AsahiKASEI

Asahi Kasei Americas

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 STD and 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, wellwoman care, mammograms, cancer screenings and PSAs are covered 100% by the plans per 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***

BENEFITS ELIGIBILITY

To be eligible for benefits, you must be an active full-time employee who works 30 or more hours per week. You are eligible to enroll in medical, dental, and vision benefits and elect supplemental life and AD&D on the first of the month following your date of hire. You are eligible to receive company provided basic life and AD&D insurance, short term disability benefits, and Long-Term disability coverage on your date of hire.

- 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, in accordance with North Carolina law, 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.

WHAT'S NEW FOR 2021?

- All employees will receive a new ID card from Blue Cross Blue Shield North America (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

MEDICAL PLAN OPTIONS

The company offers three group medical plan options for 2021: PPO Plan A , PPO Plan 2 and CDHP. The differences between these three plans are highlighted on the following pages.

MEDICAL PLAN OPTIONS

	PLAN 2		PLAN A		CDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible						
Individual	$100	$250	$750	$1,600	$1,400	$2,800
Family	$200	$500	$2,250	$3,200	$2,800*	$5,600*
Coinsurance OOP Maximum						
Individual	$400	$1,250	$2,250	$5,000	$1,250	$2,500
Family	$800	$2,500	$3,750	$15,000	$2,500	$5,000
True OPP Maximum						
Individual	$500	$1,500	$3,000	$6,600	$2,650	$5,300
Family	$1,000	$3,000	$6,000	$18,200	$5,300	$10,600
Services						
Primary Care Physician Office Visits (Internal Medicine, Family Practitioner, Pediatrician, OB/GYM)	100% after $20 co-pay	70% after deductible	100% after $25 co-pay	70% after deductible	80% after deductible	60% after deductible
Specialist Office Visits (Dermatologist, Orthopedic, etc.)	100% after $20 co-pay	70% after deductible	100% after $50 co-pay	70% after deductible	80% after deductible	60% after deductible
Teladoc® Consultation	100% after $5 co-pay		100% after $5 co-pay		80% after deductible	
Urgent Care	100% after $20 co-pay	70% after deductible	100% after $50 co-pay		80% after deductible	
Routine & Preventive Care	100%		100%		100%	
Other Physician Charges	90% after deductible	70% after deductible	85% after deductible	70% after deductible	80% after deductible	60% after deductible
Chiropractic Services	$20 co-pay	70% after deductible	80% of covered expenses, limited to 25 visits annually		80% of covered expenses, limited to 25 visits annually	
Hospital Facility Charges						
Inpatient	90% after deductible	70% after deductible	85% after deductible	70% after deductible	80% after deductible	60% after deductible
Outpatient	90% after deductible	70% after deductible	85% after deductible	70% after deductible	80% after deductible	60% after deductible
Outpatient X-Rays/Lab	90% after deductible	70% after deductible	85% after deductible	70% after deductible	80% after deductible	60% after deductible
Emergency Room	$50 co-pay		100% after $150 co-pay on first visit, 100% after $300 co-pay on additional visits (co-pay waived if admitted)		80% after deductible	
Prescription Drugs						
Retail Pharmacy - 30 Days						
Tier 1	$10 co-pay		$10 co-pay		80% after deductible	
Tier 2	$20 co-pay		$35 co-pay		80% after deductible	
Tier 3	$40 co-pay		$45 co-pay		80% after deductible	
Tier 4 (Specialty)	$40 co-pay		$50 co-pay		80% after deductible	
Mail Order - 90 Days						
Tier 1	$10 co-pay		$25 co-pay		80% after deductible	
Tier 2	$20 co-pay		$87.50 co-pay		80% after deductible	
Tier 3	$40 co-pay		$112.50 co-pay		80% after deductible	
Tier 4 (Specialty)	$40 co-pay**		$50 co-pay**		80% after deductible**	
Plan Lifetime Maximum						
Lifetime Maximum	Unlimited		Unlimited		Unlimited	

*The CDHP plan does not pay for anyone in the family until the Family Deductible has been met
**30 day supply maximum

TELADOC®

Your Blue Cross and Blue Shield of North Carolina (Blue Cross NC) health plan includes telehealth services from Teladoc®. It's a good option for minor health problems. Plus, it's often more convenient (avoids waiting rooms) and cost effective than urgent care.

