AspenDental®

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Benefits Guide 2021

Welcome

Part of our commitment to your health and well-being is to provide you and your family with valuable benefits. This guide is an overview of the benefits available to you.

Please read it carefully in order to make the best choices for you and your family in 2021.

Log in to myaspenbenefits.com to begin.

In this guide, we use the term Company to refer to Aspen Dental Management Inc.; to independently owned and operating practices under the brand Aspen Dental; or to urgent care centers operating under the brand WellNow Urgent Care. This guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

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Eligibility & enrollment

You and your family have unique needs. That is why a variety of benefit plans are offered. Consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

All full-time team members with 30 or more Standard Hours per week are benefits-eligible. Team members losing full-time status during the year are given the opportunity to continue Medical Insurance, HSA and/or Medical FSA participation through the end of the calendar year. After a Standard Measurement Period (10/12/2019 - 10/11/2020), coverage ends on 12/31/2020 for those who have not met an average of 30 or more hours per week. On the other hand, team members who have worked an average of 30 or more hours per week will be eligible for coverage effective January 1 for the following calendar year.

When does coverage begin?

The elections you make during Open Enrollment are effective on January 1, 2021. Newly hired team members are eligible the 1st of the month following 60 days of full-time employment, and **must select benefits within 60 days of their hire date.** Team members experiencing an employment status change to full-time must enroll within 60 days of the effective date of their status change. Team members who are rehired within 13 weeks of their termination date are eligible to reinstate their Medical Insurance, HSA or Medical FSA on the date of rehire. All other benefits are effective on the 1st of the month following 60 days of full-time employment. Team members who are rehired beyond 13 weeks of their termination date are treated as a newly hired team members. Due to IRS regulations, once you have made your choices for the 2021 Plan Year, you won't be able to change your benefits until our next annual Open Enrollment period unless you experience a Qualified Life Event.

Eligible dependents

Dependents eligible for coverage in the benefits plans include:

- Your legal spouse (or common-law spouse in states which recognize common-law marriages) or domestic partner
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, children for whom legal guardianship has been awarded to you or your spouse and children of your domestic partner)
- A dependent child, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return and is approved by your Medical Plan to continue coverage past age 26

Verification of dependent eligibility will be required upon enrollment.

Things to consider

Take the following situations into account before you enroll to make sure you have the right coverage:

- Does your spouse or domestic partner have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Coverage expansion is available in certain states. Additional details can be found in the Eligible dependents section of this guide.

Qualified life events

When one of the following events occur, you have 30 days from the date of the event to notify your Employee Benefit Service Center to request changes to your coverage:

- Change in your legal marital status (marriage, divorce or legal separation)
- Dissolution of your domestic partner relationship
- Change in the number of your dependents
  (for example, through birth or adoption, or if a child isno longer an eligible dependent)
- Change in your spouse's or domestic partner's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to your Employee Benefits Service Center.

Preparing to enroll

The Company provides its team members with comprehensive coverage. As a committed partner in your health, the Company will be absorbing a significant amount of the costs. Your share of the premiums/ contributions for Medical, Vision and FSA/HSA is deducted on a pre-tax basis, which lessens your tax liability.

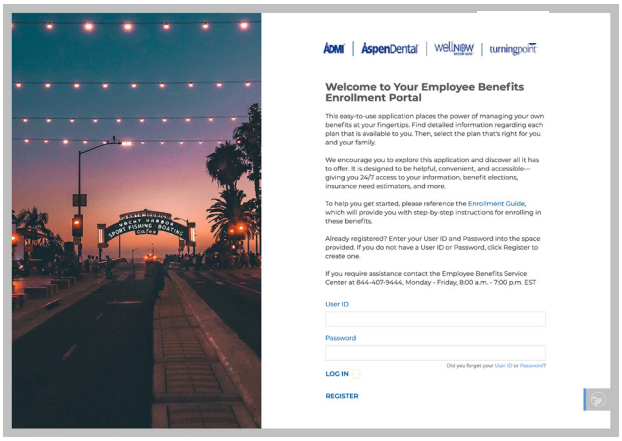
Please note that team member premiums for Medical and Vision coverage vary depending on the level of coverage you select.

Keep in mind that you may select any combination of Medical and/or Vision plan coverage. For example, you could select Medical coverage for you and your entire family, but select Vision only for yourself. The only requirement is that you must elect coverage for yourself in order to elect dependent coverage.

Be sure to have Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information. As a reminder, verification of dependent eligibility will be required for new dependents upon enrollment.

How to enroll + access your benefit information

1. Log in to myaspenbenefits.com
2. Click on the **"Register"** button.
3. Complete the following: your first name, last name, date of birth and Social Security number. Click **NEXT**.
4. Create a user ID of your choice.
5. Create a password with at least: eight characters, one letter, one number, one symbol (i.e. * & + # $).
6. Select a Security Question and answer (must be at least 6 characters). When finished, click **NEXT**.
7. Read the Terms of Service Agreement. To continue, click on **"I AGREE"** at the bottom of the page.
8. At the Enrolling in your Benefits screen, click in the area of the waving flag to continue with your enrollment.



Wellness program

We are making your health a priority. Preventing and detecting disease early is important to living a healthy life. The wellness program will promote a proactive and preventive approach to your good health and well-being.

