENEFIT OVERVIEW

MEDICAL COVERAGE — Capital BlueCross
GROUP NUMBER — 00525203
CUSTOMER SERVICE NUMBER — 1-800-962-2242
www.capbluecross.com

Steinman Communications offers two Preferred Provider Options (PPO) to elect for medical coverage. The two PPOs have different deductibles and out-of-pocket maximums with all other coverages identical.

WELLNESS PROGRAM

CUSTOMER SERVICE NUMBER — 1-800-425-4657

The basis of our Wellness Program is to help employees be aware of their health. In an effort to keep our employees healthy and health care costs low, Steinman Communications is continuing participation with Wellworks For You for the 2022 plan year. The program is entirely voluntary.

If you choose not to participate you will miss out on the wellness incentives, and this will impact your medical premiums. Those who choose to participate will receive a discounted bi-weekly medical premium. Our Wellness Program is an outcomes based program. The goals and credits are listed in the chart below.

2022 GOALS & CREDITS

		2022 MONTHLY REWARD	
PARTICIPANT		**EMPLOYEE**	**SPOUSE**
Health Assessment	Complete	$30	$30
Biometric Screening	Complete	Included Below	Included Below
Nicotine	Negative	$50	$50
Waist Circumference	Men: ≤40” Women: ≤35”	$30	$30
Blood Pressure	≤140/90 mmHg	$30	$30
LDL Cholesterol	≤130 mg/dL	$30	$30

Alternative Options

If you do not meet the goals, an appeal can be filed to confirm you will be working with your doctor to improve your healthy ranges. This is outlined in the Wellworks For You Program guide located on the Wellworks Portal. Wellworks For You customer service is available to assist you with questions.

TELEMEDICINE (VIRTUAL CARE)

Can't get an appointment? Office is closed? Try Telemedicine!
From your phone, tablet or computer, you have access to a doctor 24/7.

	MEDICAL	COUNSELING	PSYCHIATRY
Doctors and counselors	Virtual care providers are licensed doctors that have an average of 15 years of experience.	Virtual care counseling services are provided by licensed psychologists and master's level counselors.	Virtual care psychiatry services are provided by board-certified psychiatrists and neurologists.
Treatment or conditions, such as:	Abdominal pain Bronchitis and other respiratory infections Flu, pink eye, strep throat	Anxiety Bereavement and grief Depression LGBTQ counseling Trauma	Anxiety disorders Anorexia/bulimia Bipolar disorder OCD Post traumatic stress disorder
Availability	24/7 through the mobile app or website (including weekends and holidays)	7:00 a.m. - 11:00 p.m. ET, 7 days a week by appointment only (same day if needed)	Patients can typically get appointments within 14 days, and schedule follow-up visits as needed.

TWO WAYS TO SIGN UP:

1. Download the free Virtual Care app
2. Visit **virtualcarecbc.com**

CAPITAL BLUECROSS LOOP

Communication to keep you connected with your health plan. Call or text the number below to be en-rolled. Please note that standard text messaging rates may apply.

How it works

Capital BlueCross Loop combines mobile text with web messaging. Each time a new message is available, you will receive a text with a link to the Loop. You can access your messages from a smartphone, tablet, or computer.

Getting started

It's easy to enroll! You simply need to have your member ID card handy and then sign up by phone or by text.

Call 855-939-5426, or text capbluecross to 73529

HEALTHWAYS FITNESS YOUR WAY

Access more than 9,500 gyms nationwide for $29 per month. Visit any participating fitness location. Signing up is easy! Visit **blue365deals.com** or call 1-888-242-2060.

SAVON SAVINGS PROGRAM FROM EXPRESS SCRIPTS

The SavOn Program is a free program geared at maximizing the assistance from drug manufacturers to lower overall plan costs for individuals who require specialty medications. 80% of all specialty medications have some form of copayment assistance program to help drive brand loyalty. This can be attributed to the extremely high cost of the prescription required to treat the condition.

The SavOn Savings Program targets more than 150 specialty drugs in 19 different therapy classes. By participating in this program, the patient responsibility for the cost of these medications could be reduced to zero! A sample of conditions covered by this program are listed in the table to the right.

Common Conditions	Average Manufacturer's Assistance
Hepatitis C	$7,500
Cystic	$2,300
Multiple Sclerosis	$2,000
Inflammatory	$1,666
Hemophilia	$1,666
Oncology	$1,250
Pulmonary Arterial Hypertension	$1,200
Blood Cell Deficiency	$1,000
Hereditary Angioedema	$1,000
Asthma & Allergy	$850

Individuals will be identified based on prior claims history and will be contacted by Express Scripts prior to January 1, 2022 to enroll in this program. If you start a new therapy of specialty medication during the plan year, SavOn will reach out to you when your first prescription is sent for processing and assist you with enrollment. For more details about this program, please contact ESI directly.

ACUPUNCTURE SERVICES

Acupuncture Services will be covered under your CBC medical plan under the therapy portion of benefits. It is subject to a $25 copayment and a 15 visit limit per calendar year.

MEDICAL/Rx BENEFITS SUMMARY

Capital BLUE

PPO 1

STEINMAN COMMUNICATIONS
ACTIVE EMPLOYEE GROUP INSURANCE PLAN

DEDUCTIBLE / MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual (Per Person)	You Pay $750	You Pay $4,000
Family (Aggregate)	You Pay $2,000	You Pay $12,000
Out-of-Pocket Maximum**		
Single (Per Person)	You Pay $4,000	You Pay $12,000
Family (Aggregate)	You Pay $10,000	You Pay $24,000

