AsahiKASEI

2024 BENEFIT GUIDE

benefits to help you *GROW*

Welcome to Your 2024 Benefits!

The Asahi Kasei benefits and offerings are designed to protect you and your family's health – both physical and financial – so that you can enjoy the greatest benefit of all, which is peace of mind.

We encourage you to read this Benefit Guide carefully so that you understand the variety of options that are available to you. Use it as a reference tool throughout the year.

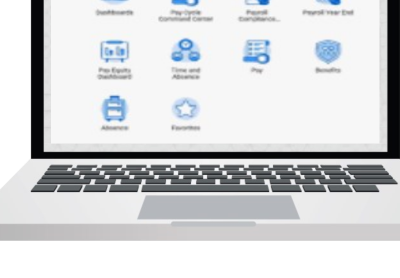
The information in this Guide applies to the Asahi Kasei Health and Welfare Plan, plan number 501. This meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

The benefit enrollment communications (the Benefit Guide, the 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 herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Asahi Kasei reserves the right to amend, modify or terminate any plan at any time and in any manner.

How to Enroll	2
Benefit Basics	3
Medical Plans and Health Savings Account (HSA)	4
Medical Plan Comparison Chart	7
Teladoc Telemedicine and Health Advocate Advocacy Services	9
Dental	10
Vision	11
Flexible Spending Accounts (FSA)	12
Life and AD&D Insurance	14
Disability	15
EAP and Legal Shield/ID Shield	17
401(k) Retirement Plan	18
Benefit Contacts	19

How to Enroll

Enrollment for benefits is through Workday, our Human Resources Information System (HRIS). The site is available 24/7. https://wd5.myworkday.com/wday/authgwy/akamerica/login.htmld All employees will receive an action item in their Workday inbox asking them to complete enrollment. Detailed information about our benefits can be found at www.akusbenefits.com



- Upon logging in to Workday, all employees will see an inbox task to enroll in benefits.
- To enroll in benefits or waive a coverage select Manage or Enroll in the applicable benefit "box" on the main screen.
- Once you select Manage/Enroll on the main screen, you will advance to the applicable benefit screen where you can enter elections.
- Once you have entered them, select Confirm and Continue.
- On the following screen, you can enter new dependents or remove existing dependents from the coverage.
- To add, select Add New Dependent.
- To remove, unselect the check box on the applicable dependent.
- Once you are finished, click Save and you will be taken back to the main screen.
- You are required to complete all fields marked with an asterisk(*).
- Once you are finished with your enrollments, you will be taken to your enrollment summary page. Please review carefully! Once you've reviewed and are ready to submit your enrollments, you must review the legal notice at the bottom of the page and select the "I agree" check box. Then select Submit.

WORKDAY MOBILE APP

You can now complete your enrollment from your mobile device! Download the Workday mobile app from the App Store today! Access Code: **akamerica** Once you **Submit** your enrollment, it provides a confirmation screen that you have the option to print for your records.

AS YOU ENROLL, DON'T FORGET THE FOLLOWING:

- Confirm your personal information is correct, including your legal name and Social Security number as stated on your Social Security Card (contact the Benefits Team if there are any changes).
- Make sure all of your dependents have their legal name, Social Security number and birth date listed; you may be required to provide back up documentation when adding a new dependent (e.g., marriage license for a spouse or birth certificate for a child).
- Go through each benefit option, making sure you either elect or waive the coverage.
- Thoroughly review your elections; all payroll deductions for benefits are listed in Workday.
- Be sure to SUMBIT your enrollment so your elections are saved in Workday.
- Print and save the confirmation statement at the end for your files.

If you have any questions about your benefits, email the Benefits Team at asahi-benefits@ak-america.com.

Benefit Basics

Eligibility

All regular employees averaging 30 or more hours per week are eligible for benefits.

If you elect coverage, your dependents are also eligible for medical, dental, vision, and voluntary life and AD&D insurance coverage. Eligible dependents include:

- Your legal spouse
- Your legal child(ren). Child includes your natural, adopted child(ren), stepchild(ren), or any child for whom you have legal custody. Eligible children include:
  - Your children up to age 26; and
  - Your mentally or physically disabled children of any age if they rely on you for support and became disabled before age 26.

When Coverage Begins

Coverage for Basic Life/AD&D, Short Term Disability, and Long Term Disability will begin on your date of hire. All other benefits begin on the first day of the month following your date of hire, or the date of the event if a qualified status change has occurred.

When Coverage Ends

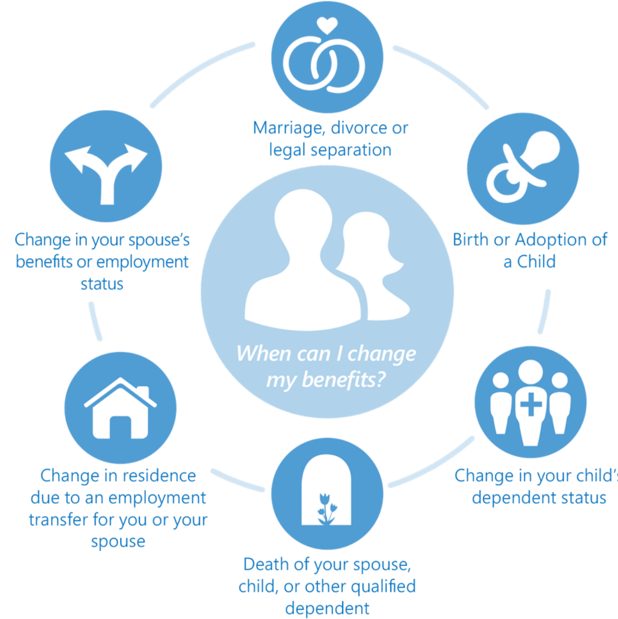
Coverage for you and your dependents terminates on your last day of employment. If your dependent has reached the maximum age, coverage ends on the last day of the month they reach age 26. If you enroll an ineligible dependent on the Plan you may be subject to disciplinary steps up to and including termination. In addition, you may be held financially responsible for ineligible claims and administrative fees paid by the Plan.

When You Can Change Coverage

Your benefit elections will be in effect for the entire Plan Year. You may only change your benefit elections during the Plan Year if you have a qualified change in status as defined by the Internal Revenue Code, and as allowed by the underlying health insurance plan.

Change in status events include those listed in the diagram below as well as:

- Being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Gain or loss of other coverage.



