ascap

Benefit Open Enrollment Guide 2022

Welcome to Open Enrollment 2022

OPEN ENROLLMENT BEGINS NOVEMBER 15

This is your annual opportunity to review the health and welfare benefits available to you and your family. This year's Open Enrollment period will run from Monday, November 15 through Friday, December 3, 2021. You will be able to access the ASCAP benefits enrollment tool, Namely, to make your enrollment elections.

Please remember that once we have passed the deadline you will not be able to change your benefit elections until the next open enrollment period, unless you experience a qualifying life event.

The ASCAP HR team is always here to help you make the best decisions for you and your family.

If you do not actively enroll during Open Enrollment, your current enrollment will remain in place.

ACTION NEEDED!

You will need to actively enroll in Flexible Spending Accounts for 2022.

What's New/Changing for 2022?

MEDICAL PLANS

Both medical plans will have a $15 copay for telehealth services through MD Live (previously $30).

There will be a few changes to out-of-network benefits for the Open Access Plus Plan. In-Network benefits will remain the same.

There will be a modest increase in employee paycheck contributions.

See pages 5–10 for details.

Cigna Total Behavioral Health

Cigna offers a variety of resources to all employees enrolled in the ASCAP medical plans. Programs include Ginger and Talkspace.

Please see pages 11-14 for more details.

DENTAL PLANS

No changes in benefits or employee cost.

See pages 16-17 for details.

VISION PLAN

No changes to benefits or employee cost.

See page 18 for details

HEALTHCARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

You can contribute up to $2,850 for healthcare expenses for 2022 and up to $5,000 for dependent care expenses for 2022.

Pursuant to optional changes made possible under recent legislation, ASCAP has decided to allow you to carry over your entire unused Health Care FSA 2021 balance into the 2022 plan year and your entire unused Dependent Care FSA 2021 balance into the 2022 plan year to avoid forfeiture of these funds. Carryover amounts are in addition to any 2022 elections.

For the 2022 plan year the Health Care FSA carry over amount into 2023 plan year will be limited to $570. There will be no carryover amount for the Dependent Care FSA for the 2022 plan year into the 2023 plan year.

See page 19 for details.

COMMUTER BENEFITS

You can contribute up to $280 for qualified transit and parking expenses for 2022.

See page 24 for details.

LIFE AND AD&D INSURANCE

There will be no changes to benefits. See information on pages 20-21 regarding requirements for increasing or adding voluntary life coverage amounts during open enrollment.

SHORT-TERM AND LONG-TERM DISABILITY INSURANCE

No changes to benefits.

See page 22-23 for details.

WHAT'S INSIDE

To help you prepare to make your 2022 health and welfare benefit elections, this brochure includes the following information (click on the linked page numbers below to go directly to that section):

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Benefits Overview

ASCAP is proud to offer a comprehensive benefits package to eligible, full-time employees. The complete benefits package is briefly summarized in this benefits overview. Plan summaries with additional details are also available in the Namely system and with Human Resources.

You share the costs of certain benefits (medical and dental insurance), and ASCAP provides other benefits at no cost to you (life, accidental death & dismemberment insurance). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions (voluntary employee life, spouse/child life, long-term disability insurance, legal plan, and identity theft protection).

We also offer discounted group rates for pet insurance with ASPCA and home/auto insurance through Farmers. You can enroll directly on the vendors' websites at any time.

The ASCAP Human Resources team is always here to help you make the best benefit decisions for you and your family. Please contact Human Resources if you have any questions.

Newly eligible employees have a 30-day benefit enrollment period to either waive or make your benefit elections.

You will be listed with waived coverage if no action is taken within the initial enrollment period.

After the initial enrollment period, you will not be able to change your benefits until the next open enrollment period, unless you experience a qualified life event.

ELIGIBILITY

You and your dependents are eligible for ASCAP benefits beginning on the first of the month coincident with or next following your date of hire.

Who's eligible for benefits:

- Full-time employees (those who work 35 hours per week),
- Your spouse or domestic partner,
- Your children under age 26, or disabled dependents of any age.

In order to enroll your dependent(s) in any of the healthcare plans, you are required to submit documentation i.e., marriage certificate for spouses and birth certificate for dependent children. A U.S. Social Security number for your dependent(s) is required, if applicable.

If you are a part-time employee or temporary employee, you may be eligible for certain benefits. For eligibility criteria, please see the summary plan description.

Domestic partners: Benefit eligible employees may enroll their domestic partners in the ASCAP medical, dental, vision, voluntary life, legal, and identity theft protection plans. ASCAP defines domestic partners as same-sex or opposite-sex partners who have met all the following requirements:

- Are both at least 18 years of age and mentally competent to consent to contract;
- Reside together, sharing the same permanent residence for at least 12 consecutive months, with the current intent to continue doing so indefinitely;
- Are each other's sole domestic partner, are not married to anyone nor have had another domestic partner within the prior 12 months;
- Are not related by blood closer than would otherwise prohibit legal marriage in the state of residence and;
- Are jointly financially responsible for basic living expenses.

To enroll your domestic partner in the eligible plans please submit the following information to Human Resources:

- Declaration of domestic partnership form (available in the Namely system, under the Resources section or you can request form from Human Resources); and
- One of the following:
  - » Proof of domestic partnership from the city or county of residence; or
  - » Proof of financial interdependency evidenced by at least four of the following (joint bank accounts, joint credit cards, joint ownership of a residence, household expenses, granting power of attorney, designating each other as sole beneficiary/ executor) or evidence of other joint financial responsibilities

***Important Note About Domestic Partnership Taxability**

Your medical, dental and vision contributions made towards coverage for your domestic partner will be deducted from your pay on a post-tax basis. Employer contributions towards medical and dental coverage for your domestic partner are considered imputed income. You will be responsible to pay taxes on the value of ASCAP's contribution towards the cost of coverage for your domestic partner. If you want to cover an eligible domestic partner for benefits and that person is your dependent for tax purposes, you must complete the Section 152 form (Certification for Tax Dependents Form) annually to be exempt from post-tax contributions and imputed income. The Certification for Tax Dependents form must be returned to Human Resources within 30 days of the date your benefits go into effect. Forms received will be processed on a prospective basis; no retroactive adjustments will be made.

Enrollment Process

MAKING CHANGES TO COVERAGE

Generally, changes are only allowed under the following circumstances:

Newly Eligible. Benefits are available to full-time ASCAP employees as outlined on page 3 of this booklet. You have 30 days from the date you are hired to make your benefit elections.

Open Enrollment Period. During this annual period, you have the opportunity to enroll or make changes to your benefit elections for the upcoming plan year. A plan year is January 1 to December 31. Enrollments made during open enrollment will become effective on the following January 1.

The open enrollment process allows you to elect benefits including medical, dental, vision coverage, enhanced long-term disability coverage, life insurance (voluntary employee, spouse, and child) as well as a healthcare flexible spending account, a dependent care flexible spending account, legal plans and identity protection. Additional benefits including corporate gym memberships, commuter benefits, 401(k), Farmers Group Select (SM) auto / home insurance and ASPCA pet health insurance programs are not part of open enrollment. These benefit plans can be updated throughout the year.

Change in Family Status. Federal regulations restrict you from making any changes to your benefits during the plan year unless you have a change in family status, or Qualifying Life Event. If you report an eligible status change within 30 days of the event, you'll be permitted to make changes during the calendar year to your benefit elections.

The change must be consistent with the change in your family status. For example, if you marry or have a child, you can add your dependents to your existing health care coverage. Qualifying changes in family status include:

- Birth or adoption
- Marriage or divorce
- Loss or gain of other coverage for you, your spouse, domestic partner, or a dependent child
  For example: change in employment status or Medicare or Medicaid entitlement
- Court orders such as judgments, decrees or Qualified Medical Child Support Orders

HOW TO ENROLL

ASCAP's online benefits enrollment tool is accessed through Namely. This easy-to-navigate site gives you 24/7 access to benefit plan information, allows you to view your current benefit elections, update personal information, and make changes to your benefit selections during the annual open enrollment period or if you have a qualified life event.

You can log onto Namely at https://ascap.namely.com/users/login.

ENROLLMENT CHART

	CONTRIBUTIONS		WHEN TO ENROLL			
Benefit	Who Contributes?	Paycheck Contribution	Newly Eligible	Qualifying Life Event	Open Enrollment	Anytime
Medical	ASCAP & Employee	Pre-tax	X	X	X	
Dental	ASCAP & Employee	Pre-tax	X	X	X	
Vision	Employee	Pre-tax	X	X	X	
Healthcare/Dependent Care FSA	Employee	Pre-tax	X	X	X	
Employee Assistance Program (EAP)	ASCAP	None	Automatic			
Commuter Benefits	Employee	Pre-tax	X		X	X
Life and AD&D						
Basic Employee Life and AD&D Plan	ASCAP	None	Automatic			
Voluntary Employee Life Plan*	Employee	Post-tax	X	X	X	
Voluntary Spouse and Child Life Plan*	Employee	Post-tax	X	X	X	
Long-Term Disability						
Basic Plan (Employer Paid)	ASCAP	None	Automatic			
Basic Plan (Employee Paid)	Employee	Post-tax	X		X	
Buy Up Plan	Employee	Post-tax	X		X	
Voluntary Benefits						
Farmers Group Select Home/Auto Insurance	Employee	Post-tax	X		X	X
ASPCA Pet Insurance	Employee	Post-tax	X		X	X
MetLife Legal Plan	Employee	Post-tax	X		X	
Allstate Identity Theft Protection	Employee	Post-tax	X		X	

*Initial amounts above the guaranteed issue amount along with incremental changes after your initial enrollment period for Voluntary Employee Life and Voluntary Spouse Life may be subject to Evidence of Insurability. Please see Life section on pages 20 and 21 for more information.