**includes deductibles, medical copays, and prescription copays

Plan pays 100% after Out-of-Pocket Maximum is met
Lifetime Maximum: Unlimited

Office Visits		
Preventive Services	You Pay $0	Plan Pays 60%
Primary Care Copay	You Pay $15	Plan Pays 60%
Specialty Care Copay	You Pay $25	Plan Pays 60%
TeleMedicine	You Pay $5	N/A
X-Ray / Lab Visits (Non Preventative)	Plan Pays 80%	Plan Pays 60%
Coinsurance	80%; You Pay 20%	60%; You Pay 40%
Emergency Care		
Facility Charges (Copay waived if admitted)	100% (after $150 copay)	100% (after $150 copay)
Professional Provider Charges	Plan Pays 80%	Plan Pays 80%
Urgent Care Center	100% (after $25 copay)	Plan Pays 60%
Inpatient Hospital Services	Plan Pays 80%	Plan Pays 60%
Outpatient Hospital Services	Plan Pays 80%	Plan Pays 60%
Physical, Occupational, & Speech Therapy	100% (after $25 copay)	Plan pays 60%
Combined 30 visits per calendar year (P)		
Combined 12 visits per calendar year (O&S)		
Chiropractic Care	100% (after $25 copay)	Plan pays 60%
Maximum 30 visits per calendar year		
Prescription Drugs (31 day Retail / 90 day Mail Order)		
Generic Formulary	You Pay greater of $10 or 20% (Retail) / $20 or 20% (Mail Order)	
Brand Formulary	You Pay greater of $30 or 30% (Retail) / $60 or 30% (Mail Order)	
Non-Formulary	You Pay greater of $50 or 40% (Retail) / $100 or 40% (Mail Order)	
Contraceptives	Covered 100% for Generic (some restrictions apply)	

For health care professionals that are Out-of-Network, members are responsible for the applicable coinsurance and the difference between the allowance and the amount billed.

See certificate of coverage for full detail.

Capital BLUE

PPO 2

STEINMAN COMMUNICATIONS ACTIVE EMPLOYEE GROUP INSURANCE PLAN

DEDUCTIBLE / MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual (Per Person)	You Pay $3,000	You Pay $5,000
Family (Aggregate)	You Pay $8,000	You Pay $12,000
Out-of-Pocket Maximum**		
Single (Per Person)	You Pay $8,700	You Pay $12,000
Family (Aggregate)	You Pay $16,700	You Pay $24,000

**includes deductibles, medical copays, and prescription copays

Plan pays 100% after Out-of-Pocket Maximum is met
Lifetime Maximum: Unlimited

Office Visits		
Preventive Services	You Pay $0	Plan Pays 60%
Primary Care Copay	You Pay $15	Plan Pays 60%
Specialty Care Copay	You Pay $25	Plan Pays 60%
TeleMedicine	You Pay $5	N/A
X-Ray / Lab Visits (Non Preventative)	Plan Pays 80%	Plan Pays 60%
Coinsurance	80%; You Pay 20%	60%; You Pay 40%
Emergency Care		
Facility Charges (Copay waived if admitted)	100% (after $150 copay)	100% (after $150 copay)
Professional Provider Charges	Plan Pays 80%	Plan Pays 80%
Urgent Care Center	100% (after $25 copay)	Plan Pays 60%
Inpatient Hospital Services	Plan Pays 80%	Plan Pays 60%
Outpatient Hospital Services	Plan Pays 80%	Plan Pays 60%
Physical, Occupational, & Speech Therapy	100% (after $25 copay)	Plan pays 60%
Combined 30 visits per calendar year (P)		
Combined 12 visits per calendar year (O&S)		
Chiropractic Care	100% (after $25 copay)	Plan pays 60%
Maximum 30 visits per calendar year		
Prescription Drugs (31 day Retail / 90 day Mail Order)		
Generic Formulary	You Pay greater of $10 or 20% (Retail) / $20 or 20% (Mail Order)	
Brand Formulary	You Pay greater of $30 or 30% (Retail) / $60 or 30% (Mail Order)	
Non-Formulary	You Pay greater of $50 or 40% (Retail) / $100 or 40% (Mail Order)	
Contraceptives	Covered 100% for Generic (some restrictions apply)	

For health care professionals that are Out-of-Network, members are responsible for the applicable coinsurance and the difference between the allowance and the amount billed.

See certificate of coverage for full detail.

VISION BENEFITS SUMMARY

BENEFIT OVERVIEW

VISION COVERAGE — National Vision Administrators (NVA)
GROUP NUMBER — 0478 (Employee Plan)
CUSTOMER SERVICE NUMBER — 1-800-468-2393
www.e-nva.com

National Vision Administrators, L.L.C.

Maintaining good vision by getting regular eye exams may prevent you from having major expenses later. Steinman Communications offers a supplemental vision plan provided through National Vision Administrators (NVA). While the medical plans do provide a routine vision exam benefit, this plan may help you and your family save on many eye care products and services including eyeglasses and contact lenses, Lasik, and other accessories.

SERVICE FREQUENCY	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER REIMBURSEMENT
Examination - Once every 12 months	Plan Pays 100% after a $10 copay	Up to $28
Contact Lens Evaluation/ Fitting - Once every 24 mo	Daily & Extended Wear, & Specialty Plan Pays 100% after a $20 copay	Daily Wear - $20 Extended Wear & Specialty - $30
Lenses - Once every 24 mo	Standard Glass or Plastic Under/Over 71 mm	Standard Glass or Plastic Under/Over 71 mm
Single Vision	Plan Pays 100% after a $15 copay	$20
Bifocal	Plan Pays 100% after a $15 copay	$30
Trifocal	Plan Pays 100% after a $15 copay	$40
Lenticular	Plan Pays 100% after a $15 copay	$60
Frames - Once every 24 mo	Plan Pays Up to $35 wholesale allowance	$35
Contact Lenses -	In Lieu of Glasses	In Lieu of Glasses
Once every 24 mo	Plan Pays Up to $75 retail allowance	$50
Medically necessary - preapproval required	Plan Pays 100%	$60

Low Vision Aids will be considered for full coverage provided a certification (Prior Authorization) is received from NVA.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

$10 Solid Tint
$12 Fashion/Gradient Tint
$10 Standard Scratch-Resistant Coating
$12 Ultraviolet Coating
$40 Standard Anti-Reflective
$20 Glass Photogrey (Single Vision)
$30 Glass Photogrey (Multi-Focal)
$75 Polarized
$90 Standard Progressive w/AR Coating
$60 Standard Progressive w/Solid Tints
$50 Progressive Lenses Standard
$65 Transitions Single Vision Standard
$70 Transitions Multi-Focal Standard
$25 Polycarbonate (Single Vision)
$30 Polycarbonate (Multi-Focal)
$30 Blended Bifocal (Segment)
$55 High Index
$35 Glare Resistant
$40 Plastic Photogrey

Options not listed will be priced by NVA providers at their wholesale cost plus 25%.