To make coverage changes due to these events, you must notify the Benefits Team:

- Within 30 days of a change in status event
- Within 60 days of the loss of Medicaid or CHIP coverage
- Within 60 days of when premium assistance under Medicaid or CHIP is determined.

If you do not notify the Benefits Team within the specified timeframe, you must wait until the next annual enrollment period to make a change.

Changes in coverage must be due to an eligible event and be consistent with the event. For example, if you have a new baby, you can elect coverage that includes the baby.

Medical Plans

You have four medical plan options: the Basic PPO Plan, the Core PPO Plan, the Enhanced PPO Plan, and the High Deductible Health Plan (HDHP) with Health Savings Account (HSA) administered by Blue Cross Blue Shield of North Carolina (BCBS NC). It's important to review your medical plan options each year to choose the right one for you and your family. While the plans are similar in some ways, each has its own features when it comes to how much you pay out-of-pocket for medical and prescription expenses. It's important to review the medical plan comparison chart to see how each plan covers different types of services.

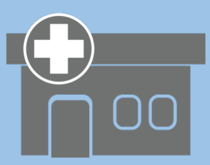
How the PPO Plans Work

- "PPO" stands for Preferred Provider Organization, where providers join together to form a network that offers discounted services to members.
- You don't need a referral—you can see any provider you want to see, even a specialist. There's a lot of freedom with a PPO plan.
- You can go outside of the BCBS NC network to see non-PPO providers, but your benefits will be reduced and you'll pay more out-of-pocket.
- To find BCBS NC PPO providers, go to www.blueconnectnc.com
- Important Notice: All In-Network providers in North Carolina and some outside North Carolina are responsible for requesting PRIOR REVIEW and receive CERTIFICATION when necessary. This is required for all inpatient services such as hospitalization, surgery, and other services such as mental health or substance abuse treatment, home health care, skilled nursing care, durable medical equipment, and hospice services. Out-of-Network providers are not obligated to request PRIOR REVIEW, which means you are responsible for ensuring that you or your out-of-network provider requests PRIOR REVIEW and receives CERTIFICATION when necessary by BCBS NC. Failure to request PRIOR REVIEW and receive CERTIFCATION will result in a financial penalty. See the "Utilization Management" section of your BCBS NC booklet for details. Contact Customer Service at BCBS NC with questions if you have a specific medical procedure or service scheduled.

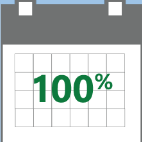
Here's How the PPO Plans Work:

You pay nothing for eligible in-network preventive care.

For certain in-network health care services you pay only a copay and that's it! The copay applies toward your out-of-pocket maximum, but does not apply toward your deductible.



For in-network services, once you meet the deductible, the plan will pay 80% (Basic PPO) 85% (Core PPO) or 90% (Enhanced PPO) coinsurance.



If your out-of-pocket costs reach the annual maximum, the plan pays 100% for eligible care the remainder of the plan year.

Medical Plans

How the HDHP with Health Savings Account (HSA) Works

The High Deductible Health Plan (HDHP) with HSA is designed to give you more control over your medical expenses while saving for future expenses. This type of plan has higher deductibles and no copays for services or prescription drugs, so all coverage is subject to deductible and coinsurance. However, the cost to enroll in the plan (employee payroll deductions) is less expensive, such that any cost savings can be re-directed to the HSA to save for qualified medical expenses.

- Under the HDHP with HSA Plan, you pay out-of-pocket for most of your healthcare costs until you reach your deductible. After you reach your deductible, coinsurance kicks in and the plan begins to pay a portion of your costs until you reach your out-of-pocket maximum. Preventive care services are always covered 100%, even if you have not met your deductible.
- Like the PPO plan, you don't need a referral—you can see any provider you want to see, even a specialist.
- You can go outside of the BCBS NC network to see non-participating providers, but your benefits will be reduced and you'll pay more out-of-pocket. (Also see Important Notice on page 4.)
- To find BCBS NC HDHP providers in North Carolina, go to www.blueconnectnc.com

What is a Health Savings Account?

A Health Savings Account (HSA) is a private savings account. You make tax-free contributions to the account and use it to pay for qualified medical, dental and vision expenses for you, your spouse, and for dependents you claim on your tax return. The money is not taxed as long as it is used for qualified expenses.

- You are considered eligible to contribute only if you:
  - ⇒Are covered under the qualified high deductible health plan (the BCBS NC HDHP with HSA is qualified)
  - ⇒Have no other health coverage under a non-qualified medical plan (such as a PPO)
  - ⇒May not be claimed as a dependent on another person's tax return
  - ⇒Are not currently enrolled in Medicare, Medicaid or TRICARE.*
  - ⇒Are not enrolled in a healthcare Flexible Spending Account. Ot general Health Reimbursement Arrangement. You must spend down your current FSA balance to $0 by December 31 to begin contributing to an HSA the following January 1st.
  - ⇒You are not a nonresident alien and have an ITIN and residential US address, and
  - ⇒You are not covered by another country's comprehensive national health care plan.
- You make contributions to your HSA with pre-tax dollars through payroll deduction. You may contribute up to the IRS maximum each year. The maximums for 2024 are $4,150 for single coverage and $8,300 for family coverage. Individuals age 55+ may make an additional $1,000 catch-up contribution.
- You may change your HSA contributions at any time.
- In addition to your contributions, Asahi Kasei will match your contribution up to $500 for single coverage and $1,000 for family coverage. The match is made each pay period.
- HealthEquity, through BCBS NC, is our HSA administrator. They keep track of your HSA balance, offer investment options and provide other important administration services.

*Veterans who seek medical care through VA services for service-connected disabilities and veterans with a disability rating from the VA are eligible to make or receive HSA contributions, as long as they are enrolled in a qualifying HDHP. Otherwise, you cannot make contributions to your HSA within 3 months of receiving medical care through the VA.

KEY ADVANTAGES OF AN HSA

Use your HSA to pay for eligible medical expenses including deductibles, co-insurance, prescriptions, vision, and dental care.

Unused funds will roll over year to year. There's no "use it or lose it" penalty. You may change your HSA contributions at any time.

Build more savings through investing. Choose from a variety of self-directed investment option with no minimum balance required.

After age 65, funds can be withdrawn for any purpose without penalty, but may be subject to income tax if not used for IRS-qualified medical expenses.

Learn more about your Health Savings Account by visiting HealthEquity's website at www.healthequity.com

IMPORTANT!