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Medical Plans

You have the option of two medical plans through Cigna.

CIGNA OAP NETWORK ONLY PLAN

The OAP Network Only plan includes providers listed under the Open Access Plus (OAP) Network. The plan provides preventive and other medical and hospital care through the use of its provider network. You do not need to choose a Primary Care Physician (PCP), nor do you need a referral to see a specialist. A current list of eligible providers in your area can be found through the provider directory on Cigna's website: www.cigna.com or myCigna.com once you have enrolled for a more customized experience. Please refer to the benefits summary in Namely for additional information. Please note that there is **no coverage** outside of the OAP network with this plan.

CIGNA OPEN ACCESS PLUS PLAN (OAP)

This plan offers flexibility to use any provider you wish. You can use providers in- or out-of-network whenever you need medical care. The in-network feature is described above under the Network Only Plan section. The out-of-network feature allows you to see any provider of your choice. Using in-network providers will reduce your cost. A current list of eligible providers in your area can be found through the provider directory on Cigna's website: www.cigna.com or myCigna.com once you have enrolled. You may be required to file claim forms in order to receive reimbursement for out-of-network services.

Please note in addition to your medical ID card, you will be receiving a separate ID card for your vision benefit described in the below chart. Please refer to the benefits summary in Namely for additional information.

PLAN COMPARISON – OAP NETWORK ONLY VS. OAP

Key Similarities

- Both plans offer the same network of providers.
- No Primary Care Physician or referrals are required.
- Offer fully covered in-network preventive care.
- Have same in-network out-of-pocket maximums that limit the amount you pay for health care per year.

Key Differences

	CIGNA OAP NETWORK ONLY PLAN	CIGNA OPEN ACCESS PLUS PLAN
Employee Paycheck Cost	Lower Paycheck Contributions	Higher Paycheck Contributions
Network	In-Network Coverage only	In or Out-of-Network Coverage

Vision Coverage	N/A	Routine eye exam $0 copay In-Network, Out-of-Network you pay 40% of cost Once every 12 months
Vision Card	N/A	You will receive a separate ID card for your vision benefit

NOTE: Eyeglasses and contact lenses are not covered under the Open Access Plus medical plan. If you would like vision coverage, you will have an option to enroll in a comprehensive vision plan through UnitedHealthcare.

2022 MEDICAL PLAN COMPARISON

	CIGNA OAP NETWORK ONLY PLAN	CIGNA OPEN ACCESS PLUS PLAN	
NETWORK COVERAGE	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Annual deductible			
Individual	$500	$750	$3,000
Family	$1,000	$1,500	$6,000
Coinsurance (You pay)	Generally 10% or 20%	10%	Generally 40%
Annual limit on out-of-pocket expenses: Annual limit excludes Rx. RX has a separate limit listed on page 7.			
Individual	$3,500	$3,500	$7,000
Family	$7,000	$7,000	$14,000
Preventive care:			
Physical (once per 12 months)	$0 per visit	$0 per visit	Not covered
Well child care (up to age 19)	$0 per visit	$0 per visit	Not covered
Well woman exam	$0 per visit	$0 per visit	Not covered
Doctor / Specialist Office Visit	$30 / $50 per visit	$30 / $50 per visit	You pay 40% after the plan deductible is met
Telehealth (MD Live)	$15 copay	$15 copay	Not applicable
Urgent care	$50 copay	You pay 10% after the plan deductible is met	You pay 10% after the plan deductible is met
Inpatient Professional Services (services performed by surgeons, radiologists, pathologists, and anesthesiologists)	You pay 20% after the deductible is met	You pay 10% after the deductible is met	You pay 40% after the plan deductible is met
Inpatient hospital treatment	$250 per admission copay, 20% coinsurance applies	$250 per admission copay, 10% coinsurance applies	You pay 40% after the plan deductible is met
Outpatient Professional Services (services by surgeons, radiologists, pathologists, and anesthesiologists)	You pay 10% after the deductible is met	You pay 10% after the deductible is met	You pay 40% after the plan deductible is met
Emergency room treatment (Additional charges apply if deemed not a true emergency)	$200 copay (waived if admitted)	You pay 10% after the plan deductible is met	You pay 10% after the plan deductible is met
Mental Health and Substance Abuse Inpatient	$250 per admission copay, 20% coinsurance applies	$250 per admission copay; 10% coinsurance applies	You pay 40% after the plan deductible is met
Mental Health and Substance Abuse Outpatient	$30 per visit copay; 10% coinsurance applies for outpatient facility	$50 per visit copay; 10% coinsurance applies for outpatient facility	You pay 40% after the plan deductible is met

Please note that coinsurance is subject to a deductible, where applicable. In addition, certain services may require pre-certification. Services rendered out-of-network under the Open Access Plus Plan will be based on allowable charges. Please refer to page 35 "Glossary of Terms" for additional information. For additional information please refer to your Cigna summary details and materials provided by the vendor. If there are any differences between the information in this summary and the official plan documents or policies, the plan documents or policies will govern.

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PRESCRIPTION DRUG PLAN COMPARISON SUMMARY	CIGNA OAP NETWORK ONLY PLAN	CIGNA OPEN ACCESS PLUS PLAN	
NETWORK COVERAGE	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Prescription Drug Deductible			
Individual	$25	$25	$25
Family	$50	$50	$50
Prescription Drug annual limit on out-of-pocket expenses:			
Individual	$3,450	$3,450	
Family	$6,900	$6,900	
Prescription drugs Per 30-day supply			
Generic	$15	$15	You pay 40% script
Preferred	You pay 35% of the cost up to a maximum of $100 per script	You pay 35% of the cost up to a maximum of $100 per script	
Non-Preferred	You pay 50% of the cost up to a maximum of $100 per script	You pay 50% of the cost up to a maximum of $100 per script	
Home Delivery Mail Order / Retail Rx drugs Up to 90-day supply* Generic / Preferred / Non-Preferred *Except Specialty, only up to 30-day supply	$20 / 30% / 45% ($200 max per script)	$20 / 30% / 45% ($200 max per script applies to Preferred / Non-Preferred)	Not covered

Please note that coinsurance is subject to deductible, where applicable. In addition, certain services may require pre-certification. For additional information please refer to your Cigna summary details and materials provided by the vendor. If there are any differences between the information in this summary and the official plan documents or policies, the plan documents or policies will govern.

2022 MONTHLY EMPLOYEE PRE-TAX CONTRIBUTION RATES

Divide the numbers below by two (2) to obtain the rate per pay period.

	Cigna OAP Network Only Plan	
	2021 Monthly Contributions	2022 Monthly Contributions
Individual	$79.80	$84.60
Employee + Child(ren)	$159.60	$169.20
Employee + Spouse / Domestic Partner	$212.10	$224.20
Family	$337.80	$358.10

	Cigna Open Access Plus Plan	
	2021 Monthly Contributions	2022 Monthly Contributions
Individual	$146.50	$155.30
Employee + Child(ren)	$277.70	$294.40
Employee + Spouse / Domestic Partner	$326.90	$346.50
Family	$521.50	$552.80

NOTE: This is an optional election. You are not required to elect medical coverage in order to enroll in dental and/or vision. You can also select different dependents for each type of benefit.

TELEHEALTH SERVICES

Telehealth services provide a more immediate and low cost alternative to traditional in person care such as emergency room, urgent care, or convenience care clinics and have the same or lower cost than Primary Care Physicians visits.

Cigna members can see a board-certified doctor with private, online, and live appointments via a secure video or phone conversation 24 hours a day using your phone, tablet or computer.

You can connect with a doctor live on MDLIVE, at the time and day that works best for you.

Telehealth doctors can treat many common health issues including:

- Cold and flu
- Joint aches and pains
- Fever
- Strep and bronchitis
- Acne and rashes
- Sinus infections

If you have children, you can can also turn to telehealth services for non-emergency pediatric care.

What to expect during your video visit:

Most doctor visits take about 10 minutes, but you can always add time if you need to. Doctors can review your history, answer questions, diagnose, treat and even prescribe medication. Prescriptions will be sent to your pharmacy of choice.

The benefits of an online visit:

- Visits Anywhere
  Install the mobile app and access healthcare from anywhere, at any time.
- Open 24 Hours
  Doctors are available 24 hours a day, 365 days a year.
- No Appointments
  Just sign in and have your video visit.
- Prescriptions
  Prescriptions are sent electronically to the pharmacy of your choice.

BEHAVIORAL HEALTH (TELEMENTAL SERVICES)

MD Live

With MD LIVE's behavioral/mental health virtual care, you get the care and attention you'd expect from an in-office visit, wherever and whenever is most convenient for you. Here's how it works:

- Talk privately with a licensed counselor or psychiatrist via video or phone.
- Have a prescription sent directly to your local pharmacy, if appropriate.

Cigna Behavioral Health

You can also receive care through Cigna's network of behavioral health providers. Cigna Behavioral Health provides access to virtual counseling through its own network of providers.

