AsahiKASEI

Daramic, LLC
Owensboro Union Employees

2021
EMPLOYEE BENEFITS OVERVIEW
Open Enrollment Oct. 27-Nov. 10, 2020

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THE IMPACT OF COVID-19

- There are NO changes to any of the medical, dental, vision, life, disability or EAP plans for 2021
- In the event that you contract COVID-19 and you are deemed disabled by the treating physician and meet the definition of disabled as defined by our policy, know that our Short-Term Disability (STD) and Long-Term Disability (LTD) benefits will cover this as a claim; if you or a covered family member passes as a result of COVID-19, this is a valid life insurance claim, and that benefit is also payable to the beneficiary; this would also be considered a Serious Health Condition under FMLA and leave would be granted to care for yourself or your spouse or child(ren) if you are eligible
- A reminder that Health Advocate is our Employee Assistance Plan (EAP). The EAP offers a 24-hour hotline with licensed master's level counselors, professional phone evaluations for personal issues for you and your family with referrals to appropriate professional counseling services or other care, and up to five (5) face-to-face or video consults with a counselor at no cost to you or your family. Please see the EAP section of this booklet for more details
- During this crisis, it is important that you take care of yourself and your family. As a reminder, preventive care services such as child immunizations, well woman care, mammograms, cancer screenings, and prostate specific antigen (PSA) tests are covered 100% by plans per Affordable Care Act (ACA) requirements. It is important to access these services when you can, because postponing them can cause health issues later on. For a comprehensive list of preventive care services, visit ***www.BlueCrossNC.com/preventive***

2021 OPEN ENROLLMENT

The annual enrollment period will be from October 27 – November 10, 2020. Workday will be used to review and make any election changes. This year, you will need to complete your Open Enrollment task in Workday in order to confirm your benefits for 2021. This process will include designating a life insurance beneficiary. Please take this opportunity to also confirm that all of your personal and dependent information is up to date.

Additionally, if you elect to opt-out of the medical plan, you must submit the "Waiver of Coverage" form. You must also submit the appropriate documents to confirm the eligibility of any dependents being added to your coverage in 2021.

WHAT'S NEW FOR 2021?

- All employees will receive a new ID card from Blue Cross Blue Shield North Carolina (BCBSNC) with a new Member ID and Group ID numbers for 2021. Current BCBSNC participants should keep their current ID card and use it through December 31, 2020. The new ID card will begin to be used on January 1, 2021 for the 2021 plan year. Your new ID card will be mailed to your home address in December
- Open Enrollment information will be available within Workday (opens Oct. 27, 2020 and closes Nov. 10, 2020)
- Health Care FSA annual maximum indexes to $2,750
- The CARES Act of 2020 added menstrual care products as qualified medical expenses and removed the requirement to have a prescription for over-the-counter medications. However, your debit card may not work because individual merchants like pharmacies and convenience stores must update their Point-of-Sale (POS) system to recognize these products as qualified medical expenses under the FSA. If this occurs, you can pay out-of-pocket and reimburse yourself with submission of an itemized receipt to Flores.

2021 BENEFITS OVERVIEW

This enrollment guide contains information about the benefits available to you in 2021. In the event of a conflict between this overview and the plan documents, the plan documents will govern.

It is important that you make an informed choice because this will be your election for the entire 2021 plan year. Because you pay for some benefits on a pre-tax basis, the Internal Revenue Service prohibits changes during the year, unless you have a change in family status.

You are responsible for notifying your benefits team within 30 days of any qualifying event. You have 60 days to make changes for loss of Medicaid or CHIP coverage. If you do not notify your benefits team within these time frames, you may not be eligible to make changes to your plans mid-year, except that if the addition of a child does not result in a coverage level change (e.g., you are not changing from employee+spouse to family), the 30 day rule is waived. Also, if you do not notify us within 30 days of a dependent losing coverage under the Plan, your payroll deduction will have to remain the same for the remainder of the year due to Section 125 Rules even though your dependent is no longer covered under the plan.

THERE ARE THREE PLAN OPTIONS FOR 2021

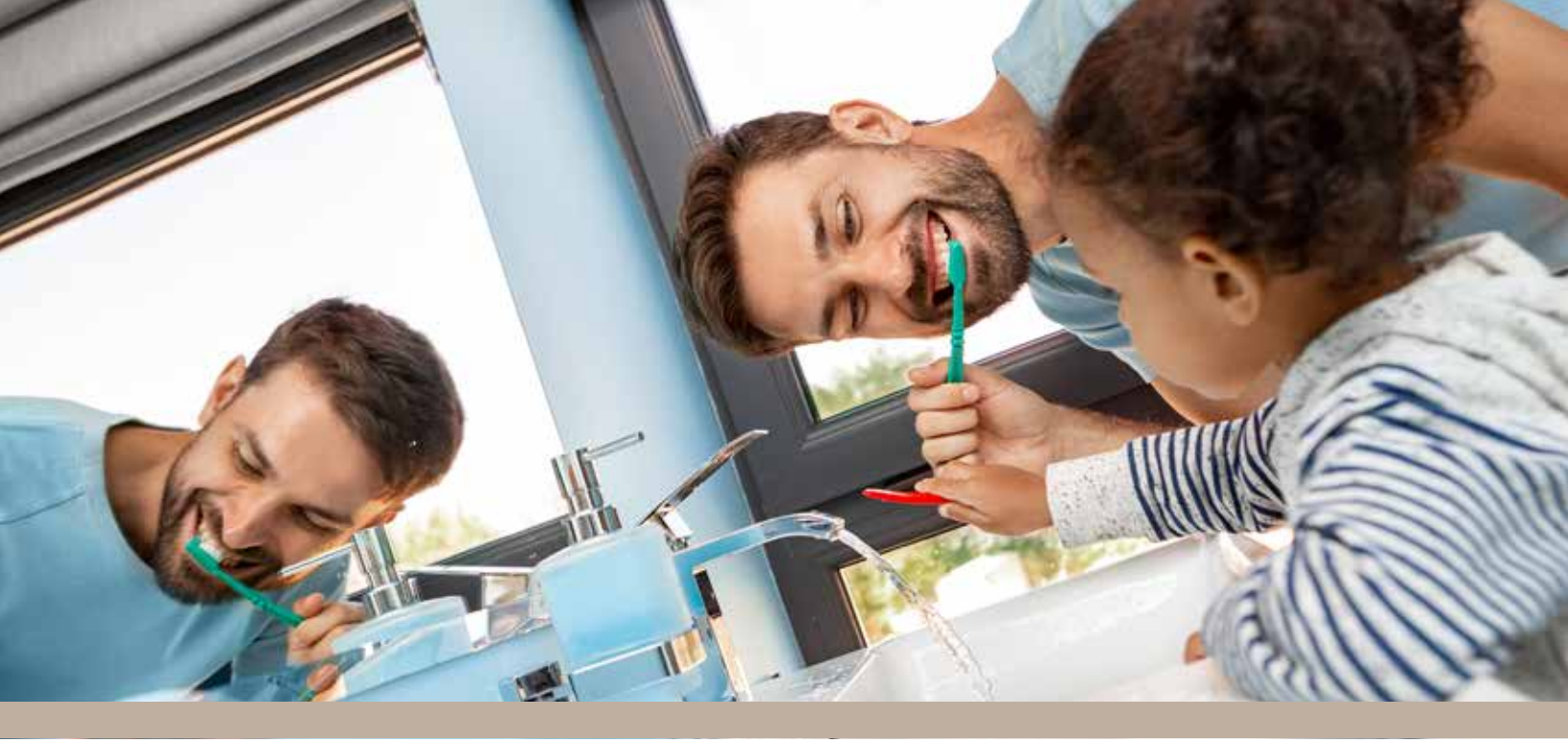
You have the opportunity to make choices based on the needs of yourself and your family. For example, if you do not have children or your children are grown, then you may want to elect the lower cost dental option that does not provide orthodontia coverage. Accordingly, you have the choice of three medical plans, three dental plans, and three vision plans outlined on the next page. They have not changed from 2020 plans.