HSA contributions are not allowed once you become eligible and enroll in Medicare. If you enroll in Medicare Part A anytime after your initial Enrollment Period, your Medicare Part A coverage will start 6 months back from the date you apply for Medicare, but no earlier than the first of the month you were eligible for Medicare. To avoid a tax penalty, you should stop contributing to your HSA at least 6 months before you apply for Medicare.

- Once your HSA account is opened,

Medical Plans

Prescription Drugs

To be eligible for prescription drug coverage, you must elect to participate in one of the medical plan options.

Medications are categorized in a *formulary*. A formulary is a list of prescription medications covered by the plan. Drugs may be included on the formulary, based on their effectiveness, safety, and cost. BCBS NC evaluates the formulary quarterly, so you may notice changes to the medications that are covered and/or the tier under which they are covered.

IS THERE A PHARMACY NETWORK?

Yes. With BCBS NC, you have access to a wide network of pharmacies. Nearly every "chain" pharmacy is in the network (CVS, Rite-Aid, Walgreens and Walmart). You can also search for participating pharmacies online at www.blueconnectnc.com

WHAT ARE SPECIALTY DRUGS?

Specialty drugs are medications used to treat complex conditions, such as multiple sclerosis or rheumatoid arthritis, generally in the form of an injectable drug. These medications must be filled at the mail order specialty pharmacy Accredo by calling 1-833-599-0513 or visiting www.accredo.com/BCNC to set up your account. You will need your BCBS NC Member ID Card and information about your prescription and the doctor who prescribed it. Accredo will help you schedule your first delivery and ship your medication and covered supplies via next-day delivery anywhere you choose in the United States.

ARE THERE RESTRICTIONS ON CERTAIN MEDICATIONS?

Yes. There are limits and restrictions on the plan. Not all prescription drugs will be covered and some are excluded.

QUANTITY LIMITS

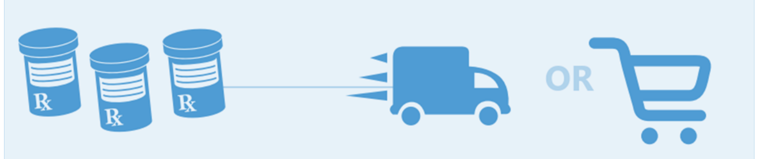
Some medications are subject to quantity limits, meaning there is a limit of how many pills you can receive in a month. You will need to work with your doctor if you think you need more than the set amount. Your doctor will need to submit a reason for medical necessity in writing to BCBS NC for approval.

PRIOR AUTHORIZATION/STEP THERAPY

Some drugs require that certain criteria must be met before coverage is provided. These drugs are typically not covered unless your physician and BCBS NC agree that the drug is medically necessary and that an alternative medication would be harmful to your health or ineffective. Please locate your medication on the BCBS NC formulary. If the drug is flagged as needing Prior Authorization or Step Therapy, you will need to reach out to your physician to take the necessary steps to have your medication covered by the Plan. *Your physician must provide BCBS NC with details to validate prior authorization or step therapy when required, or you will be responsible for the entire cost of the medication.*

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Maintenance medications are drugs you take on a regular basis. BCBS NC utilizes Express Scripts Pharmacy for the home delivery mail order prescription drug program. This program enables you to receive a 90 day supply of medication delivered to your home, saving you time and money. To set up a prescription for home delivery, your provider can send the prescription to them electronically. You can create an account at www.express-scripts.com, call the Express Scripts Pharmacy at 833-599-0449, or visit www.esrx.com/BCNC



Medical Plan Comparison Chart

Item/Service	Basic PPO *	Core PPO
	In-Network	In-Network
Calendar Year Deductible	$5,000 Single $10,000 Family[1]	$750 Single $1,500 Family[1]
Coinsurance	**80% BCBS NC 20% Plan Participant**	**85% BCBS NC 15% Plan Participant**
Annual Out-of-Pocket Maximum (includes Deductible, Coinsurance & Copays)	$9,100 Single $18,200 Family[1]	$3,000 Single $6,000 Family[1]
Preventive Care Services		
Health Maintenance Exam	Covered 100%, one per year	Covered 100%, one per year
Annual Gynecological Exam	Covered 100%, one per year	Covered 100%, one per year
Pap Smear Screening (lab services only)	Covered 100%, one per year	Covered 100%, one per year
Well-Baby and Child Care	Covered 100%	Covered 100%
Immunizations	Covered 100%	Covered 100%
Routine Mammography Screening	Covered 100%	Covered 100%
Physician Office Services		
Primary Care Provider Office Visit	$25 copay	$25 copay
Specialist Physician Office Visit	$50 copay	$50 copay
Chiropractic Care[2]	20% coinsurance	15% coinsurance
Emergency Medical Care		
Hospital Emergency Room	$150 copay first visit, $300 thereafter; waived if admitted	$150 copay first visit, $300 thereafter; waived if admitted
Urgent Care Center	$50 copay	$50 copay
Diagnostic Services		
Laboratory and Pathology Tests	20% after deductible	15% after deductible
Diagnostic Tests and X-rays	20% after deductible	15% after deductible
Hospital Care		
Inpatient Physician & Nursing Care, Hospital Services & Supplies	20% after deductible	15% after deductible
Outpatient Mental Health Care & Substance Abuse Treatment	Office visit: $50 copay 20% after deductible	Office visit: $50 copay 15% after deductible
Prescription Drugs		
Retail Pharmacy—30 day supply		
Tier 1: Generic	$10 copay	$10 copay
Tier 2: Preferred Brand	$35 copay	$35 copay
Tier 3: Non-Preferred Brand	$45 copay	$45 copay
Tier 4: Preferred Specialty	$50 copay	$50 copay
Mail Order—90 day supply		
Tier 1: Generic	$25 copay	$25 copay
Tier 2: Preferred Brand	$87.50 copay	$87.50 copay
Tier 3: Non-Preferred Brand	$112.50 copay	$112.50 copay
Tier 4: Preferred Specialty	$125.00 copay	$125.00 copay

[1]Both the deductible and out-of-pocket maximum are embedded. Once one plan participant within the family meets the deductible, the plan will begin to pay at the coinsurance, and if one person within the family meets the out-of-pocket maximum, the plan will begin to pay 100% for that family member. The remainder of the full family deductible and out-of-pocket maximum must be satisfied by the family.

[2]Limited to 25 visits per year.