To find a Cigna Behavioral Health network provider:

- Visit myCigna.com, go to "Find Care & Costs" and enter "Virtual counselor" under Doctor by Type.
- Or, call the number on your Cigna ID card.

Review Available Doctors

Choose Your Pharmacy

Start Your Video Visit

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ACCESS THE MDLIVE FOR CIGNA TELEHEALTH APP

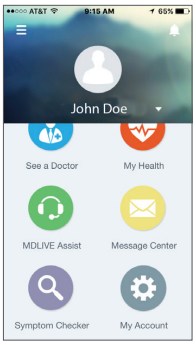
It's easy to get the care you need for minor medical conditions.

1 Download the MDLIVE for Cigna App from the App Store or Google Play.*

MDLIVE for Cigna®

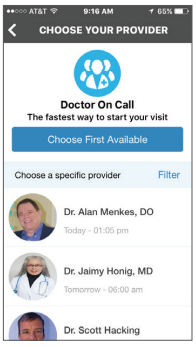
- **Log in to your existing MDLIVE for Cigna account.**
- **Or, sign up for the first time on the app.** It will ask about your medical history, medications, allergies and more.
- **Create a six digit PIN for easier access** (if you'd like)**.**

2 Set up an appointment.



- **Choose "See a Doctor" from the menu list.**
- **Confirm the visit** (who the appointment is for, location, provider type and phone number)**.** Then, click "Continue."

3 Choose a doctor.



- **Select "Choose First Available."** Or, "Choose a specific provider" from the list provided.
- **Select "Request Appointment."** (Choose your appointment date/time, and type of visit – video/phone).
- **During your appointment**, discuss your concerns with the doctor via phone or video chat.

* The downloading and use of any mobile app is subject to the terms and conditions of the mobile app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

Cigna®

TIPS FOR HEALTHCARE COST SAVINGS

Enrollment selection question

- Are all my providers in the OAP network?
- Should I select a healthcare FSA?

Communicate with your provider and ask questions.

- Start by establishing a relationship with a primary care provider. The more familiar you are with your doctor and your doctor with you, the better understanding they will have of your medical history and ongoing treatment needs, if any.
- Take an active role in your care; ask your doctor questions about the care you are receiving.
  - » Is the service necessary?
  - » What is the expected outcome?
  - » Are there risks or side effects?
  - » Are there less costly alternatives that are effective?
- Review billing and Explanation of Benefits statements (EOBs) for accuracy.

Medical costs can vary depending on where you have services performed.

- Use in-network providers.
  - » With the Open Access Plus Plan, when you go to a non-participating provider you will pay a higher coinsurance percentage **and** you may have to pay the difference in price between the in-network provider's discounted fee, and the non-participating provider's "regular" fee.
  - » Use in-network laboratory services including LabCorp and Quest.
- Hospitals tend to be the most expensive option.
  - » Only go to the hospital emergency room for **true** emergencies. For non-emergencies, urgent care facilities and telehealth are convenient cost saving and time saving options.
- Freestanding surgical and diagnostic centers are alternatives to hospitals if you need outpatient surgery or tests such as MRIs, CAT scans, and X-rays.
- Consider using telehealth services. You can contact a physician 24/7 regarding straight-forward medical issues (e.g., sinus problems, allergies, urinary tract infections) that do not require a lab test and obtain a prescription when appropriate. This is the lowest cost type of medical care.

Make careful decisions about prescription drugs.

- Use generic drugs whenever possible.
  - » Before your physician finishes writing your prescription, ask about generic equivalents, or lower cost brand name drugs to treat the same condition.
- Use a mail order pharmacy.
  - » Ordering prescriptions by mail can save 10 – 15 percent and is perfect for patients with chronic conditions who take medication on an ongoing basis and can place orders in advance.
- Compare prices.
  - » Shop around for the pharmacy that offers the best value for your needs. You may even need to get different medications from different pharmacies depending on which offers a better price.

You have access to many tools and resources with Cigna for your healthcare needs.

myCigna.com key features include:

- Tracking for deductibles, coinsurance, and out-of-pocket maximums, so you can see not only pricing but how much you will pay out of your own pocket.
- Explanation of Benefits statements for all your claims

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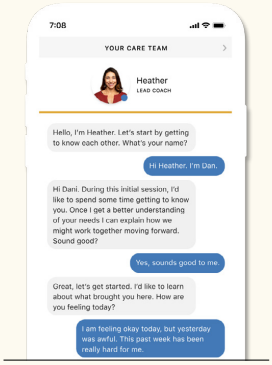
ginger Cigna®

Incredible mental healthcare *when you need it.*

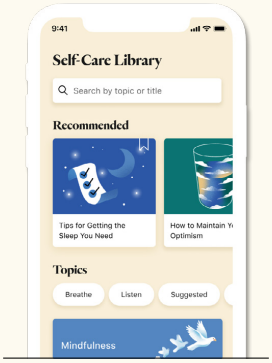
Everyone deserves access to incredible mental healthcare. That's why Ginger created the world's first integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. It's like a virtual clinic without the waiting room. Ginger's mental health services are in-network and accessible through your behavioral health benefits.

All your *care*. All in *one place*.



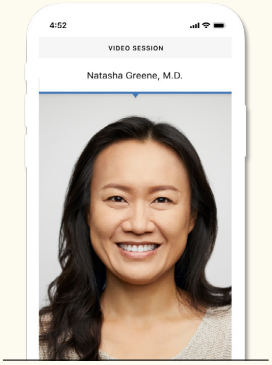
Behavioral health coaching

You'll first chat with a behavioral health coach via text, who can help you with a range of issues, like anxiety, depression, relationships, sleep, and more. Coaches offer immediate support when you need it, and are available for scheduled appointments, too.



Skill-building content

Our library of clinically-validated resources includes activities, articles, classes, podcasts, and more. In-app content is tailored to your needs and available anytime to help you build skills and work towards your goals.



Therapy + psychiatry

A coach can recommend a licensed therapist or psychiatrist to be added to your care team if you need extra support. Therapy and psychiatry sessions are video-based and offer flexible hours, including evenings and weekends.

Ready to *get started?*

Visit **ginger.com/cigna** to learn more.

Download the Ginger Emotional Support app.

Download on the App Store GET IT ON Google Play

Questions? Email **help@ginger.com** or visit us at **ginger.com**.

Frequently Asked Questions

What is Ginger?

Ginger offers confidential mental healthcare through behavioral health coaching via text-based chats, self-guided learning activities and content, and, if needed, video-based therapy and psychiatry. Support is available anytime (we're serious about 24/7/365), anywhere (we go where your phone goes), for a variety of mental health challenges you may be struggling with—all from the privacy of your smartphone.

How do I begin chatting with a Ginger behavioral health coach?

Download the Ginger emotional support app from your smartphone. Follow the instructions sent to your email. Enter your: First name, last name, DOB and your Member ID # to verify your eligibility. Then, answer a few simple questions, and you're ready to get started! Choose to schedule an appointment with your coach at a time that works best for you, or chat right away.

What kinds of things can a Ginger coach help me with?

With a behavioral health coach, anyone can get personalized support to help overcome life challenges and reach goals in their moment of need. Coaches can help with any issue you're struggling with such as stress, anxiety, depression, issues with work, relationships, sleep, and more.

Is there a *cost* for behavioral health coaching?

Yes. Access to Ginger includes 30 days of unlimited behavioral health coaching, and Ginger's self-care content library, including learning activities, for a cost similar to a doctor's office visit. Out of pocket costs are determined by your benefit plan.

Get started today

Visit talkspace.com/cigna to register and confirm benefit eligibility

Complete intake and assessment to see your curated list of therapist matches

Review professional profiles and choose your dedicated therapist

Create an account and download the app (iOS and Android) for easy future access

Messaging can begin the same day as registration

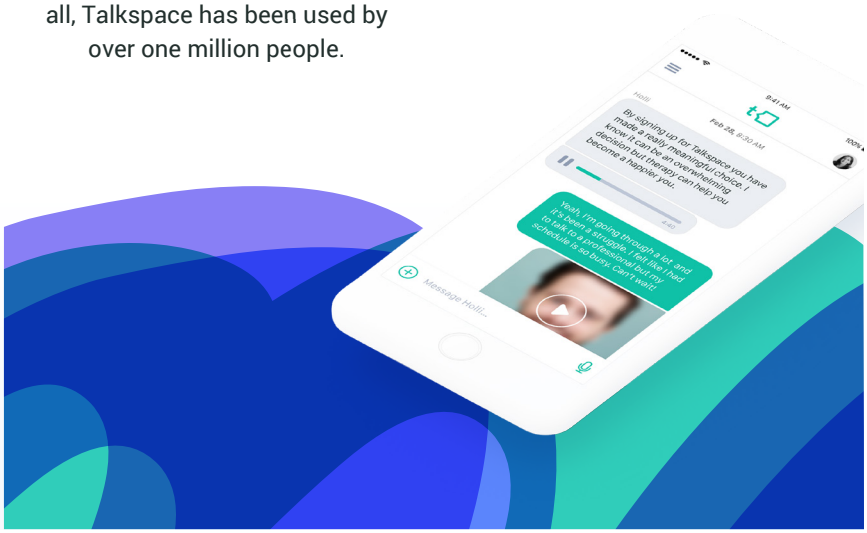
talkspace

Founded in 2012 with the mission to eliminate the stigma associated with mental health and make therapy available to all, Talkspace has been used by over one million people.