OPTI-VISION BENEFITS SUMMARY

BENEFIT OVERVIEW

VISION DISCOUNT PROGRAM — Opti-Vision
GROUP NUMBER — 09980478 (Employee and Dependent Plan)

Opti-Vision is the vision discount program available for yourself and dependents. It may also be used if you have a scheduled vision examination outside of the 2 year guideline.

WHERE TO GET BENEFITS

NVA has a network of participating Ophthalmologists, Optometrists, and Opticians to service you. A list of participating providers can be found at **www.e-nva.com**.

You must use an NVA participating provider in order to obtain vision care benefits.

HOW THE PROGRAM WORKS

National Vision Administrators has designed the program to be simple to use. All you or your eligible dependents have to do is present your NVA identification card to a participating provider. The NVA participating providers will service you according to the following schedule of benefits.

VISION CARE SERVICES	IN-NETWORK YOU PAY
Annual routine eye exam (does not include contact lens analysis	$38
Clear Lenses (per pair)	
Glass	
Single Vision	$30
Bifocal	$41
Trifocal	$50
Plastic	
Single Vision	$31
Bifocal	$45
Trifocal	$55

Lens Options
The NVA participating provider will charge you up to the wholesale cost, plus fifty percent (50%) on each option selected, or their usual, customary, and reasonable fee, whichever is less.

Exclusions
The following services and materials are not covered under this program: Medical or surgical treatments of the eye, drugs or medications, non-prescription lenses, examinations or materials not listed as a covered service, services or materials provid-ed by Federal, State, Local Government of Workers' Compensation, and Low vision aids.

DENTAL BENEFITS SUMMARY

BENEFIT OVERVIEW

DENTAL COVERAGE — Delta Dental
GROUP NUMBER — 5044
CUSTOMER SERVICE NUMBER — 1-800-932-0783
www.deltadentalins.com

Maintaining good dental health by getting regular check-ups may prevent you from having major expenses later. Steinman Communications offers dental coverage provided through Delta Dental.

DELTA DENTAL PPO	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Max		
Diagnostic and Preventative Care	$1,500	$1,500
Calendar Year Deductible		
Per Individual	You Pay $50	You Pay $50
Per Family	You Pay $150	You Pay $150
Preventive & Diagnostic Care Cleanings (once every 6 months) Routine X-Rays (once every 6 months) Sealants (under age 14) Fluoride Treatments (under age 19) Injectable Antibiotics	Plan Pays 100%* No Deductible	Plan Pays 100%*, No Deductible **Note:** Injectable Antibiotics not covered Out-of-Network
Basic Restorative Care Fillings Oral Surgery, Simple Extractions Periodontics Endodontics Anesthetics Oral Surgery, all except Simple Extractions	Plan Pays 80%*, After Deductible	Plan Pays 80%*, After Deductible
Major Restorative Care Crowns/Inlays/Onlays Dentures / Bridges Implants	Plan Pays 50%*, After Deductible	Plan Pays 100%*, After Deductible
Orthodontics Coverage for eligible Dependents up to age 19	Plan Pays 50%*, After Deductible	Plan Pays 100%*, After Deductible
Orthodontics Lifetime Maximum	$2,000	$2,000

*Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Please refer to the Plan Document for more information on reimbursements.

Members that use non-participating providers will be responsible for the appropriate coinsurance and any difference between the billed and allowed amounts.

When choosing your primary dentist it is important to keep in mind that there are **3 separate tiers that a dental provider can fall into.**

Under Delta Dental there are 2 kinds of participating dentists that are considered In-Network; **1)** PPO Dentists and **2)** Premier Dentists. All other dentists fall into the **3)** Out-of-Network category.

From the example below you can see that the greater discounts come from using a PPO dentist. The second best discount is from a Premier dentist, and the lowest discount is from Out-of-Network Non-Delta dentists.

Delta Dental PPO Plus Premier Plan Payment Example

	DELTA DENTAL PARTICIPATING PROVIDERS		
EXAMPLE	**PPO DENTISTS**	**PREMIER DENTISTS**	**NON-DELTA DENTAL DENTISTS**
Dentist's charge for a crown	$1,300	$1,300	$1,300
Plan allowance	$700	$900	$900
Percentage paid by plan	50%	50%	50%
Plan payment	$350	$450	$450
PATIENT PAYMENT	$350 ($700 - $350 =)	$450 ($900 - $450 =)	$850 ($1,300 - $450 =)

2022 BI-WEEKLY EMPLOYEE CONTRIBUTIONS

Contributions will vary based upon outcome results.

You decide how much you pay for your medical insurance.
Your Medical contributions will be based upon the results of the following:

- Biometric Screening ***(completed prior to October 30, 2021)***
  Results for LDL Cholesterol, Blood Pressure, Waist Circumference and Glucose
- Health Risk Assessment
- Tobacco Atesstation

The following pre-tax contributions for benefits eligible employees reflects employee/ spouse participation with maximum incentive and non-participation contribution.

MEDICAL Wellness Initiative	MAXIMUM INCENTIVE - Employee & Spouse Participation	MAXIMUM INCENTIVE - Employee Only; No Spouse Participation	Employee Non-Participation; Maximum Spouse Incentive	Non-Participation
New Hires after October 30, 2021 will have a grace period to participate. The light yellow rates for Employee & Spouse Participation will apply during the grace period.				
PPO 1				
Employee	$75.17	$75.17	$167.48	$167.48
Employee + Child(ren)	$169.28	$169.28	$261.59	$261.59
Employee + Spouse	$176.74	$269.05	$269.05	$361.36
Family	$244.45	$336.76	$336.76	$429.07
PPO 2				
Employee	$50.50	$50.50	$142.81	$142.81
Employee + Child(ren)	$113.62	$113.62	$205.93	$205.93
Employee + Spouse	$118.21	$210.52	$210.52	$302.83
Family	$163.54	$255.85	$255.85	$348.16

DENTAL & VISION	
Employee	$4.80
Employee + Child(ren)	$11.41
Employee + Spouse	$11.50
Family	$16.21

EMPLOYEE BENEFITS TO GO

In today's world who has time to sit in front of a computer or sit on hold on the phone to receive information on their benefits? You don't have to waste your time waiting; you can take your benefit information with you!