This benefits summary is intended for use only as a source of reference. Official benefits, conditions, exclusions, and limitations are documented in the BCBS NC booklets as part of the Summary Plan Description (SPD) and Plan Documents. If there are discrepancies between this document and the SPD and/or Plan Documents, the SPD and Plan Documents will prevail.

** PLEASE NOTE: The Basic PPO does not meet the requirements for Massachusetts Creditable Coverage. If you elect this plan and live in the state of Massachusetts you may be subject to tax penalties pursuant to state law.*

Medical Plan Comparison Chart

Item/Service	Enhanced PPO	HDHP with HSA Plan
	In-Network	In-Network
Calendar Year Deductible	$100 Single $200 Family[1]	$1,600 Member $3,200 Per Family[2]
Coinsurance	**90% BCBS NC 10% Plan Participant**	**80% BCBS NC 20% Plan Participant**
Annual Out-of-Pocket Maximum (includes Deductible, Coinsurance & Copays)	$500 Single $1,000 Family[1]	$3,000 Member $6,000 Family[2]
Preventive Care Services		
Health Maintenance Exam	Covered 100%, one per year	Covered 100%, one per year
Annual Gynecological Exam	Covered 100%, one per year	Covered 100%, one per year
Pap Smear Screening (lab services only)	Covered 100%, one per year	Covered 100%, one per year
Well-Baby and Child Care	Covered 100%	Covered 100%
Immunizations	Covered 100%	Covered 100%
Routine Mammography Screening	Covered 100%	Covered 100%
Physician Office Services		
Primary Care Provider Office Visit	$20 copay	20% after deductible
Specialist Physician Office Visit	$20 copay	20% after deductible
Chiropractic Care[3]	$20 copay	20% after deductible
Emergency Medical Care		
Hospital Emergency Room	$150 copay	20% after deductible
Urgent Care Center	$20 copay	20% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	10% after deductible	20% after deductible
Diagnostic Tests and X-rays	10% after deductible	20% after deductible
Hospital Care		
Inpatient Physician & Nursing Care, Hospital Services & Supplies	10% after deductible	20% after deductible
Outpatient Mental Health Care & Substance Abuse Treatment	Office visit: $20 copay 10% after deductible	20% after deductible
Prescription Drugs		
Retail Pharmacy—30 day supply		
Tier 1: Generic	$10 copay	20% after deductible
Tier 2: Preferred Brand	$20 copay	
Tier 3: Non-Preferred Brand	$40 copay	
Tier 4: Preferred Specialty	$40 copay	
Mail Order—90 day supply		
Tier 1: Generic	$20 copay	20% after deductible
Tier 2: Preferred Brand	$40 copay	
Tier 3: Non-Preferred Brand	$80 copay	
Tier 4: Preferred Specialty	$80 copay	

[1]Both the deductible and out-of-pocket maximum are embedded. Once one plan participant within the family meets the deductible, the plan will begin to pay at the coinsurance, and if one person within the family meets the out-of-pocket maximum, the plan will begin to pay 100% for that family member. The remainder of the full family deductible and out-of-pocket maximum must be satisfied by the family.

[2]The deductible and out-of-pocket maximum are aggregate, which means the full family deductible must be satisfied under a two-person or family contract before the plan will begin to pay at the coinsurance, and the full family out-of-pocket maximum applies.

[3]Limited to 25 visits per year.

Note: The Enhanced PPO offers a $15,000 per lifetime interfertility benefit, and hearing aid coverage with no age or dollar limit every 36 months, subject to deductible and coinsurance.

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Value-Added Benefits

Teladoc Visits

Enrollment in any of the medical plans includes telehealth services from Teladoc for a $5 copay on the PPO plans, and 20% coinsurance after deductible on the HDHP with HSA. This service gives you access to online medical, behavioral health, and dermatology services anywhere in the US through the phone or video chat. Online doctors are available for virtual consultations with or without an appointment. Great for when you can't get to your primary care doctor's office or when you need care after hours. Online doctors are able to call in non-narcotic prescriptions to your local pharmacy to help with your care. Use Teladoc any time for non-emergency health concerns such as:

- Rash, sunburn, or insect bites
- Cold and flu
- Eye irritation or redness
- Sore throat
- Other minor illnesses or injuries

Teladoc also gives you more choices for visiting with a therapist or psychiatrist. From the comfort of home, everyone covered under your plan can make an appointment and talk through difficult challenges you may be facing such as anxiety, depression, or grief.

Download the Teladoc app, visit www.teladoc.com or call 800-835-2362 to activate your account and seek care.

NOTE: It is recommended to activate your Teladoc account before you need it, which includes a brief medical history.

Health Advocate

Health Advocate is available at no cost to employees, spouses and dependents, and is completely confidential.

Health Advocate provides support to help you make sense of healthcare and take control of your health. Advocates are available over the phone, online, or through the mobile app. Connect with them for help with:

ENROLLMENT

Learn and ask questions about the differences in the medical plans, how they work, what they cover, and more.

MEDICAL CARE

Get answers about medical conditions, find out about the latest research, and connect with the right in-network providers for second opinions.

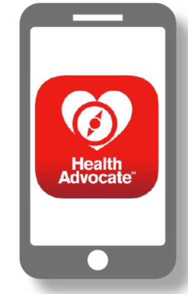
ADMINISTRATIVE ISSUES

Navigate through issues you are having with eligibility, coverage questions, medical bills, transferring medical records, and more.

ON THE GO

Download the app to access your Health Advocate benefits, as well as check the status of your cases and upload documents.

You can reach Health Advocate by calling 866-799-2728, emailing answers@HealthAdvocate.com, or by visiting www.healthadvocate.com/members. They also have a mobile app available on the App Store and Google Play for added convenience. Your Health Advocate benefit can be accessed during their normal business hours Monday - Friday, from 8 a.m. to midnight, Eastern Time. Staff is available for assistance after hours and on weekends.



It's important to note this is not a way to enroll over the phone; this is just a resource for questions.

Dental

Asahi Kasei offers a PPO dental coverage option for you and your family, administered by Delta Dental of North Carolina.

PPO PLAN

You can receive services from any dentist you choose. However, when you select a dentist that participates in one of the Delta Dental networks, that dentist has agreed to accept Delta Dental's approved amount for services. If you visit a dentist that does not participate in the network, you may be balance billed for amounts exceeding the approved payment amount. This can result in significant out-of-pocket costs.

To find a participating dentist, visit www.deltadentalnc.com and click on "Find a Dentist" link, or call (800) 662-8856.