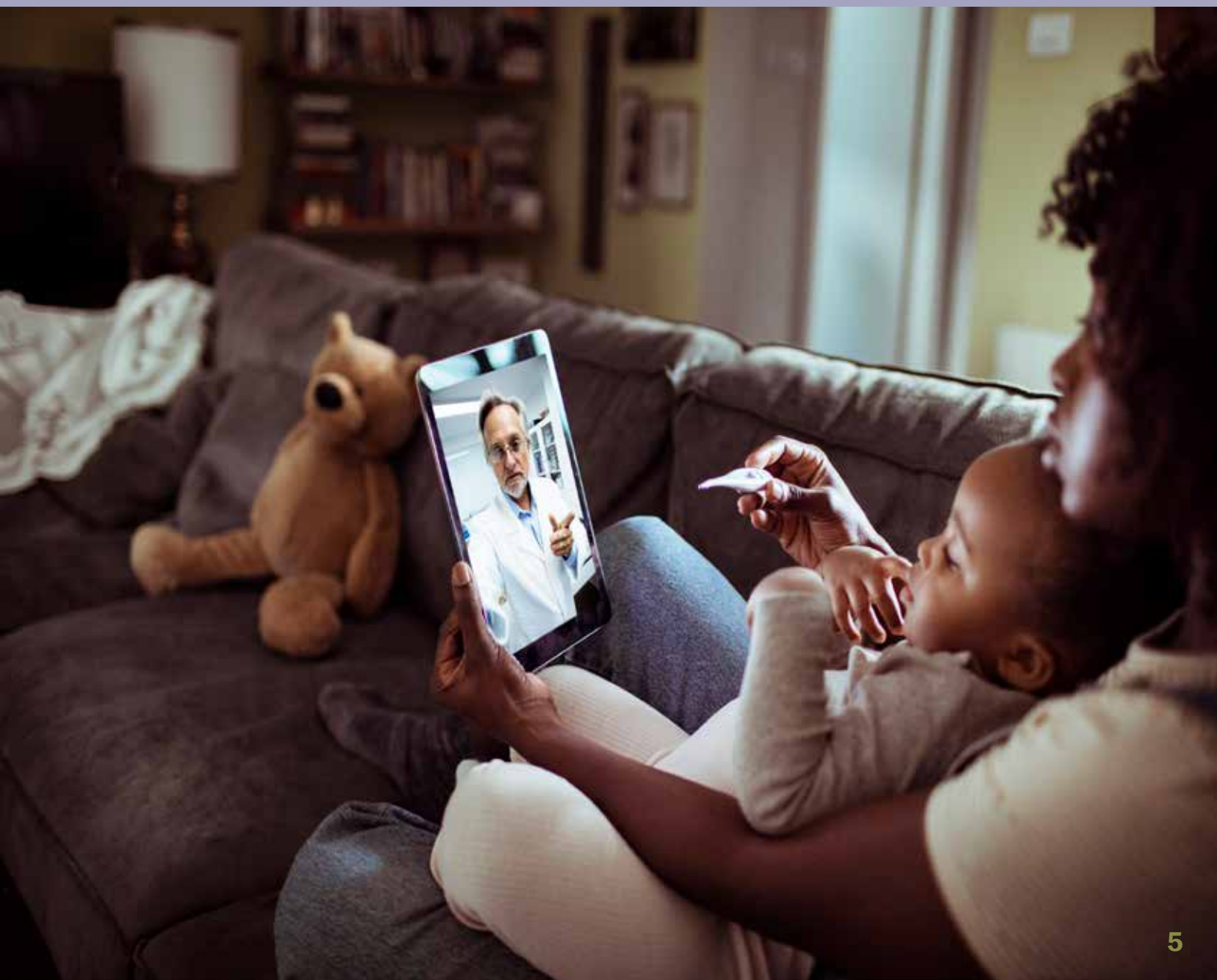
There are three ways to activate: mobile app, online or by phone. Once your account is set up, you can request a telephonic or video-based visit 24/7/365 with a board-certified doctor. Teladoc's doctors can diagnose symptoms, prescribe non-narcotic medication and send prescriptions to your pharmacy. Teladoc® also handles many non-emergency health problems including behavioral health.