It is critically important you have a primary care doctor and take actions to improve your wellness. This includes taking advantage of preventive services provided through the medical plan. Remember, in-network preventive services, such as adult physical exams and immunizations, OB/GYN exams, well child visits and immunizations, and certain screenings, are all covered 100% by the plan. This means you do not pay anything for these services.

Tobacco-free

You can save up to $600 every year. If you are tobacco-free, your annual medical premiums will be discounted by $300. This tobacco-free incentive also applies to your enrolled spouse/domestic partner.

If you are enrolling in medical coverage for 2021, you must complete the tobacco attestation during Open Enrollment. You must also attest on behalf of your enrolled spouse/domestic partner.

If you are not tobacco-free and want to get the lower premiums, you will need to complete the free Quit For Life tobacco cessation program. Your enrolled spouse/domestic partner will need to do the same if they are not tobacco-free. Most importantly, saying YES to quitting is good for your health!

Say yes to quitting!

Tobacco use has been proven to cause a host of illnesses, including cancer, heart disease, stroke and emphysema. It's the #1 most preventable cause of illness. So, kicking the habit is important.

With the Quit For Life Program, you'll work with a professional Quit Coach over the phone and receive unlimited access to online discussion forums to receive the personal support you need to quit successfully! The Quit For Life Program is FREE to all eligible Excellus BlueCross BlueShield members 18 years or older.

This **FREE** program includes:

- One-on-one counseling with a professional Quit Coach
- Medication recommendations, if appropriate
- Free nicotine replacement products (patch, lozenges or gum) delivered to your home, if recommended
- Easy-to-use "Quit Guides" for support between sessions
- Online interactive discussion forums available 24/7
- Help guide for family and friends

Call the **Quit For Life Program** today at **800-442-8904** for more information. TTY is available at **877-777-6534**. Quit Coaches are available from 8 a.m. to midnight (Eastern time), seven days a week. Once you complete the Quit For Life Program, Excellus BCBS will report this to the Company and the tobacco-free discount will be honored for the remainder of the calendar year. There is no better time than now to quit tobacco.

Wellness screenings

You and your spouse/domestic partner will have until October 31, 2021 to complete an annual wellness checkup with your primary care provider. Your provider or provider's staff must complete the Biometric Screening form to take advantage of the 2022 wellness premium discount.

It's easy! Here is what you (and your covered spouse/domestic partner) need to do:

1. Go to my.onsitehd.com/signup/aspendental to register.
2. Create a **secure** Onsite Health Diagnostics account.
    - Complete the form (Please note – **both you and your covered spouse/domestic partner** should use your Aspen Dental/WellNow employee ID number in the Employee ID field.)
    - Confirm identity
    - Create password
3. Print the **Primary Care Physician Biometric Screening form**
4. Schedule your routine physical with your primary care physician prior to **October 31, 2021**.
5. Have your physician or member of your physician's team complete and sign the Biometric Screening form.
6. Upload the completed form to the website above or fax to **214-203-0395**.
7. You will receive an email from Onsite Health Diagnostics when your results are available for review.

Privacy reminder: The company does not have access to individual health information. Personal health information is always treated privately and we take this very seriously.

Medical benefits

Our Medical coverage helps you maintain your well-being through preventive care, access to an extensive network of providers, and affordable prescription medication. Medical benefits are offered through Excellus BCBS. It is up to you to choose the Plan that best matches your needs. Please keep in mind that the option you elect will be in place for all of the 2021 Plan Year, unless you experience a Qualified Life Event.

Medical premiums

Premiums for Medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your biweekly premiums.

Biweekly premiums	$1,500 deductible plan	$2,000 deductible plan	$3,000 deductible plan
With full biometric discount What you pay if you (and your spouse/domestic partner, if applicable) completed the 2020 biometric screenings. Please note new medical plan participants on or after January 1st, 2020, automatically get these discounted rates for 2021.			
Team member only	$174.95	$75.84	$36.66
Team member + spouse	$366.91	$158.16	$78.22
Team member + child(ren)	$380.12	$164.46	$87.03
Team member + family	$575.86	$277.40	$158.17
With partial biometric discount What you pay if you (or your spouse/domestic partner) completed the 2020 biometric screening.			
Team member only	$174.95	$75.84	$36.66
Team member + spouse	$378.45	$169.69	$89.76
Team member + child(ren)	$380.12	$164.46	$87.03
Team member + family	$587.40	$288.94	$169.71
Without biometric discount What you pay if you (and your spouse/domestic partner) did not complete the 2020 biometric screening.			
Team member only	$186.49	$87.38	$48.20
Team member + spouse	$389.99	$181.23	$101.29
Team member + child(ren)	$391.66	$176.00	$98.57
Team member + family	$598.93	$300.48	$181.25

Please note an additional $11.54 per pay period per user will be applied to the above contributions if you and/or your spouse/domestic partner are tobacco/nicotine users.

How to find a provider

To see a current list of Excellus BCBS network providers online, go to excellusbcbs.com/aspendental. If you prefer to speak with a representative, please call Excellus BCBS Customer Care at **877-253-4797** for assistance.