WHAT IS TALKSPACE?

Convenient, safe and secure online therapy from any location

Learn more at
talkspace.com/cigna



Therapy from anywhere

Talkspace is an online therapy service that connects users to a dedicated, licensed therapist via private messaging (text, voice, video) or live video session. The platform is fully HIPAA-compliant and uses banking-grade encryption to protect data.

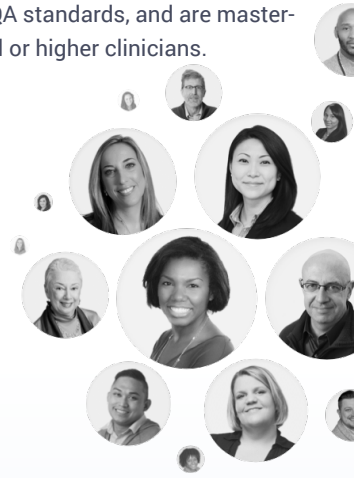
Talkspace treats a wide range of behavioral conditions including depression, anxiety, relationships, PTSD, addiction, eating disorders and more.

No office or commute needed

Every user selects a dedicated therapist from a curated list of in-state matches. Users can regularly contact their dedicated therapist through text, voice and video message as life happens - anytime, anywhere. Therapists engage daily.

A national network of therapists

The Talkspace clinical network features thousands of licensed therapists across all 50 states. They are credentialed according to NCQA standards, and are master-level or higher clinicians.



70% of users participating in a recent study report improvement within 3 months on Talkspace. Learn more at research.talkspace.com.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program, administered by Cigna Behavioral Health, is available to all ASCAP benefits eligible employees and household family members free of charge. This program provides 24/7 access to advocates who can help resolve a variety of personal issues including conflicts at work or home, emotional difficulties, parenting concerns, family and relationship issues, substance abuse and other personal concerns.

Contact Cigna Behavioral Health at **800.554.6931** or visit their website at www.cignabehavioral.com.

Online access to information, benefits, educational materials and more.

1. Log in
2. Type "ASCAP" (in lowercase letters with no spaces) for your Employer ID
3. Type the word "employee" for your PIN

Immediate Help During A Crisis: Get quick and effective intervention when your emotional needs reach a critical point.

Local Resources: Cigna can direct you to sources in your community for information and assistance on a wide range of topics.

Productive Work and Healthy Families: Get tips and guidance to help balance work with family life. Working-parent issues, handling conflict in the workplace and effective time-management techniques are just a sampling of topics covered.

In-Person Counseling: If you need to meet with a counselor in person, you can get a referral by yourself online, or by going through us—it's your choice.

Online Support For Emotional Wellbeing and Life Events: You can go online to discover even more services designed to improve your emotional well-being and productivity.

With Emotional WellBeing and Life Events, you can:

- Review your employee benefits
- Take a self-assessment
- Obtain a list of recommended readings or a suggested course of action
- Complete a therapy-preparedness questionnaire
- Browse a large collection of behavioral health articles
- Review Frequently Asked Questions
- Find a care provider by yourself
- Quickly get an online provider referral

Access Family and Caregiving Resources to:

- Get information for managing the care and education of family members
- Use specialized databases for finding care providers
- Read, print and download articles of interest
- Link to other resources
- Review the regulations of your state
- Use interactive tools to help you with adoption, child care, senior care and educational issues

Use Health and Wellness Resources to:

- Support a healthy lifestyle
- Read and download articles of interest
- Link to other resources
- Use interactive tools related to physical wellness

Explore Daily Living Resources for:

- Care provider databases
- Support articles
- Links to other resources
- Online calculators
- Interactive tools for help finding everything from pet sitters to plumbers

Dental Plans

You have the option of two dental plans through Cigna:

- Dental Care Plan (DHMO)
- Dental PPO Plan (DPPO)

CIGNA DENTAL PLAN (DHMO)

Under this plan, you may only use a Cigna Dental HMO network provider. A current list of eligible providers in your area can be found through the provider directory on Cigna's website: www.cigna.com. There is a $5 copayment for office visits and most preventative and restorative procedures are covered at either a low cost or no cost to you. The cost of treatment is detailed in the Cigna Dental Care fee schedule L1-V9. Please see the below chart for a highlight of common procedures and patient costs.

CODE	PROCEDURE DESCRIPTION	PATIENT CHARGE
	Office visit fee	$5.00
DIAGNOSTIC/PREVENTIVE		
D0150	Comprehensive oral evaluation – New or established patient	$0.00
D0180	Comprehensive periodontal evaluation – New or established patient	$45.00
D0210	X-rays intraoral – Complete series of radiographic images *(limit 1 every 3 years)*	$0.00
D1110	Prophylaxis (cleaning) – Adult *(limit 2 per calendar year)*	$0.00
	Additional prophylaxis (cleaning) – In addition to the 2 prophylaxes (cleanings) allowed per calendar year	$45.00
D1206	Topical application of fluoride varnish *(limit 2 per calendar year). There is a combined limit of a total of 2 D1206s and/or D1208s per calendar year.*	$0.00
	Additional topical application of fluoride varnish – In addition to any combination of two (2) D1206s (topical application of fluoride varnish) and/or D1208s (topical application of fluoride) per calendar year.	$15.00
D1351	Sealant – Per tooth	$17.00
RESTORATIVE (FILLINGS, INCLUDING POLISHING)		
D2140	Amalgam – 1 surface, primary or permanent	$6.00
D2330	Resin-based composite – 1 surface, anterior	$6.00
D2390	Resin-based composite crown, anterior	$88.00
D2391	Resin-based composite – 1 surface, posterior	$47.00
CROWN AND BRIDGE		
	Per tooth charge for crowns, inlays, onlays, post and cores, and veneers if your dentist uses same day in-office CAD/CAM (ceramic) services.	$150.00
D2510	Inlay – Metallic – 1 surface	$380.00
D2542	Onlay – Metallic – 2 surfaces	$440.00
D2740	Crown – Porcelain/ceramic substrate	$460.00
D6740	Crown – Porcelain/ceramic	$470.00
ENDODONTICS (ROOT CANAL TREATMENT, EXCLUDING FINAL RESTORATIONS)		
D3310	Anterior root canal – Permanent tooth (excluding final restoration)	$275.00
D3330	Molar root canal – Permanent tooth (excluding final restoration)	$440.00
PERIODONTICS (TREATMENT OF SUPPORTING TISSUES [GUM AND BONE] OF THE TEETH)		
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant *(limit 4 quadrants per consecutive 12 months)*	$60.00
D4910	Periodontal maintenance *(limit 4 per calendar year) (only covered after active periodontal therapy)*	$77.00
ORTHODONTICS (TOOTH MOVEMENT) Orthodontic treatment (maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8670	Periodic orthodontic treatment visit – As part of contract Children – Up to 19th birthday: 24-month treatment fee Charge per month for 24 months Adults: 24-month treatment fee Charge per month for 24 months	 $2,280.00 $95.00 $3,000.00 $125.00

Please refer to your Cigna fee schedule on the Cigna website for additional details.

If there are any differences between the information in this summary and the official plan documents or policies, the plan documents or policies will govern.

CIGNA DENTAL PPO PLAN (DENTAL PPO)

This plan allows employees to see a dentist either in or out of the Total PPO Dental network and still receive coverage. A current list of in-network providers in your area can be found through the provider directory on Cigna's website: www.cigna.com. It is important that you consult with your dentist regarding the cost of treatment prior to making an appointment and receiving treatment.

For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.

	DPPO ADVANTAGE NETWORK	DPPO NETWORK OR OUT-OF-NETWORK PROVIDERS
Annual Deductible	$50 individual $100 family	$50 individual $100 family
Annual Benefit Maximum	$1,500	$1,500
Preventive Dental Services (cleanings, exams, x-rays)	100% (no deductible)	80% (no deductible)
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%	80%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%	50%
Orthodontic Services Dependent children under age 19	50% $1,000 lifetime maximum	50% $1,000 lifetime maximum

2022 MONTHLY EMPLOYEE PRE-TAX CONTRIBUTION RATES

Divide the below numbers by two (2) to obtain the rate per paycheck.

	CIGNA DENTAL CARE (DHMO) PLAN	CIGNA DENTAL PPO PLAN
	Monthly Cost to Employee	
Individual	$4.14	$13.00
Employee + Child(ren)	$8.28	$26.00
Employee + Spouse / Domestic Partner	$8.28	$26.00
Family	$15.52	$40.10

NOTE: This is an optional election. You are not required to elect dental coverage for the same number of dependents as you are electing for medical and/or vision coverage.

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Vision Plan

The UnitedHealthcare vision plan covers eye examinations, glasses, contact lenses and offers discounted laser vision correction. Employees may use UHC Standard network providers or out-of-network providers. The reimbursement amounts vary based on the type of exam, lenses or frames. In-network providers can be found through the provider locator on the UHC Vision website: https://www.myuhcvision.com. ID cards are not automatically generated, however you can print an ID card from the UHC website.