The differences among the plans are the employee contributions, deductibles, coinsurance maximums and office visit copays. You have the choice of the following tiers of coverage: employee only, employee plus dependent child(ren), employee plus spouse, and family.

COMPARING YOUR HEALTH PLAN OPTIONS

	PLAN I	PLAN II	PLAN III
2021—Weekly Employee Contributions			
Employee	$19.75	$47.40	$67.14
Employee + Child(ren)	$27.65	$55.29	$75.04
Employee + Spouse	$31.59	$59.25	$78.99
Family	$39.50	$67.14	$86.89

	PLAN I		PLAN II		PLAN III	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible						
Individual	$600	$1,500	$800	$2,000	$300	$750
Family	$1,800	$4,500	$2,400	$6,000	$900	$2,250
Coinsurance Maximum						
Individual	$1,500	$3,500	$2,000	$4,000	$1,000	$3,000
Family	$4,500	$10,500	$6,000	$12,000	$3,000	$9,000
True OOP Maximum						
Individual	$2,100	$5,000	$2,800	$6,000	$1,300	$3,750
Family	$6,300	$15,000	$8,400	$18,000	$3,900	$11,250
Office Visits						
Physician Office Visits	60%; after deductible	50%; after deductible	100% after $25 copay	70% of R&C	100% after $15 copay	70% of R&C
Routine & Preventive	100%	100%	100%	100%	100%	100%
Other Physician Charges	60%; no deductible	50%; after deductible	90%; no deductible	70% of R&C; no deductible	90%; no deductible	70% of R&C; no deductible
Chiropractic Services	60%; no deductible	50%; after deductible	80% of covered expenses, limited to $25 visits annually and $1,000 annual maximum	80% of covered expenses, limited to $25 visits annually and $1,000 annual maximum	80% of covered expenses, limited to $25 visits annually and $1,000 annual maximum	80% of covered expenses, limited to $25 visits annually and $1,000 annual maximum
Hospital Facility Charges	**After deductible**		**After deductible**		**After deductible**	
Inpatient	80%	50%	90%	70%	100%	70%
Outpatient Surgery	80%	50%	90%	70%	100%	70%
Outpatient X-Rays/Lab	70%	50%	80%	70%	90%	70%
Emergency Room	80% after $150 copay (copay waived if admitted)		100% after $100 copay (copay waived if admitted)		100% after $100 copay (copay waived if admitted)	
Retail Pharmacy (30-Day Supply)						
Generic	Lesser of $5 / 5% of cost		$12		$12	
Preferred Brand	Lesser of $20 / 10% of cost		$27		$27	
Non Preferred Brand	Lesser of $35 / 15% of cost		$42		$42	
Mail Order (90-Day Supply)						
Generic	Lesser of $0 / 0% of cost		$18		$20	
Preferred Brand	Lesser of $20 / 10% of cost		$33		$35	
Non Preferred Brand	Lesser of $35 / 15% of cost		$48		$50	
	Maximum annual copay per insured individual (employee & dependents) - $1,000		No maximum		No maximum	
Plan Lifetime Maximum						
Lifetime Maximum	Unlimited		Unlimited		Unlimited	



OPT OUT PROGRAM

We will provide compensation of up to $100 per month for those employees who opt-out of medical coverage for themselves and/or eligible dependents, per the schedule shown. You have to re-enroll for opt-out compensation every year.

You cannot opt out for a spouse who is also a Polypore employee.

Opt Out Program	
Employee	$75 per month
Employee + Spouse	$100 per month
Employee + Child(ren)	$75 per month
Family	$100 per month
Spouse Opt Out	$75 per month

MEDICAL, DENTAL AND VISION ELIGIBILITY

To be covered under the plan, you must be an active full-time employee who works 30 or more hours per week. To be covered under the plan, your dependents must be one of the following:

- Your spouse under an existing marriage that is legally recognized under any state law
- Your or your spouse's dependent children through the end of the month of their 26th birthday
- A dependent child who is and continues to be either mentally or physically handicapped and incapable of self-support may continue to be covered under the plan regardless of age if the condition exists and coverage is in effect when the child reaches the end of eligibility for dependent children. The handicap must be medically certified by the child's doctor and may be verified annually by the plan.