Medical plan summary

The chart below gives a summary of the 2021 Medical coverage provided by Excellus BCBS. All covered services are subject to Medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	$1,500 Deductible		$2,000 Deductible		$3,000 Deductible	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar year deductible						
Individual	$1,500	$3,000	$2,000	$4,000	$3,000	$6,000
Family	$3,000	$6,000	$4,000	$8,000	$6,000	$12,000
Coinsurance (you pay)	20%*	40%*	20%*	40%*	30%*	50%*
Calendar year out-of-pocket maximum (includes deductible)						
Individual	$3,800	$7,600	$5,200	$10,400	$6,550	$13,100
Family	$7,600	$15,200	$6,550	$13,100	$13,100	$26,200
Copays/coinsurance (you pay)						
Office visits	20%*	40%*	20%*	40%*	30%*	50%*
Outpatient services	20%*	40%*	20%*	40%*	30%*	50%*
Inpatient services	20%*	40%*	20%*	40%*	30%*	50%*
Preventative services	0%*	40%*	0%*	40%*	0%*	50%*
Emergency room	20%*	20%*	20%*	20%*	30%*	30%*

*After deductible

Take control of your healthcare

You can manage the cost of your care by optimizing your available options.

Urgent Care centers vs. freestanding emergency rooms

Consider an urgent care center as an extension of your primary care physician. By reserving Emergency Room visits for a more serious level of care, and visiting an in-Network Urgent Care facility, you can save money. Balance billing may apply if out-of-network.

- 3.5 times the cost of visiting an Urgent Care Center
- 7.9 times the cost of visiting your health care provider
- 15.1 times the cost of using Telemedicine

Telemedicine

Telemedicine through MDLive is an additional benefit available to team members and their dependents that are enrolled in an Excellus Medical plan. With MDLive, you have on-demand access to board-certified doctors and pediatricians by online video, phone or secure email. You can be treated for various general health and general pediatric care issues without leaving the comfort of your home. This service can be utilized for after-hours nonemergency care, when your primary care physician is not available, to make requests for prescriptions or refills, or if you are traveling and need general medical care. Examples of items that can be treated include allergies, asthma, headache, pink eye, respiratory infections, ear infections and much more. Please note that some states do not allow physicians to prescribe medications via telemedicine. For those enrolled in the Medical plan, the fee is $40/encounter, subject to deductible and coinsurance. Team members not enrolled in the Medical plan, the fee is $59.99/encounter. Behavioral Health encounters vary in cost based on plan participation, duration of visit and type of provider seen.

For more information, or to register online, visit excellusbcbs.com/telemedicine or call **1-866-692-5045**

If you register online, an e-mail confirmation is required.

When you register, you'll be asked for:

- Your name
- Date of birth
- Address
- Phone number(s)
- Excellus BCBS membership ID Number
- A unique username and password
- The answer to a security question of your choice

You'll also need the name, address, fax number and phone number of your primary care physician and/or pediatrician. You can also register other members of your family who are covered under your Excellus BCBS plan.

Doctor visits are easier and more convenient with the **MDLIVE App**.
Be prepared. Download today.
https://www.mdlive.com/mobileapp/

Pharmacy benefits

Prescription drug coverage for medical plans

Our Prescription Drug Program is coordinated through Excellus BCBS. That means you will only have one ID card for both Medical care and prescriptions.

You may find information on your benefits coverage and search for network pharmacies by logging on to excellusbcbs.com/aspendental or by calling the **Customer Care Number** on your ID card. Your cost is determined by the Tier assigned to the prescription drug product. All products on the list are assigned as Tier 1 (generic), Tier 2 (preferred), or Tier 3 (non-preferred).

	$1,500 deductible	$2,000 deductible	$3,000 deductible
Retail rx (30-day supply)			
Tier 1 (generic)	$15 copay**	20%*	40%*
Tier 2 (preferred)	$30 copay**	20%*	40%*
Tier 3 (non-preferred)	$45 copay**	20%*	40%*
Mail order rx (90-day supply)			
Tier 1 (generic)	$30 copay**	20%*	40%*
Tier 2 (preferred)	$60 copay**	20%*	40%*
Tier 3 (non-preferred)	$90 copay**	20%*	40%*

*After deductible

**$0 generic copay for kids

Q&A: Generic drugs

What is a generic drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- Contain the same active ingredients as the innovator drug (inactive ingredients may vary)
- Be identical in strength, dosage form, and route of administration
- Have the same use indications
- Be bioequivalent
- Meet the same batch requirements for identity, strength, purity and quality
- Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit fda.gov. There, you will find a catalog of FDA-approved drug products, as well as drug labeling information.

Dental + Invisalign discounts

More reasons to smile

Our Dental Discount Program and Invisalign Discount offer benefits for you and your eligible dependents when services are offered through any Aspen Dental branded facility. When you access services, there is no annual deductible and benefits are unlimited for covered services.

Dental discount program

The chart below summarizes the 2021 Dental Discount Program which provides team members and their eligible dependents discounted pricing in Aspen Dental practices.

Practices owned and operated under the Aspen Dental® trade name make independent clinical decisions and determine whether or not they will see pediatric patients.

