Legal Notices

There are several legally required notices that you should be aware of, as they may apply to you. This summary includes those notices and provides other important information about your benefits.

Contents

Qualified Changes in Status

Be sure to consider your choices carefully before making your benefit elections. Once you make your elections, they will remain in effect through the end of the calendar year, unless you have a qualified change in status as defined by the IRS during the year, such as:

- Marriage, divorce, legal separation, or annulment,
- Birth, adoption, or placement of a child for adoption,
- Any event that changes your employment status or the employment status of your spouse or dependent, such as terminating or starting employment, change in worksite, or change of employment classification (for example, part-time to full-time or vice versa) that causes a loss or gain of coverage,
- You lose coverage through a parent or stepparent's health care plan due to reaching the limiting age for a dependent,
- Your spouse acquires or loses coverage through his/her employer,
- Your child gains or loses eligibility for your coverage,
- Your dependent spouse or child dies,
- A significant increase or decrease in your or your spouse's benefit cost or coverage, or
- A change in your place of residence that causes a loss or gain of coverage.

When you have a major life event that can affect your coverage, you have 31 calendar days after the event to make changes.

You may make changes to your coverage when you experience a qualified status change through the ***Arkema Benefits Online*** website or by calling the Arkema Benefits Center at **1-800-406-9823, Monday to Friday, 9 a.m. – 6 p.m. Eastern**.

Continuation Coverage Rights Under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and eligible dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end (called “qualifying events”).

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the federal law. In some states, state law continuation provisions may also apply to the insurers offering benefits under the plan. For more information, please contact the COBRA Administrator at the address shown in *Contacting the COBRA Administrator* later in this document or call the Arkema Benefits Center.

Continuation coverage under COBRA is provided subject to your eligibility for coverage. Arkema reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the plan.

The table below provides a summary of the COBRA provisions outlined in this section.

Qualifying Events that Result in Loss of Coverage	**Maximum Continuation Period**		
	Employee	**Spouse**	**Child(ren)**
Employee’s work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse divorce	N/A	36 months	36 months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 months*	36 months*
Child(ren) no longer qualifies as a dependent	N/A	N/A	36 months

* 36-month period is counted from the date you become entitled to Medicare.

Qualifying Events

If you are an employee covered by an Arkema-sponsored group health plan, you have a right to choose this continuation coverage if your employment terminates (for any reason other than your gross misconduct) or if your hours worked are reduced so that you lose your group health coverage, you, your covered spouse and dependent child(ren) may continue medical coverage under the plan for up to 18 months. If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the FMLA leave period.

If you should die, become divorced/terminate domestic partnership or become entitled to Medicare, your covered dependents whose health coverage under the plan would be reduced or terminated due to one of these events, may continue medical coverage under the plan for up to 36 months. Also, your covered child(ren) may continue medical coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

QMCSO: A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Arkema during the covered employee's period of employment with Arkema is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked.

Your Duties

Under the law, an active employee or a family member of an active employee has the responsibility to inform the COBRA Administrator of a divorce, or a child losing dependent status under the medical plan. You must contact the COBRA vendor within 60 days from the date of the divorce or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event) and include the following information:

1. The name of the employee who is or was covered under the plan;

2. The name(s) and address(es) of all qualified beneficiary(ies) who lost (or will lose) coverage under the plan due to the qualifying event;

3. The qualifying event giving rise to COBRA coverage;

4. The date of the qualifying event;

5. The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if it is requested. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, or marriage license.

The notice must include information about the qualifying event that gave rise to the individual's right to continuation coverage. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

1. Death: A copy of the death certificate.

2. Divorce: A copy of the divorce decree.

3. Child(ren) no longer qualifying as a dependent: A copy of a driver's license or birth certificate showing the child(ren)'s age [in the case of a child(ren) becoming too old for coverage).

4. Entitlement to Medicare: A letter from the Social Security Administration indicating the employee is entitled to Medicare benefits.

The notice should be mailed to the COBRA Administrator at the address listed in *Contacting the COBRA Administrator* later in this document. This notice must be provided within 60 days from the date of the divorce or child losing dependent status (or if later, the date coverage would normally be lost because of the event). If you or a family member fails to provide this notice to the COBRA Administrator during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage.