To find a doctor, go to *www.teladoc.com* and check "Set Up an Account" or call 1-800-805-2362.

There's an app for that!
Search "Teladoc®"

Teladoc® doctors can treat many conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Sore throat
- Respiratory infection
- Skin problems and more!



HEALTH SAVINGS ACCOUNTS

Employees who enroll in the CDHP Option are eligible to contribute on a pre-tax basis to a Health Savings Account (HSA). In 2021, the company's contributions will be made each pay period and will match an employee contribution up to $500 per year for employee only coverage and up to $1,000 per year for family coverage.

In addition, you may make pre-tax employee contributions to your HSA account provided that the total of yours and the company's contributions in 2021 do not exceed:

- $3,600 annually* for employee only coverage; and
- $7,200 annually* for employee plus one or more dependents coverage

* Persons age 55 or older may make additional "catch-up" contributions of $1,000 in 2021.

Your pre-tax HSA contributions are made through payroll deductions in equal installments throughout the year; however, they are not subject to the Section 125 rules regarding midyear changes. This means you may change your HSA payroll deduction amount during the year without a valid change in family status. You may use your HSA funds to pay for medical, dental and vision care out-of-pocket expenses. You will receive a debit card to facilitate these payments. A complete list of expenses eligible for payment/ reimbursement from an HSA account may be found in IRS Publication 502 at www.irs.gov/

There's an app for that!
Search "Health Equity"

You are not eligible for an HSA if

- You are covered by another health care plan that is not HSA compliant, including an FSA, Medicare or PPO plan
- If you can be claimed as a dependent on someone else's tax return
- Are enrolled in a Health FSA with a balance greater than $0

Unused HSA funds accumulate from year-to-year and the account remains yours – even if you change employers or retire. As long as you use your HSA funds for qualified medical expenses, you pay no taxes. You do not have to be enrolled in a "high deductible" CDHP plan to use your HSA funds; only to be eligible to contribute to the HSA. Non-qualified HSA distributions are taxable and subject to a 20% penalty. After age 65 the penalty no longer applies; however, non-qualified distributions are still taxable after age 65.

HSA funds are not available to you until they are in your HSA account. This is different from a medical FSA account where the entire amount of your medical FSA annual contribution is available to you after January 1st even though the payroll deductions have not yet been made.

There's an app for that!
Search "Delta Dental"

DENTAL PLAN

As a Delta Dental PPO plus Premier member, you may see any dentist you like. However, there are advantages to choosing a dentist who belongs to the Delta Dental or Delta Dental Premier Network.

	2021 Bi-weekly Employee Contributions	Annual Deductible**
Employee	$4.43	$50.00
Employee + Child(ren)	$8.28	$150.00
Employee + Spouse	$9.74	$100.00
Family	$14.90	$150.00

	In-Network	Out-of-Network*
Diagnostic and Preventive Services (exams, cleanings, fluoride, sealants, X-rays, periodontal maintenance, etc.)	100%	100%
Basic Services (fillings, crowns, root canals, periodontal gum services, oral surgery, etc.)	80%	80%
Major Services (bridges and dentures)	80%	80%
Orthodontic Services (up to age 19)	50%	50%
Orthodontic Lifetime Maximum Per Individual	$1,500	$1,500
Dental Annual Maximum Per Individual	$1,500	$1,500

Family deductible is inclusive of all enrolled family members.
*If you visit a dentist that does not participate in the network, you may be balanced billed for amounts exceeding the approved payment amount. This can result in out-of-pocket costs.
**The deductible amount is exclusive of routine/preventive care, which is covered at 100%. You need only meet the deductible amount for charges that fall outside routine/preventive care.