Calendar year deductible	You pay
Individual	$0
Family	$0
Calendar year maximum	**You pay**
Per person	Unlimited
Covered services	**You pay**
Preventive services (Routine exams, cleanings, fluoride treatments, sealants, bitewing X-rays)	0%
Basic services (Full-mouth X-rays, extractions, fillings)	20%
Major services (Root canals, oral surgery, gum disease treatment, crowns, bridges, dentures)	50%

Invisalign discount

The Company offers a significant Invisalign orthodontia treatment discount to team members and their eligible dependents when services are provided at an Aspen Dental office location.

Team members have three ways to pay for Invisalign treatments:

1. Pay the full cost up front
2. Financing through Care Credit or
3. Financing via payroll deductions as described below:

- Eligible team members may choose to utilize payroll deductions over 26 pay periods (12 months) to pay for the cost of their personal Invisalign treatments.
- Payroll deductions may be used for the full cost of Invisalign treatments or any balance due after insurance or when partial payment is made up front.
- Payroll deductions will commence immediately following receipt of the first set of aligners.
- Any remaining balance will be automatically deducted from the final paycheck for team members whose employment terminates before the full balance is paid. If the final check does not cover the remaining balance, the employee will be billed for the remaining amount owed.
- The payroll deduction option is not available for eligible dependents, and team members with an outstanding patient account balance are not be eligible for the payroll deduction option.

All team members and their eligible dependents applying for Invisalign treatments will be managed through the standard patient management process. Eligibility and availability of treatment and benefit is at the discretion of the Practice Owner and/or treating dentist.

Vision benefits

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, a comprehensive Vision Plan is provided through **Aetna**.

Vision premiums

Premiums for Vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your biweekly premium.

	Aetna Enhanced Plan	Aetna Standard Plan
Biweekly premiums		
Team members only	$4.08	$2.15
Team member + 1 dependent	$7.46	$3.94
Team member + family	$12.96	$6.86

Vision plan summary

Vision Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2021 Vision coverage provided through Aetna. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. In-network copayments are paid directly to the provider. Out-of-network services will be reimbursed up to the scheduled amounts below.

	Aetna Enhanced Plan		Aetna Standard Plan	
	In-network	Out-of network reimbursement	In-network	Out-of-network reimbursement
Copays				
Examination	$10 copay	up to $40	$10 copay	up to $30
Benefit frequency				
Comprehensive exam	Once every 12 months		Once every 12 months	
Spectacle lenses	Once every 12 months		Once every 12 months	
Frames	Once every 12 months		Once every 24 months	
Contact lenses (in lieu of eye glasses)	Once every 12 months		Once every 12 months	
Covered materials				
Lenses benefit				
Single vision lenses	$10 copay	up to $40	$25 copay	up to $25
Bifocal lenses	$10 copay	up to $60	$25 copay	up to $35
Trifocal lenses	$10 copay	up to $80	$25 copay	up to $40
Lenticular lenses	$10 copay	up to $80	$25 copay	up to $60
Progressive lenses	See Benefit Summary for details		See Benefit Summary for details	
Frames benefit				
Private practice provider	$175 allowance (Additional 20% off balance over the allowance)	up to $45	$130 allowance (Additional 20% off balance over the allowance)	up to $35
Retail chair provider				
Contact lenses benefit in lieu of eyeglasses				
Medically necessary contact lenses	$0 copay	up to $250	$0 copay	up to $250
Elective contact lenses	$175 allowance (Additional 15% off balance over the allowance for conventional lenses)	up to $175	$130 allowance (Additional 15% off balance over the allowance for conventional lenses)	up to $75

Health Savings Accounts

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free, and no matter what, the money in the account is yours. Use it to pay for eligible Medical, Dental and Vision expenses when you are enrolled in a qualified High Deductible Health Plan ($2,000 Plan or $3,000 Plan).

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in our $2,000 Deductible Plan or $3,000 Deductible Plan
- You are not covered by your spouse/domestic partner's medical plan, and your spouse/domestic partner does not have a Health Care Flexible Spending Account or Health Reimbursement Account
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare, Medicaid or TRICARE
- You have not received Department of Veterans Affairs Medical benefits in the past 90 days for non-service-related care (service-related care will not be taken into consideration.)

Individually owned account

You own and administer your Health Savings Account. You determine how much you'll contribute to the account, when to use the money to pay for qualified expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it during the calendar year. The money in this account goes with you, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to enroll

You must elect the $2,000 Plan or $3,000 Plan to be eligible for an HSA. You will need to complete all HSA enrollment materials and designate the annual amount you want to contribute on a pre-tax basis. An HSA account will be established in your name and contributions are deposited once the bank account information has been provided and verified by you. **Verification will be sent to you via e-mail by Discovery Benefits. You will need to log on to the Discovery Benefits website to activate your account**.

Contributions

You may change your contribution amount at any time during the Plan Year, even if you don't experience a Qualified Life Event. However, your annual election must be divided equally over the remaining pay periods of the 2021 Plan Year (you cannot "front load" your account).

Maximize your tax savings

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account with Discovery Benefits). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified Medical expenses, they are spent tax-free.