Check out the information below, because there is an app for that!

CAPITAL BLUE CROSS

Download the Capital Blue Cross Mobile App from your App store today!

- Create profiles for you and your family members
- List medicines, ID cards and health conditions in one place
- Find a doctor or medical locations wherever you are
- ID medicines with photos of your bottles or packaging
- Connect to your MyCapBlueCross account
- Tap to call a Capital Blue Cross Nurse
- Read the latest health and welfare news

EXPRESS SCRIPTS FOR PRESCRIPTIONS

Download the Express Scripts Mobile App or go to Express-Scripts.com/mobileapp to obtain.

- Order refills and renewals
- View your current prescription orders
- Transfer prescriptions to home delivery
- Find the closest retail pharmacy
- Check for possible drug interactions

- View a virtual member ID card

DELTA DENTAL OF PA

Download the Delta Dental Mobile App from the Apple Store or Google Play

- Find a Participating Dentist
- Add the dentist to your contacts
- Get directions to their office sent to your phone
- View Your ID card
- See an overview of your benefit coverage
- View claims, deductibles and/or maximums (claims may not be as current as website)
- Use the toothbrush timer with your kids—fun music makes it fun to brush for the recommended two minutes

NVA

Download the NVA Mobile App today from the Apple Store or Google Play

- Find Vision Care Providers
- View Beneifts
- Access your ID Card
- Discover the NVA Smart Buyer

LIFE & LONG TERM DISABILITY

BASIC LIFE

Steinman Communications provides employer paid Group Life coverage to all eligible employees through Cigna. The basic life insurance amount is 1 X base salary for each benefit eligible employee.

VOLUNTARY SUPPLEMENTAL LIFE

Steinman Communications offers you the option to purchase additional life insurance under Cigna's supplemental term life insurance plan. The plan remains 100% employee paid, through payroll deductions.

Life coverage at 1, 2, 3, 4, or 5 times your annual compensation, not to exceed $500,000. Guaranteed Issue amount will be the greater of $100,000 or the amount equal to your Life Insurance benefit coverage in effect on the termination date of the prior plan year.

For current employees who have not enrolled in Supplemental Life in the past and wish to do so for the first time, or who wish to increase existing Supplemental Life coverage, a Medical Underwriting questionnaire and approval by Cigna is required.

LONG TERM DISABILITY (LTD)

The LTD plan, insured through Cigna, provides you with long term income protection if you are absent from work due to accident or sickness. The amount of any benefit payable shall be reduced by the total amount of all other income benefits, including any amount for which you could collect but did not apply. Benefits are payable for employees who have been disabled for 180 days or more. LTD is a program that will replace 60% of your monthly salary if you are approved when you become ill or injured and are not able to work. Completion of an Evidence of Insurability is required for anyone enrolling for the first time.

SHORT TERM DISABILITY (STD)

Provides for 66.7% of pay beyond your initial waiting period of 8 days (0 days for an accident) up to a maximum of 26 weeks (less waiting period). The STD benefit starts 90 days after the start of employment and coordinates with sick days/vacation.

Please contact Human Resources at 717-295-5067 when short term disability may apply.

CIGNA

You have the option to purchase additional insurance products for yourself and/or your eligible dependents through Cigna.

Please note that any voluntary insurance options you elect may be deducted via payroll deduction and the premiums you pay will be on a after tax basis only.

THERE ARE 2 PLAN OPTIONS AVAILABLE:

ACCIDENT BENEFIT PLAN

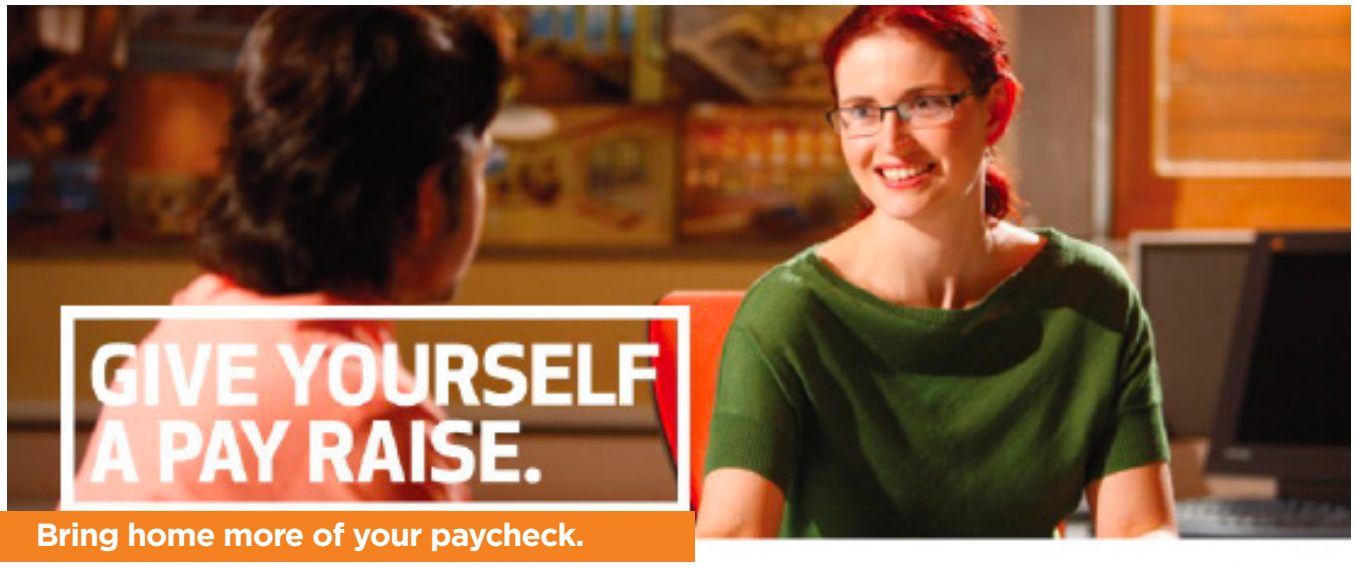
This plan pays benefits directly to you based on the type of injury sustained.