When the Arkema Benefits Center is notified that one of these events has happened, the Arkema Benefits Center in turn will notify you that you have the right to choose continuation coverage. If an active employee or a family member fails to notify the Arkema Benefits Center and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Arkema's Duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occur that will result in a loss of coverage:

1. The employee's death or termination (for reasons other than gross misconduct),

2. A reduction in the employee's hours of employment, or

3. Notification of an employee's entitlement to Medicare.

Electing and Paying for COBRA Continuation Coverage

To elect or inquire about COBRA coverage, contact the Arkema Benefits Center.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after the COBRA Administrator provides you with notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage. To elect COBRA coverage you must complete the election form that is part of the medical plan's COBRA election notice. You must mail or hand-deliver this completed notice to the COBRA Administrator. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you choose continuation coverage, Arkema is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the end of the month in which the qualifying event occurs. If you return your election form waiving your rights to COBRA and change your mind within the 60-day period, you may revoke your waiver and still elect COBRA coverage as long as it is within the 60-day window. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Newly Eligible Child: If a former employee elects COBRA coverage and then has a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the COBRA Administrator with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 31 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the COBRA Administrator within the 31 days, you will not be offered the option to elect COBRA coverage for the newly acquired child. Other newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the plan's rules for adding a new dependent.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child(ren) is entitled to elect continuation coverage even if the covered employee does not make that election. A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. And, at subsequent open enrollments, a spouse or dependent child may elect a different coverage option from the coverage option the employee elects.

Cost

Continuing Active Coverage: You will be required to pay the full cost of covering an employee, and any eligible dependents, if applicable, subject to any applicable government subsidy. In addition, there is a 2% administrative fee, making your payment a total of 102% of the cost of coverage.

Premium Due Date: If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Additional Cost Requirements for Continuation of Active Coverage Only: The cost of coverage for months 19 through 29 of coverage under the disability extension is (1) 102% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and (2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided on the next page.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during months 19 through 29), then the rate for months 19 through 36 of the COBRA continuation period is (1) the 102% rate for all family members participating in the same coverage option as the disabled individual, and (2) the 102% rate for any family members in a different coverage option than the disabled individual.

Duration of COBRA

If you lose plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

Additional qualifying events (such as a death, divorce or child turning age 26) may occur while the continuation coverage is in effect. These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

Medicare: When plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits within 18 months BEFORE termination or reduction of hours, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement.

COBRA coverage can end before any of the above maximum periods for several reasons. See the *Early Termination of COBRA* later in this document for more information.

Additional Qualifying Events

Under the law, in order to receive an extension of continuation coverage, a former employee or family member of a former employee has the responsibility to inform the COBRA Administrator of the death of an employee, divorce or a child losing dependent status under the medical plan, or

entitlement of an employee to Medicare which occurs after an employee's termination of employment or reduction in hours.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days from the later of (1) the date of the second qualifying event, or, if later, (2) the date on which the qualified beneficiary would have lost coverage because of the event under the terms of the plan (if it had occurred while the qualified beneficiary was still covered under the plan as an active participant).

Written notice of the additional qualifying event must be provided to the COBRA Administrator. This notice should be mailed or hand-delivered to the COBRA Administrator at the address listed in *Contacting the COBRA Administrator* later on in this document and must include the following information:

1. The name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;

2. The second qualifying event;

3. The date of the second qualifying event;

4. The signature, name and contact information of the individual sending the notice.

In addition, the employee or qualified beneficiary must provide the COBRA Administrator with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

1. Death: A copy of the death certificate.

2. Divorce: A copy of the divorce decree.

3. Child no longer qualifying as a dependent: A copy of a driver's license or birth certificate showing the child's age (in the case of a child becoming too old for coverage).

4. Entitlement to Medicare: A letter from the Social Security Administration indicating the employee is entitled to Medicare benefits.

When the COBRA Administrator is notified that one of these events has happened, the family member will automatically be entitled to an extended period of continuation coverage. If a former employee or family member fails to provide the appropriate notice and supporting documentation to the COBRA Administrator during this 60-day notice period, the family member will not be entitled to extended continuation coverage.

Special Rules for Disability

The 18 month continuation period due to termination of employment or reduction in hours may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) prior to the qualifying event or at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

1. The date of the Social Security Administration's disability determination;
2. The date of the covered employee's termination of employment or reduction of hours; and
3. The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

1. The name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
2. The name and addresses of the disabled qualified beneficiary;
3. The date that the qualified beneficiary became disabled;
4. The date that the Social Security Administration made its determination of disability;
5. A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
6. The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand-deliver this notice to the COBRA Administrator.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this redetermination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

If a qualified beneficiary is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

Early Termination of COBRA Continuation Coverage

COBRA continuation of health coverage for any person may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

1. The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
2. After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by Arkema that does not

contain an exclusion or limitation affecting the person's preexisting condition, or the other plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.