HSA funding limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2021, contributions are limited to the following: Your HSA can be used for qualified expenses, including those for your spouse and/or tax dependent(s), even if they are not covered by your Plan. A debit card will be issued to you by Discovery Benefits, giving you direct access to your account balance. When you have a qualified Medical expense, you can use your debit card to pay. You must have contributions in your account to use your debit card. Eligible expenses include doctors' office visits, eye exams, prescription expenses and laser eye surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found on irs.gov

	Team member	Family	Catch up contribution (age 55+)
HSA funding limits	$3,600	$7,200	$1,000

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for out-of-pocket health care expenses such as deductibles, copays and coinsurance, as well as dependent care expenses.

Health Care FSA

You can contribute up to $2,750 for qualified medical, dental and vision expenses with pre-tax dollars, which will reduce the amount of your taxable income. You can even pay for eligible expenses with an FSA debit card at the same time you incur them, allowing you to avoid waiting for reimbursement.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription.

Limited Purpose FSA for Vision and Dental

Designed to complement a Health Savings Account, a Limited Purpose Flexible Spending Account allows for reimbursement of eligible dental and vision expenses. You must decide how much to set aside for this account. You may contribute up to $2,750 in the Limited Purpose Flexible Spending Account.

Note: At the end of the 2021 Plan Year, the Health Care FSA and Limited Purpose FSA will roll over a maximum of $550; any unused funds exceeding the $550 maximum will be forfeited.

Dependent Care FSA

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well—whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is in your account at that time.

Note: This benefit is not for Medical expenses.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis
- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes
- In order to be reimbursed, you must provide the tax identification number or Social Security Number of the party providing care

Eligible Dependent Care FSA expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than the age of 13 and claimed as a dependent on your federal income tax return or a disabled dependent who spends at least eight hours a day in your home.

Examples of eligible dependent care expenses include:

- In-home baby-sitting services (other than by an individual you claim as a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the Flexible Spending Account programs. Please check with your tax advisor to determine if any exceptions apply to you.

How to use the account

You may use your Health Care or Limited Purpose FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact **Benefit Strategies** at **888-401-3539**. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from Benefit Strategies. You should always retain a receipt for your records.

Note: All Dependent Care FSA claims will need to be submitted for reimbursement (a debit card is not provided for these expenses).

General rules and restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the 2021 Plan Year
- Your dollars cannot be transferred from one FSA to another
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time
- You must “use it or lose it” — at the end of the 2021 Plan Year, any unused funds left in the Dependent Care FSA will be forfeited. The Health Care and Limited Purpose FSA will roll over a maximum of $550; any unused funds in your account over $550 will be forfeited
- You cannot change your FSA election in the middle of the Plan Year unless you experience a Qualified Life Event such as marriage, divorce or birth of a child

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanations of Benefits (EOBs) for any debit card charges. Failure to provide proof that an expense was valid can result in your card being turned off and your expense(s) being deemed taxable.

FSA vs. HSA: Which is right for you?

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are two ways to save pre-tax money to pay for your eligible healthcare costs. But how do you know which one is right for you? The chart below explains the main differences between FSAs and HSAs to help you make the right choice for you and your family.

	FSA	HSA
Ownership	The FSA is owned by your employer. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave your employer.
Eligibility & enrollment	The employer determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualified Life Event.	You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
Taxation	Contributions are tax free via payroll deduction.	The money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
Contributions	You can contribute to the account according to the IRS limits. The contribution limit for 2021 is $2,750.	You can contribute to the account according to IRS limits. The contribution limit for 2021 is $3,600 for individuals and $7,200 for families. If you are 55 or older, you may make a "catch up" contribution of $1,000 per year.
Payment	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.

	FSA	HSA
Roll over or grace period	You must use the money in the account by end of the Plan Year. Our Plan allows up to $550 to roll over to the next Plan Year. Any unclaimed funds at the end of the Plan Year that do not roll over are forfeited and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses, even for medical expenses that occur during retirement.
Qualified expenses	Physician services, hospital services, prescriptions, dental care and vision care. A full listing of eligible expenses is available at irs.gov	Physician services, hospital services, prescriptions, dental care, vision care,Medicare Part D plans, COBRA premiums and long term care premiums. A full listing of eligible expenses is available at irs.gov
Other types	Other types of FSAs include: ▪ **Dependent Care FSA** – Allows you to set aside pre tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before and after school care. ▪ **Limited Purpose FSA** – Only covers eligible Dental and Vision expenses. Limited Purpose FSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Health Care FSA and an HSA.	There is only one type of HSA.

Life insurance

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Life Insurance benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you have Life Insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Life and AD&D benefits are essential to the financial security of you and your family. As such, it is important to understand how your Plan works and what benefits you will receive.

The company provides team members with Basic Life and AD&D insurance through MetLife. Life and AD&D insurance pays a benefit to loved ones, such as a spouse or other designated beneficiary(ies).

Your Basic Life and AD&D insurance benefit is 1x your basic annual earnings, up to $50,000. If you are a full-time team member, you automatically receive Life and AD&D insurance even if you elect to waive voluntary coverage.

Beneficiary designation

A beneficiary is the person you designate to receive your Life Insurance benefits in the event of your death. This includes any benefits payable under Basic Life and AD&D coverage offered by your employer. Dependent Life and AD&D insurance pays a benefit to you.