DENTAL PLAN

Dental coverage is provided through Delta Dental, a network dental plan with an extensive list of participating local dentists. In-network visits eliminate the need for participants to file claims; network dentists will file claims for you. Network dental services are not subject to benefit payment reductions due to charges in excess of usual and customary.

DENTAL PLAN			
	Plan I	**Plan II**	**Plan III**
Deductible	$50	No deductible	No deductible
Class A Services (Preventive)	80%	80%	100%
Class B Services (Basic)	60%	60%	80%
Class C Services (Major)	60%	60%	80%
Dental Annual Maximum per Individual	$1,000	$1,000	$1,000
Orthodontic Services (up to age 20)	Not Covered	50%	50%
Orthodontic Lifetime Maximum per individual	NA	$1,000	$1,000
2021—Weekly Employee Contributions			
Employee	$0.72	$1.72	$2.44
Employee + Child(ren)	$1.00	$2.00	$2.72
Employee + Spouse	$1.15	$2.15	$2.87
Family	$1.43	$2.44	$3.15

VISION PLAN

Flores & Associates administers the vision plan.

There's an app for that!
Search "United Healthcare"

Submit claims to Flores & Associates (PO Box 31397, Charlotte, NC 28231-1397) or if your eye doctor will not file the claims for you, you will need to complete a claim form and submit to Flores.

VISION PLAN			
	Plan I	Plan II	Plan III
Annual Eye Exam Reimbursement (once per insured employee or dependent every 12 months)			
Optometrist	$25.00	$50.00	$85.00
Ophthalmologist	$25.00	$50.00	$85.00
Lenses (once per insured employee or dependent every 12 months)			
Single Vision	$18.00	$ 35.00	$ 53.00
Bi-focal	$23.00	$ 45.00	$ 68.00
Tri-focal	$28.00	$ 55.00	$ 83.00
Contacts (in lieu of eyeglass frames & lenses)	$75.00	$100.00	$125.00
Frames (once per insured employee or dependent every 12 months)			
	$50.00	$75.00	$100.00
2021—Weekly Employee Contributions			
Employee	$0.10	$0.20	$0.28
Employee + Child(ren)	$0.12	$0.24	$0.30
Employee + Spouse	$0.15	$0.26	$0.34
Family	$0.17	$0.28	$0.38

BASIC LIFE AND AD&D INSURANCE

Life insurance offers important financial protection for you and your family.

The company automatically provides AND pays the cost of basic life insurance and accidental death and dismemberment (AD&D) coverage equal to $30,000. This amount reduces to 65% when you reach age 70 and to 50% when you reach age 75.

SHORT-TERM DISABILITY

ELIGIBILITY

As a regular full-time hourly employee of Daramic, LLC, you are eligible for Accident and Sickness benefits on the first day of employment with the Company.

If you are not "actively at work" on the day you would normally become eligible, you will not become eligible until the day you return to active work. "Actively at work" means the performance of all duties that pertain to your job at the place where it is normally done, or where it is required to be done by the company.

COST

The Company pays the full cost of your Short-Term Disability benefits.

WHEN BENEFITS BEGIN

Benefits for any "period of disability" will begin after a three (3) consecutive day waiting period. However, if your disability is due to an accidental injury, benefits will begin on the first day of absence. Benefits will continue until you are able to return to work or until you receive the total amount of benefits payable.

TOTAL BENEFITS PAYABLE

Short-Term Disability benefits may continue for up to 26 weeks. However, you must be under the direct care of a doctor who may periodically be required to certify that you continue to be disabled. The direct care starts when the doctor examines you. A "doctor" is defined as a physician legally licensed to practice medicine and surgery, or any other legally licensed practitioner of the healing arts who renders services within the scope of his or her license. A "Doctor" does not include a resident doctor, an intern, or a person in training.

PERIODS OF DISABILITY

A period of disability is defined as the entire period of disability time during which you are continuously and totally unable to perform all the duties of your job.

For two periods of disability; if the two periods of disability are due to the same or related cause or condition and are separated by a period of not more than two consecutive weeks, they are considered one continuous period of disability.

If the two periods of disability are due to unrelated causes and/or are separated by a period of more than two consecutive weeks, they are considered separate periods of disability. If you return to work for at least one day, and are then disabled due to different and unrelated causes, a new period of disability will go into effect.

REMINDER

Have you updated your beneficiaries?

BENEFIT

If you become disabled and are unable to perform all of the duties pertaining to your work, your benefit amount will equal to 60% of your base hourly rate, based on a 40-hour work week.

BENEFITS LIMITATIONS

No benefits are payable under the Short-Term Disability benefits for more than 26 weeks for any one period of disability, for any period during which you are not under the care of a doctor, for any injury or sickness due to employment with any employer or self-employment, for a disability for which benefits are payable under any Workers' Compensation, occupational injury or sickness or similar laws, or for a disability due to self-inflicted injuries.

LONG-TERM DISABILITY

Long-term disability coverage replaces part of your earnings if you become disabled and cannot work for an extended period of time. This coverage is provided through Lincoln.

The benefit is equal to 60% of your monthly base salary to the maximum monthly benefit in the Summary Plan Description (SPD). Benefits begin after you have been totally disabled for 180 consecutive days and may continue until age 65 as long as you continue to be determined totally disabled based on the plan's definition. Benefits may be reduced by other sources of income and disability earnings.

VOLUNTARY/EMPLOYEE PAID BENEFITS

The company makes available several additional benefits that you may choose to purchase through payroll deduction. A description of each is provided below. Unless otherwise noted, payroll deductions for 2021 benefits will begin as of the first paycheck dated on or after 1/1/2021.

SUPPLEMENTAL LIFE INSURANCE

You may choose to purchase supplemental term life coverage of $25,000, $50,000, $75,000, $100,000, $125,000 or $150,000. The cost of this coverage is $0.295 per $1,000 per month. Changes in the cost will be made by the insurance company upon proper notification. This benefit is provided through Lincoln. It includes an equal amount of Accidental Death and Dismemberment coverage, which means the death benefit will double in the event death is due to an accident. For new hires, no Evidence of Insurability (EOI) is required for elections made within the Initial Election Period*. For active employees with no coverage currently in force, EOI is required for any election. For active employees with current coverage in force, EOI is required for an increase in excess of one level. The EOI application can be accessed online through Lincoln's website via the link in Workday. Your Supplemental Group Term Life Insurance amount reduces to 65% when you reach age 70 and to 50% when you reach age 75.