Please see your dental benefits booklet for specific details about benefits, limitations and exclusions. This is intended as a high level summary of the Plan. If there are any discrepancies between this summary and the SPD and Plan Document (booklet), the SPD and Plan Summary will prevail.

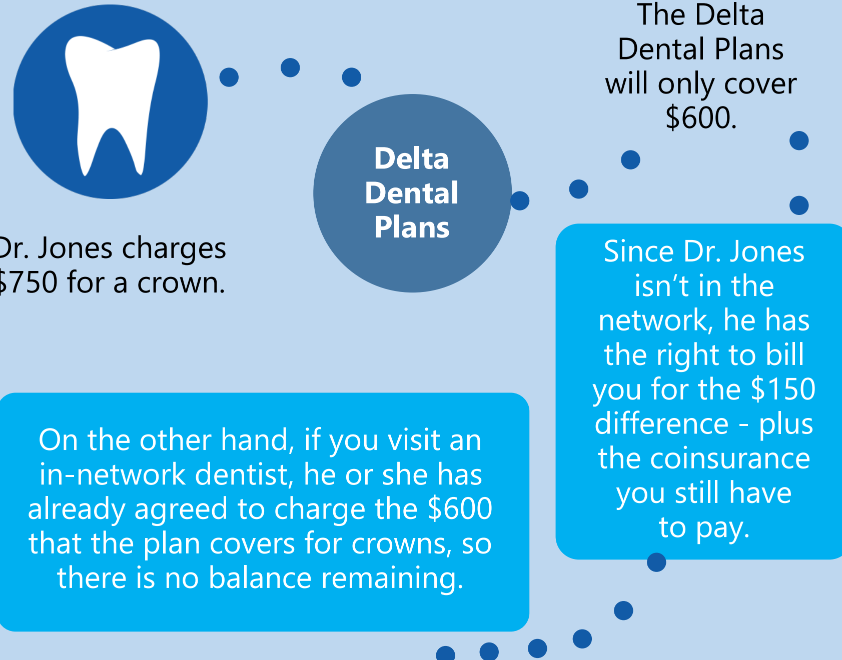
Dental Care Services	PPO		
	PPO Select	Premier Dentist	Non-Participating Dentist*
Annual Deductible (applies to Class II, III)	$50 Single / $150 Family		
Annual Benefit Maximum (applies to Class II & III)	$2,000 per benefit year, per covered person		
Lifetime Maximum (applies to Class IV)	$1,500 per lifetime, per covered person		
Class I: Diagnostic & Preventative Services			
• Oral Exams • Fluoride • X-rays • Sealants • Cleanings	100%	100%	100%
Class II: Basic Services			
• Fillings • Root Canals • Extractions • Crowns • Periodontal • Repairs	80%	80%	80%
Class III: Major Services			
• Bridges • Dentures • Implants	80%	80%	80%
Class IV: Orthodontic Services			
• Orthodontic Services—Braces • Children up to age 19	50%	50%	50%

*When you receive services from a Non-participating Dentist, the percentages in this column indicate the portion of Delta Dental's Non-participating Dentist Fee that will be paid for those services. The Non-participating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

Stay In-Network and Save!

Delta Dental PPO Dentists	• No balance billing on covered services • Significant network discounts and large network • Dentists file claims
Delta Dental Premier Dentists	• No balance billing on covered services • Significant network discounts and larger network • Dentists file claims
Non-Participating Dentists	• May be balance billed • No network discounts • May need to file own claims

HOW DOES BALANCE BILLING WORK?



A Dental ID card is not required to receive services.

Vision

New for 2024! The vision plan will be insured by EyeMed, a national vision carrier with a large network of over 115,000 provider locations, which include Pearle Vision, Target Optical, and LensCrafters. These providers are PLUS providers in select areas, so you receive enhanced benefits including a $0 copay for the exam and an additional $50 credit for your frame allowance. They are noted as such when you search for a provider in your area. There are also individual practitioners that participate with EyeMed. You will receive the maximum benefits when you obtain care from an in-network provider. However, you also have the choice to see an out-of-network provider. If you choose an out-of-network provider, you will pay out-of-pocket at the time of service and then submit a claim form to EyeMed for reimbursement at the out-of-network allowance. For a listing of EyeMed participating providers in your area, visit www.eyemedvisioncare.com Scroll to the bottom of the page and click on "Find an Eye Doctor" and select the Insight network from the drop down menu.

Members do not need an ID card to obtain care as in-network providers can look up eligibility online. However, you can also download the EyeMed Members App to your smart phone and view and save your virtual ID card.

Vision Care Services	PPO	
	In-Network (Member Cost)	**Out-of-Network Allowance**
Eye Exam—Once every calendar year		
Exam	$10 copay	Up to $40
Frames—Once every calendar year		
Frames	Up to $130 allowance and 20% off balance over $130[1]	Up to $91
Standard Plastic Lenses (in lieu of contact lenses)—Once every calendar year		
Single Vision	$30 copay	Up to $30
Lined Bifocal	$30 copay	Up to $50
Lined Trifocal	$30 copay	Up to $70
Lenticular	$30 copay	Up to $70
Contact Lenses[2] (in lieu of glasses)—Once every calendar year		
Conventional	$110 allowance and 15% off of balance over $110.	Up to $77
Disposable	$110 allowance	Up to $77

[1]20% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.

[2]Coverage for fitting and follow up is provided at up to $40 for standard service and 10% of the cost for premium service.

Additional EyeMed Discounts!

Receive 15% off standard or 5% off promotional pricing for lasik or PRK vision correction at US Laser Network. For more information, call 866-939-3633 or visit **www.eyemedvisioncare.com**

Get up to a 40% discount on an additional pair of eyeglasses or contact lenses at in-network providers after your vision benefits have been exhausted.

Save up 64% off high-quality hearing aids when you buy them through EyeMed's partner Amplifon Hearing Health Care Network. For more information, call 866-939-3633 or visit- **www.eyemedvisioncare.com**

Contact EyeMed at (866) 939-3633 or at ***www.eyemedvisioncare.com***

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) let you set aside money on a pre-tax basis to pay for your out-of-pocket health and dependent (day) care costs. Money is taken from your pay before taxes are withheld, which lowers your taxable income. And you will never be taxed on the money you use from the account to pay for eligible expenses. There are two types of accounts: the Health Care FSA and the Dependent Care FSA. You can participate in a flexible spending account even if you are not enrolled in a medical plan. They are administered by Flores & Associates.

Health Care FSA

You can use your Health Care FSA to pay for eligible expenses not covered by your medical, dental, and vision plans. Examples of eligible expenses include medical, prescription drug, dental, and vision copayments and coinsurance; orthodontia expenses; LASIK eye surgery; fertility treatments; and smoking cessation programs.

A complete list of qualified expenses is available on the IRS website, www.irs.gov Enter “Publication 502” in the search box.

Dependent Care FSA

The Dependent Care FSA allows you to pay for your dependents’ daycare while you are at work or school. If you have dependent children under the age of 13 or tax dependents of any age who are unable to care for themselves, you can enroll in this plan and choose the amount you want to put aside for daycare. These services must be necessary for you and your spouse to work to be eligible for reimbursement.

Some examples of eligible Dependent Care Expenses include babysitters,* after school care, daycare centers, nursery schools, summer day camps, and elder care. If you are electing to participate in the Dependent Care FSA, be sure to keep record of the name of your daycare provider and tax identification number (or SSN) for your personal tax purposes.

A complete list of qualified expenses is available on the IRS website, www.irs.gov. Enter “Publication 503” in the search box. If you contribute to a Dependent Care FSA, you must file IRS Form 2441 with your Federal Income Tax Return. Form 2441 is simply an informational form on which you report the amount you pay and who you paid for day care.

*Important Note: The babysitter must claim his/her wages for tax purposes. If he or she is not claiming their wages, you will not be reimbursed for these expenses.

2024 Annual Limits

- Health Care FSA: $3,200
- Dependent Care FSA: $5,000 ($2,500 if married filing separately)

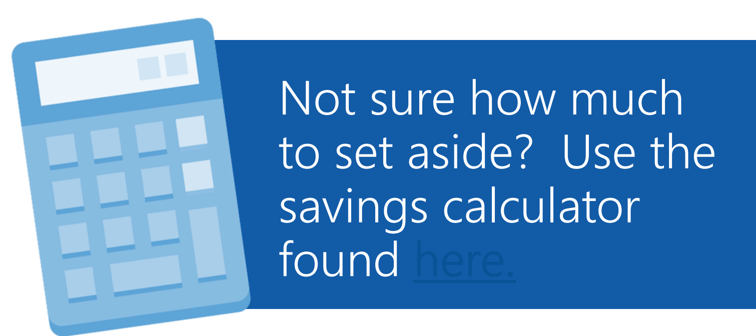
How FSAs Work

Each year during the annual enrollment period, you decide how much to set aside for health care and/or dependent care expenses. Your contributions are deducted from your paycheck on a pre-tax basis in equal amounts throughout the plan year. Once you enroll in a FSA, you cannot change your contribution amount for the rest of the plan year unless you have a qualifying change in status.

Use It or Lose It

When you elect to participate in an FSA, funds in your account must be used for qualified medical or dependent care expenses, or they are forfeited at the end of the year.

FSA Claim Deadlines				
	2024 Contributions		2025 Contributions	
	Eligible Dates of Service	Claims Submissions Due By	Eligible Dates of Service	Claims Submissions Due By
Medical FSA	Jan. 1, 2024 – March 15, 2025	April 15, 2025	Jan. 1, 2025 – March 15, 2026	April 15, 2026
Dependent Care FSA	Jan.1, 2024 – Dec. 31, 2024	March 31, 2025	Jan.1, 2025 – Dec. 31, 2025	March 31, 2026



Flexible Spending Accounts

Health Care FSA Claims Submission

When you enroll in a Health Care FSA, you will automatically receive a debit card by mail. Use this card to pay your eligible medical, dental, and vision care expenses—just as you would a traditional bank debit card or credit card. Claims can also be submitted via the Flores & Associates website or via the mobile app.

The Health Care FSA allows you to access your FSA balance immediately—you do not need to pay eligible expenses first and wait for reimbursement. However, in accordance with IRS regulations, you still must keep and submit receipts to validate that your expenses were eligible for reimbursement through your Health Care FSA.

If you do not provide the required documentation, your FSA Debit Card will be deactivated until you are able to substantiate your expenses. Register receipts, which do not outline the service or supply, generally are not considered valid documentation. Ask your provider to give you an itemized, detailed receipt for services.

All new Health Care FSA enrollees will receive a FSA Debit Card from Flores & Associates. Cards will be mailed directly to your home. Be aware it may arrive in an unmarked envelope.

Mobile App

Flores Mobile lets you file claims and attach documentation using your smart phone. Just select "Capture" from the main screen, photograph your documentation using your device's camera and tap "Submit." It's that easy! Download the Flores & Associates app in the App Store or Google Play.

KEEP YOUR RECEIPTS

Even though you may use your FSA Debit Card to pay for eligible healthcare expenses, you should always save your receipts in case additional documentation is required.

Quick Tips for Using the Benefits Card

- The card may be declined for one of a few reasons:
  1. The merchant does not accept the Benefits Card.
  2. The expense is not eligible under the Health Care FSA.
  3. Your card has been temporarily suspended due to an unsubstantiated or ineligible expense.
- You may have to submit expense documentation for transactions from some merchants, and not from others. Many eligible merchants can automatically substantiate – or verify that the expenses paid for with the card are Health Care FSA eligible – your transaction at the point of sale. Others, including most health care providers, may not have this capability.
- You will receive Documentation Requests by email if you have an email address on file. These emails are not spam messages, so be sure to watch for them.
- Save your card, even after you use up your Health Care FSA funds or the plan year ends. It can be used for different plan years until the expiration date on the card.
- If enrolled in the Dependent Care FSA, you will not receive a debit card. You pay for eligible expenses as you normally would and then submit your claim for reimbursement, along with receipts to Flores & Associates.

Life and AD&D Insurance

Basic Life and AD&D

Asahi Kasei provides all eligible employees with basic life insurance that is equal to two times your annual earnings up to a maximum of $750,000. This life insurance policy will pay your beneficiary a benefit in the event of your death.

In addition, Asahi Kasei provides all eligible employees with accidental death and dismemberment (AD&D) insurance that is equal to two times your annual earnings up to a maximum of $750,000. Examples of accidental injuries covered include accidental loss of limb (e.g., arm, leg), sight, or permanent paralysis.

Asahi Kasei pays the full cost of basic life insurance and AD&D coverage, and you are automatically enrolled if you are eligible.

Life and AD&D benefits begin to reduce for employees age 70 and older. Review the carrier certificate for details.