It is important that your beneficiary designation is clear so there is no question as to your intentions. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If you name more than one beneficiary, please show the amount of insurance to be paid to each beneficiary in percentages, which must equal 100%.

For example:

Primary
Mary J. Doe, Wife (34%)
Jane Doe, Daughter (33%)
John Doe, Son (33%)

Contingent
Joseph W. Doe, Son (50%)
Jane Doe, Daughter (50%) OR
Estate of the Insured (100%)

Supplemental Life and AD&D Insurance

Eligible team members may purchase Supplemental Life and AD&D insurance for themselves and their families. Premiums are paid through post-tax payroll deductions.

Log in to myaspenbenefits.com to view rates.

Supplemental life	
Coverage amount	Increments of $25,000
Maximum benefit	$1,000,000
Guarantee issue amount	2x your annual earnings or less
Evidence of insurability (EOI) required	If you elect more than 2x your basic annual earnings, or increase coverage after initial offer
Supplemental dependent life	
Coverage amount	**Spouse:** Increments of $10,000 **Child(ren):** Increments of $5,000
Maximum benefit	**Spouse:** The lesser of 50% of your supplemental life benefits or $250,000 **Child(ren):** $20,000
Guarantee issue amount	$20,000 or less
Evidence of insurability (EOI) required	**Spouse:** Amounts over $20,000, or increase in coverage after initial offer
Supplemental AD&D	
Coverage amount	**Team member:** Increments of $25,000 **Spouse only:** An amount equal to 50% of Your Voluntary Accidental Death and Dismemberment Insurance **Spouse and child(ren):** An amount equal to: (a) 40% for Your Spouse Only; and (b) 10% for each Child; of Your Voluntary Accidental Death and Dismemberment Insurance **Child(ren) only:** An amount equal to 15% of Your Voluntary Accidental Death and Dismemberment Insurance for each child
Maximum benefit	**Team member:** The lesser of 10 times your basic annual earnings or $1,000,000 **Spouse:** $500,000 **Child(ren):** $150,000
Evidence of insurability (EOI) required	No EOI required

Income protection

We also offer disability coverage to protect you against non-work-related illness or injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short-term Disability (STD) Insurance

Short Term Disability (STD) benefits are available to you on a voluntary basis. STD insurance protects a portion of your income if you become partially or totally disabled for a short period of time. It pays a weekly benefit based on the amount of coverage you purchase ranging from $100 to $750. Coverage levels you are eligible to purchase depend on your current annual earnings. You must be sick or disabled for at least 7 days before you can receive a benefit payment. Payments may last up to 26 weeks. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Summary Plan Description or plan certificate for details or contact your Employee Benefits Service Center for specific benefits.

Long-term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are also available to you. LTD insurance protects a portion of your income if you become partially or totally disabled for an extended period of time. This insurance replaces 60% of your income, up to the maximum noted in the chart below, depending on your annual earnings. You must be sick or disabled for at least 26 weeks before you can receive a benefit payment. Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Summary Plan Description or plan certificate for details, or contact your Employee Benefits Service Center for specific benefits.

	Short-term disability	Long-term disability
Summary of disability benefits		
Benefit	$100, $250, $500, $600 or $750 per week (depending on your eligible earnings)	60% of eligible earnings
Monthly maximum benefit	Purchase amount	All Team Members - $5,000 Directors, Mid-level Providers - $8,000 Execs MCD, MDs, DOs, Medical Providers, Sr. Mgrs - $15,000
Waiting period	7 days	180 days
Benefit duration	26 weeks	No longer considered disabled, or reach Social Security Normal Retirement Age
Disability premiums		
Employee coverage	Rates based on age	The Company provides this benefit at no cost for Directors and above

Retirement planning

It's never too early—or too late—to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The Aspen Dental 401(k) Plan (administered by T. Rowe Price) provides you with the tools and flexibility you need to retire comfortably and securely.

You can defer up to 90% of pre-tax or post-tax earnings, subject to IRS limits to save towards retirement.

Eligibility

On the first of the month following 60-days of employment, you are eligible to contribute to the 401(k). However, your employer match will start the first day of the first month following your satisfaction of one year of service, if you have worked at least 1,000 hours.

Contributing to the plan

Deferred contributions are based on a percentage of your eligible earnings not to exceed Plan limits set by the IRS. The limit for 2021 is $19,500.

Catch-up contributions

If you are, or will be, age 50 or older during this calendar year and you have contributed to the IRS regular maximum 401(k) savings limit ($19,500 in 2021), you are eligible for "catch up" contributions. These additional contributions ($6,500 allowed in 2021) will automatically continue at the same contribution percentage after you have reached the regular limit. There is no action required on your part unless you choose to change your contribution percentage.

Employer matching contributions

Your employer matches 100% of your deferral up to 3%, and then 50% of the next 2% of your contribution, for a total match of 4%. You are immediately vested in all contributions.

Changing or stopping your contributions

You may change the amount of your contributions at any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. Once you stop making contributions, you may start again at any time.

Consolidating your retirement savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer or roll over that account into the Plan any time, even if you are not yet eligible to contribute. To initiate a rollover, contact **T. Rowe Price** at **800-922-9945** for details.