SUPPLEMENTAL LIFE INSURANCE		
Option 1	$ 25,000	($7.38/month)
Option 2	$ 50,000	($14.75/month)
Option 3	$ 75,000	($22.13/month)
Option 4	$100,000	($29.50/month)
Option 5	$125,000	($36.88/month)
Option 6	$150,000	($44.25/month)

*INITIAL ELECTION PERIOD = 31 DAYS AFTER HIRE DATE

LIFE INSURANCE FOR SPOUSE

You may choose to purchase Lincoln's dependent life insurance for your spouse, and have the premium conveniently payroll deducted. The cost of this coverage is $0.255 per $1,000 per month. You are automatically the beneficiary of this coverage. Elections over the Guaranteed Issue amount of $50,000 or an election more than one level above your current coverage amount will require Evidence of Insurability. The Evidence of Insurability application can be accessed online through Lincoln's website via link in Workday. Your Supplemental Spousal Group Term Life Insurance amount reduces to 65% when your spouse reaches age 65 and to 50% when your spouse reaches age 70. Maximum life insurance for your spouse is $100,000.

FOR YOUR SPOUSE		
Option 1	$ 25,000	($ 6.38/month)
Option 2	$ 50,000	($12.75/month)
Option 3	$ 75,000	($19.13/month)
Option 4	$100,000	($25.50/month)

LIFE INSURANCE FOR CHILDREN

You may choose to purchase Lincoln's dependent life insurance for your children, and have the premium conveniently payroll deducted. You may choose either Option 1 or Option 2 to cover all of your dependent children between the ages of 1 month through 25 years. If your children exceed these ages, do not elect this coverage. If you have elected this coverage previously and all of your children exceed these ages, you should notify the benefits team to terminate this coverage. The employee is automatically the beneficiary of this coverage. The cost is the same whether you have one child or several. You may increase coverage on your children by only one level during the annual enrollment.

FOR YOUR CHILDREN		
Option 1	$ 5,000	($0.45/month)
Option 2	$10,000	($0.90/month)

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Some employees desire more AD&D coverage than the amount provided with your basic life insurance. This benefit offers additional protection for accidental death and dismemberment for you, and optional coverage for your family.

Underwritten by Lincoln, this benefit provides coverage when death is caused by an accident, regardless if on or off the job, including travel by public or private transportation. In addition, this policy will pay benefits if you suffer from an accident that results in paralysis or the loss of a limb, speech, hearing or sight. You may elect coverage for only yourself, or for your entire family. Coverage is available in $10,000 increments from $10,000 up to $500,000 with a maximum election of 10 times your base annual earnings. Your children may be covered from age one month through age 25. If you elect family coverage, your benefits will be as follows:

A spouse only:	50% of your coverage
A spouse and child(ren):	40% of your coverage on spouse, 10% of your coverage on each child
Child(ren) only:	15% of your coverage up to $20,000 on each child

The monthly cost of this coverage is $0.04/ $1,000 for yourself or $0.06/$1,000 for your family.

CANCER/SPECIFIED DISEASE INSURANCE

Cancer/Specific Disease Insurance is no longer offered. This benefit was available through American Heritage Life Insurance (Allstate) but is being discontinued effective December 31, 2020.

If you were enrolled in this plan previously, your contact information was shared with Allstate; they will reach out to you to ask if you would like to continue coverage on a direct bill basis.

You can reach out to Allstate directly at 904-994-1776 and ask to convert your policy to direct bill at the same cost you are paying now through payroll deductions.

FLEXIBLE SPENDING PROGRAM

MEDICAL FLEXIBLE SPENDING ACCOUNT

The Medical Flexible Spending Account (FSA) benefit allows you to set aside earnings, tax-free (up to $2,750 per year), to help pay for health care expenses such as deductibles, coinsurance, doctor visit and prescription drug copays, and certain uncovered prescription drugs and medical procedures (e.g., Lasik Surgery). Cosmetic services and products are not eligible for Medical FSA reimbursement. You cannot change your FSA election during the year unless you have a qualified change in status.

How Does FSA Work?

- Contributions are automatically withheld–in equal amounts–from your paychecks throughout the year
- Contributions are credited to an account(s) set up in your name
- You pay for eligible expenses as you normally would and then submit your receipts, along with a claim form that may be obtained on the Flores website

How Does the Debit Card Work?

- Your debit card is preloaded and immediately available with your full annual contribution amount
- Your debit card is linked to your FSA so you can pay for eligible expenses right at the point-of-purchase
- You may be required to substantiate certain claims so keep all of your receipts

REMINDER

You Must Re-enroll for 2021

Dependent Care Flexible Spending Account

You also have an option to participate in a Dependent Care Flexible Spending Account. This account allows reimbursement for certain planned dependent day care expenses while you are at work. Expenses can be reimbursed for your dependent children up to age 13. Examples of these covered expenses are day care expenses, after school care expenses and summer day camp. Please note that any dependent day care expenses that are reimbursed under this account cannot be deducted from your year end tax returns. You can set aside up to $5,000 per year in a Dependent Care Flexible Spending Account.

You cannot be reimbursed for dependent medical expenses from a Dependent Care Flexible Spending Account.

FSA Claim Deadlines				
	2020 Contributions		2021 Contributions	
	Eligible Dates of Service	Claim Submission Due By	Eligible Dates of Service	Claim Submission Due By
Medical FSA	Jan 1, 2020 - March 15, 2021	April 15, 2021	Jan 1, 2021 - March 15, 2022	April 15, 2022
Dependent Care FSA	Jan 1, 2020 - Dec 31, 2020	March 31, 2021	Jan 1, 2021 - Dec 31, 2021	March 31, 2022

You must re-enroll if you want to continue your participation in Flexible Spending Accounts for 2021.

Flores & Associates administers our FSA. You may contact them at 1-800-532-3327 or at *www.flores247.com*.

GLOSSARY

Defining these common healthcare terms may be helpful to you

CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. Each state has its own rules about who qualifies for CHIP. You can apply at anytime.

CLAIM

A request by a plan member or a plan member's health care provider for the plan to pay for medical services.

COBRA

A federal law that requires employers with 20 or more employees to offer continuing coverage to individuals who would otherwise lose their benefits due to termination of employment, reduction in hours or certain other events.

COINSURANCE

A certain percent you must pay each benefit period after you have paid/met your deductible.

COPAYMENT

The amount you pay to a health care provider at the time you receive services.

CORONAVIRUS

A type of common virus that infects humans, typically leading to an upper respiratory infection (URI.) The viruses are spread through the air by coughing and sneezing, close personal contact and/or touching an object or surface contaminated with the virus

COVID-19

A mild to severe respiratory illness that is caused by a coronavirus. It is transmitted chiefly by contact with infectious material (such as respiratory droplets) or with objects or surfaces contaminated by the causative virus, and is characterized especially by fever, cough, and shortness of breath and may progress to pneumonia and respiratory failure

DEDUCTIBLE

The amount you pay for health care services before your plan pays.

DEPENDENT COVERAGE

Coverage for your dependents who qualify.

EXCLUSION OR LIMITATION

Any specific situation, condition or treatment that a plan does not cover.

EOB (EXPLANATION OF BENEFITS)

Created after a claim has been processed by your plan. It explains that actions taken on a claim such as the amount that will be paid, the benefit available, discounts, reasons for denying the payment and the claims appeal process.

FSA (FLEXIBLE SPENDING ACCOUNT)

Often set up through an employer plan, it allows you to set aside pre-tax money for common medical costs and dependent care. FSA funds must be used by the end of the benefit year.

HIPAA

A law designed to protect personal information and data collected and stored in medical records used in all doctors' offices, hospitals and other businesses. Also gives patients the right to view their medical records and request changes if their data is incorrect.

NETWORK PROVIDER/IN-NETWORK PROVIDER

A provider who is part of a plan's network.

NON-NETWORK PROVIDER/OUT-OF-NETWORK PROVIDER

A health care provider who is **not** part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan.

OUTPATIENT SERVICES

Services that do not need an overnight stay in a hospital–often provided in a doctor's office, hospital or clinic.

OUT-OF-POCKET COST

Costs you must pay.

OUT-OF-POCKET LIMIT

The most you will pay during a benefit period before your plan begins to pay 100% of the allowed amount.

PPO (PREFERRED PROVIDER OPTION/ORGANIZATION)

A plan that offers more extensive coverage for the services of health care providers who are part of the plan's network but still offers some coverage for providers who are not part of the plan's network. Premiums tend to be higher.

PRE-EXISTING CONDITION

A condition, disability or illness that you have been treated for before applying for new health coverage.

PREMIUM

Payments you make to your plan provider to keep your coverage.

PRESCRIPTION DRUG TIER

A prescription drug list has different levels of payment coverage called "tiers." These tiers determine how much you will pay out-of-pocket for your prescription drug based on the terms of your pharmacy benefit and whether the drug is covered on the drug list. Drugs in a lower tier will often cost less than drugs in a higher tier.

PREVENTIVE CARE SERVICES

Routine health care that includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.

PRIMARY CARE PHYSICIAN (PCP)

The physician you choose to be your primary source for medical care. Your PCP coordinates all your medical care, including hospital admissions and referrals to specialists.

PROVIDER

A physician, health care professional or health care facility licensed, certified or accredited as required by state law.

SPECIALTY DRUG

A prescription drug used to treat complex health care conditions. These drugs are often given as a shot but may be added to the skin or taken orally.

Asahi Kasei Health and Welfare Plan Annual Notices January 1, 2021 - December 31, 2021

THIS PACKAGE CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS AND BENEFITS UNDER THE ASAHI KASEI HEALTH AND WELFARE PLAN FOR THE 2021 PLAN YEAR.

If you have any questions about the information included in this package, please contact:

Plan Adminstrator
Attn: Benefits Department
13800 South Lakes Drive
Charlotte, NC 28273

Or call 704-587-8882 or email ***asahi-benefits@ak-america.com***. As an alternative to viewing plan materials online on our intranet site or the Plan Administrator's offices, you may request printed copies by contacting the Plan Administrator.

Summary of Material Modification

The information in this document and in the benefit guide applies to the **Asahi KASEI Health and Welfare Benefits Plan, Plan Number 501 (the "Plan")**. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

The Plan Administrator reserves the right to amend, modify or terminate the Plan at any time and in any manner, including, but not limited to, modifying cost-sharing requirements, eligibility terms and covered and excluded benefits.

Disclosure About the Benefit Enrollment Communications

The Plan Administrator has prepared a combined legal plan and summary plan description for the Plan which complies with various disclosure requirements mandated by law, and sets forth administrative procedures and eligibility conditions under the Plan. Other documents and materials prepared by our insurers and vendors (referred to as "Supplemental Plan Documents") further provide specific descriptions of covered and excluded benefits as well as a description of the terms and conditions to receive such benefits. Although we highlight in these benefit enrollment materials a number of rights and benefits, you should carefully review the Plan and the Supplemental Plan Documents to fully understand your legal rights and benefits. These documents, and for more information about any of the rights explained in these benefit enrollment materials, are available by contacting the Plan Adminsitrator.

The benefit enrollment materials (including any benefit guides and this Benefit Plan Notice Requirements document, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained in these benefit enrollment materials and the official Plan and Supplemental Plan Documents, the official Plan and Supplemental Plan Documents prevail.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 22 for more details.

Qualified Changes in Status/Changing Your Pre-Tax Contribution Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1 – December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child
- Marriage, legal separation, annulment or divorce
- Death of a dependent
- A change in employment status that affects eligibility under the plan
- A change in election that is on account of, and corresponds with, a change made under another employer's plan
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within **30 days** of the change in status. If you do not notify Asahi KASEI Benefits within 30 days, you must wait until the next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

Date	October 14, 2020
Name of Entity/Sender	Asahi KASEIAmerica, Inc
Contact—Position/Office	Asahi KASEI Benefits
Address	13800 South Lakes Dr., Charlotte, NC 28273
Phone Number	704-587-8882

HIPAA Notice of Special Enrollment Rights

You may have the right to enroll in the medical and other benefits offered under the Plan during special enrollment periods, including when you lose coverage under another group health plan, Medicaid or State Children Health Insurance Programs, or when you acquire a new dependent. For more information regarding these special enrollment rights, please review the Plan document or contact the Plan Administrator.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Plan to maintain the privacy of your protected health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Plan Administrator or review a copy of the Notice attached as an Appendix to the Plan document.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is also known as "Janet's Law." This law requires that our medical coverage includes benefits for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient

Benefits will be payable on the same basis as any other illness or injury under the health plan, including the application of appropriate deductibles, coinsurance and copayment amounts. Please refer to your benefit plan booklet for specific information regarding deductible and coinsurance requirements. If you need further information about these services under the health plan, please contact the Customer Service number on your member identification card.

Continuation of Coverage (COBRA)

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal law requiring most group health benefit plans to offer employees and their families the opportunity to temporarily extend their health

Contact the Plan Administrator if you or your spouse or dependent children lose group health coverage due to the occurrence of a COBRA Qualifying Event, which may include your termination or reduction in hours of employment, death, divorce, no longer satisfying dependent eligibility conditions, etc. **Under the law, the employee or the family member is responsible for informing the Plan Administrator of any family status change (e.g. divorce or attaining the limiting age) within 60 days of the event. Otherwise, COBRA rights will be lost.**

For more information about COBRA and to see a list of events eligible for COBRA, please refer to the General/Initial COBRA Notice as well as the Plan document.

Summary of Benefits and Coverage

You will receive a Summary of Benefits and Coverage ("SBC") explaining the Medical Plan options available to you as part of these enrollment materials. A copy of the SBC also will be available on our intranet website.

Newborns and Mothers Health Protection Notice

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay for the mother or newborn child in connection with childbirth to less than 48 hours following a vaginal delivery or 72 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending health care provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the Health Plan will not require a provider to obtain authorization from the Health Plan for prescribing a length of stay of 48 hours (or 96 hours, if applicable) or less.

Patient Protection Notices

If the Plan provides for or requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

Health Insurance Marketplace Notice

The state in which you reside has a website, called the Health Insurance Marketplace, where you can buy medical insurance directly from insurance companies.

The marketplace offers "one-stop shopping" to find and compare medical insurance options for you and your family. Open enrollment for the marketplace begins and ends on the dates posted on the applicable state's marketplace website. You may buy health insurance for yourself and your family members from your state's marketplace.

However, if you and your dependents are offered medical coverage through the Plan, your employer pays a portion of the cost of that coverage, so you may not find less expensive coverage through your state's marketplace. Also keep in mind that the contributions you and your employer make to the cost of coverage in the Plan are made with pre-tax dollars that are not subject to income tax. If you buy health insurance through your state marketplace, you will pay for it with after-tax dollars.

Also, except for unusual circumstances, you will not be eligible for federal premium assistance (explained below) to help pay the cost of a marketplace policy whenever the Plan meets government "minimum value" and "affordability" standards.

A federal tax credit that lowers the monthly premium of an individual health insurance policy purchased from the Marketplace is available to families with incomes between 100% and 400% of the federal poverty level. If you are employed and your income is at this level, you and your family members are eligible for premium assistance if one of the following applies:

- Your employer does not offer health coverage to you at all,
- Your employer offers you coverage but it does not meet the federal government's "minimum value standard," or
- Your employer's health plan is not "affordable" for you, meaning the cost of single coverage (that is, coverage for just you, not you plus your family members) is more than 9.83% to your household income for the year

For more information about available benefits and your premium costs under the Plan, please contact the Plan Administrator identified above.

For more information about the Marketplace, go to ***www.healthcare.gov*** and select your state's marketplace website. You may be asked for information about your offer of group medical coverage under the Plan, which can be found in the Plan document or by contacting the Plan Administrator.

Timeframe Extensions During COVID-19 Outbreak Period

You have an extended period of time to take certain actions that otherwise would have been due during the Outbreak Period as explained below. The Outbreak Period relates to COVID-19 pandemic and begins on March 1, 2020 and ends 60 days after the announced end of the National Emergency Period. For example, if the National Emergency ends on October 31, 2020, the Outbreak Period ends on December 30, 2020.

> Note: The deadlines used in the examples below are hypotheticals assuming that the National Emergency for the COVID Pandemic ends on October 31, 2020. The Outbreak Period could end later than December 30, 2020, if in fact the National Emergency ends later than October 31, 2020.

Special Enrollment Events. You generally are required to notify the Plan Administrator within 30 days of a HIPAA special enrollment event (loss of other coverage or acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption) or within 60 days of a Medicaid/CHIP event (loss of Medicaid CHIP eligibility or becoming eligible for premium assistance under Medicaid/CHIP). If you experience a HIPAA special enrollment event or Medicaid CHIP event during the Outbreak Period, your 30 or 60-day period will not begin until after the Outbreak Period ends.

Example: Assume your child is born on March 15, 2020 and the National Emergency Period ends on October 31, 2020. You will have until January 29, 2021 (30 days after the Outbreak Period ended on December 30, 2020) to enroll your newborn child, you and/or your spouse into one of the medical plan options (your newborn and spouse must be enrolled in the same medical plan option as you).

COBRA Election Period. You and your Eligible Dependents generally are required to elect COBRA coverage within 60 days of the date you lose coverage (or receive the COBRA election package, if later). If you experience a COBRA qualifying event during the Outbreak Period, the 60-day election period will not begin until after the Outbreak Period ends.

Example: Assume you lose active coverage under the Plan health plan options as of, and receive your COBRA election package on April 30, 2020. Assume further that the National Emergency ends on October 31, 2020. The 60-day election period to elect COBRA coverage for you and your Eligible Dependents does not end until March 30, 2021 (i.e., 60 days after the Outbreak Period ends on December 30, 2020). If you timely elect COBRA by this date, your COBRA coverage will be retroactively effective as of May 1, 2020.

The COBRA Premium Payment Period. You generally have 45 days from the date you elect COBRA coverage to pay your first premium for COBRA coverage and subsequently monthly premium payments must be made by the end of the 30-day grace period that starts at the beginning of each coverage month. Your first premium or any subsequent premiums will not be due until after the Outbreak Period ends. Of course, you can decide to continue your normal payments during the Outbreak Period to avoid having a large amount owed for back-premium payments after the Outbreak Period ends.

Example: You are covered under COBRA and you failed to make your COBRA premiums for March, April, May and June. Assume the National Emergency ends on October 31, 2020. You will have until January 29, 2021 (i.e., 30 days after the Outbreak Period ends on December 30, 2020) to pay your COBRA premiums for the months of March, April, May, June and July. If you pay for two months of COBRA premiums by January 29, 2021, then your COBRA coverage will be effective for the months of March and April, 2020, and then will end effective May 1, 2020 for failure to timely pay your premiums for May and subsequent months. The Employer may suspend payment of claims you incurred during this extended grace period until it receives payment from you.

COBRA Notices from Employees re Divorce/Legal Separation, Child Reaching Age 26, and Disability. You generally must notify the Plan Administrator within 60 days of the event that (i) causes your Eligible Dependent to cease being eligible for active coverage under the Plan or (ii) qualifies your Eligible Dependent to extend COBRA coverage for an additional 18 months in the event of divorce legal separation/order of separate maintenance or your child attaining the age of 26. You also must notify the Plan Administrator within 60 days of a social security disability determination, which allows you to extend COBRA coverage beyond 18-months. If you experience any of these qualifying events during the Outbreak Period, the 60-day notification period will not begin until after the Outbreak Period ends.

Example: Assume you and your spouse have active coverage under the Plan, you and your spouse finalize your divorce effective April 1, 2020, causing the spouse to lose eligibility for coverage. Assume the National Emergency ends on October 31, 2020. You or your spouse must notify the Plan Administrator of the divorce to preserve your former spouse's COBRA rights no later than February 28, 2021 (i.e. 60 days after the Outbreak Period ends on December 30, 2020).

The Plan's Benefit Claim Filing Deadline. Any deadline imposed by ERISA or other law regarding benefit claims are extended during the Outbreak Period, as follows:

Other than flexible spending accounts, you generally have one year from the date that a benefit expense was incurred to file a claim for benefits under the Plan. Assume you have medical coverage under the Plan and received medical treatment on March 1, 2020. Assume the National Emergency ends on October 31, 2020. The one-year period to submit your claim does not begin until December 31, 2020 (which is after Outbreak Period ends on December 30, 2020).

For the health flexible spending account, you generally have until March 31, 2020 to sumbit claims for reimbursements of eligible health care expenses incurred prior to December 31, 2019. You already were able to submit claims for reimbursement of eligible health care expenses for two months (January and February) before the Outbreak Period began on March 31, 2020. This leaves you with one month after the Outbreak Period ends to submit your claims for eligible health care expenses.

You generally have 180 days for health and disability benefit-related claims and 60 days for all other types of claims to file an appeal of the Plan Administrator's denial of your claim. Assume you receive notification that your disability claim was denied by the Plan Administrator on January 1, 2020, and assume the National Emergency ends on October 31, 2020. You will have 120 days (180 days – 60 days following January 1 to March 1) after the Outbreak Period ends on December 30, 2020, which is April 29, 2021, to submit your appeal to the Plan Administrator.

For medical or prescription benefit-related claim, you generally have four months after the date of a denial of your claim to request an external review if the claim involves medical judgment or rescission of coverage. Assume your medical claim is denied on April 1, 2020, based on medical judgment and the National Emergency ends on October 31, 2020. You will have four months to request an external review of your denied claim after the Outbreak Period ends on December 30, 2020, which is April 30, 2021, to submit your appeal to the Plan Administrator.

Employer COBRA Election Notice Deadline. Under COBRA, the Plan Administrator generally must provide a COBRA qualifying events notice and election package notice to you and/or your Eligible Dependents who experiences a qualifying event within 44 days from the loss of coverage. This 44-day period also is extended by the Outbreak Period. Assume you lose your active coverage under the Plan effective April 1, 2020 as a result of your termination of employment and the National Emergency ends on October 31, 2020. The Plan Administrator will send you the COBRA qualifying events notice and election package no later than 44 days after the Outbreak Period ends on December 30, 2020 (i.e., by February 12, 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 or 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 **1-877-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 **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your state for more information on eligibility.

ALABAMA—Medicaid

Website: *http://myalhipp.com/*
Phone: 1-855-692-5447

ALASKA—Medicaid

The AK Health Insurance Premium Payment Program
Website: *http://myakhipp.com/*
Phone: 1-866-251-4861
Email: *CustomerService@MyAKHIPP.com*
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS—Medicaid

Website: *http://myarhipp.com/*
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA—Medicaid

Website: *https://dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx*
Phone: 916-440-5676

COLORADO—Medicaid

Health First Colorado Website: *https://www.healthfirstcolorado.com/*
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+: *Colorado.gov/pacific/hcpf/child-health-plan-plus*
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA—Medicaid

Website: *https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html*
Phone: 1-877-357-3268

GEORGIA—Medicaid

Website: *http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp*
Phone: 678–564-1162 ext.2131

INDIANA—Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: *http://www.in.gov/fssa/hip/*
Phone: 1-877-438-4479
All other Medicaid
Website: *https://www.in.gov/medicaid/*
Phone 1-800-457-4584

IOWA—Medicaid

Medicaid Website: *https://dhs.iowa.gov/ime/members*
Medicaid Phone: 1-800-338-8366
Hawki Website: *http://dhs.iowa.gov/Hawki*
Hawki Phone: 1-800-257-8563

KANSAS—Medicaid

Website: *http://www.kdheks.gov/hcf/default.htm*
Phone: 1-800-792-4884

KENTUCKY—Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: *https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx*
Phone: 1-855-459-6328
Email: *KIHIPP.PROGRAM@ky.gov*
KCHIP Website: *https://kidshealth.ky.gov/Page/index.aspx*
Phone: 1-877-524-4718
Kentucky Medicaid Website: *https://chfs.ky.gov*

LOUISIANA—Medicaid

Website: *www.medicaid.la.gov* or *www.ldh.la.gov/lahipp*
Phone: 1-888-342-6207 (Medicaid Hotline) or 1-855-618-5488 (LaHIPP)

MAINE—Medicaid

Website: *https://www.maine.gov/dhhs/ofi/applications-forms*
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS—Medicaid and CHIP

Website: *http://www.mass.gov/eohhs/gov/departments/masshealth/*
Phone: 1-800-862-4840

MINNESOTA—Medicaid

Website: *https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp*
Phone: 1-800-657-3739

MISSOURI—Medicaid

Website: *http://www.dss.mo.gov/mhd/participants/pages/hipp.htm*
Phone: 573-751-2005

MONTANA—Medicaid

Website: *http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP*
Phone: 1-800-694-3084

NEBRASKA—Medicaid

Website: *http://www.ACCESSNebraska.ne.gov*
Phone: 1-855-632-7633; Lincoln (402) 473-7000; Omaha (402) 595-1178

NEVADA—Medicaid

Website: *http://dhcfp.nv.gov/*
Phone: 1-800-992-0900

NEW HAMPSHIRE—Medicaid

Website: *https://www.dhhs.nh.gov/oii/hipp.htm*
Phone: 603-271-5218
HIPP program toll free number: 1-800-852-3345 ext.5218

NEW JERSEY—Medicaid

Website: *http://www.state.nj.us/humanservices/dmahs/clients/medicaid/*
Phone: 609-631-2392
CHIP Website: *http://www.njfamilycare.org/index.html*
CHIP Phone: 1-800-701-0710

NEW YORK—Medicaid

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

NORTH CAROLINA—Medicaid

Website: *https://medicaid.ncdhhs.gov/*
Phone: 919-855-4100

NORTH DAKOTA—Medicaid

Website: *http://www.nd.gov/dhs/services/medicalserv/medicaid/*
Phone: 1-844-854-4825

OKLAHOMA—Medicaid and CHIP

Website: *http://www.insureoklahoma.org*
Phone: 1-888-365-3742

OREGON—Medicaid

Website: *http://healthcare.oregon.gov/Pages/index.aspx*
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA—Medicaid

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

RHODE ISLAND—Medicaid

Website: *http://www.eohhs.ri.gov/*
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—Medicaid

Website: *https://www.scdhhs.gov*
Phone: 1-888-549-0820

SOUTH DAKOTA—Medicaid

Website: *https://www.scdhhs.gov*
Phone: 1-888-549-0820

TEXAS—Medicaid

Website: *http://gethipptexas.com/*
Phone: 1-800-440-0493

UTAH—Medicaid AND CHIP

Website: *https://medicaid.utah.gov*
CHIP Website: *http://health.utah.gov/chip*
Phone: 1-877-543-7669

VERMONT—Medicaid

Website: *https://www.greenmountaincare.org*
Phone: 1-800-250-8427

VIRGINIA—Medicaid

Website: *https://www.coverva.org/hipp*
Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON—Medicaid

Website: *https://www.hca.wa.gov/*
Phone: 1-800-562-3022

WEST VIRGINIA—Medicaid

Website: *http://mywvhipp.com*
Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN—Medicaid AND CHIP

Website: *https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm*
Phone: 1-800-362-3002

WYOMING—Medicaid

Website: *https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/*
Phone: 1-800-251-1269

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

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

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

Important Notice from Asahi Kasei 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 with Asahi KASEI 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. **Asahi KASEI has determined. that the prescription drug coverage offered by the Asahi KASEI America, Inc. Health & Welfare Benefits 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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Asahi KASEI coverage may be affected. For more information, please refer to the benefit plan's governing documents. If you do decide to join a Medicare drug plan and drop your current Asahi KASEI coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

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 Asahi KASEI and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if

you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Asahi KASEI 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).

SUMMARY ANNUAL REPORT

For Polypore International, LP Employee Welfare Benefits Plan

This is a summary of the annual report of the Polypore International, LP. Employee Welfare Benefits Plan, EIN 57-1006871, Plan No. 501, for the period January 01, 2019 through December 31, 2019. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Aetna Life Insurance Company, American Heritage Life Insurance Company, Federal Insurance Company, Sun Life Assurance Company of Canada and UnitedHealthcare Insurance Company to pay health, dental, vision, life insurance, long-term disability, prescription drug, cancer, business travel accident and accidental death & dismemberment claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2019 were $795,843.

Additional Plan Information

Polypore International, LP has also committed itself to pay certain self-funded health, dental, employee assistance plan, flexible spending account and prescription drug claims incurred under the terms of the plan.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call:

Human Resources Department of Polypore International, LP
11430 North Community House Road
Charlotte, NC 28277

Or by telephone at 704-587-8574. These portions of the report are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan

Human Resources Department of Polypore International, LP
11430 North Community House Road
Charlotte, NC 28277

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room
Room N-1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13)(PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the

U.S. Department of Labor
Office of the Chief Information Officer
Attention:Departmental Clearance Officer
200 Constitution Avenue, N.W.
Room N-1301
Washington, DC 20210

or email ***DOL_PRA_PUBLIC@dol.gov*** and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)

CONTACT INFORMATION

Asahi Kasei Benefits
13800 South Lakes Dr.
Charlotte, NC 28273

704-587-8882
asahi-benefits@ak-america.com

IMPORTANT BENEFITS CONTACT INFORMATION

- **Medical/Prescription**
  BlueCross BlueShield of North Carolina
  877-275-9787
  www.mybcbsnc.com
- **Dental**
  Delta Dental of North Carolina
  800-662-8856
  www.deltadentalnc.com
- **Vision**
  UnitedHealthcare
  800-638-3120
  www.myuhcvision.com
- **Life and Disability**
  Contact Local HR
- **Flexible Spending Account**
  Flores & Associates
  800-532-3327
  www.flores247.com
- **Cancer & Specified Disease Insurance**
  Allstate
  800-521-3535
  www.allstatebenefits.com/mybenefits
- **Employee Assistance Program (EAP)**
  Health Advocate
  877-240-6863
  www.healthadvocate.com
- **LegalShield**
  800-654-7757
  www.legalshield.com
- **IDShield**
  888-494-8519
  www.idshield.com

This Employee Benefits Overview is only intended to highlight some of the major benefit provisions of the Asahi Kasei Health and Welfare plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's Summary Plan Descriptions for further detail. Should this overview differ from the Summary Plan Descriptions, the Summary Plan Descriptions prevail.