3. After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)
4. In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
5. Arkema terminates all its group health plans.

COBRA coverage may also be terminated for any reason the plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, Arkema reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

If you become covered by another group health plan, the medical plan may terminate your COBRA coverage.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health. Arkema, the insurance carriers and/or HMOs may require repayment to the plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled.

Contact the Arkema Benefits Center for further details. Also, if you or your spouse has changed your address, please notify the COBRA Administrator.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Contacting the COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA Administrator at the address listed below. You may also 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 website at **www.dol.gov/ebsa.**

Also, if your marital status has changed, or you, your spouse or a dependent have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you must notify the Arkema Benefits Center if you are an active employee or the COBRA Administrator if you are a former employee, in writing immediately at the address listed below.

All notices and other communications regarding COBRA and the Arkema Inc. Medical Plan should be directed, as discussed above, to the COBRA Administrator at:
Health Equity/Wage Works
P.O. Box 226101
Dallas, TX 75222
1-877-722-2667

Alternatives to COBRA Continuation Coverage

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.**

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 (in NH only)
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 Email:
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/agencies/ebsa** 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Special Enrollment Rights

If you are declining enrollment in Arkema's medical plans for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan without waiting for the next Open Enrollment period, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 31 calendar days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 31 days after the marriage, birth, adoption or placement for adoption.

Arkema will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or

- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 calendar days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Arkema group health plan. Note that this 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Women’s Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). 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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator at the Member Services number listed on your medical plan ID card.

Newborns' and Mothers' Health Protection Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Massachusetts Minimum Creditable Coverage Statement

The PPO and CDHP health plan options both meet Minimum Creditable Coverage standards for Massachusetts residents effective January 1, 2022, as part of the Massachusetts Health Care Reform Law.

HIPAA Privacy Notice Reminder

Arkema Inc.

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Arkema Inc. Group Health Plan (the “Plan”) to periodically send a reminder to participants about the availability of the Plan’s Privacy Notice and how to obtain that notice. The Privacy Notice explains participants’ rights and the Plan’s legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice, review the Privacy Notice in the Medical Summary Plan Description through the ***Arkema Benefits Online*** **website** or request a copy by calling the Arkema Benefits Center at **1-800-406-9823**, Monday through Friday from 9:00 a.m. to 6:00 p.m., Eastern Time.

You may also contact the Plan’s Privacy Official at **1-610-205-7349** or **Robert.Follis@arkema.com** for more information on the Plan’s privacy policies or your rights under HIPAA.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital, hospital outpatient center, critical access hospital, or ambulatory surgical center, you are protected from surprise billing or balance billing. The No Surprises Act Final Rules require certain group health plans to disclose on a public website information about your protections against surprise billing. Please carefully review this "Your Rights and Protections Against Surprise Medical Bills" notice.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may send complaints about potential violations of federal or state law to:

- The U.S. Department of Health & Human Services at:
    - Phone: **+1 800 985 3059**
    - Website: **Consumers: protections against surprise medical bills | CMS**, at https://www.cms.gov/nosurprises/consumers.
- Your state agency, which can be located through **State Consumer Assistance Programs | CMS**, at https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Review the No Surprises Billing notice for Aetna

Visit https://www.aetna.com/individuals-families/member-rights-resources/rights/federal-no-surprises-act.html to learn more.

Transparency in Coverage — Machine-Readable Files

The Transparency in Coverage Final Rules require certain group health plans to disclose on a public website information regarding covered items and services for both in-network provider rates and historical out-of-network allowed amounts and billed charges in two separate machine-readable files (MRFs). This requirement arises under the amendment of the Public Health Service Act under the “Health Care Prices Revealed and Information to Consumers Explained Transparency Act,” also known as the “Health Care PRICE Transparency Act.”

The MRFs for Aetna are available at https://health1.aetna.com/app/public/#/one/insurerCode=AETNACVS_I&brandCode=ALICSI/machine-readable-transparency-in-coverage?searchTerm=9452682&lock=true. Please call Aetna for specific search instructions.