Investing in the plan

You decide how to invest the assets in your account. Our 401(k) Plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, refer to your 401(k) Enrollment Guide.

Employee Assistance Program (EAP)

The EAP connects you and your immediate family members to counseling and support professionals 24/7 who can assist with a variety of work/life issues (up to three sessions free). All sessions are completely confidential.

For more information, contact:
Phone: 888-319-7819
Web (metlifeeap.lifeworks.com) or **Mobile App** (Search "LifeWorks" on iTunes App Store or Google Play):
Username: metlifeeap
Password: eap

Grief counseling

Whether it's help coping with a loss or a major life change, the professional counselors and services offered through LifeWorks US Inc. are ready to support you and your family to move forward.

For confidential support 24/7, contact **MetLife** at **888-319-7819** or visit metlifegc.lifeworks.com:
Username: metlifeassist
Password: support

Additional benefits

Critical Illness Insurance - METLIFE

Critical Illness Insurance helps protect against the financial impact of certain illnesses such as heart attack, stroke, cancer and more. A lump-sum payment is paid directly to you and can be used to help offset out-ofpocket medical expenses (deductibles, coinsurance, etc.) or other expenses such as lost income and household bills. Critical Illness Insurance benefits are not limited or affected by your medical plan/benefits. Eligible team members will be able to elect coverage regardless of prior health history.

Accident Insurance – METLIFE

Accident insurance coverage provides you with a lump-sum payment when you suffer a covered injury or undergo covered testing, medical services, or treatment and meet the group policy and certificate requirements. There are more than 150 covered events and there is no limit on the number of different accidents that will be covered.

Payments are made directly to you to use as you see fit. They can be used to help pay medical plan deductibles and copays, out-of-network treatments, for your family's everyday living expenses, or whatever else you need while recuperating from an accident. Eligible team members will be able to elect coverage regardless of prior health history.

Universal Life - TRANSAMERICA

You also have the option to purchase Universal Life Insurance. With a Universal Life Insurance policy, you are the policy owner and can maintain the coverage, whether or not you leave your employer, for as long as you choose to continue to pay the premium.

Legal benefits - ARAG

The ARAG Assistance Plan offers you economical access to attorneys for common legal services such as will preparation, estate planning, family law and more. You also have the flexibility to use a participating attorney and get reimbursed for covered services according to a set fee schedule.

Legal advice will be just a phone call away. A knowledgeable client service representative can help you locate a participating attorney in your area. You'll also have convenient online access to resources that will assist with court appearances, document review and preparation, or real estate matters.

Identity theft protection - Allstate Identity Protection

Identity theft protection services from Allstate Identity Protection help assess your risk, deter theft attempts, detect fraud, and manage the restoration process in the event of an identity theft. Your identity will be monitored to uncover fraud at its inception. You will be offered an annual credit report, monthly credit scores, and monitoring of your TransUnion credit file.

Allstate Identity Protection offers privacy advocates that are certified and trained in identity restoration. If they detect suspicious activity, a privacy advocate can act as a dedicated case manager.

Payroll purchasing - PURCHASING POWER®

This industry-leading purchase program makes it possible for you to buy products you need and want using payroll deduction. Purchasing Power® gives you the flexibility to turn to a payroll purchasing program when you may not have cash on hand or have limited credit options.

Purchasing Power® is a responsible financing program that offers you the ability to buy products and services from a selection of more than 7,000 brand-name options. Through payroll deduction, you can make manageable payments over a 12-month period with no interest, hidden fees, or credit check.

Employee Referral Program

Your knowledge, experience and commitment are valued and appreciated. You know what it takes to succeed and we're confident you know others who will, too! Visit the employee referral center at aspendentalERP.com to learn how you can earn rewards ranging from $100 to $10,000.

Continuing education

Explore and take advantage of our multimedia training library dedicated to your professional development. Earn Interactive CE credit when you sign up for live webinars or follow a self-study course; all CE credit is provided by an approved ADA CERP provider. Visit aspendentallearning.com to learn more.

Student loan refinancing

Program through SoFi offering variable rates.
Contact SoFi at **855-456-7634** or visit SoFi.com/aspendental for details.

Employee discounts

We are proud to offer a variety of entertainment and retail discounts through **PlumBenefitsTM** and **Perkspot**.

For discounted tickets to arts and theater, family attractions, and sporting events, visit: plumbenefits.com use **company code AC0329209.**

For access to over 30,000 national and local offers from restaurants to travel, visit: aspendental.perkspot.com

Paid time off

Vacation

	Administrative entry level	Management & supervisory level	Professional & executive level
Upon hire	No time available	Jan & Feb - 5 days March - 4 days April - 3 days May - 2 days June - 1 day After 90 consecutive days of employment	Jan & Feb - 10 days March - 8 days April - 7 days May - 6 days June - 5 days After 90 consecutive days of employment
First January 1	5 days	5 days	10 days
Second January 1 through fifth January 1	10 days	10 days	10 days
Sixth january 1 through tenth January 1	15 days	15 days	15 days
Eleventh January 1	20 days	20 days	20 days

- Vacation time is pro-rated based on the standard number of days (or hours) your work per week
- Full-time regular team members hired between October 1 & December 31 are eligible for the time shown in “First January 1” row shown above following 90 days of consecutive employment
- Vacation benefits may not be carried over from one calendar year to the next

2021 Holiday Schedule

- Full-time regular team members are eligible for Holiday pay following 90 days of consecutive employment
- Holidays - New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day

Personal/Sick Time

Full-time regular team members earn up to three personal days during a calendar year. On January 1, team members will be granted personal time based on the following:

- For each four months actively employed in the previous calendar year, the team member will receive one personal day
- Personal days cannot be carried from one calendar year to the next an team members will not be paid for unused personal days

Glossary

Coinsurance
Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20.