NOTE: According to the IRS regulations, the value of employer-provided group term life insurance over $50,000 is taxable income. This "additional taxable income" is subject to Social Security and Medicare taxes and must be reported on the employee's W-2 Form as "other" compensation.

Optional Life and AD&D

In addition to the basic coverage provided to you at no cost, you can purchase optional life insurance and/or AD&D coverage for you, your spouse, and your children under the plan.

- You must elect employee coverage in order to elect coverage for your spouse and/or children.
- For optional life insurance, the cost of employee and spouse coverage depends on the employee's age for employee optional life insurance, or the spouse's age for optional spouse life insurance. Rates are age banded and can be found in Workday.

- Deductions will be adjusted annually if you fall into a new age band, and all deductions for optional life and/or AD&D benefits are taken post-tax from your pay.
- Monthly rates for AD&D are $0.03 per $1,000 of benefit for employee only coverage or $0.048 per $1,000 of benefit, which includes spouse and/or child(ren).
- Coverage effective dates and increases in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

Optional Life Benefits	
Employee	Increments of $25,000 up to the lesser of $750,000 or 5x your annual salary
Spouse	Increments of $25,000, up to a maximum of $375,000 or 50% of the employee's elected optional life insurance amount
Children	Increments of $10,000 to a maximum of $50,000, or 50% of the employee's elected optional life insurance amount
Age Reduction	Employee and spousal coverage will be reduced as you age. See carrier certificate for specific details.

Optional AD&D Benefits	
Employee	Increments of $50,000 to a maximum of $500,000
Spouse	Increments of $25,000 to a maximum of $250,000 or 50% of the employee's elected optional AD&D amount
Child(ren)	Increments of $5,000 to a maximum of $50,000 or 10% of the employee's elected optional AD&D amount
Age Reduction	Employee and spousal coverage will be reduced as you age. See carrier certificate for specific details.

Life and AD&D Insurance

Evidence of Insurability (Proof of Good Health)

If you are applying for coverage during your initial enrollment period (e.g., new hire enrollment period) you can request coverage up to the Guarantee Issue (GI) amounts below. Any application over these Guarantee Issue amounts will be subject to Evidence of Insurability (EOI).

- Employee Optional Life Insurance: $500,000 (GI amount reduces to 65% ($325,000) at age 70, and to 50% ($250,000) at age 75.)
- Spouse Optional Life Insurance: $50,000 (GI amount reduces based on employee's age and schedule.)

Evidence of Insurability is also required if:

- You or your spouse waived coverage during your initial enrollment period as a new hire and want to elect coverage during annual enrollment for any amount you elect.
- You or your spouse elect to increase the benefit level more than one $25,000 increment either at annual enrollment or due to a change in status.
- You or your spouse want to change your election amount as a result of a change in status and that amount exceeds the GI amount.
- You wish to increase your benefit above the GI amount and were denied previously.

Optional life coverage is effective once you (and your dependents) are approved for the coverage, and payroll deductions have begun. Optional life deductions are taken from your pay check on a post-tax basis. Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

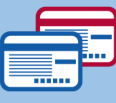
Children Optional Life Insurance and Optional Employee and Spouse AD&D coverage do not require evidence of insurability.

Evidence of Insurability is completed online through the Lincoln Financial portal, which you can access via the link in Workday. Use the employer code: **ASAHIKASEI**

5 Reasons to have Life Insurance

Life is expensive, death can be even more costly. Don't leave loved ones unprotected - life insurance allows your loved ones time to grieve without financial worry.

$6,560
AVERAGE COST OF A
Funeral



$6,772
AVERAGE COST OF A
Credit Card Debit

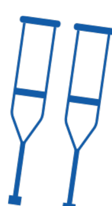
$18,133
AVERAGE COST OF A
A Four-Year College per Year

$16,803
AVERAGE YEARLY COST OF HOUSING
Renting and Owning

$24,560
AVERAGE YEARLY EXPENSES
Utilities, Health Care, and Miscellaneous Cash

Disability

Short Term Disability



The Short Term Disability (STD) plan provides important financial security in the event of a brief illness or injury. This benefit is paid for by Asahi Kasei, and is insured by Lincoln Financial.

Your coverage effective date may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

Item	STD Benefit
Weekly Benefit	66 2/3% of basic weekly earnings, up to a maximum weekly benefit of $2,500.
Elimination Period	Benefits begin on the 8th day from an accident or illness.
Maximum Benefit Period	Benefits are payable for up to 25 weeks, as long as you remain disabled throughout this time.

Payments are made to you directly from Lincoln Financial.

Long Term Disability

The Long Term Disability (LTD) plan provides income to employees who are disabled for an extended period of time. Asahi Kasei pays the full cost of this plan and eligible employees are automatically enrolled in coverage. This benefit is also insured through Lincoln Financial.

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Review the carrier certificate for details.

Item	LTD Benefit
Monthly Benefit	66 2/3% of your basic monthly income, up to a maximum benefit of $12,500 per month.
Elimination Period	You need to satisfy a 180-day Elimination Period before benefits begin.
Maximum Benefit Period	For a disability which begins before you reach age 60, the Maximum Benefit Period will be the greater of the Social Security Normal Retirement Age (SSNRA) or to age 65 (but not less than 5 years). If you become disabled at age 60 or later, the benefit duration is based on a maximum payment schedule. See carrier certificate for details.

Payments are made to you directly from Lincoln Financial.

STD & LTD PROTECT YOUR FINANCES

1 IN 4 WORKERS will experience a period of disability before they retire.

46%

On top of that, 46% OF AMERICANS wouldn't be able to cover a $400 emergency expense without resorting to accumulating debt.

If you were unable to work due to a short medical emergency, HOW WOULD YOU PAY FOR IT?

Additional Benefit Programs

We offer additional benefit programs that go beyond monetary benefits that can help you cope with life's challenges.

Health Advocate Employee Assistance Program (EAP)

A free, confidential counseling and referral service to help you and your family resolve problems affecting your personal or work lives, not matter what the issue! Through the Employee Assistance program (EAP), you may take advantage of the following benefits and services:

24-Hour Telephone Access – Call 866-799-2728 24 hours a day, seven days per week.

Confidential Counseling – Get access to a Licensed Professional Counselor who can help with stress, depression, relationship issues, addictions, work/life balance issues, and more! Call, email, or access via the web or app for 24/7 support or receive up to eight free in person counseling sessions and referrals to community services

Interactive Web Resources – Use a full range of web-based tools and resources on a variety of behavioral health, work/life and other relevant topics.

ID Theft Shield

Receive assistance with criminal and financial identity theft issues, as well as:

- Credit report with analysis and score for member and spouse/domestic partner
- Continuous monitoring with activity alerts
- Full identity restoration with a licensed investigator through Kroll

Legal Shield

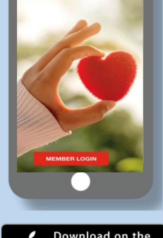
Get trusted legal advice and resources when you need them from Legal Shield to prevent legal problems from becoming serious or financially devastating. This service offers assistance with common legal issues such as tragic accident, debt collection, DUI/DWI, child support, foreclosure, tenant/landlord issues, bankruptcy, IRS audits, custody/visitation, and wills, and includes the following:

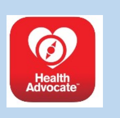
- Legal Advice – Business or personal emergency assistance 24/7, after-hours legal consultation for covered legal emergencies, and letters and phone calls on your behalf at the discretion of your provided attorney.
- Document Review – Legal documents/contracts up to 10 pages.
- Moving Traffic Violations – Available 15 days after enrollment.
- Wills – Standard will preparation with yearly reviews/updates with Living Will, Healthcare Power of Attorney.
- Accidents – Defense for charges of manslaughter, negligent homicide, or vehicular homicide.
- IRS Audit Services – One hour of consultation, advice or assistance when your 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.
- Discounts – 25% off additional legal services.

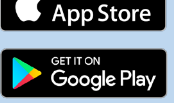
Costs for ID Theft and Legal Shield can be found in Workday.

TO ACCESS THE HEALTH ADVOCATE EAP OR ADVOCACY SERVICES

- Call 1-866-799-2728
- Visit www.healthadvocate.com/members and enter the company name Asahi Kasei
- Email answers@healthadvocate.com
- Download the app.







Retirement Plan

Asahi Kasei offers employees the opportunity to save for retirement through the Asahi Kasei 401(k) Retirement Plan. It is a salary deferral plan and is designed to help you attain a comfortable retirement. It gives you the option of saving money for your retirement on a pre-tax or on an after-tax (Roth) basis. Transamerica Retirement Solutions is the Plan's recordkeeper.

The company contributes generously to the 401(k) Plan. The company will match 100% of the first 5% you defer, up to the IRS maximum. The company will also make a 3% non-elective contribution on your behalf, even if you don't contribute to the Plan. This means that if you choose to defer AT LEAST 5% of your pay, the company will contribute 8%! Contributions are deposited into your account each pay period.

You may increase or decrease your 401(k) deferral contributions or change the type of your 401(k) contributions (Roth or pre-tax) at any time by notifying Transamerica by phone or through the website. Changes may take up to two payrolls to take effect. You may also change your investment choices at any time by notifying Transamerica.

Employees who do not make an election will default and 5% of your eligible compensation will be contributed to your account each pay period. Also, your contribution level will increase by 1% each year, until it reaches 10% of your eligible compensation. These increases will occur each year on July 1st. Employees can prevent default by making an active election with Transamerica, even if the election is to defer 0%.

Employees are eligible to join the plan the first of the month following 30 days from the date of hire.

Contact Transamerica at 800-755-5801 or by logging in at Transamerica.com/portal

SET UP YOUR ACCOUNT AT TRANSAMERICA

Employees can set up their account with Transamerica AFTER they have received their first paycheck.

- Go to Transamerica.com/portal/home to get started!
- Click "Create an account" in the top-right corner
- On the next page, you'll be prompted to enter your Social Security number and go through a verification process.

REVIEW YOUR ACCOUNT

Once you have established your account with Transamerica, you can take control of your retirement and plan and for your financial future.

- Check account balance
- Use education tools to help you create and easily modify your retirement income strategy
- Transfer between funds
- Review investment performance
- Manage contributions and fund allocations

NAME YOUR BENEFICIARIES

This simple but important step ensures your account assets will go where you choose in the event of your death.

- Look for "Beneficiaries" in your account Home menu on the Transamerica website.

CONSIDER CONSOLIDATING

If you have retirement accounts with other financial providers or in IRAs, you may roll over, or transfer, any portion of your balances to your plan account at any time.

- This could make planning easier, simply your finances, and offer other benefits.
- For step-by-step guidance, email Transamerica at consolidate@transamerica.com or call 800-275-8714.

Benefit Contacts

Provider	Benefit	Contact Information	
Blue Cross Blue Shield of North Carolina (BCBS NC)	Medical/Prescription Plans	Customer Service and Prior Authorization/Certification	(877) 275-9787 www.blueconnectnc.com
		HealthLine Blue - 24/7 Nurse Access	(877) 477-2424
		Express Scripts Maintenance Drug Mail Order Program	(833) 599-0449 www.express-scripts.com esrx.com/BCNC
		Express Scripts Accredo Specialty Pharmacy (Specialty Drug Mail Order)	(833) 599-0513 www.accredo.com/BCNC
Health Advocate	Advocacy Services and Employee Assistance Plan (EAP)	Customer Service	(866) 799-2728 www.healthadvocate.com/members answers@healthadvocate.com
Teladoc Health (BCBS NC Medical Plans)	Telemedicine	To request a visit	(800) 835-2362 www.teladoc.com
Delta Dental	Dental PPO Plan	General Information/ Find a Provider	(800) 662-8856 www.deltadentalnc.com
EyeMed	Vision	General Information/ Find a Provider	(866) 939-3633 www.eyemedvisioncare.com
Health Equity (BCBS NC HDHP Medical Plan)	Health Savings Account	Customer Service	(866) 346-5800 www.healthequity.com
Flores & Associates	Flexible Spending Accounts	Customer Service	(800) 532-3327 www.flores247.com
Lincoln Financial Group	Life Insurance/AD&D	Contact the Benefits Team	
Lincoln Financial Group	Short Term Disability	Disability Intake	(888) 408-7300 www.mylincolnportal.com
Lincoln Financial Group	Long Term Disability	Disability Intake	(888) 408-7300 www.mylincolnportal.com
Legal Shield	Pre-Paid Legal Advice Plan	Customer Service	(800) 654-7757 www.legalshield.com
ID Theft Shield	ID Theft Protection Plan	Customer Service	(888) 494-8519 www.idshield.com
Transamerica	401(k) Retirement Plan	Customer Service	(800) 755-5801 asahikasei.trsretire.com
Feel free to contact the Asahi Kasei Benefit Team by sending an email to asahi-benefits@ak-america.com			