To find a dentist, call Delta Dental at 1-800-662-8856 or search the PPO or Premier networks online at *www.deltadentalnc.com/findadentist*.

VISION PLAN

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

The company vision plan provides coverage for vision care expenses such as eye exams, lenses, and frames.

The vision plan is administered separately through United Healthcare (UHC). You should use providers that participate with UHC in order to receive the maximum benefit. However, you may use other providers and file with UHC for reimbursement.

VISION PLAN BI-WEEKLY CONTRIBUTIONS	
Employee	$0.54
Family	$1.50
CO-PAYS/ALLOWANCES*	
Exam	$10.00
Single Vision Eyeglasses*	$30.00
Contact Lens Fitting & Materials (in lieu of eyeglasses)*	$105.00 allowance
REIMBURSEMENT FOR OUT-OF-NETWORK PROVIDER*	
Exam	up to $42.00
Single Vision Lenses	up to $29.00
Bi-focal Lenses	up to $39.00
Tri-focal Lenses	up to $48.00
Frames	up to $37.00
Contact Lenses	up to $73.00

*one time per calendar year

To be reimbursed for out-of-network provider charges, you will need to complete the out-of-network claim form and send to:

UnitedHealthcare Vision
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
Fax: 248-733-6060

To find an in-network provider in your area, go to *www.myuhcvision.com* or call 1-800-638-3120.

BASIC LIFE AND AD&D INSURANCE

Life insurance offers important financial protection for you and your loved ones. The company automatically provides AND pays the cost of basic life insurance and accidental death and dismemberment (AD&D) coverage, through Lincoln, equal to the lesser of: Two times your basic yearly earnings or $750,000. Your amount of Basic Life and AD&D Insurance reduces to 65% when you reach age 70 and to 50% at age 75.

There's an app for that!
Search "Lincoln"

Life insurance in excess of $50,000 will result in non-wage compensation being added to your W-2. You will pay taxes on this and it is referred to as imputed income.

SHORT-TERM DISABILITY

Eligibility

As a regular full-time employee of the company, you are eligible for Short-Term Disability benefits through the salary continuation program beginning on the date you are hired. 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 the material 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 through the salary continuation program.

When Benefits Begin

You must be disabled due to an injury or illness for seven (7) calendar days before benefits will begin. This is known as the elimination period.

Benefit Amount and Time Period

If you are unable to perform at least one of the material duties pertaining to your regular job on a part-time or full-time basis, you are under the regular care of a doctor, and you are unable to generate weekly earnings which exceed 80% of your weekly earnings due to that same injury or sickness, you are deemed disabled. A disability resulting in the inability to generate current earnings greater than 20% of your weekly earnings, less other income benefits, your weekly benefit will be the lesser of 66 2/3% of your weekly earnings, less other income benefits, or the maximum weekly benefit. The maximum weekly benefit is $2,500, less any other income benefits. If you are disabled and able to generate current earnings that equal between 20%

and 80% of your weekly earnings, the weekly benefit will be the weekly benefit payable while disabled, unless the sum of

- The gross weekly benefit while you are disabled, plus
- Other income benefits you receive or are eligible to receive, plus
- Current earnings while you are disabled exceeds 100% of your weekly earnings. If this sum exceeds 100% of your weekly earnings, the weekly benefit will be reduced by the excess amount

Benefits can continue for up to 26 weeks (which includes the 7-day elimination period) or until Long-Term Disability benefits begin. Payments are taxable wages and paid by the company on your normal payroll schedule. All deductions will continue to be taken from your STD payments.

REMINDER

Have you updated your beneficiaries?

If Your Disability Occurs Again

A recurrent disability will be treated as part of your prior claim and you will not be required to satisfy another elimination period if:

(a) You were continuously covered under the plan for the period between your prior claim and your recurrent disability; and
(b) Your recurrent disability occurs within 180 days of the end of your prior claim.