UNITEDHEALTHCARE VISION PLAN

	IN-NETWORK (any UHC provider)	**OUT-OF-NETWORK** (any qualified non-network provider of your choice)
Eye Exam — once every 12 months	$10 copay	Up to $40 reimbursement
Materials Copay	$10 copay	
Lenses — once every 12 months		
Single Vision Lenses	Covered in full after $10 copay	Up to $40 reimbursement
Lined Bifocal Lenses	Covered in full after $10 copay	Up to $60 reimbursement
Lined Trifocal Lenses	Covered in full after $10 copay	Up to $80 reimbursement
Frames — once every 24 months	$130 allowance	Up to $45 reimbursement
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	$105 allowance	Up to $105 reimbursement

UnitedHealthcare offers access to discounted laser vision correction procedures through Laser Vision Network of America (LVNA). Members receive a discount of 15% off standard prices or 5% off promotional prices with any in-network surgeon.

2022 MONTHLY EMPLOYEE PRE-TAX CONTRIBUTION RATES

Divide the numbers by two (2) to obtain the rate per paycheck.

	UNITEDHEALTHCARE VISION
	Monthly Cost to Employee
Individual	$6.94
Employee + Child(ren)	$12.59
Employee + Spouse / Domestic Partner	$12.89
Family	$20.30

NOTE: This is an optional election. You are not required to purchase vision coverage for the same number of dependents as you are electing for medical and/or dental coverage.

Flexible Spending Account

Flexible Spending Accounts enable you to set aside money, on a pre-tax basis via payroll deduction, for many kinds of common unreimbursed healthcare and dependent care expenses. If you elect to contribute funds to an FSA, you will reduce your taxable income (Federal, State-in most cases, or FICA taxes) while paying for services you would pay for anyway.

Your election is binding. Once you elect to contribute funds to an FSA, you cannot change or cancel that election until the next annual open enrollment period unless you experience a qualified life event.

IMPORTANT!

You must re-enroll in the Flexible Spending Accounts if you want to participate in 2022.

It is important to plan your contribution to your FSA carefully. For active employees, all covered expenses must be incurred during the 2022 calendar year (January-December), with claims filed by 3/31/2023, in order to be reimbursed from your 2022 FSA account.

Visit irs.gov to find a listing of covered expenses. Visit Cigna's website, myCigna.com, to view account activity, forms, plan documentation and more..

HEALTHCARE FSA

A Healthcare FSA allows you to pay for healthcare expenses such as medical, dental and vision, for yourself, or any dependent you claim on your federal tax return (through the end of the tax year in which they attain age 26), that are not reimbursable by your insurance plan. **The minimum annual contribution to the Healthcare FSA is $130; the maximum is $2,850**.

Pursuant to optional changes made possible under recent legislation, ASCAP has decided to allow you to carry over your entire unused Health Care FSA 2021 balance into the 2022 plan year to avoid forfeiture of these funds. Carryover amounts are in addition to any 2022 elections.

For the 2022 plan year the Health Care FSA carry over amount into 2023 plan year will be limited to $570.

Examples of covered healthcare expenses are over-the-counter drugs, deductibles, coinsurance amounts, copays, orthodontia, eyewear, saline solution, and amounts exceeding the allowable charge for a service that was performed by an out-of-network provider.

If you elect to contribute to a healthcare FSA, you will be sent a Cigna debit card. You can use the debit card, anywhere VISA is accepted, to pay for qualified out of pocket expenses such as deductibles, copayments, and coinsurance.

You will use the same Cigna debit card until the earlier of the date you opt out of the Healthcare FSA or the debit card expires (expiration date is noted on the front of the card). Cigna will mail a new FSA debit card to your home prior to the expiration date.

DEPENDENT CARE FSA

A Dependent Care FSA allows you to pay for dependent care expenses for eligible dependents who live with you. Services provided must allow you (and your spouse) to go to work, seek employment or attend school full-time. Eligible dependents include children under age 13, a disabled spouse, a parent or disabled child over the age of 13.

The minimum annual contribution to the Dependent Care FSA is $130; the maximum is $5,000 ($2,500 if married and filing separately).

Pursuant to optional changes made possible under recent legislation, ASCAP has decided to allow you to carry over your entire unused Dependent Care FSA 2021 balance into the 2022 plan year to avoid forfeiture of these funds. Carryover amounts are in addition to any 2022 elections.

There will be no carryover amount for the Dependent Care FSA for the 2022 plan year into the 2023 plan year.

Examples of eligible dependent care expenses are dependent/child care centers, adult day care, nursery school, pre-school, after school programs, summer day camp programs, and services provided by individuals (including relatives other than immediate family members) who provide care for an eligible dependent in or outside your home.

For Dependent Care FSA, you cannot submit a claim for funds that have not yet been contributed to the account. For example, if you have a claim for $2,000 but have only contributed $1,000 to the account, you will only be reimbursed $1,000.

The IRS requires that FSA plans be evaluated to ensure that they pass specific nondiscrimination tests. As a result, the company may, from time to time, need to limit contributions to the FSAs for highly compensated employees. Should this be necessary, you will be notified of any needed change.

Life Insurance and Accidental Death & Dismemberment Insurance

EMPLOYER-PROVIDED BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The company provides Basic Life and Accidental Death & Dismemberment (AD&D) Insurance automatically at no cost to you, administered by Lincoln Financial Group. You have Basic Life and AD&D Insurance coverage equal to two times your Annual Base Salary, to a maximum coverage of $1,000,000.

Accidental Death & Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident.

VOLUNTARY EMPLOYEE LIFE INSURANCE

In addition to your basic life and AD&D benefits, you may purchase additional life insurance in increments of $10,000 to a maximum coverage amount of $560,000 or 5 times your salary, whichever is less.

In general, you must complete an Evidence of Insurability Statement if:

- You are a benefits-eligible new hire (or newly eligible employee) and you are electing coverage in excess of $250,000 or three times your base salary, whichever is less.
- You currently do not have coverage and you want to elect coverage in any amount for the first time during an open enrollment period.
- You currently have coverage and you want to increase your coverage by an amount more than $10,000 during an open enrollment period. Incremental increases of $10,000 do not require Evidence of Insurability unless they cause your total benefit amount to exceed three times your base salary or $250,000.

Please note that insurance coverage amounts will decrease by the following schedule:

- 20% at age 65
- 50% at age 70

The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000. The table below summarizes the voluntary life insurance premium rates.

AGE	MONTHLY EMPLOYEE RATE PER $1,000 OF COVERAGE
Under 30	0.06
30-34	0.08
35-39	0.09
40-44	0.14
45-49	0.20
50-54	0.34
55-59	0.59
60-64	0.72
65-69	1.27
70+	2.06

Example:

Employee earning $30,000, age 33, purchases $40,000 of voluntary life coverage (in addition to $60,000 basic life coverage).

Amount of coverage purchased	$40,000
Divide by $1,000	$40
Multiply by monthly rate based on age	x 0.08
Monthly Cost	$ 3.20

VOLUNTARY SPOUSE / DOMESTIC PARTNER AND CHILD LIFE INSURANCE

You must enroll in the voluntary employee life coverage in order to enroll in spouse / domestic partner or child life coverages.

Spouse / Domestic Partner Life Insurance

You can purchase coverage in increments of $10,000 up to a maximum of $100,000 of life insurance coverage for your spouse or domestic partner. The cost for coverage depends upon the amount of insurance purchased and your spouse's / domestic partner's age.

Your spouse / domestic partner must complete an Evidence of Insurability Statement if:

- You are a benefits eligible new hire (or newly benefits eligible employee) and you want to purchase coverage for your spouse /domestic partner in an amount greater than $20,000.
- You currently do not have coverage for your spouse / domestic partner and you want to elect coverage at any amount during an open enrollment period.
- You currently have coverage for your spouse / domestic partner and you want to increase your coverage by an amount more than $10,000 during an open enrollment period.

Spouse / domestic partner coverage cannot exceed 100% of your voluntary life coverage.

Please note that spousal insurance coverage amounts will not decrease due to age reduction.

The table below summarizes the life insurance premium rates for spouses / domestic partners.

AGE OF SPOUSE / DOMESTIC PARTNER	MONTHLY SPOUSE / DOMESTIC PARTNER RATE PER $1,000 OF COVERAGE
Under 30	0.06
30-34	0.08
35-39	0.09
40-44	0.14
45-49	0.20
50-54	0.34
55-59	0.59
60-64	0.72
65-69	1.27
70+	2.06

Example:

Employee purchases $30,000 of life insurance coverage for spouse, age 42

Amount of coverage purchased	$30,000
Divide by $1,000	$30.00
Multiply by monthly rate based on age	x 0.14
Monthly Cost	$4.20

Child Life Insurance

You can purchase life insurance coverage for $0.20 per month regardless of the number of dependent children you have up to age 26. The coverage amount per child is $4,000.

EMPLOYER-PROVIDED BUSINESS TRAVEL ACCIDENT INSURANCE

The company provides Business Travel Accident Insurance automatically at no cost to you, administered by Chubb Insurance Company. You have coverage of four times your annual salary subject to a minimum of $100,000 and a maximum of $1,000,000.

Business travel accident insurance includes $50,000 of coverage for your spouse / domestic partner and $10,000 coverage for each dependent child.

Disability Coverage

Disability coverage provides you and your family with a source of income replacement should illness or injury prevent you from working for a continual period of time. ASCAP provides two types of disability coverage:

- **Short-Term Disability (STD)** coverage continues a portion of your pay when a non-occupational short-term illness or injury prevents you from working.
- **Long-Term Disability (LTD)** coverage continues a portion of your pay when you can no longer work for more than 180 days.

