2022 BENEFITS **ENROLLMENT**

This publication contains important information about your employee benefit program.

Please read thoroughly.

Nidec
All for dreams
MCE

Table of Contents

Your 2022 Benefits Guide

At Nidec, we offer our employees a competitive and comprehensive benefits program. This is one of many ways we recognize how important you are to the company. This benefits guide briefly summarizes our program in a quick and easy-to-understand way.

New Hire Enrollment

As a new employee, you are eligible for coverage on your first day of employment. You must enroll in benefits within 30 days of your date of hire.

Annual Enrollment

Annual enrollment is your opportunity to review your current benefits and make benefit changes for the upcoming plan year. During annual enrollment, you can add, change, or decline coverage. In addition, you can add and/or drop dependents during this time. Keep in mind that any dependent you add will need to go through a dependent audit verification process.

Qualifying Life Event

Once you make your elections, you will not be able to make changes until the next annual enrollment period unless you experience a qualifying life event. A qualifying life event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying events include the following.

- Change of legal marital status (e.g., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (e.g., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status

Working Spouse Coverage

If you have a spouse who works full-time and is offered benefits at his or her own employer, your spouse must elect coverage through that employer. If your spouse later loses eligibility under his or her employer's plan, this is considered a qualifying event and he or she would be eligible to enroll in the Nidec plan as long as an application is made within 30 days of the loss of coverage.

Benefits Eligibility

Eligible Employees

You may enroll in the benefits program if you are a regular full-time employee who is actively working a minimum of 30 hours per week.

Eligible Dependents

Eligible dependents generally include your legally married spouse and children up to age 26. Children may include natural, adopted, step-children, or children obtained through court-appointed legal guardianship.

SSN Required

You must provide a valid Social Security Number for yourself and each enrolled dependent. Employers are required to provide names and Social Security Numbers to the federal government for each individual enrolled for medical coverage

Open Enrollment Overview

The Open Enrollment period will be from October 18 to 29, 2021.

Changes for 2022

Prescription Drug Changes

Beginning January 1, we will have a new prescription drug formulary called Source Rx. A formulary is a list of drugs, both generic and brand, selected by our health plan to treat certain health conditions. You can view the new list at **AlabamaBlue.com/SourceRX1DrugList4T**.

Also we are introducing a new prescription drug network called the Value One Pharmacy Network. While this new network does not include CVS pharmacies, Walgreens and Rite Aid continue to be in the network. You can find more about the network at **AlabamaBlue.com**.

Along with these changes, we are expanding the Split Fill Program for high-cost drugs.

Hinge Health to Help with Back and Joint Pain

Nidec is partnering with Hinge Health to provide a program that will assist all our employees with back and joint pain issues…at no cost to you. The program helps employees avoid injuries, prepare for surgeries if needed, and remain healthy and pain free. For more on Hinge Health, see page 9.

Short-Term Disability Coverage

In 2022, Nidec is providing short-term disability (STD) coverage for all non-union and bi-weekly employees. This key benefit provides protection if you have a qualifying disability. For more on the STD program see page 14.

What's *NOT* New!

We are pleased to report that there are no increases in plan deductibles, copays, coinsurance, or out-of-pocket maximums for the PPO and CHP medical plans for 2022.

Additionally, if you complete your wellness activities by October 31, 2021, you can reduce your premium costs for 2022. To learn more about how to save, see page 8.

What Happens if You Don't Enroll

This year's enrollment is a passive enrollment. This means if you do nothing you will be automatically re-enrolled in the coverage choices you had in 2021 for medical, dental, vision, life, and disability benefits. However, if you wish to contribute to either a Health Savings Account (HSA) or a Flexible Spending Account (FSA), you will need to make those elections during the open enrollment period.

What You Need to Do

Review the 2022 plan changes in the OE Guide. Log in to Workday during the OE period. Enroll and submit your 2022 benefits during the Open Enrollment period (10/18-10/29). Remember—you will not have another opportunity to change benefits in 2022 unless you experience a qualifying life event.