CRITICAL ILLNESS BENEFIT PLAN

This plan pays benefits directly to you based on the type of diagnosis received.

Full descriptions of these benefit plans can be found on Steinman Circle.

FLEXIBLE SPENDING ACCOUNT (FSA)



Bring home more of your paycheck.

What is a Flex Spending Account (FSA)?

An FSA works like a personal expense account. You set aside a portion of your salary before taxes and decide how much you want to contribute up to the maximum set by your employers or the IRS. Contributions are used to pay certain dependent care and medical expenses.

What are the different types of FSAs?

The most common types of FSAs include:

- **Dependent Care Account (DCA):** Allows reimbursement of dependent care expenses incurred by eligible dependents. To qualify, you and your spouse (if applicable) must be employed full-time or your spouse must be a full-times student.
- **Medical Spending Account (MSA):** Allows reimbursement of qualifying medical expenses.

Please check with your employer to see which plans are offered.

May I use the MedicalFSA to reimburse my spouse's deductible and/or co-payment expenses, even if he/she is enrolled in a different health insurance plan?

Yes. All eligible out-of-pocket medical expenses incurred by you and your qualified dependents can be reimbursed by your MedicalFSA, even if such dependents are not enrolled in your employers' health insurance plan.

Where can I find out what is a reimbursable expense?

Please visit **www.wexinc.com/insights/benefits-toolkit/eligible-expenses**
to find our most up to date eligibility lists.

Note: Some over-the-counter products require a doctor's prescription. Also, due to frequent updates to the regulations governing FSAs and HSAs, this list does not guarantee reimbursement and is intended to be utilized solely as a guide.

Can I change my FSA election after the plan year starts?

Certain qualifying events allow an employee to either increase/decrease the election or begin/cease participation in the plan. Common qualifying events include marriage, divorce, birth, death or a change in the cost of dependent care.

The adjustment to the election must be consistent with the event. For example, an increase in the cost of daycare would not allow you to decrease your election; however, if the increase made the cost of care unaffordable, one could justify no longer participating in the plan.

Please refer to your employer's Plan Document for further guidance on qualifying status change events applicable to your plan.

When and why do I need to substantiate benefits debit card transactions?

Due to IRS regulations, certain benefits debit card transactions need to be substantiated. Substantiating means validating the transaction to ensure the card was used to IRS-approved items/services within the allowed timeframe.

Can I carryover unused funds?

Yes, participants in the Medical FSA plan may carryover up to $550 of their funds into the following plan year. Unused funds exceeding $550 will be forfeited. Carryover funds should be prioritized for claim reimbursement.

How long do I have to file claims from the previous year?

Participants have until March 31st each new plan year to file eligible claims inccured on or before 12/31 of the previous plan year.

Discovery Benefits®
simplify.℠

FLEX SPENDING ACCOUNT (FSA)

BENEFITS SPENDING MADE EASY

One debit card for all of your benefits
Ability to request free additional cards for a spouse or eligible dependent
No fees for lost or stolen cards
www.benefitslogin.discoverybenefits.com

Discovery Benefits® simplify.℠

The Benefits Debit Card

The Benefits debit card is fastest and most convenient way to pay for expenses. The debit card makes it easy to access funds in your benefits accounts, reducing your out-of-pocket pocket costs. At many merchants, it also simplifies the way expenses are for eligibility.

How It Works

Swipe your benefits debit card to instantly pay for expenses with funds from your benefits accounts. Where you swipe the card will determine whether any steps are needed after that.

In addition to using your benefits debit card to pay for services at your healthcare provider's office, you can also use it at the following types of merchants:

Inventory Information Approval System (IIAS)
Many merchants provide IRS-required information for documentation right at the point of sale through an Inventory Information Approval System (IIAS). An IIAS merchant auto-substantiates the claim, so you won't need to provide additional documentation on qualifying expenses.

90% Merchants
Our debit card also works at pharmacies or drug stores that meet the IRS' 90 percent rule. At least 90 percent of the gross sales at these merchants come from eligible medical expenses.

For a list of IIAS and 90 % rule merchants, visit www.discoverybenefits.com.

Submitting Documentation for Debit Card Transactions

Occasionally, documentation will be needed to verify the eligibility of an expense paid for on your debit card. Even places like doctors' and dentists' offices may require you to submit documentation because some expenses available at these facilities may not be IRS-eligible (e.g. cosmetic procedures, teeth whitening).

When Documentation Isn't Needed

- When used at an IIAS merchant
- When used for recurring expeses that match the provider and dollar amount for previously substantiated claims
- When used for co-payments tied
- to the account holder's health plan (Note: These amounts need to communicated to Discovery Benefits by your employer)
- When used to access HSA funds

If none of the above criteria apply, you'll be notified via email or mail that or documentation is required.

What To Submit

When submitting documentation for a debit card transaction, an Explanation of Benefits (EOB) from your insurance company will typically be your best bet, as it contains all the information you need to substantiate a claim.

But, when in doubt, the IRS has identified the criteria for what needs to be included when submitting documentation for eligible expenses:

- Name of the provider/merchant
- Date(s) of service
- Type(s) of service
- Amount (after insurance)
- Name of person who received services (if the account covers dependents)

How To Submit

You can submit documentation in seconds using the **Benefits Mobile App** by Discovery Benefits. The app is the quickest and easiest way to submit documentation because it lets you use your phone's camera to take pictures of your documents and upload them on the spot.

You can also submit documentation through your **online account**, or via **fax** or **mail**. No matter how you choose to submit documentation, we'll process your claim in two business days.

To learn more about submitting documentation for debit card transactions, watch the Easy Substantiation video by logging into your Discovery Benefits account, www.benefitslogin.discoverybenefits.com

Download the free app on Apple and Android smartphones and tablets.