SHORT-TERM DISABILITY

If you become disabled for more than seven consecutive calendar days and meet the eligibility requirements, the company continues 100% of your salary up to a maximum number of weeks based on your length of service.

The allotment shown below is the total annual allowance awarded for any certified disability incurred in a calendar year, for a regular full-time employee. Please refer to the employee handbook for eligibility requirements for full-time and part-time employees.

LENGTH OF SERVICE AT ONSET OF DISABILITY	WEEKS OF SALARY CONTINUATION (FULL PAY) DURING A CALENDAR YEAR
0-3 months	None
3 months but less than 6 month	1
6 months but less than 1 year	2
1 year but less than 2 years	3
2 years but less than 3 years	5
3 years but less than 4 years	7
4 years but less than 5 years	9
5 years but less than 6 years	11
6 years but less than 7 years	13
7 years but less than 8 years	15
8 years but less than 9 years	17
9 years but less than 10 years	19
10 years but less than 11 years	21
11 years but less than 12 years	23
12 years and over	25

LONG-TERM DISABILITY

Long-term disability insurance protects income if employees suffer from an illness or injury that will prevent them from working for an extended period of time. There is a 180 day waiting period before employees are eligible for long-term disability benefits.

Long-Term Disability Basic Coverage (Employer Paid)

ASCAP provides LTD Basic Coverage, at no cost to you. The LTD Basic Coverage will pay you up to 50% of your base salary up to a monthly maximum benefit of $15,000. The benefit payments are taxable.

Long-Term Disability Basic Coverage (Employee Paid)

You may opt to pay for your LTD Basic Coverage (50% of your annual base salary) on an after-tax basis up to a monthly maximum benefit of $15,000, at the monthly rate of $0.162 per $100 of monthly salary. Paying for your coverage with after-tax payroll deductions allows you to receive your LTD benefits on a tax-free basis.

Long-Term Disability Buy-Up Option (Employee Paid)

You also have the option to increase your LTD coverage by an additional 10% to cover 60% of your salary. The monthly cost to buy-up to 60% coverage is $0.104 per $100 of monthly salary. The additional 10% of LTD coverage is paid for with after-tax payroll deductions. Paying for the buy-up option on an after-tax basis allows you to receive the additional 10% of LTD benefit payments on a tax-free basis.

Below is a chart summarizing your LTD options and the 2022 rates.

OPTIONS	COVERAGE	COST
Basic Long-Term Disability	Up to 50% of your monthly salary. Benefit is taxable.	**No cost to employee – Paid for by ASCAP**
Employee Paid Long-Term Disability Note: Payroll deduction is after-tax.	Up to 50% of your monthly salary. Tax-free Benefit Payment	**0.162/$100 of Monthly Salary** **Example:** Annual Salary of $30,000 Salary per month: $2,500 Divide by 100 $25 Multiply by x 0.162 **Monthly Cost $4.05**
Buy-up for Basic Long-Term Disability Note: Payroll deduction is after-tax	10% Buy-up portion is a Tax-free Benefit Payment.	**$0.104/$100 of Monthly Salary** **Example:** Annual Salary of $30,000 Salary per month: $2,500 Divide by 100 $25 Multiply by x 0.104 **Monthly Cost $2.60**

Commuter Benefit Plan

ASCAP's Commuter Benefit Plan is an easy–to-use employee benefit program that allows you to use pre-tax wages to pay for certain work-related commuting expenses (subject to IRS limits – $280 pretax per month for 2022). Pre-tax contributions to the Commuter Benefit accounts are exempt from federal income and Social Security taxes as well as most state and local taxes.

What are Eligible Commuting Expenses?

There are two categories of eligible transportation expenses:

- Transit (e.g., subway, bus train, ferry) or vanpooling expenses (e.g., Uberpool, Lift Line)
- Parking expenses (e.g., garage, parking lot, or meter)

Benefits of eTrac through Benefit Resource, Inc.:

eTrac through Benefits Resources provides a pre- and post-tax option for both transit and parking expenses listed above.

For the transit account, the eTrac card functions like a debit card to be used to pay for your commuting costs at your transit provider. You are required to use the issued debit card to pay for your eligible transit expenses (per IRS rules no cash reimbursements are allowed under any circumstances).

You can also use the card to reload money on to your transit pass.

For the parking account, you have the option to use the card or submit for reimbursement using a claim form under the eTrac Plan.

Eligibility – When Can You Enroll

You are eligible to enroll on or any time after your benefits eligibility date.

How to Enroll or Make Changes

For eTrac you must enroll/make changes directly on their website www.benefitresource.com.

What Happens After You Enroll

You will receive your eTrac Card by the end of the month if your election is completed by the seventh day of that month.

- Your account will be funded with one full month of your contributions by the end of the month.
- You can start incurring and submitting commuter claims by the first of the following month.
- The pre-tax contributions from your paycheck will commence by the first paycheck of the following month.

How to Change or Stop Your Election(s)

Once enrolled in the Commuter Benefit Plan you will remain enrolled until you elect to stop participation in the Plan or separate from service with ASCAP. Until then, your contributions will continue to be deducted from each paycheck throughout the year and into the next year. Updates to your elections for the following month must be completed on the Benefit Resource, Inc. website by the seventh of the current month.

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Other Benefits

FARMERS GROUP SELECT (SM) HOME & AUTO

The Farmers Group Select (SM) Auto & Home® Group Insurance Program provides ASCAP employees with access to home & auto insurance with attractive savings. Many valuable discounts are available. Maximize your benefits and start saving:

- Save up to an additional 10% right away with Farmers Group Select (SM)'s Welcome Discount for NEW customers.
- Qualify for a group discount of up to 15% off your policy.
- Earn an additional discount when you pay your premium through automatic payroll deduction.
- Receive extra savings if you've been with your company for a long time.
- Save more with Farmers Group Select (SM)'s superior driver discount.
- Earn multi-vehicle savings when you insure more than one vehicle with Farmers Group Select (SM)'s.
- Make the most of Farmers Group Select (SM)'s multi-policy discounts when you insure both your home and auto with Farmers Group Select (SM)'s Auto & Home.

Farmers Group Select (SM)'s Auto & Home offers a broad line of insurance policies:

- Auto
- Boat Insurance
- Flood
- Motorcycle
- Personal Excess Liability
- Recreational Vehicle
- Renters
- Condo

Employees can get quotes and information by phone or online. By providing quick and simple shopping and service experiences, Farmers Group Select (SM)'s makes it easier for your employees to get the right coverage. Since everyone's insurance policies renew at different times during the year, you may apply for group auto and home insurance at any time.

Coverage is 100% portable, so if you change jobs you can take your policy with you. For more information, go to https://www.farmers.com/MetPolicy/FAQ/ or call **800.438.6381**.

To make the most accurate comparisons, please have your current policies with you when you call, and provide the discount code: 0HY.

CORPORATE GYM MEMBERSHIP

Crunch Fitness

All Crunch: $81 per month (plus applicable sales tax) – access to all Crunch clubs nationwide.

- Go to www.onlineccs.com to join, enroll a spouse or domestic partner or convert an existing membership
- Click “Employee/Member Login”
- Enter password (case sensitive): ascap*emp

Follow 3 easy steps to enroll. Please pay attention to the section called “Important Notes Pertaining to Your Membership” for further instructions and/or details regarding the corporate membership. You will receive a series of 3 emails confirming your enrollment and giving you further instructions on how to take advantage of what’s included with your membership.

New York Sports Club (NYSC)

Cost: $69 per month ($34.50 per paycheck) for access to all NYSC facilities in New York, New Jersey, Connecticut.

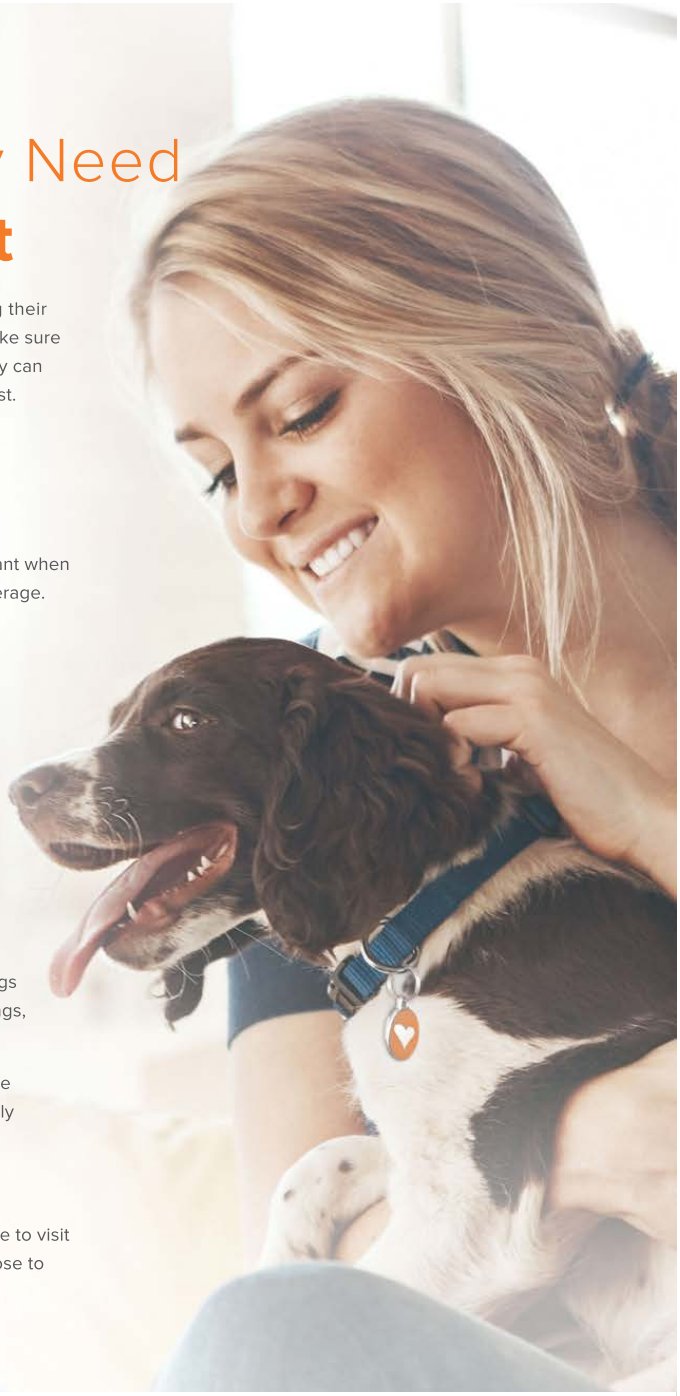
http://www.mysportsclubs.com/regions/NYSC.htm

Contact Melynda Egenberg at **646.553.3351**.