Copay
The fixed amount you pay for health care services received, as determined by your insurance plan.

Deductible
The amount you owe for health care services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB)
A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs)
An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period).

- **Health Care FSA** – With the Health Care FSA, participants can use their accounts to cover eligible Medical expenses for themselves and their eligible dependents such as copays, eye exams, prescriptions and more. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription.
- **Limited Purpose FSA** – With the Limited Purpose FSA, participants with an HSA can use this account to cover eligible dental and vision expenses.
- **Dependent Care FSA** – A Dependent Care FSA helps to reimburse participants for eligible expenses associated with caring for a qualified dependent, such as a dependent younger than age 13 or another dependent that may be incapable of selfcare. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

At the end of the 2021 Plan Year, the Health Care and Limited Purpose FSA will rollover a maximum of $550; any unused funds over $550 will be forfeited. Any unused funds left in the Dependent Care FSA will be forfeited.

Health Savings Account (HSA)
A personal health care bank account funded by your tax-free dollars to pay for qualified Medical expenses. You must be enrolled in a High Deductible Health Plan (HDHP) to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

High Deductible Health Plan (HDHP)
Plan option that provides choice, flexibility and control when it comes to spending money on health care Preventive care is covered at 100% with in-network providers, there are no copays, and all qualified team member-paid Medical expenses count toward your deductible and your out-of-pocket maximum.

In-Network
In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network
Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum

The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications

Medications typically made available without a prescription. Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: Generic, Preferred or Non-Preferred.

- **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding Preferred or Non-Preferred versions. The color or flavor of a Generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs** – Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.

Reasonable and Customary Allowance (R&C)

Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a Medical service in a geographic region based on what providers in the area usually charge for the same or similar Medical service.

Summary of Benefits and Coverage (SBC)

Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Required notices

Important notice from Aspen Dental about your prescription drug coverage and Medicare under the Excellus plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Aspen Dental and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Aspen Dental has determined that the prescription drug coverage offered by the Excellus plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current Aspen Dental coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current Aspen Dental coverage, be aware that you and your dependents will not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with Aspen Dental and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Aspen Dental changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of 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**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2021
Name of Entity/Sender: Aspen Dental Management, Inc.
Contact—Position/Office: Employee Benefits Service Center
Address: 281 Sanders Creek Parkway, East Syracuse, NY 13057
Phone Number: 315-454-6000

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at: **(800) 965-6470 opt 4**.

HIPAA privacy and security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has been recently updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at: **(800) 965-6470 opt 4.**

HIPAA special enrollment rights

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

Loss of eligibility includes but is not limited to:

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

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

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at: **(800) 965-6470 opt. 4**

Important contacts

Coverage	Contact	Coverage	Contact
Medical	**Excellus BCBS** 877-253-4797 excellusbcbs.com	**Telemedicine**	**MDLive** 866-692-5045 ExcellusBCBS.com/Telemedicine
Dental	**Your Local Aspen Dental Office** 877-277-4479 aspendental.com	**Identity theft**	**Allstate Identity Protection** 800-789-2720 www.myaip.com
Vision	**Aetna** 877-973-3238 aetna.com	**Legal**	**ARAG** 800-247-4184 ARAGlegalcenter.com Access Code 18339asp
Employee Assistance Program (EAP)	**MetLife** 888-319-7819 Web: metlifeeap.lifeworks.com Username: metlifeeap Password: eap Mobile App - Search "LifeWorks" on iTunes App Store or Google Play. Username: metlifeeap Password: eap	**Life insurance AD&D**	**MetLife General Life plan questions:** 800- 438-6388 **Life Claim Questions:** 800-638-6420, Prompt#2 **Statement of Health Questions:** 800-638-6420, Prompt#1
Grief counseling	**MetLife** 888-319-7819 metlifegc.lifeworks.com User Name: metlifeassist Password: support	**Flexible Spending Accounts**	**Benefit Strategies** 888-401-3539 benstrat.com
Health Savings Account	**Discovery Benefits** 866-451-3399 discoverybenefits.com	**Exclusive employee discounts at Perkspot**	aspendental.perkspot.com/login
Disability	**MetLife General Disability plan questions:** 800-438-6388 **Disability Customer Response Center** (claims): 800-858-6506	**Payroll purchasing**	**Purchasing Power®** 888-923-6236 purchasingpower.com
Retirement	**T. Rowe Price** 800-922-9945 rps.troweprice.com	**Employee benefits service center**	844-407-9444
Critical illness/accident	**MetLife** 800-438-6388	**Human Resources Benefits Department**	281 Sanders Creek Parkway East Syracuse, NY 13057 800-965-6470, opt 4 hrsupport@aspendental.com