ASPEN AEROGELS, INC.

BCBS DISCOUNTED RATE AFFIDAVIT

Please use this form to determine your eligibility for a discounted contribution rate within the Blue Cross/Blue Shield of MA (BCBS) medical insurance plan. Note: Do not submit this form to the Benefits Department, you will complete the affidavit online when completing your Open Enrollment submission.

You are eligible for the discounted contribution rate if you can certify that you meet the following two requirements:

- Completed <u>any</u> two (2) Wellness Requirements from the list below during the past twelve (12) months or will do so within next six (6) months; AND
- Declare that you are Tobacco/Tobacco-Like Products Free or in a Tobacco Cessation Program (see next page for more details).

Wellness Requirements - you must have completed two (2) from the list below:

- ☐ Well Visit with a Primary Care Physician*
- ☐ Cancer Screenings*
- ☐ Sensory Screenings* (includes: Eye Exam, Hearing Assessment)
- ☐ Flu Shot*
- ☐ Dental Exam
- ☐ Gym Membership (as per the BCBS guidelines for Gym Membership Reimbursement)
- ☐ Weight Loss Program Membership (as per the BCBS guidelines for Weight Loss Program Membership Reimbursement)
- ☐ Member of virtual online workout and/or weight loss program (i.e. Peloton, BeachBody, NordicTrack, etc.)
- ☐ Actively utilizing BCBS' ***<u>ahealthymerewards</u>*** account throughout the year

Please refer to BCBS of MA document "Preventative Screening Guidelines for Healthy Adults"

Tobacco/Tobacco-Like Products Free Requirements – *you have not used tobacco or tobacco-like products for the last 12 months.* *Note that tobacco use is defined as tobacco or tobacco-like products intended for human consumption, and when used orally or inhaled, produces smoke or smoke-like vapor. This includes but is not limited to: cigarettes, e-cigarettes, loose tobacco smoked via pipe or hookah, cigars, chewing tobacco, snuff, dip, and vaporizers.*

ATTENTION: Providing inaccurate or falsifying any information relating to this program will result in loss of reduced premium for the remainder of the year and you will be excluded from accessing the discount for the following plan year!

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Benefits Department at benefits@aerogel.com

Aspen Aerogels, Inc. Wellness program uses aggregate information it collects to design wellness initiatives based on identified health risks in the workplace. Your personal health information will never be disclosed either publicly or to your employer. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive.

TOBACCO CESSATION PROGRAM PARTICIPATION CERTIFICATION

Please indicate which Smoking Cessation option(s) you have signed up for:

- ☐ Telephonic Programs (Please provide documented proof of program enrollment)
  - 1-800-TRY-TO-STOP (Massachusetts Residents)
  - 1-800-QUITNOW (National Hotline)
- ☐ A Hospital-based Tobacco Cessation Program (Please provide a Well-Visit Verification Form completed by your PCP)
- ☐ Use of a nicotine replacement product monitored by your doctor (Please provide a Well-Visit Verification Form completed by your PCP)
- ☐ Use of an Alternative Therapy (i.e. Hypnosis, Acupuncture) monitored by a Practitioner (Please provide documented proof of program enrollment)
- ☐ Smoking Cessation Counseling Support from KGA, the Company provided EAP plan. (KGA will provide documented proof of program enrollment)
- ☐ Other (please describe): _____

I hereby certify that I have signed up for the program indicated above, to help me quit using tobacco and tobacco-like products.

Please provide written proof of participation by the provider. You will not be considered for the lower premium rate without documentation of participation in a Tobacco Cessation Program.

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