YMCA (Nashville)

Call Mike Meitzenheimer
615.254.0631 ext. 70915
Email: mmeitzenheimer@ymcamidtn.org

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.



The Coverage They Need
The Way You Want

There are many reasons why more pet parents today are covering their pets with ASPCA® Pet Health Insurance. Most of all, they want to make sure they'll have financial support if their pet is sick or hurt. That way, they can give their pets the best care possible without worrying about the cost. Let us help you find the perfect plan for you and your pet.

Complete Coverage℠

With ASPCA Pet Health Insurance, you can choose the care you want when your pet is hurt or sick and take comfort in knowing they have coverage.

EXAM FEES, DIAGNOSTICS, AND TREATMENTS

- Accidents
- Illnesses
- Hereditary Conditions
- Cancer
- Dental Disease
- Behavioral Issues

CUSTOMIZABLE OPTIONS

Annual Limit - from $5,000 to unlimited.

Reimbursement Percentage - 90%, 80%, or 70% of your vet bill.

Deductible - select $100, $250, or $500. You'll only need to satisfy it once per 12-month policy period.

Add Preventive Care - Get reimbursed scheduled amounts for things that protect their pet from getting sick, like vaccines, dental cleanings, and screenings for a little more per month.

Select Accident-Only Coverage - If you're just looking to have some cushion when your pet gets hurt, you can choose coverage that only includes care for accidents.

SIMPLE TO USE

Just pay your vet bill, submit claims, and get reimbursed! You're free to visit any vet, specialist, or emergency clinic you want, and you can choose to receive reimbursement by direct deposit or mail.

Get your customized quote and enroll today!

SAVE WITH YOUR DISCOUNT!

www.aspcapetinsurance.com/ASCAP | 1-877-343-5314

YOUR PRIORITY CODE: EB20ASCAP

ASPCA® PET HEALTH INSURANCE

PETS ARE DEPENDENTS, TOO.

*Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit www.aspcapetinsurance.com/terms. Current customers enrolled on product Levels 1-4 should visit the Member Center for their policy benefits. Products, rates, and discounts may vary and are subject to change. The ASPCA® is not an insurer and is not engaged in the business of insurance. Products are underwritten by the United States Fire Insurance Company, produced and administered by C&F Insurance Agency, Inc. (NPN # 3974227), a Crum & Forster company. Through a licensing agreement, the ASPCA receives a royalty fee that is in exchange for use of the ASPCA's marks and is not a charitable contribution. C&F and Crum & Forster are registered trademarks of United States Fire Insurance Company. Crum & Forster Pet Insurance Group™ is a trademark of United States Fire Insurance Company. The Crum & Forster group of companies is rated A (Excellent) by AM Best Company 2018. U0718-WELCOME1

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Legal Plans

Provides access to legal expertise
for both expected and unexpected events.

Legal experts on your side, whenever you need them

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans, formerly known as Hyatt Legal Plans, gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft, or caring for aging parents.

Reduce the out of pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone, or by email and online tools to do-it-yourself or plan your next move — we make it easy to get legal help. And, you will always have a choice in what attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly premium conveniently paid through payroll deduction, an expert is on your side as long as you need them.

When you need help with a personal legal matter, MetLife Legal Plans is there for you to help make it a little easier.

For added protection, your spouse and dependent children are also covered.

Estate planning at your fingertips:

Our newly redesigned website provides you with the ability to create wills, living wills and powers of attorneys online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly.

MetLife

Legal Plans

Helping you navigate life's planned and unplanned events.

For **$21.00 a month**, you get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms, when using a network attorney for a covered matter.

Money Matters	• Debt Collection Defense • Identity Management Services[3]	• Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy	• Promissory Notes • Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary & Title Disputes • Deeds • Eviction Defense • Foreclosure	• Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home	• Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Divorce (20 hours) • Garnishment Defense • Guardianship	• Immigration Assistance • Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection	• Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	• Defense of Traffic Tickets[4] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

To learn more, visit **info.legalplans.com** and enter access code **9904200** or call **800.821.6400** Monday – Friday 8:00 am – 8:00 pm (ET).

1. You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.
2. Existing participants will be automatically re-enrolled.
3. This benefit provides the Participant with access to LifeStages Identity Management Services provided by CyberScout, LLC. CyberScout is not a corporate affiliate of MetLife Legal Plans.
4. Does not cover DUI.

MetLife

MetLife Legal Plans, Inc. | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

Allstate IDENTITY PROTECTION

stay connected, stay protected

Since so much of daily life is now spent online, it's more important than ever to stay connected. But more sharing online means more of your personal data may be at risk. In fact, 1 in 6 Americans were impacted by an identity crime in 2020.[1]

Identity theft can happen to anyone. That's why your company is offering you Allstate Identity Protection as a benefit. So you can be prepared and help protect your identity and finances from a growing range of threats.

For 90 years, Allstate has been protecting what matters most. Prepare for what's next with:

- Financial account and credit monitoring
- 24/7 alerts and fraud recovery
- Up to $2 million identity theft expense coverage†

Sign up during open enrollment

Questions? 1.800.789.2720

Plans and pricing

Allstate Identity Protection Pro Plus

$9.95 per person / month
$17.95 per family / month

1: 2021 Identity Fraud Study, Javelin Strategy & Research

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

With Allstate Identity Protection Pro+, get new and enhanced features designed to help you defend yourself from today's risks*

- See and control your personal data with privacy insights and privacy management in our unique tool, Allstate Digital Footprint℠
- Learn more about your risk potential by checking your Identity Health Status
- Receive personalized threat insights to help you protect yourself against the latest trends in scams and fraud
- Protect yourself and your loved ones with a family plan that includes senior family coverage for parents, in-laws, and grandparents over the age of 65 (everyone "under your roof and wallet")
- Get reimbursed for many of your out-of-pocket costs, with additional coverage for:
  - Home title fraud expense reimbursement up to $1 million†
  - Professional fraud expense reimbursement up to $2 million†
  - Stolen wallet emergency cash up to $500†

You'll also be able to:

- Monitor social media accounts for questionable content and signs of account takeover
- View and manage alerts in real time
- Catch fraud early with tri-bureau monitoring and an annual tri-bureau credit report and score
- Lock your TransUnion credit report in a click and get credit freeze assistance
- See if your IP addresses have been compromised
- Receive alerts for cash withdrawals, balance transfers, and large purchases
- Get reimbursed for fraud-related losses, like stolen 401(k) & HSA funds, with our identity theft expense coverage†

*Terms and conditions apply. Certain features require additional activation and will not be available until a later date. Product may be updated or modified prior to availability.

†Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

It's easy to get started

1. **Choose your plan**
   You're protected from your effective date.
2. **Activate key features**
   Explore additional features in our easy-to-use portal.
3. **Live your best life online**
   We've got you covered with 24/7 alerts.

Allstate℠
IDENTITY PROTECTION

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Benefits Advocacy Center

Ask Your Advocate

Helping you make the most of your healthcare benefits.

Gallagher

Insurance | Risk Management | Consulting

Gallagher is ready to help you get the most from your benefit programs by providing an advocate at no cost to assist you with:

- **Explanation of benefits.** Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
- **Prescription/pharmacy problems.** Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help getting an authorization on a medication?
- **Benefits questions.** Are you unsure if the insurance will pay for a certain procedure?
- **Claim issues.** Did you receive a bill from a doctor but don't know why?
- **Difficult situations.** Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

You have a dedicated Advocate ready to handle any situation in a discreet and confidential manner.