- Confirm your changes by reviewing your elections and clicking "I Agree" and "submit" on the last summary screen
- Make sure your contact and beneficiary information is up to date

ID Card Reminder

As a reminder, Cigna does not issue dental cards. If you require a card, please download from the Cigna app, or simply provide your dentist with the Group Number 3339200. All other vendors will begin issuing ID cards in late December or early January. Temporary ID cards can be pulled from the vendors' websites after January 1, 2022.

Medical

We partner with Blue Cross Blue Shield of Alabama (BCBSA) and Kaiser Health to offer you and your eligible dependents healthcare insurance. When you receive care in-network you benefit from our negotiated discounts and greater plan coverage for your services.

Nidec offers two BCBSA medical plan choices—a Preferred Provider Organization (PPO) and a Consumer Healthcare Plan (CHP). The premiums (the amount you pay each month for benefit coverage) for each plan vary.

If you select the PPO, your benefits are higher when you visit a provider in the plan's network. Additionally, you will pay a copay for primary care visits to your doctor, as well as for telemedicine, specialist treatment, and urgent care. Preventive care is covered 100%, as long as you are treated by an in-network provider.

If you select the CHP you will first meet a deductible before the plan covers a percentage of covered expenses. This plan is paired with a special tax-advantaged Health Savings Plan (HSA) to help pay for medical costs, including the higher deductible.

If you select the Kaiser plan you will be enrolled in a health maintenance organization (HMO). Participants in an HMO first seek care through a primary care provider who helps patients with primary care and recommends care from specialists if needed.

The chart below provides an overview of the benefits of the Kaiser HMO.

Plan Details

	Kaiser HMO	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$0	Not covered
Family	$0	Not covered
Out-of-Pocket Maximum (includes deductible)		
Individual	$3,000	Not covered
Family	$6,000	Not covered
Hospital Services		
Inpatient	$250 copay	Not covered
Outpatient Surgery	$100 copay	Not covered
Office Visits		
Preventive Care	100% covered	Not covered
Primary Care Physician	$20 copay	Not covered
Specialist	$20 copay	Not covered
Urgent Care	$20 copay	Not covered
Emergency Room	$150 copay	
Prescription Drugs (for 1 to 100 days supply)		
Generics	$10 copay	Not covered
Preferred Brands	$20 copay	Not covered
Non-Preferred Brands	$20 copay	Not covered

This is a summary of coverage. Full coverage details are available in your Summary Plan Description (SPDs) or official plan documents. In the event there are differences between this summary and your official plan documents, your plan documents prevail.

The following chart provides an overview of the benefits of each BCBSA plan.

Plan Details

	BlueCross BlueShield of Alabama PPO		BlueCross BlueShield of Alabama CHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual	$1,200	$2,400	$2,800	$5,600
Family	$2,400	$4,800	$5,600	$11,200
Out-of-Pocket Maximum (includes deductible)				
Individual	$5,450	Not applicable	$6,400	Not applicable
Family	$12,800	Not applicable	$12,800	Not applicable
Hospital Services				
Inpatient	$250 copay; deductible then 20% coinsurance	$250 copay; deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Outpatient	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Office Visits				
Telemedicine	$20 copay	Not covered	Deductible then 20% coinsurance	Not covered
Preventive Care	100% covered	Not covered	100% covered	Not covered
Primary Care Physician	$30 copay	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Specialist	$50 copay	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Urgent Care	$50 copay	Deductible then 50% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance
Emergency Room	$200 copay, deductible then 20% coinsurance; 50% coinsurance non-emergencies		Deductible then 20% coinsurance; 50% coinsurance non-emergencies	
Prescription Drugs				
Retail (30-day supply)				
Tier 1	$10 copay	Not covered	Deductible then 20% coinsurance	Not covered
Tier 2	$35 copay	Not covered	Deductible then 20% coinsurance	Not covered
Tier 3	$60 copay	Not covered	Deductible then 20% coinsurance	Not covered
Tier 4	$120 co-pay	Not covered	Deductible then 20% coinsurance	Not covered
Mail Order (90-day supply)				
Tier 1	$25 copay	Not applicable	Deductible then 20% coinsurance	Not applicable
Tier 2	$87.50 copay	Not applicable	Deductible then 20% coinsurance	Not applicable
Tier 3	$150 copay	Not applicable	Deductible then 20% coinsurance	Not applicable

This is a summary of coverage. Full coverage details are available in your Summary Plan Description (SPDs) or official plan documents. In the event there are differences between this summary and your official plan documents, your plan documents prevail. Find network providers, facilities, and pharmacies at **www.bcbsal.org**.

Wellness for 2022

Our wellness program is available only to employees who have enrolled in a Blue Cross Blue Shield of Alabama (BCBSA) plan.

We know that your health plays a key role in your overall well-being, which is why we introduced a comprehensive wellness program through Asset Health and an easier way to participate via a PC or by phone.

Since January 1, 2021, employees have had access to the following:

- Online wellness portal
- Health assessment
- Physician form
- Online courses tailored to your health needs
- Wellness challenges
- Personalized incentive tracking to monitor your progress

Nidec has communicated the program and activities needed to earn a discount on your medical plan premiums throughout the year.

You still have time to earn the incentive discount for 2022! Just complete your activities by **October 31, 2021**. The next program year begins on November 1, 2021 and runs till October 31, 2022.

Follow These Simple Steps and Save

1. Register or log in at **assethealth.com/nidec**
2. View the list of activities
3. Complete the activities by October 31, 2021
4. Pay a lower medical plan rate for the entire 2022 plan year

Here are the Discounts You Can Earn

Level	Points Earned	Discount on Medical Plan Rates for 2022 (applies to employee-only portion)
Bronze	120	5% discount
Silver	320	10% discount
Gold	500	15% discount

Hinge Health for Back and Joint Pain

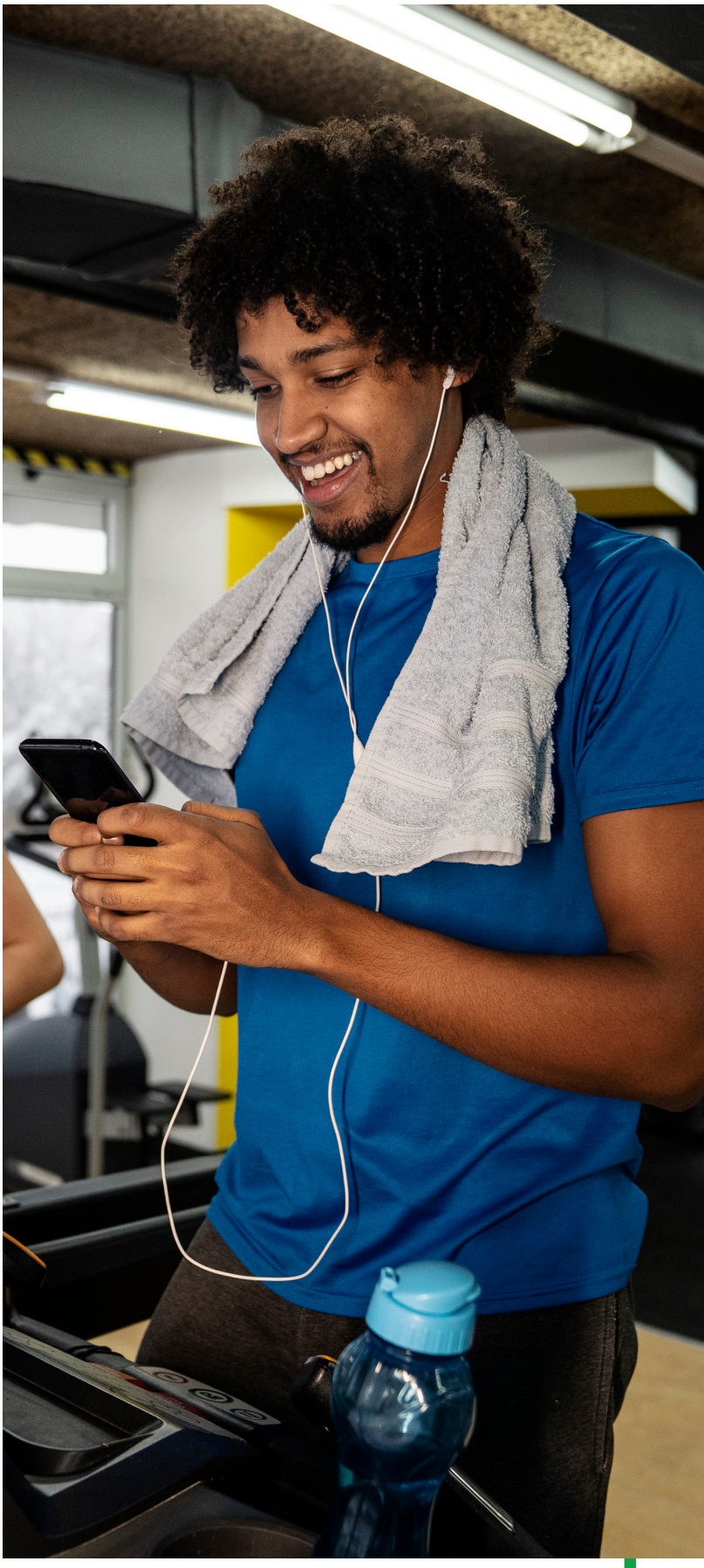
Nidec is excited to announce we are partnering with Hinge Health to help you conquer back and joint pain, recover from injuries, prepare for surgery, or stay healthy and pain free. Best of all, Hinge Health's programs are **provided at no cost** to you and your eligible dependents enrolled in a medical plan.

Hinge Health provides all the tools you need to get moving again from the comfort of your home. Here are some of the ways your treatment plan could be tailored to you:

- Get a personal care team, including a physical therapist and health coach
- Schedule as many personal physical therapy sessions as needed
- Receive wearable sensors that give live feedback on your form in the app
- Get a second opinion on your recommended surgery and treatment plan

If you don't have pain and are just looking to stay healthy, you can sign up for their free app. Recommended exercises will be tailored to you based on your job and lifestyle.

For questions, you can call Hinge Health at **855.902.2777** or send an email to **hello@hingehealth.com**.



Health Savings Account (HSA)

What is a Health Savings Account?

An HSA is a tax-favored account you can use to pay for eligible current and future healthcare expenses with tax-free dollars. You must enroll in the HSA plan to be eligible to open a health savings bank account. There is no use it or lose it rule. Any unused money will remain in your HSA for future use.

Nidec does not own the account. You own the account. If you leave, you keep the funds. You may choose to make contributions to your HSA on a pre-tax basis.

Funds may be withdrawn at any time to pay for qualified medical expenses tax-free for most medical, dental, and vision care. For a complete list of eligible expenses, please refer to IRS Publication 502 at **irs.gov**.

HSA expenses can be incurred by you, your spouse, and dependents claimed on your personal tax return even if the dependents are not enrolled in the HSA plan.

You are Eligible to Open a Health Savings Account if

- You are enrolled in an HSA plan (qualified high deductible health plan)—the CHP
- You are not covered by your spouse's health plan, any other health plan, or flexible spending account
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare, TRICARE, or TRICARE for Life
- You have not received veterans administration benefits in the past three months

Funding Your Account

You may contribute up to the annual IRS limits. It's important you do not go over the IRS limit. Please note the IRS limits shown below are inclusive of the company contributions to your account.

Coverage Tier	IRS Annual Maximum Limit	Nidec Contribution	Employee Maximum*
Employee	$3,650	$788	$2,862
Employee + Spouse	$7,300	$1,600	$5,700
Employee + Child(ren)	$7,300	$1,600	$5,700
Employee + Family	$7,300	$2,400	$4,900

* Individuals age 55 and older who reach age 55 by December 31, 2022 can make a catch-up contribution of up to $1,000 in addition to the employee maximums shown in the table above.

Keep in Mind...

- Nidec contributes HSA seed money to all employees enrolled in the CHP monthly.
- The CHP has the lowest employee paycheck contributions for medical coverage.
- If you switched from the PPO to the CHP you can put those premium savings into your HSA and have those funds to use tax-free during the year when you need them!

Flexible Spending Account (FSA)

What is a Flexible Spending Account?

This voluntary benefit is available to regular (non-temporary) full-time employees. Nidec offers a flexible spending account (FSA) through Health Equity which allows you to set aside pre-tax dollars from your paycheck to pay for qualified medical or dependent care expenses you would normally pay for out of your pocket with after-tax dollars.

Healthcare FSA

The healthcare FSA helps you pay for certain IRS-eligible expenses with pre-tax dollars. The 2022 maximum contribution is $2,750.

Funds you elect to contribute to the healthcare FSA are available in full on the first day of the plan year. For example, if you elect to contribute $1,000, the full election is available to you on day one. You'll continue to pay for the election pre-tax from your paycheck throughout the plan year.

Dependent Care FSA

The dependent care FSA lets you set aside pre-tax dollars to use toward qualified dependent care. The maximum amount you may contribute to the dependent care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Funds you contribute to the dependent care FSA are available as you accrue them during the plan year.

Use It or Lose It

The Healthcare FSA have a "use it or lose it" rule. You need to use up your Healthcare FSA funds by the grace period deadline of March 15, 2022. The claim submission deadline for run out is April 15, 2022 for expenses incurred.

Eligible Expenses

Healthcare FSA

- Doctor's visit copays
- Prescription drug copays
- Medical and dental deductibles
- Over-the-counter medications (with a written prescription)
- Hearing aids
- Eyeglasses/contacts

Dependent Care FSA

- Cost of child or adult daycare*
- Nursery school
- Preschool (excluding kindergarten)

* Eligible dependent: tax dependent child under age 13; tax dependent spouse, parent, or child unable to care for themselves

Dental

We partner with Cigna to offer you and your family members dental insurance. Access to good oral healthcare can help keep your overall health costs down. Regular oral health exams can help detect significant medical conditions before they become serious. Visit **www.cigna.com** to find in-network providers and access a variety of online tools and programs.

Plan Details

	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$0	$25
Family	$0	$75
Annual Maximum Benefit		
	$1,500	$1,500
Dental Care Services		
Preventive Care	100% covered no deductible	80% covered no deductible
Basic Care	20% coinsurance	Deductible then 20% coinsurance
Major Care	50% coinsurance	Deductible then 50% coinsurance
Orthodontia		
Coinsurance	50% covered no deductible	
Lifetime Maximum	$1,000	
Benefit Applies To	Adults and children	

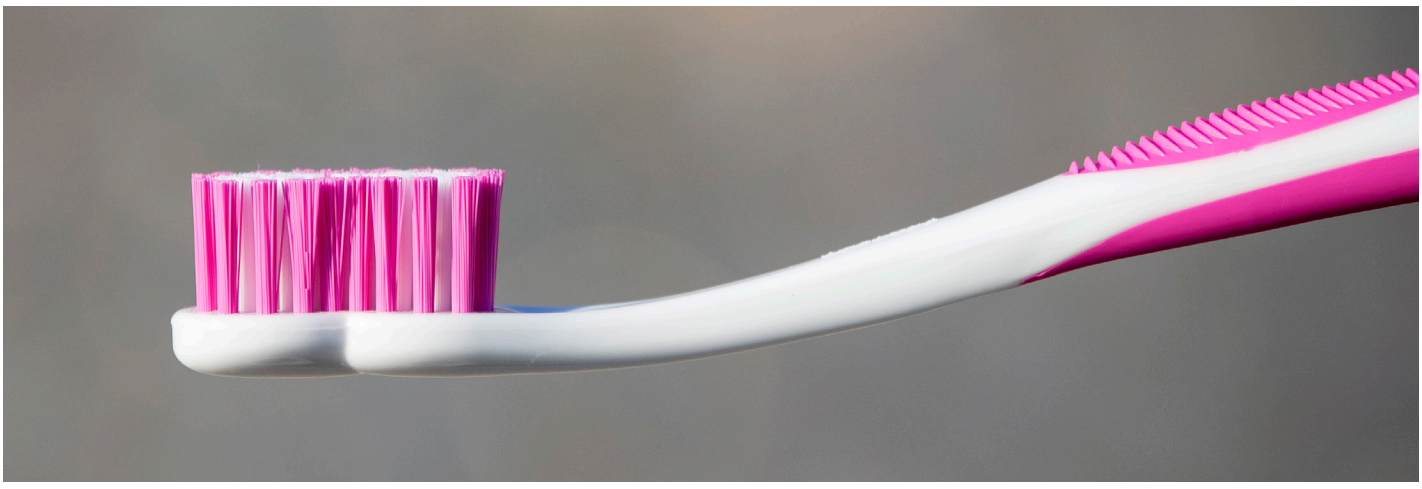
This is a summary of coverage. Full coverage details are available in your Summary Plan Description (SPDs) or official plan documents. In the event there are differences between this summary and your official plan documents, your plan documents prevail.