Total Benefits Payable

Short-Term Disability benefits are payable at 66 2/3% of your weekly salary, up to a maximum of $2,500 per week, for a maximum of 26 weeks or until Long-Term Disability begins. However, you must be under the direct care of a physician, who may periodically be required to certify that you continue to be disabled. The direct care starts when the physician examines you. A physician is a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC); a licensed doctoral clinical psychologist; or where required by law, any other licensed practitioner who is acting within the scope of his/her license. A physician does not include you, a person who lives with you or is part of your family (your spouse; or a child, brother, sister, or parent of you or your spouse).

You may be eligible for other benefits, such as maternity leave, state mandated disability benefits and/or salary continuation. Please check with the benefits team prior to beginning any leave of absence for additional details.

If Disability Continues Beyond 6 Months

If your disability continues beyond the period for which Short-Term Disability benefits are payable, you may qualify for Long-Term Disability benefits.

Other income benefits include any amounts under Worker's Compensation, Social Security, unemployment, state-mandated disability benefits, third party recoveries by judgement, settlement, or otherwise, and other offsets. Contact the benefits team for specific details.

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 and is paid by the company.

The monthly benefit is equal to 66 2/3% of your monthly base salary to a maximum monthly benefit of $12,500. Benefits begin after you have been totally disabled for 180 consecutive days and may continue until age 65 if you are determined to be totally disabled by Lincoln based on the plan's definition. Completed forms should be returned to Lincoln Financial Group as they review and approve claims. If you supply all of the necessary information, your benefits payments can be processed in a timely manner.

Benefits may be reduced by other sources of income and disability earnings.

Taxability

Because LTD benefit payments are tax-free should you ever need them, the Internal Revenue Service (IRS) requires that you be taxed on the LTD premium amount (the amount that the company pays to Lincoln Financial Group for your LTD coverage) at your normal tax rate. This is similar to the imputed income that each employee pays for the company-paid life insurance. Not applicable to employees eligible for the IDI program.

SUPPLEMENTAL LIFE/AD&D

You may choose to purchase supplemental term life insurance, provided by Lincoln and have the premium payroll deducted. You can purchase increments of $25,000 up to a maximum of 5x your annual base pay. However, the overall maximum coverage amount for supplemental and your company provided life insurance may not exceed $750,000.

Evidence of Insurability (EOI) is required if you are newly electing coverage. If you have coverage currently in force, any increase in excess of one level will be subject to EOI. Lincoln will review your complete EOI application and notify you of approval. Coverage will not go into effect and deductions will not be taken for any amounts that require EOI until approved by Lincoln.

INSURED PARTICIPANT'S AGE	MONTHLY RATE FOR EACH $1,000 IN COVERAGE
Under 25	0.076
25 – 29	0.076
30 – 34	0.086
35 – 39	0.103
40 – 44	0.167
45 – 49	0.247
50 – 54	0.423
55 – 59	0.744
60 – 64	0.805
65 – 69	1.270
70 – 79*	2.060
80+	2.060**
Child Rate	$0.20 per $1,000.00

*Benefits reduce by 65% at age 70 and by 50% at 75.
**Not applicable to spouses

- Divide your election amount by 1,000
- Multiply the result by the rate in the chart based on your age
- This is your monthly cost. Final deduction amounts may vary based on rounding

LIFE INSURANCE FOR SPOUSE

You may choose to purchase Lincoln's dependent life insurance for your spouse and have the premium payroll deducted. You must elect coverage for yourself in order to elect coverage for your spouse and/or child(ren). This applies to both voluntary life and AD&D plans. You are automatically the beneficiary of this coverage.

If your spouse is newly electing coverage or is electing to increase his/her current benefit amount by more than one level, he/she will need to complete an EOI application online via the link in Workday. Lincoln will review your completed EOI application and notify your of approval. Coverage will not go into effect and deductions will not be taken for any amounts that require EOI until approved by Lincoln.

Evidence of Insurability is now completed online through the Lincoln Financial portal which you can access via link in Workday. When completing the online EOI form, you will need to enter the employer code as ASAHIKASEI.

LIFE INSURANCE FOR CHILDREN

You may choose to purchase Lincoln's dependent life insurance for your children, and have the premium payroll deducted. Increments of $10,000 up to $50,000 may be purchased for 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.