CONTACT INFORMATION

ASCAP Advocate Center
Toll Free (833) 630-0817
bac.ascap@ajg.com

Hours of Operation:
Monday - Friday 8:00 a.m. – 6:00 p.m. EST

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Benefit Contact Information

CONTACT/ BENEFIT VENDOR	WEBSITE/EMAIL ADDRESS	CUSTOMER SERVICE PHONE NUMBER
ASCAP BENEFITS DEPARTMENT		
Mark McLeod	mmcleod@ascap.com	212.621.6508
MEDICAL COVERAGE		
Cigna OAP Network Only Plan	www.cigna.com or myCigna.com	800.244.6224
Cigna Open Access Plus Plan (OAP)	www.cigna.com or myCigna.com	800.244.6224
MAIL ORDER PRESCRIPTION DRUG PROGRAM		
Express Scripts	www.myCigna.com	800.835.3784
FLEXIBLE SPENDING ACCOUNTS		
Cigna	www.cigna.com or myCigna.com	800.242.2269
DENTAL COVERAGE		
Cigna Dental Care Plan (DHMO)	www.cigna.com or myCigna.com	800.244.6224
Cigna Dental PPO Plan (Dental PPO)	www.cigna.com or myCigna.com	800.244.6224
VISION		
UnitedHealthcare Vision	https://www.myuhcvision.com	800.638.3120
EMPLOYEE ASSISTANCE PROGRAM		
Cigna Behavioral Health (EAP)	www.cignabehavioral.com	800.554.6931
EMPLOYEE SAVINGS AND SALARY DEFERRAL PLAN (401K)		
Merrill Lynch	www.benefits.ml.com	800.228.4015
AUTO & HOME		
Farmers Group Select (SM)	https://www.farmers.com/MetPolicy	800.438.6381
COMMUTER BENEFITS		
eTrac – Benefit Resources, Inc.	www.benefitresource.com	800.473.9595
OTHER BENEFITS		
ASPCA Pet Insurance	www.aspcapetinsurance.com/ASCAP	877.343.5314
MetLife Legal Plan	www.info.legalplans.com	800.821.6400
Allstate Identity Protection	https://www.allstateidentityprotection.com/	800.789.2720

Who to Contact for Healthcare Coverage Assistance

ASCAP wants to make sure you have the resources you need to help with any questions or issues you may have with your benefits.

QUESTION OR ISSUE	WHO TO CALL
COVERAGE QUESTIONS OR CLAIM ISSUES • Medical, Pharmacy, Healthcare flexible spending account, Dependent Care flexible spending account, Vision and Dental plans • ID Cards • Pre-authorization process for covered medical procedures • Claim questions or errors	**STEP 1** **Cigna – (Medical, Dental, HCFSA and DCFSA)** The first point of contact would be Cigna for any general coverage or claim questions. A Cigna representative is available 24/7. 800.Cigna24 or 800.244.6224 **UnitedHealthcare – Vision** The first point of contact is UnitedHealthcare for any general coverage or claim questions. An UnitedHealthcare representative is available 24/7. 800.638.3120
ESCALATED CLAIM ERRORS AND ISSUE RESOLUTION Often, a significant amount of time, effort, and money can be spent trying to understand your benefits and resolving claim issues, including: • General benefit questions (i.e., how the plans work, coverage, network, provider searches) • Provider billing & claims support (helps resolve outstanding claims issues and claims appeal process) • Referrals to Health Resources (i.e., Nurse advocates, medicare experts) • Assistance with prescription drug issues	**STEP 2** **Gallagher Benefit Advocacy Center** The Gallagher Benefit Advocacy Center offers a personalized service for you and your dependents to assist with answering your benefit questions. Gallagher Benefits Advocacy Center 833.630.0817 or bac.ascap@ajg.com Hours of Operation: Monday – Friday 8:00 a.m. – 6:00 p.m. EST
BENEFITS PORTAL (NAMELY) AND BENEFITS ENROLLMENT / ESCALATED ISSUES • Namely Enrollment Issues (for new hires and annual benefits enrollment) • Dependent eligibility, verification requirements and documentation • Qualifying life events • General benefits eligibility questions • Any escalated issues that Cigna, UnitedHealthcare, or the Benefits Advocacy Group was not able to assist	**STEP 3** **Human Resources Team at ASCAP** Your Human Resources team at ASCAP is able to assist with any of your questions on ASCAP's benefits and the enrollment process. Contact Mark McLeod at 212.621.6508

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

Glossary of Healthcare Terms

Terms that are commonly used when describing healthcare benefits are defined below:

GENERAL PLAN TERMS:

Annual Deductible: The amount you owe for healthcare services your health insurance covers before your health insurance begins to pay. For example, if your deductible is $500, your plan won't pay anything until you've met your $500 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Copayment (copay): A fixed amount (for example, $20) you pay for a covered healthcare service, at the time of the service. The amount can vary by the type of covered healthcare service.

Coinsurance: Your share of the costs of a covered healthcare service, calculated as a percent (for example 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance allowed amount for a procedure is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance pays the rest of the allowed amount.

Annual Out-of-Pocket Maximum (Payment Limit): The most you pay during a plan year before your health insurance begins to pay 100% of the allowed amount. This limit does not includes your premium, balance-billed charges, or healthcare your health insurance doesn't cover. Your health insurance may have an in-network and out-of-network out-of-pocket limit.

In-Network (Preferred) Provider: Doctors, hospitals and other healthcare providers who agree to provide care based on preset rates are considered to be in-network in the medical plan. As a result of these negotiated rates, your out-of-pocket costs are lower. Additionally, these providers must agree to comply with the network's quality review procedures.

Out-of-Network (Non-Preferred) Provider: A provider who doesn't have a contract with your health insurer to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance.

Explanation of Benefits (EOB): Statement issued by the insurance company which summarizes how a claim has been paid.

Balance Billing: an out-of-network provider can bill the patient for the difference between the actual charges and the amount that the plan will reimburse.

MEDICAL PLAN TERMS:

Primary Care Physician (PCP): A primary care physician (PCP), or primary care provider, is a health care professional who practices general medicine.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Emergency Care: Immediate medical treatment for life threatening or severe medical conditions which, if not treated immediately, might result in a long-term medical problem, severe disability or loss of life.

In the event of a suspected emergency, you should always use your best judgment. You are not expected to diagnose a potential emergency situation and should look to qualified medical personnel to make that determination.

Urgent Care: This is not the same as emergency care. It is for a sudden illness or injury that is not life threatening, but care still needs to be given quickly so the person does not develop more serious pain or problems. Examples include a sprained ankle or knee; small laceration; a situation when you are unable to see you primary doctor for an illness you may have incurred.

Medically Necessary: Medical care that is required to identify and treat an illness or injury. All care (except preventive care) must be considered medically necessary before benefits are paid.

Precertification: Precertification helps avoid unnecessary and costly medical treatment. When you call Member Services to pre-certify your care, qualified medical professionals will check your doctor's course of treatment against standard medical practice. You must pre-certify any inpatient hospital stays and certain medical care (e.g., skilled nursing, hospice care, etc.) whether in- or out-of-network.

DENTAL PLAN TERMS:

Annual Maximum: The maximum that the insurance plan will pay for dental treatments per year.

Lifetime Maximum: the maximum amount the dental plan will pay toward a covered person during that individual's lifetime. Once an individual has exhausted his or her lifetime maximum benefit under the plan, the plan will not pay any additional charges.

Maximum Reimbursable Charge: A charge is considered reasonable, usual and customary if it matches the general prevailing cost of that service within your geographic area, which is calculated by your insurance company. This means that if your doctor charges above the reasonable and customary charge, you may have to pay the remainder.

Annual Employer Health Benefits Notices

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, call Human Resources.

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

American Society of Composers, Authors & Publishers (ASCAP) is committed to the privacy of your health information. The administrators of the American Society of Composers, Authors & Publishers Health & Welfare Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

HIPAA SPECIAL ENROLLMENT RIGHTS

American Society of Composers, Authors & Publishers (ASCAP) Initial Notice of Your HIPAA Special Enrollment Rights

You are eligible to participate in the American Society of Composers, Authors & Publishers Health & Welfare Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources.

CERTIFICATE OF CREDITABLE (DRUG) COVERAGE

Important Notice from American Society of Composers, Authors & Publishers (ASCAP) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage American Society of Composers, Authors & Publishers (ASCAP) 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. **American Society of Composers, Authors & Publishers (ASCAP) has determined that the prescription drug coverage offered by the American Society of Composers, Authors & Publishers Health & Welfare Plan 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 and each year from October 15th to December 7th.

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 American Society of Composers, Authors & Publishers coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current ASCAP coverage, be aware that you and your dependents will 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 American Society of Composers, Authors & Publishers 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 Human Resources.

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 American Society of Composers, Authors & Publishers 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 www.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 www.socialsecurity.gov, or call them at **1.800.772.1213** (TTY **1.800.325.0778)**.

Remember: Keep this Creditable Coverage 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).

Name of Entity/Sender:
American Society of Composers, Authors & Publishers (ASCAP)

Contact –
Position/Office: Human Resources

Address: 250 West 57th Street, 12th Floor, New York, NY 10107

Phone Number: 212.621.6508

Updated October 15, 2021

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPPcom Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPPPROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

REMEMBER: The deadline in 2022 benefit elections is Friday, December 3, 2021.

MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa 800.862.4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 Human Resources.

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 The American Society of Composers, Authors, Publishers		4. Employer Identification Number (EIN) 13-0434220
5. Employer address 250 West 57th Street, 12th Floor		6. Employer phone number 212-621-6508
7. City New York	8. State NY	9. ZIP code 10107
10. Who can we contact about employee health coverage at this job? Mark McLeod		
11. Phone number (if different from above)	12. Email address	

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

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

☒ All employees. Eligible employees are:

All Full-time Employees

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses, dependent children, and domestic partners

☐ We do not offer coverage.

☒ 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.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting