Takeda

Better Health, Brighter Future

CREATE YOUR BENEFITS PLAN
2021 BENEFITS AT-A-GLANCE

Highlights of your Takeda benefits effective January 1, 2021

This summary highlights key features of the health and welfare benefits available to you as an employee of Takeda and includes premium costs effective January 1, 2021.

NOTE: *All dollar amounts noted in this guide are accurate as of the publish date.*

10.05.20

Medical Benefits (provided by **Aetna**)[1]

PLAN FEATURES	AETNA PPO PLAN		AETNA PPO/HSA PLAN[2]	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Employee Only	$300	$600	$1,500	$3,000
Employee + Spouse	$600	$1,200	$3,000	$6,000
Employee + Child(ren)	$600[3]	$1,200[3]	$3,000	$6,000
Employee + Family	$900	$1,800	$3,000	$6,000
Coinsurance				
Preventive Care[4]	No copay, 100% deductible waived	70% after deductible	100% deductible waived	70% after deductible
All Other Qualified Medical Expenses	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Annual Out-of-Pocket Maximum[5]				
Employee Only	$2,000	$4,000	$3,000	$6,000
Employee + Spouse	$3,500	$7,000	$4,300	$8,600
Employee + Child(ren)	$3,500[3]	$7,000[3]	$4,300	$8,600
Employee + Family	$4,000	$8,000	$6,000	$12,000
Annual HSA Contribution From Takeda[6]				
Employee Only	NA		$900	
Employee + Spouse	NA		$1,800	
Employee + Child(ren)	NA		$1,600	
Employee + Family	NA		$2,430	
Annual HSA Contribution From You[6]				
Employee Only	NA		Up to $2,700	
Employee + Spouse	NA		Up to $5,400	
Employee + Child(ren)	NA		Up to $5,600	
Employee + Family	NA		Up to $4,770	
Covered Medical Services				
Doctor's Office Visit	$20 copay per visit, then 100%	70% after deductible	90% after deductible	70% after deductible
Specialist Office Visit	$35 copay per visit, then 100%	70% after deductible	90% after deductible	70% after deductible
Urgent Care Facility Visit	$35 copay per visit, then 100%	$35 copay per visit, then 100%	90% after deductible	90% after deductible
Emergency Room	$150 copay[7] per visit, then 100%[8]	$150 copay[7] per visit, then 100%[8]	90% after deductible	90% after deductible
Ambulance	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Second Opinion Consultation (Office Visit)	$35 copay per visit, then 100%	70% after deductible	90% after deductible	70% after deductible
Inpatient Hospital Stay	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Inpatient Surgeon's Fee	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Outpatient Surgical Facility	90% after deductible	70% after deductible	90% after deductible	70% after deductible

1 In addition to Aetna, the Kaiser HMO is available to all benefits-eligible employees who live in California, Colorado and Georgia. See bi-weekly premium rates on page 5 of this guide.
2 Eligible employees who are or turn 55 years of age during the plan year can contribute an additional $1,000 catch-up contribution to their HSA.
3 If coverage extends to more than one child, employee + family annual deductible and annual out-of-pocket maximum amounts apply.
4 Preventive care includes routine care for children and adults (e.g., mammograms and prostate-specific antigen tests).
5 Annual out-of-pocket maximum includes annual deductible. Note there is a separate annual out-of-pocket maximum for prescription drugs ($1,000 for employee coverage and $2,000 for all other coverage levels).
6 Annual IRS limit combines Takeda's contribution plus your own; find 2021 limits at irs.gov, search "HSA, limit." Takeda will prorate contributions for new employees based on start date.
7 Emergency Room copay is waived if patient is admitted to hospital.
8 If not a true emergency – as defined by the plan – annual deductible applies and plan pays a reduced level of coinsurance: 90% in-network and 70% out-of-network.

Medical Benefits for 2021 (provided by **Aetna**)[1] *(continued)*

SERVICE	AETNA PPO PLAN		AETNA PPO/HSA PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity Benefits				
Initial Visit to Confirm Pregnancy	$35 copay, then 100%	70% after deductible	90% after deductible	70% after deductible
Prenatal/Postnatal Visit	100%, no deductible	70% after deductible	100%, no deductible	70% after deductible
Hospital Delivery	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Mental Health, Alcohol and Drug Abuse Rehabilitation Benefits				
Inpatient	90% after deductible	70% after deductible	90% after deductible	70% after deductible
Outpatient	$20 copay per visit, then 100%	70% after deductible	90% after deductible	70% after deductible

1 In addition to Aetna, the Kaiser HMO is available to all benefits-eligible employees who live in California, Colorado and Georgia. See bi-weekly premium rates on page 5 of this guide.

Medical Benefits for 2021 (provided by **Kaiser** HMO)[1]

PLAN FEATURES	KAISER CA HMO *Plan Provider In-Network Benefits*	KAISER CO HMO *Plan Provider In-Network Benefits*	KAISER GA HMO *Plan Provider In-Network Benefits*
Annual Deductible			
Individual/Family	None	None	None
Coinsurance			
Carrier/Member	N/A	N/A	N/A
Annual Out-of-Pocket Maximum			
Individual/Family *(includes deductible, copay and coinsurance amounts)*	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000
Office Visits			
• Primary Care Physician	$20 copay	$20 copay	$20 copay
• Pediatrician	$20 copay	$20 copay	$20 copay
• OB/GYN	$20 copay	$20 copay	$20 copay
• Specialist	$35 copay	$35 copay	$35 copay
• Telemedicine	$0 copay	$0 copay	$0 copay
Preventive Services			
(Physical Exams, Well Child Care, Well Woman Care, Immunizations, and Screenings)*	Covered in full	Covered in full	Covered in full
Outpatient Diagnostic Services			
• Lab and Radiology/X-ray	$10 copay	$10 copay/$10/copay/ Covered in full	$10 copay
• Mammography Testing	$10 copay	100% covered	$10 copay
• CT Scans, PET Scans and MRI	$10 copay	$50 copay	$10 copay
Hospitalization			
• Inpatient Services	$250 copay	$250 copay	$250 copay
• Outpatient Surgery	$100 copay	$100 copay	$100 copay
Lifetime Maximum	None	None	None
Maternity			
• Delivery & Inpatient Services	$250 copay	$250 copay	$250 copay
• Pre- and Post-natal visits	$0 copay	$0 copay	$0 copay
Emergency Visits			
• E.R. Visit	$75 copay	$75 copay	$75 copay
• Urgent Care Facility	$20 copay	$20 copay	$20 copay
Physical, Speech & Occupational Therapy	$20 copay (no limits)	$20 copay (20 visits per therapy per year)	$20 copay (20 visits per therapy per year)
Spinal Treatments	$20 copay (30 visits per year)	$20 copay (30 visits per year)	$20 copay (30 visits per year)
Mental Health/Substance Abuse			
• Inpatient Services	$250 per admission	$250 per admission	$250 per admission
• Outpatient Visits	$20 copay	$20 copay	$20 copay
Durable Medical Equipment	20%	20%	20%

1 The regional Kaiser plans operate more like a traditional Health Maintenance Organization (HMO) — charging co-pays for most services and covering in-network services only, except in cases of emergency. Kaiser offers strong regional provider networks in California, Colorado and Georgia. Kaiser medical coverage also includes prescription drug coverage.

Prescription Drug Benefits for 2021 (provided by **Aetna**)[1]

SERVICE	AETNA PPO PLAN[2]		AETNA PPO/HSA PLAN[3]	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Pharmacy Coinsurance *(30-day supply)*	80% deductible waived	70% deductible waived	90% after deductible	70% after deductible
Generic Prescription Copay	• Minimum: $10 • Maximum: $55	NA	NA	NA
Brand Formulary (Retail) Prescription Copay	• Minimum: $20 • Maximum: $55	NA	NA	NA
Brand Non-Formulary (Retail) Prescription Copay	• Minimum: $35 • Maximum: $55	NA	NA	NA
Mail Order Coinsurance *(90-day supply)*	80% deductible waived	NA	90% after deductible	NA
Generic Prescription Copay	• Minimum: $20 • Maximum: $110	NA	NA	NA
Brand Formulary (Mail) Prescription Copay	• Minimum: $40 • Maximum: $110	NA	NA	NA
Brand Non-Formulary (Mail) Prescription Copay	• Minimum: $70 • Maximum: $110	NA	NA	NA
Preventive Prescription Drugs	100% copay waived		100% deductible waived	70% after deductible

1 The cost of prescription drug coverage is included in the premium contributions for Medical program coverage.
2 Annual out-of-pocket maximum is $1,000 for employee coverage and $2,000 for all other coverage levels.
3 The PPO/HSA plan does not have a separate deductible for Rx, since it is included in the medical coverage deductible.

Prescription Drug Benefits for 2021 (provided by **Kaiser** HMO)

SERVICE	KAISER CA, CO, and GA HMO
Retail Pharmacy Coinsurance *(30-day supply)*	
• Generic	$15 copay
• Brand	$30 copay
Mail Order Coinsurance	
• Generic	$30 copay
• Brand	$60 copay
Rx Out-of-Pocket Maximum	
Individual/Family	Combined with Medical OOP Max

Dental Benefits for 2021 (provided by Delta Dental/Massachusetts & CIGNA Dental HMO)[1]

	Delta Dental PPO	Delta Dental Premier	Out-of-Network[2]	CIGNA Dental HMO
COVERED SERVICES				
Annual Deductible	$50/person; $150/family			N/A
Annual Maximum Benefit (per person)	$2,000			N/A
Coinsurance				
Preventive and Diagnostic	100% – deductible waived			100%
Basic Treatment[3]	90% after deductible	80% after deductible	80% after deductible	Copay schedule applies for basic and major treatments
Major Treatment[4]	60% after deductible	50% after deductible	50% after deductible	
Orthodontia (children and adults)	50%, no deductible – up to a $2,000 per person lifetime maximum			Copay schedule applies. Lifetime maximum of 24 months in treatment also applies.

1 In addition to Delta Dental, the Cigna Dental HMO plan will be available to benefits-eligible employees in qualifying zip codes. If you qualify for dental coverage through Cigna, that option will be presented to you on the Takeda Benefits portal. See bi-weekly premium rates at the bottom of this page.
2 Benefits are based on reasonable and customary (R&C) charges; you pay any amount in excess of the applicable R&C charge.
3 Basic Treatment services include amalgam and composite fillings, root canal treatment and simple extractions.
4 Major Treatment services include crowns, fixed, removable and partial dentures and bridgework.

Vision Benefits for 2021 (provided by VSP)

COVERED SERVICES	In-Network[1]	Out-of-Network[1]
Examination	$10 copay per visit, then 100%	Up to $45
Lenses[2,3]	$25 copay per visit, then 100%	• Up to $30 for single-vision lenses • Up to $50 for bifocal lenses • Up to $65 for trifocal lenses • Up to $100 for lenticular lenses
Frames[2,3]	Up to $160 retail	Up to $70
Contact Lenses – Medically Necessary[3,4,5]	$10 copay per visit, then 100%	Up to $210
Contact Lenses – Elective[3,4]	Up to $160	Up to $105

1 Specified benefits are paid once every 12 months for you and each covered dependent.
2 Each covered person receives a 20% discount toward the purchase of additional complete pairs of prescription glasses (lenses, lens options and frames) from a VSP provider.
3 In any 12-month period, the plan pays benefits for eyeglass lenses and frames OR contact lenses for a covered participant, but not both.
4 The cost of a VSP doctor's professional services are discounted 15% when buying contact lenses; materials are provided at customary fees.
5 Medically necessary contact lenses must be prescribed by a VSP doctor for certain conditions (subject to prior approval from VSP).

Bi-Weekly Premium Costs: Medical, Dental and Vision Benefits for 2021[1]

	MEDICAL			DENTAL		VISION
COVERAGE LEVEL	**PPO**[2] *(Aetna)*	**PPO/HSA**[2] *(Aetna)*	**HMO**[3] *(Kaiser)*	**Delta Dental**	**Cigna HMO**[4]	**VSP**
Employee Only	$51.00	$31.00	$41.00	$7.00	$3.00	$3.89
Employee + Spouse	$143.00	$92.00	$104.00	$13.00	$8.00	$7.79
Employee + Child(ren)	$107.00	$75.00	$79.00	$14.00	$9.00	$8.33
Employee + Family	$199.00	$128.00	$146.00	$19.00	$14.00	$13.32

1 In general, the cost you pay for program coverage through premium contributions for yourself and your dependents will be deducted from your pay on a pre-tax basis. Under federal tax guidelines, however, if you include a domestic partner or the eligible dependents of a domestic partner under your coverage, the portion of the premium contribution that covers the cost of their coverage will be deducted from your pay on a post-tax basis.
2 The cost of prescription drug coverage is included in the premium contributions for Medical program coverage.
3 In addition to Aetna, the Kaiser HMO is available to all benefits-eligible employees who live in California, Colorado and Georgia. The cost of prescription drug coverage is included in the premium contributions for Kaiser HMO Medical program coverage.
4 In addition to Delta Dental, the Cigna Dental HMO plan will be available to employees in qualifying zip codes. If you qualify for dental coverage through Cigna, that option will be presented to you on the Takeda Benefits portal.

Life and Accident Insurance Benefits for 2021 (provided by Lincoln Financial)

TYPE OF COVERAGE	BENEFIT
Company-Paid Insurance	
Basic Life Insurance[1]	Automatic coverage for yourself equal to 2x your base salary – up to $1,500,000 maximum benefit **OR** $50,000
Accidental Death & Dismemberment Insurance[1]	Automatic coverage for yourself equal to 2x your base salary – up to $1,500,000 maximum benefit
Supplemental Life Insurance[1,4]	
For Employees	Optional coverage for yourself equal to 1x to 8x your base salary – up to $3,000,000 maximum benefit[2]
For Spouse[3]	Optional coverage for your eligible spouse or domestic partner – $10,000-$500,000 in $10,000 increments
For Dependent Child(ren)	Optional coverage for your eligible dependent child(ren) – $5,000, $10,000, or $25,000

Supplemental Life Insurance Rates: 2021 Monthly Premium Costs *(Based on salary and age as of January 1, 2021)*

Employee Supplemental Life (per $1,000)												
Age	**Under 24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
Rate/$1,000	$0.033	$0.025	$0.026	$0.036	$0.055	$0.089	$0.143	$0.219	$0.316	$0.460	$0.791	$2.020

Spouse Supplemental Life (per $1,000)												
Age	**Under 24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
Rate/$1,000	$0.049	$0.040	$0.041	$0.054	$0.078	$0.122	$0.190	$0.286	$0.411	$0.596	$1.019	$2.020

Dependent Child – Rates/$1,000 of coverage based on coverage amount *(EOI not required)*			
Coverage Amount	$5,000	$10,000	$25,000
Rate/$1,000	$.046		

1 Basic Life, Supplemental Life and AD&D insurance coverage is reduced by 50% at age 70.
2 The amount of coverage available on the date of hire without an Evidence of Insurability (EOI) Statement is $600,000 or 4x base salary.
3 If you and your spouse (or domestic partner) are both employed by the company, you are not eligible to elect Supplemental Life Insurance for Spouse.
4 You can buy Supplemental Life Insurance for your eligible dependents ONLY if you buy Supplemental Life Insurance for yourself. The amount of Supplemental Life Insurance you elect for your dependents may not be greater than your Supplemental Life Insurance amount.

Disability Benefits for 2021 (provided by Lincoln Financial)

PLAN FEATURES	SHORT-TERM	LONG-TERM
Plan Benefits	**Short-Term Disability (STD) Benefits** provide 100% of your pre-disability base salary regardless of whether you are full-time or part-time.	**Long-Term Disability (LTD) Benefits** provide 66-2/3% of your pre-disability base salary – up to a maximum benefit of $12,000 per month.

Flexible Spending Accounts (FSA) for 2021

COVERED SERVICES	HEALTH CARE FSA	DEPENDENT CARE FSA
Minimum Contribution	$100 per year	$100 per year
Maximum Contribution	$2,750 per year	$5,000 per year – if married and filing a joint return $2,500 per year – if married and filing separate returns

Starting in 2021, PayFlex will be the FSA provider for all benefits-eligible employees in the U.S.

If you choose to participate in an FSA, you must renew your enrollment each year during Annual Enrollment.
Budget your estimated expenses carefully. You will forfeit any unused money in an FSA at the end of the calendar year.

Glossary

Annual deductible	The amount you pay in a calendar year – excluding premiums and copays – before your medical or dental coverage begins paying benefits.
Annual out-of-pocket maximum	The most you will pay through a combination of the annual deductible, coinsurance and copays for covered medical services in a calendar year.
Coinsurance	The percentage of the total cost that you must pay for a given medical procedure or prescription.
Copay	A set dollar amount you must pay at the time of service for certain procedures, services and products.
Coverage level	You choose your coverage level based on whether you want medical, dental and/or vision coverage for you only or for you and one or more eligible dependents. • Employee Only – yourself only. • Employee + Spouse – yourself plus your spouse or qualified domestic partner. • Employee + Child(ren) – yourself plus one or more eligible child. • Employee + Family – yourself plus your spouse or qualified domestic partner plus all eligible children.
In-network	Refers to procedures, services and products received from or purchased through a medical, dental or vision care provider who is a member of the applicable vendor network. Network members accept negotiated rates as payment in full for services provided to plan participants which means that the charges for any services you receive are discounted, so you pay less for in-network services.
Out-of-network	Refers to procedures, services and products received from or purchased through a medical, dental or vision care provider who is NOT a member of the applicable vendor network. Negotiated (discounted) rates do not apply, so you pay more for out-of-network services.
Premium (payroll contribution)	The pre-tax amount you pay through automatic payroll deductions for any medical, dental and/or vision coverage you elect. Premiums for 2021 are presented on page 5 of this brochure.

LEARN ABOUT YOUR OPTIONS: Go to **myTakeda > USHR > myBenefits > Benefits Enrollment**

Contact Your 2021 Health Care Providers

Benefit	Provider	Website	Phone
Medical	**Aetna**	**aetna.com**	**866-723-7110**
	Kaiser CA *(HMO)*	**kp.org**	**800-278-3296**
	Kaiser CO *(HMO)*		**855-249-5005**
	Kaiser GA *(HMO)*		**888-865-5813**
Prescription Drugs	**Aetna**	**aetna.com**	**888-792-3862**
Dental	**Delta Dental**	**deltadentalma.com**	**800-872-0500**
	Cigna DHMO *(Employees in qualifying zip codes)*	**cigna.com**	**800-244-6224**
Vision	**Vision Service Plan (VSP)**	**vsp.com**	**800-877-7195**
Life & Accident Insurance	**Lincoln Financial**	**www.lfg.com/public/individual**	**888-787-2129**
Health Savings Account (HSA)	**Health Equity**	**healthequity.com**	**844-281-0928**
Flexible Spending Account (FSA)	**PayFlex**	**payflex.com**	**888-678-8242**

This *Benefits At-A-Glance* includes reference to certain benefit programs and plans available to eligible Takeda employees. If there is a discrepancy between the information contained in this *Benefits At-A-Glance* and the terms and provisions of a program or plan's legal documents, the legal documents will govern. Takeda's benefit programs and plans do not constitute a promise or contract of employment and do not affect your status as an at-will employee. Nothing contained in this *Benefits At-A-Glance* is intended to or shall evidence or create any express or implied contractual obligations that are binding upon you or Takeda. Takeda reserves the right in its sole discretion and at any time to change, suspend, interpret and/or cancel, in whole or in part, any and all of Takeda's benefit programs and plans.