Orthodontia Services Note

The lifetime maximum illustrated is different from the calendar year maximum. For orthodontia services, this limit does not reset each year, this is the most your plan will cover for your services for the lifetime of your participation in this program.

Examples of Services

- Preventive—exams, cleanings, fluoride, x-rays, and sealants
- Basic—fillings, extractions, periodontics, repairs, and oral surgery
- Major—crowns, inlays, dentures, and dental impacts



Vision

We partner with Cigna to offer you and your family members vision insurance. Whether you need consistent access to comprehensive vision insurance or are exploring this benefit for the first time, our vision insurance coverage is designed to meet a variety of needs. Visit **www.cigna.com** to find in-network providers and access a variety of online tools and programs.

Plan Details

	In-Network	Out-of-Network
Exam (once every 12 months)	$10 copay	Up to $45
Lenses (once every 12 months)		
Single Vision	$15 copay	Up to $32
Bifocal	$15 copay	Up to $55
Trifocal	$15 copay	Up to $65
Lenticular	$15 copay	Up to $80
Approved Contact Lenses (once every 12 months; in lieu of lenses or frames)		
Elective	Up to $150	Up to $120
Therapeutic	Covered 100%	Up to $210
Approved Frames (once every 12 months)		
	Up to $150	Up to $83

This is a summary of coverage. Full coverage details are available in your Summary Plan Description (SPDs) or official plan documents. In the event there are differences between this summary and your official plan documents, your plan documents prevail.

When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

Life and Disability Insurance

Basic Life and AD&D Insurance

Nidec offers company paid life and accidental death and dismemberment (AD&D) insurance. This coverage offers financial protection to you or the beneficiaries you designate during enrollment. You do not pay any premium for this benefit.

Voluntary Life Insurance

In the event you need to purchase additional insurance coverage for your family you may purchase voluntary life insurance at competitive group rates. Once you purchase coverage for yourself you may also purchase coverage for your spouse and eligible dependents.

If you are newly eligible and have not previously waived your opportunity to elect coverage, you can elect up to the plan's guaranteed issue amounts without submitting evidence of insurability (EOI). If you are a late entrant and have previously waived the opportunity to purchase additional coverage, you may be required to submit EOI. EOI requirements are communicated to you when you enroll.

Disability

Nidec offers short term and/or long term disability. Eligibility is based upon business unit and location. Please work with your local benefits partner for additional details.

Our short term disability plan covers a portion of your weekly earnings while you are unable to work due a non-work related short term illness or injury. Our long term disability plan covers a portion of your monthly earnings while you are unable to work due a non-work related short term illness or injury.

Please contact your HR team for more information regarding your life and disability benefits.

Hospital Indemnity Coverage

Why Hospital Indemnity Coverage?

Hospital Indemnity coverage, available through Cigna, pays a benefit when you or your covered dependents are admitted to the hospital for a covered stay. This coverage can complement your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds which can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as coinsurance, copays, and deductibles.

Plan Features

- Delivers a tax-free lump sum benefit
- No pre-existing condition exclusion
- Coverage is portable; if you leave Nidec, you can take this with you

Summary of Benefits	
Benefit Type	Benefit Amount
Hospital Admission (limited to one benefit per year)	$500
Hospital Confinement	$100 per day, up to 30 days
ICU Confinement	$200 per day, up to 30 days

Employees are responsible for the cost of coverage, but will receive a group discount through this plan.

Hospital Indemnity Monthly Premiums

Hospital Indemnity—Cigna	
Employee Only	$9.19
Employee + Spouse	$21.61
Employee + Child(ren)	$16.34
Family	$28.76

These rates shown above are displayed as post-tax.

Additional Benefits

Employee Assistance Program (EAP)

The EAP is a confidential service designed to help employees and families with personal or work/life balance issues. Your employer is providing the EAP to help you toward an early resolution of most any personal concern. This includes access to tens of thousands of clinicians throughout the country without a predetermined, artificial cap on the number of in-person sessions.

Accessing the EAP is easy. Simply call the EAP. Counselors are available, 24 hours a day, 7 days a week. The EAP will gather some information, evaluate your needs, and suggest a possible plan of action.

What Does The EAP Cost?

There is no charge for services provided within the EAP. Your employer has provided short-term counseling, research, consultation, and referral services for you, your family, and your significant others. When necessary, you may be referred to services that go beyond the scope of the EAP. Charges for the services outside the EAP are your responsibility. In some cases, however, your health insurance may cover a portion of the cost of the services you require.

How Confidential Is The EAP?

No information, including your name, can be released without your written consent. The only exceptions are those required by law such as the duty of counselors to warn someone of a serious threat or the mandated reporting of a child and elder abuse.

Teladoc

Teladoc consultations that are available at a low cost to you and your covered family members. Teladoc provides you virtual visit access to a doctor for non-emergency healthcare anytime, anywhere in the U.S. You can talk to a physician without an appointment by using your mobile device or computer to have a private video visit.

Teladoc can be used to treat conditions such as:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems

Issues Addressed By The EAP

- Stress management
- Emotional issues
- Depression, anxiety, and panic attacks
- Elder care resources
- Relationship and family problems
- Chemical dependency
- Eating disorders
- Domestic violence
- Job stress
- Career frustration
- Child care needs
- Grief or loss
- Work/life issues
- Financial resources
- Nutritional questions
- Legal resources
- Health coaching needs

314.845.8302/800.832.8302

Contact Information

Nidec Benefit Center
One Source Vital
833.464.3322
ndecbenefits@onesourcevirtual.com

Medical
Blue Cross Blue Shield of Alabama
800.783.2197
www.bcbsal.org

Dental
Cigna
800.244.6224
www.cigna.com

Vision
Cigna
877.487.7557
www.cigna.com

Life Insurance
Cigna
800.423.1282
Hours: 7:00 a.m. to 7:00 p.m. CST
(Monday–Friday)
www.cigna.com

Disability Insurance
800.36.CIGNA (**24462**)
Hours: 7:00 a.m. to 7:00 p.m. CST
(Monday–Friday)
www.cigna.com

Employee Assistance Program
H&H Health Associates
800.832.8302
www.hhhealthassociates.com

401K
Vanguard 401K
800.523.1188
www.vanguard.com

FSA
Health Equity
877.288.0719
www.healthequity.com

HSA
Health Equity
877.288.0719
www.healthequity.com

Hospital Indemnity
Cigna
800.754.3207
www.cigna.com

Teladoc
Blue Cross and Blue Shield of Alabama
855.477.4549
Teladoc.com/Alabama

Important Notices

Important Notice From Nidec Motor Corporation 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 Nidec Motor Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Nidec Motor Corporation has determined that the prescription drug coverage offered by the Nidec Motor Corporation Employee Healthcare Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the Nidec Motor Corporation Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Nidec Motor Corporation Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Nidec Motor Corporation Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Nidec Motor Corporation prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact Human Resources 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 Nidec Motor Corporation changes. You also may request a copy.

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 (**800.633.4227**). TTY users should call **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 **800.772.1213** (TTY **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 whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Nidec Motor Corporation
Contact—Position/Office: Human Resources

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA Comprehensive Notice of Privacy Policy and Procedures

Comprehensive Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is provided to you on behalf of:
Nidec Motor Corporation Group Healthcare Plan

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of healthcare to you, or payment for the healthcare is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Nidec Motor Corporation that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Healthcare Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other healthcare professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one healthcare plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Healthcare Operations:** The Plan may use and disclose your PHI in the course of its "healthcare operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Nidec Motor Corporation) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the healthcare system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or healthcare operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired, or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or *breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, varies per location. Please contact Human Resources for your Privacy Official.

Organized Healthcare Arrangement Designation

The Plan participates in what the federal privacy rules call an "Organized Healthcare Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for healthcare operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

Nidec Motor Corporation Employee Healthcare Plan

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Nidec Motor Corporation
Human Resources

* **This notice is relevant for healthcare coverages subject to the HIPAA portability rules.**

GENERAL COBRA NOTICE

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this Notice of COBRA healthcare coverage continuation rights because you have recently become covered under one or more group health plans. The plan (or plans) under which you have gained coverage are listed at the end of this Form, and are referred to collectively as "the plan" except where otherwise indicated.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For more information about your rights and obligations under the plan and under federal law, you should either review the plan's Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description.

Note you may have other options available to you when you lose group health coverage. When you become eligible for COBRA, you may also become eligible for other coverage options not provided by your employer that may cost less than COBRA continuation coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage and "Qualifying Events"

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the **spouse of a covered employee**, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or

- You become divorced or legally separated from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you actually lost coverage earlier. **If you notify the Plan Administrator or its designee within 0 days after the divorce or legal separation and can establish that the employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for a period after the divorce or legal separation (but not for the period between the date your coverage ended, and the date of divorce or legal separation)**. But you must provide timely notice of the divorce or legal separation to the Plan Administrator or its designee or you will not be able to obtain COBRA coverage after the divorce or legal separation. See the rules in the box below, under the heading entitled, "Notice Requirements," regarding the obligation to provide notice, and the procedures for doing so.

Your covered **eligible children** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an "eligible child."

Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been **timely notified** that a qualifying event has occurred. When the qualifying event is:

- The end of employment or reduction of hours of employment,
- Death of the employee,

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 0 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 0-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

Once the Plan Administrator or its designee receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.. **If you or your spouse or eligible children do not elect continuation coverage within the 60-day election period described above, you will lose your right to elect continuation coverage.**

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to **36 months.**

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to **18 months.**

There are three ways in which the period of COBRA continuation coverage can be extended…

1. **Disability extension of 18-month period of continuation coverage.**

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage **and you notify the Plan Administrator or its designee in writing and in a timely fashion**, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum o**f 29 months.**

You must make sure that the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* In addition, your notice must include

- The name of the disabled qualified beneficiary,
- The date that the qualified beneficiary became disabled, and
- The date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. **If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.**

2. **Second qualifying event extension of 18-month period of continuation coverage.**

If your family experiences **another qualifying event** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of **36 months (including the initial period of COBRA coverage).**

This extension is available to **the spouse** and **eligible children** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- Dies,
- Gets divorced or legally separated.

The extension is also available to an **eligible child** when that child stops being eligible under the plan as an eligible child.

In all of these cases, you must make sure that the Plan Administrator or its designee is notified in writing of the second qualifying event within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* Your notice must also **name the second qualifying event and the date it happened.** If the second qualifying event is a divorce or legal separation, your notice must include **a copy of the divorce decree or legal separation agreement.**

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. **Medicare Extension for Spouse and Eligible Children.**

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is **36 months** from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Other Rules and Requirements

Same Rights as Active Employees to Add New Dependents. A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, "*Children Born or Placed for Adoption with the Covered Employee During COBRA Period*," for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. **Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change** (*adding or dropping dependents, for example*). See the rules in the box above, under the heading entitled, "*Notice Procedures*," for an explanation regarding how your notice should be made.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period. A child born to, adopted by, or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). **Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.** See the rules in the box above, under the heading entitled, *"Notice Procedures*," for an explanation regarding how your notice should be made.

Alternate Recipients Under Qualified Medical Child Support Orders. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. **Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes, other coverage options not sponsored by your employer may be available. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions

Questions concerning your plan or your COBRA continuation rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at **www.dol.gov/ebsa**."

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Plan and Plan Contact Information

Nidec Motor Corporation
Human Resources

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Nidec Motor Corporation Employee Healthcare Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

The Nidec Motor Corporation Employee Healthcare Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator.

Notes

Notes

2022 BENEFITS **GUIDE**

This benefits guide is only intended to highlight some of the major benefit provisions of the company 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 guide differ from the summary plan descriptions, the summary plan descriptions prevail.

[Rev 10/06/21] NIDMO 22BG Nidec MCE 977366.pdf

Nidec
All for dreams