Download on the App Store

GET IT ON Google Play

FLEXIBLE SPENDING ACCOUNT (FSA)

Discovery Benefits®
simplify.℠

PARTICIPATION SERVICES CONTACT INFORMATION

Hours of Operation
6 a.m. to 9 p.m. CST (M-F)

Toll-Free Phone Number
866-451-3399

Toll-Free Fax Number
866-451-3245

Email Address
customerservice@discoverybenefits.com
(This email is for inquiries only. Please do not submit documentation to this address.)

Mailing Address
Discovery Benefits
PO Box 2926
Fargo, ND 58108

How can I be reimbursed for out-of-pocket expenses?

If you do not use your benefits debit card, you can file claims for out-of-pocket expenses in three ways:

1. Online
2. Using the Out-of-Pocket Reimbursement Request Form
3. Via the Discovery Benefits mobile application

How will I be reimbursed for claims that I file?

There are two reimbursement options:

1. Direct Deposit
2. Check (can be sent to you or the provider)

How do I log into my account?

You can access your online account from our website at **www.BenefitsLogin.DiscoveryBenefits.com**

What happens if my employment terminates?

Your employer will communicate your final service date to Discovery benefits. Then, debit card functionality (if offered by your employer) will be shut off on the designated date. Please refer to your employer's Plan Document for further guidance on the amount of time given to file claims.

The Discovery Benefits app lets you upload receipts, check balances, file claims, view dates, and contact customer service all from the palm of your hand!

What are the benefits of using the Discovery Benefits mobile app?

The app allows you to manage your Flexible Spending Account, Health Savings Account, or Health Reimbursement Arrangement information on the go, with convenient access to your Discovery Benefits account information.

Need to review details about a claim or report a lost or stolen debit card? No problem. Open up our mobile application and do it all from your mobile device.

Will my information be safe?

Most definitely. The data transfer in our app is completely secure, as we utilize 128-bit SSL on all mobile transmissions and require a passcode each time you enter the app. No pictures will be stored on your phone, so you can rest assured that your information is safe.

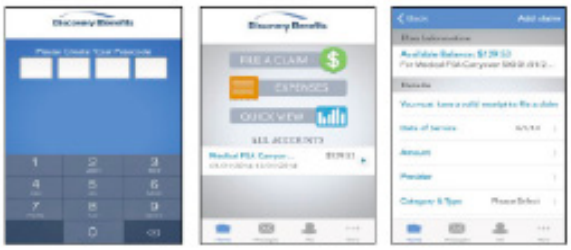
Which devices support the app?

Our mobile app is availebl for iPhone, iPad and Android devices.

How much does it cost?

The app is completely free to download in the iTunes or Google Play stores.

What does the interface look like?



FLEX SPENDING ACCOUNT (FSA)

Use this table to estimate your covered expenses.

MEDICAL EXPENSES	YOU	SPOUSE	DEPENDENTS
Deductibles and Co-Insurance	$	$	$
Office Visit Co-Pays	$	$	$
Prescription Drug Co-Pays	$	$	$
Chiropractic Treatment/Acupuncture	$	$	$
Chiropractic Treatment/Acupuncture	$	$	$
Infertility Treatments	$	$	$
Birth Control Pills, Devices, and Surgical Procedures	$	$	$
Medical Equipment and Supplies (wheelchairs, braces, crutches, oxygen, etc.)	$	$	$
Transportation (mileage, lodging and meals if necessary to obtain health care)	$	$	$
Over the Counter Medication with a Doctor's Prescription	$	$	$
Other (See IRS Publication 502 for listing of deductible medical expenses.)	$	$	$
VISION and HEARING CARE EXPENSES			
Eye Exams	$	$	$
Frames and Lenses	$	$	$
Contact Lenses, Cleaning Solutions and Supplies	$	$	$
Hearing Aids and Batteries	$	$	$
Lasik or Radial Keratotomy Surgery to Correct Vision	$	$	$
DENTAL EXPENSES			
Deductibles and Co-Insurance	$	$	$
Exams, Cleanings, and X-Rays	$	$	$
Fillings	$	$	$
Flouride Treatments	$	$	$
Crowns, Bridges, and Dentures	$	$	$
Orthodontia	$	$	$
Other Eligible Dental Expenses (See IRS Publication 502.)	$	$	$

TOTAL ESTIMATED UNINSURED MEDICAL EXPENSES
(Sum of your expenses, plus your spouse's and dependent(s)' expenses)

HEALTH ADVOCATE

Health Advocate™

What is your most precious commodity?
Your time!

Navigating today's healthcare maze is not only time consuming, it can be extremely frustrating! Save yourself time & aggravation!

Contact Health Advocate first and let them do the work for you.

There is NO COST to you no matter how many times you use this benefit. It's free to you, your immediate family, your parents, and your in-laws, and it's available 24/7.

Health Advocate can help with:

- Finding a new physician
- Scheduling appointments when convenient for you
- Obtaining appointments earlier with specialists
- Securing second opinions
- Resolving insurance claim issues & denials
- Coordinating care between multiple providers
- Uncovering claim errors and assist in corrective action
- Finding options/alternatives for non-covered services
- Negotiating pre- and post-claim fees & costs
- Assistance with prescription drug issues
- Explaining your benefit plan in easy to understand language
- Clarifying and assisting with Medicare plans/options
- And many other items!

Call 1-866-695-8622
or visit HealthAdvocate.com/members

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP is administered through **Carebridge** for our employees in all locations, as an additional benefit to you and your family.

Feel secure knowing your choice to participate in the Carebridge EAP program is confidential and anonymous.

Let's face it, balancing your work and home life is not easy. With your *confidential* Employee Assistance Program (EAP), you don't have to face life's challenges alone.

The EAP provides guidance for personal issues that you might be facing and information about other concerns that affect your life.

Carebridge will help with:

- Education
- Dependent Care and Care Giving
- Lifestyle & Fitness Management
- Legal and Financial

SUPPORT IS JUST A PHONE CALL OR A CLICK AWAY.

- Unlimited free telephonic consultation with an EAP Counselor is available **24/7**
  1-800-437-0911
- Email Carebridge at:
  clientservice@carebridge.com
- Register on the website for access to additional resources:
  www.myliferesource.com
  company code: EKPRA
- Referrals to local counselors: Up to three sessions are **FREE** of charge.

RETIREMENT SAVINGS PLAN (401k)

401(k)

You may chose to participate in a 401(k) plan. You may enroll in a traditional (pre-tax) 401(k) or Roth (after tax) 401(k). Steinman Communications may also make contributions based on company profitability on a discretionary basis.

You are eligible for this benefit following 90 days of employment.
Go to Newport Group's website to enroll.

www.NewportGroup.com
1-844-749-9981

Right now, you have an opportunity to make a real difference in the future of your retirement. How? By joining the **Steinman Communications Retirement Savings Plan** (the "Plan").

The Plan we offer is a valuable benefit to help you invest for your future. Investing now can help you have the income you will need at retirement. The Steinman Communications Retirement Savings Plan has an ***automatic enrollment feature*** that makes participating in the Plan easy once you become eligible. Each pay period, a portion of your pay **(6%)** will be automatically contributed to your Plan account through convenient payroll deduction. **You may change your contributions at anytime by visiting www.newportgroup.com.**

It is important to remember that you will be automatically enrolled in the Plan at a 6% deferral rate unless you specifically elect out of it. Steinman Communications Plan may also make contributions to your account. Contributions are then allocated to the Plan's investment options you select.

There are significant tax advantages when enrolling in the traditional pre-tax 401(K), too. For example, your qualifying contributions, employer contributions and all earnings on your account are not subject to current federal income tax (or, where applicable, state or local taxes), and may not be taxed until you withdraw funds out of your plan. This tax deferral gives your retirement assets the ability to grow under the most favorable terms possible. By combining convenience with these special tax benefits, your retirement plan offers you of the best ways to fund your future. A Roth 401(K) (after tax) option is also available.

We are excited to offer you this worthwhile benefit and we hope you will use it to help make your retirement dreams a reality. Get started today and take the first step toward a brighter financial future!

IMPORTANT COMPLIANCE NOTICES

Following are federally required notices related to your Steinman Communications Benefits Program.

Women's Health and Cancer Rights Act Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Maternity and Newborn Length of Stay Under federal law, group health plans and health coverage issuers offering group coverage generally may not 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 normal vaginal delivery; or
- Less than 96 hours following a cesarean section.

They may also not require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of those periods. The law generally does not prohibit an attending provider of the mother or newborn (in consultation with the mother) from discharging the mother or newborn earlier than 48 hours or 96 hours, as applicable.

Special Enrollment Rights Under HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides the following special enrollment rights. If you do not enroll for medical coverage for yourself and your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or you dependents in this plan, as long as you request enrollment within 31 days after your other coverage ends. You will need to provide proof that your other coverage has ended. In addition, if you have a new dependent as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents as long as you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Notice of Health Information Privacy Practices (HIPAA)

The privacy of your medical information is important to us. As a participant in a medical plan sponsored by Steinman Communications, you may receive a HIPAA Privacy Notice. The HIPAA Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

For more information about our privacy practices or for additional copies of the HIPAA Privacy Notice, please contact us using the information provided.

Contact: Human Resources
Address: 101 N Queen Street,
PO Box 1328
Lancaster, PA 17608
Phone: 717-295-5067

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's summary plan description or contact the plan administrator. COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a qualifying event, as listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because your hours of employment are reduced or your employment ends for any reason other than your gross misconduct.
If you are the spouse or dependent child of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- The employee dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his or her gross misconduct;
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The employee becomes divorced or legally separated; or
- If you are a dependent child, you stop being eligible for coverage under the plan as a "dependent child."

(Continued)

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. You must provide this notice to the benefits staff.
Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the plan administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
If your family experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to your spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If you have questions about your plan or your COBRA continuation coverage rights, refer to the contact listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other

•laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

•In order to protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

•For more information about Medicare prescription drug plans, visit **www.medicare.gov.**
Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
•Call **1-800-MEDICARE** (1-800-633-4227).
TTY users should call 1-877-486-2048.

•For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **1-800-772-1213** (TTY 1-800-325-0778).

•Notice of Lifetime Limit No Longer Applies and Enrollment Opportunity

•The lifetime limit on the dollar value of benefits under Steinman Communications medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan during open enrollment..

•Preventive Services and the Affordable Care Act
Under the Affordable Care Act, you and your family may be eligible for some important preventive services which can help you avoid illness and improve your health—at no additional cost to you.

What this means for you: If your plan is subject to these new requirements, you would not have to pay a co-payment, co-insurance, or any deductible to receive preventive health services, such as recommended screenings, vaccinations, and counseling. For example, depending on your age, you may have free access to such preventive services as:

·Blood pressure, diabetes, and cholesterol tests;
·Many cancer screenings, including mammograms and colonoscopies;
·Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use;
·Routine vaccinations against diseases such as measles, polio, or meningitis;
·Flu and pneumonia shots;
·Counseling screening, and vaccines to ensure healthy pregnancies;
·Regular well-baby and well-child visits, from birth to age 21

Some Important Details:
·If your health plan uses a network of providers, be aware that health plans are only required to provide these preventive services through an in-network provider. Your health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.
·Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.
·To know which covered preventive services are right for you—based on your age, gender, and health status—ask your health care provider.

WELLNESS PROGRAM DISCLOSURE (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NOTICE OF PRIVACY PRACTICE

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 of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by Steinman Communications to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how Steinman Communication, collectively we, us, or our may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permit-ted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting Steinman's Human Resources or by accessing Steinman Circle.

Contact: Human Resources Department
Address: 101 N Queen Street
PO Box 1328
Lancaster PA 17608-1328
Phone: (717) 295-5067

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees: major medical coverage, dental coverage, and vision coverage.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and dis-closures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and dis-close your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

• We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.

• We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations

• We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.

Notice of Privacy Practice (Continued)

• We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.

• We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).

• We may disclose your PHI to the proper authorities for law enforcement purposes.

• We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

• We may use or disclose your PHI for cadaveric organ, eye or tissue donation.

• We may use or disclose your PHI for research purposes, but only as permitted by law.

• We may use or disclose PHI to avert a serious threat to health or

• We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.

• We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.

We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from Steinman Communications at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/ correction request. Amendment request forms are available from us at the address below.

Contact: **Human Resources Department**
Address: **101 N Queen Street**
PO Box 1328
Lancaster PA 17608-1328
Phone: **(717) 295-5067**

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the ad-dress below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Notice of Privacy Practice (Continued)

Restrictions on Use and Disclosure of Your PHI – You have the right to re-quest restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To Comply with this law, we are asking that you not provide any genetic information when responding to requests for medical information.

Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

FREE OR LOW-COST HEALTH COVERAGE FOR CHILDREN AND FAMILIES

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 or 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, you can 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 1-877-KIDS NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If your 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 1-866-444-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 July 31st 2020. You should contact your State for further information on eligibility

PENNSYLVANIA – Medicaid

Medicaid Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx**
Medicaid Phone: **1-800-692-7462**

NEW JERSEY – Medicaid and CHIP

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: **1-800-701-0710**

NEW YORK – Medicaid

Medicaid Website: **https://www.health.ny.gov/health_care/medicaid/**
Medicaid Phone: **1-800-541-2831**

To see if any more States have added a premium assistance program since July 31, 2020 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Amanda Carmichael Sr. HR Business Partner (717) 295-5067.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Steinman Communications		4. Employer Identification Number (EIN) 23-0785160
5. Employer address 101 N Queen St PO Box 1328		6. Employer phone number 717-295-5067
7. City Lancaster	8. State PA	9. ZIP code 17608
10. Who can we contact about employee health coverage at this job? Amanda Carmichael Sr. HR Business Partner		
11. Phone number (if different from above) 717-295-5067	12. Email address acarmichael@steinmancommunications.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  [x] All employees. Eligible employees are:

  Employees who work 30 hours or more per week

  [ ] Some employees. Eligible employees are:

- With respect to dependents:

  [x] We do offer coverage. Eligible dependents are:

  Your legal spouse

  Your dependent children up to age 26

  [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

HERE IS SOME BASIC INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER:

- As your employer, we offer a health plan to: All of our benefit eligible employees. We recognize that our employees' needs and preferences vary so we offer a variety of benefit options and coverage levels.

- With respect to dependents: We do offer coverage. Eligible dependents are: children up to the age of 26 and your spouse.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Listed above is the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

EXCHANGE NOTICE QUESTIONS

With the implementation of the Health Care Exchanges there have been many questions which have risen. Before you call your employer's Human Resources Department, please read through these frequently asked questions.

Q. What is a health insurance exchange?

A. The exchange is a new way to explore available options when buying insurance for yourself and your family. You can purchase insurance through them over the phone or in person.

Q. Where can I go to find additional information on the health insurance exchanges?

A. The first place to start is **www.healthcare.gov.** This is an HHS-created website to aid in understanding and utilizing the health care reform provisions. To find materials on the Health Insurance Marketplace please go to **www.healthcare.gov/marketplace**.

Q. If I already have a plan, can I still shop at the exchanges?

A. Yes, you can research your options through the exchanges to see if you can find a plan more suitable than your current one. It is recommended you do so if you qualify for the premium subsidies.

Q. What does the term "premium discount" mean?

A. It is a discount on the health insurance premium that the employee may be eligible to receive should they elect to purchase coverage through the Health Insurance Marketplace. Premiums for Marketplace plans may vary dependent on the plan design selected (Deductibles, Copays, etc.), and also on an employee's income and/or family size. Generally, the lower the household income and the larger size of the family will result in higher potential discounts.

Q. Do I have to buy health insurance?

A. No, but starting in 2014 if you do not have coverage you will be subject to a tax penalty of $95 or 1% of your income, whichever of the two is greater.

Q. Do I qualify for Medicaid?

A. If you are considered to be low income you may qualify. To find out if your state is expanding Medicaid coverage visit **www.healthcare.gov/do-i-qualify-for-medicaid**.

DISCLAIMER

The information provided in this Guidebook is advisory. Separate plan documents explain each benefit in more detail, and the various benefits are controlled by the language of the plan documents. Benefits may be modified, added, or terminated at any time, at the Company's discretion, or by the insurance company. This information is provided for general information purposes only and should not be considered legal or tax advice or legal or tax opinion on any specific facts or circumstances. Readers and participants are urged to consult their legal counsel and tax advisor concerning any legal or tax questions that may arise. Any tax advice contained in this communication (including any attachments) is not intended to be used, and cannot be used, for purposes of (i) avoiding penalties imposed under the U. S. Internal Revenue Code or (ii) promoting, marketing or recommending to another person any tax-related matter.

STEINMAN COMMUNICATIONS

WHERE DO I GO FOR CARE?

The Emergency Room May Not Be The Answer!

Did you know the Average Wait Time In The ER For Non-Emergent Issues Is Over 4 Hours! You have other options!

Nurseline - 1-800-452-2583	Virtual Care - 1-833-433-5914 - Telemedicine
No Cost	$5 Co-Pay
When you're uncertain, start here.	Access a virtual/online doctor visit.
Examples: • Anytime you're not sure where to get care • 3 a.m. fever • Weekend sprained ankle • Sore throat on vacation	Examples: • Bronchitis, Cold/Flu, Diarrhea • Ear aches, Fever • Migraine headaches • Pink eye, Rash, Sinus

Your Family Physician	Urgent Care	Emergency Room
$15 Co-Pay	$25 Co-Pay	$150 Co-Pay
Knows your medical history,	Requires treatment but not life threatening.	For emergencies
Examples: • Physicals • Ear Pain, Sore throat, Fever • Back pain	Examples: • More serious virus • Sprains, strains and minor fractures • Flu symptoms • Minor burns & cuts	Examples: • Difficulty breathing • Difficulty speaking/ walking • Pain in the chest • Fainting or dizzy and weak • Sudden or severe pain • Changes in vision