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 which 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 as follows:

EMPLOYEE ONLY COVERAGE				
Increments of $50,000 to a maximum of $500,000 at a cost of $0.03/$1,000				
FAMILY COVERAGE at a cost of $0.048/$1,000				
$50,000 employee $25,000 spouse $5,000 child	$100,000 employee $50,000 spouse $10,000 child	$150,000 employee $75,000 spouse $15,000 child	$200,000 employee $100,000 spouse $20,000 child	$250,000 employee $125,000 spouse $25,000 child
$300,000 employee $150,000 spouse $30,000 child	$350,000 employee $175,000 spouse $35,000 child	$400,000 employee $200,000 spouse $40,000 child	$450,000 employee $225,000 spouse $45,000 child	$500,000 employee $250,000 spouse $50,000 child

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

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*.

HEALTH ADVOCATE

There's an app for that!
Search "Health Advocate"

Health Advocate offers you access to health care experts who provide personalized support to help you navigate the health care system and insurance-related issues at no cost to you or your family. You, your spouse/domestic partner, your child/ren, parents and parents-in-law can contact Health Advocate.

What issues can Health Advocate assist with?

- Finding the right medical provider
- Expediting appointments
- Research complex medical conditions and locating the latest treatment options
- Coordinate care and schedule follow-up visits
- Arranging specialized treatments and medication
- Providing procedure cost estimates
- Identifying gaps in care
- Personal nurse contact
- Web-based health information and decision support
- Insurance claims resolution service
- Locating eldercare

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP), provided by Health Advocate, is a confidential program designed to assist you and your immediate family members. EAP can assist you in resolving any concerns that are affecting your personal or work lives such as mental health issues, finances, parenting, work-life balance, stress and aging parents.

There is no charge to you or your family for using this confidential program. If you choose to use any referrals to additional resources, those charges, if any, would be your responsibility and may be covered under your medical plan.

Under EAP, you can receive:

- Up to five face-to-face counseling sessions with EAP network providers
- Referrals to community services
- Online access to an extensive library of articles and tip sheets on various topics as well as audio and video clips

Contact Health Advocate by calling 866-799-2728, visit *www.healthadvocate.com/members* or email *answers@healthadvocate.com*.

LEGALSHIELD AND IDSHIELD

LegalShield

This benefit is specifically designed to meet the legal needs encountered by employees and their families. Plan benefits provide preventive legal care to help keep legal problems from becoming serious or financially devastating. Some common legal issues they can help with include tragic accidents, tenant/landlord issues, debt collection, bankruptcy, DUI/DWI, IRS audits, child support, custody/visitation, foreclosure and wills. To enroll your eligible dependents in LegalShield, visit Workday.

IDShield

Covering all areas of identify theft, criminal and financial, this also provides credit reports with analysis and scores for member and spouse/domestic partner, continuous monitoring with activity alerts and full identity restoration with a licensed investigator through Kroll.

WHAT ARE MY BI-WEEKLY ENROLLMENT OPTIONS	
LegalShield only	$7.36
LegalShield and IDShield	$12.42
LegalShield and IDShield + minors	$12.42
IDShield only	$5.98
IDShield (family) only	$6.44
NY Resident: LegalShield only	$6.44
NY Resident: LegalShield and IDShield	$11.03
NY Resident: LegalShield and IDShield + minors	$11.49

NOTE: LEGAL SHIELD AND IDENTITY THEFT WILL NOT COVER ISSUES THAT BEGAN PRIOR TO YOUR EFFECTIVE DATE OF COVERAGE

There's an app for that!
Search "LegalShield" and "IDShield"

What services does the LegalShield benefit provide?

- Business or personal 24/7 emergency assistance
- After-hours legal consultation for covered legal emergencies
- Letters and phone calls on your behalf available at the discretion of your provided lawyer
- Legal document/contract review (up to 10 pages each)
- Standard will preparation with yearly reviews/ updates with Living Will, Health Care Power of Attorney
- Moving traffic violations (available 15 days after enrollment)
- Accidents: Defense for charges of manslaughter, negligent homicide or vehicular homicide
- IRS audit services - One hour of consultation, advice or assistance when you are notified of an audit by the IRS
- Trial defense assistance if you or your spouse is named in a covered civil or job-related criminal action filed in court
- 25% off additional legal services

The LegalShield benefit covers you, your spouse or domestic partner, your never-married children under age 21 who are living in your home, your never-married children under age 18 for whom you are the legal guardian, your never-married full-time college students up to age 23 who are dependent on you, and children who are physically or mentally challenged and who live in your home.

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.

HSA (HEALTH SAVINGS ACCOUNT)
Available only to employees who enroll in the CDHP plan. HSA is an account allowing you to save for future medical costs. Funds may accumulate year to year and not subject to federal income tax when deposited.

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.

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 23 for more details. If you disclose medical information or undergo a medical service as part of Asahi's wellness program, please see pages 19-20 for more details.

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.

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% of 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.

Voluntary Wellness Initiatives

The Plan Administrator, at its sole discretion, may implement certain wellness initiatives and rewards for you and your family members to encourage and promote health and/or prevent disease. Additional information about the wellness program (including a description of any medical information that is being obtained as part of the program, how it will be used, who will receive it and the restrictions on disclosure) will be provided to you. If you fail to timely complete the enrollment process, you may not be eligible for the wellness program, including the rewards, for that Plan Year. If you fail to timely satisfy any requirements of the wellness program, you may forfeit the right to continue your participation in and/or receive any available rewards under the wellness program for the remainder of the Plan Year. **If you reasonably believe you are unable to participate in any wellness initiative, please contact the Plan Administrator as reasonable alternative standards or goals to achieve a reward may be available to you under the wellness program.**

ADA/EEOC Wellness Program

Certain employee groups covered under the Plan are eligible for voluntary wellness incentive program. The program is administered in accordance with federal rules for employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you are employed in a group that is offered the program and you voluntarily choose to participate in the program, you will be asked to complete biometric screening, which includes a blood test for heart disease, infection, kidney and liver disorders, anemia, bone, blood and muscle disease (including certain types of cancer) and other health issues such as diabetes or high cholesterol.

You are not required to participate in the wellness program (e.g. you can decide not to complete the biometric screening). However, if you choose to participate in the wellness program, you may be eligible for reduced premium costs for your coverage under the Plan. If you fail to timely complete the biometric screening process, you will not be eligible for the wellness program rewards, for that Plan Year.

The medical information collected will be used to provide you

with information to help you understand your current health and potential risks, and also may be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

The employer is required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the employer may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and 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. Anyone who receivesmyour information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only entity that will receive your personally identifiable health information under the wellness program is the third party administrator for the biometric screening and wellness program, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections againstndiscrimination and retaliation, please contact the Plan Administrator (see the cover page for contact information).

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 begain 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

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

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

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 Asahi Kasei North America Health & Welfare Benefits Plan

This is a summary of the annual report for the Asahi Kasei North America Health & Welfare Benefits Plan, EIN 38-1842563, Plan No. 502, for the period of January 1, 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 Pre-Paid Legal Services Inc. dba LegalShield, Provident Life and Accident Insurance Company, and Reliastar Life Insurance Company to pay life insurance, long-term disability, prepaid legal plan, disability 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 $467,235.

Additional Plan Information

Asahi Kasei Plastics North American, Inc. has also committed itself to pay certain self-funded medical, dental, vision, 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 Asahi Kasei Plastics North America, Inc.
900 E Van Riper
Fowlerville, MI 48836-7936

Or by telephone at 517-223-2000. 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

Asahi Kasei Plastics North America, Inc.
900 E Van Riper
Fowlerville, MI 48836-7936

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

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
11430 North Community House Road
Suite 350
Charlotte, NC 28277

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**
  Lincoln Financial Group
  Disability Leave & Intake Line: 888-408-7300
  www.mylincolnportal.com
- **Health Spending Account**
  Health Equity
  866-346-5800
  www.healthequity.com
- **Flexible Spending Account**
  Flores & Associates
  800-532-3327
  www.flores247.com
- **Health Advocate and EAP**
  Health Advocate
  866-799-2728
  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 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.