# Arkema Inc. Flexible Spending Accounts Plan

## Summary Plan Description

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**Disclaimer Note**

This summary plan description describes certain benefits as they apply to eligible employees. Complete details about the benefit plan are in the legal plan documents. If there is any difference between the information provided in this summary plan description and provisions of the legal plan documents, the plan documents govern. Arkema Inc. reserves the right to terminate, suspend, withdraw, amend or modify any of the plans at any time and for any reason.

# About This Summary Plan Description

This summary plan description (SPD) summarizes the main provisions of the Arkema Inc. Flexible Spending Accounts Plan, effective January 1, 2021. It describes the benefits as they apply to eligible employees of Arkema Inc. (the Company). Certain policy limitations and exclusions apply to coverage. Complete details of the plan are contained in the official plan document. If there is any difference between the information in this SPD and in the official plan document, the plan document will govern.

Arkema reserves the right to modify, suspend or amend the plan described in this document at any time, in whole or in part. This means the plan may be discontinued in its entirety, changed to provide different levels of benefits and/or cost sharing between the Company and employees. Any such change or termination shall be solely at the discretion of the Company. If such termination or change occurs, participants will be promptly notified.

We encourage you to read this SPD carefully and share it with your family members. If you have any questions about the benefits, please contact the Arkema Benefits Center at 1-800-406-9823. You may also access *Arkema Benefits Online* website at **benefits.myplansconnect.com/Arkema** for more benefits information.

Keep this Summary Plan Description (SPD) and other applicable SPDs for your future reference when you want to find details about Arkema-sponsored benefit plans and programs. When changes are made to these programs, Arkema communicates those changes to participants. In many, but not all instances, changes are communicated through Summaries of Material Modifications (SMMs). SMMs are frequently part of the Open Enrollment materials. Please keep the communications that notify you of changes in the employee benefit programs with this document for future reference.

# Eligibility and Enrollment

This booklet includes important information about your participation in the Arkema Inc. Flexible Spending Accounts Plan (the "plan" or "FSA Plan"), including eligibility information, when to enroll, when you can make election changes and when coverage ends.

## Eligibility

You are eligible to participate in the FSA Plan only if you are a regular, full-time employee or a regular, part-time employee who is regularly scheduled to work at least 20 hours per week. A person in any other status is not eligible to participate in the FSA Plan.

An employee who is covered by a collective bargaining agreement is eligible to participate only if the applicable labor contract incorporates the benefit at issue, and if the employee meets the eligibility requirements described above as set forth in the collective bargaining agreement.

## Enrollment

You must enroll within 31 days after you initially become eligible for participation in the FSA Plan. When you enroll, you authorize the Company to deduct any required contributions from your pay.

### If You Are a New Hire

If you are a new employee enrolling during the year, coverage will begin as of your first active date of employment. However, you must enroll in the plan to receive benefits. You are required to enroll within 31 days of your employment date. When you enroll within the 31-day grace period, your coverage is retroactive to your first active day of employment. Your initial election will continue through December 31 of your first year in the plan.

If you fail to enroll during the initial 31-day enrollment period or choose to waive coverage, you may not enroll for coverage until the following Open Enrollment period unless you experience a qualified change in family status or qualify for HIPAA special enrollment rights. For more information, see *Making Changes During the Year* on page 5.

### Annual Open Enrollment

If you are a current employee, you may enroll for coverage, change your contribution amount, or waive coverage during the annual Open Enrollment period, which is held each fall for the following plan year. Coverage will begin on January 1 and remain in effect through December 31. According to IRS rules, you may only make changes in your election during the year if you have a qualified change in status, become entitled to a HIPAA special enrollment rights or if you

experience a different event permitting a mid-year election change. For more information, see *Making Changes During the Year* on page 5.

## If You and Your Spouse Have Access to FSAs

If both you and your spouse have access to FSAs through your employer, you may both participate in the FSA Plans. With respect to the Health Care Flexible Spending Account (Health Care FSA) or Limited Purpose Health FSA (Limited FSA), you may each contribute up to the maximum annual individual amount allowed, which is $2,750 per year in 2021.

However, under the Dependent Care Flexible Spending Account (Dependent Care FSA) rules, the annual limit is subject to specific rules. In 2021, married individuals who file joint tax returns can contribute up to $5,000 (up to $10,500 adjusted by the American Rescue Plan Act in March 2021 for 2021 only) in total; those filing separately can contribute up to $2,500 (up to $5,250 when adjusted by the American Rescue Plan Act for 2021 only) each.

Any changes to these maximums are announced annually by the IRS.

## If You Don't Enroll

If you are a new hire and you do not enroll for coverage within 31 days, you will not be able to participate in the FSA Plan.

If you are a current employee and you do not enroll during Open Enrollment, you will not be able to participate in the FSA Plan. You must make a new election each year during Open Enrollment. If you don't enroll for the coming year you will not have an FSA account, and you will not be able to enroll until the next Open Enrollment, which applies to the next calendar plan year — unless you have a qualified status change or become entitled to a HIPAA special enrollment rights. For more information, see *Making Changes During the Year* on page 5.

## If You Waive Coverage

If you waive coverage as a new hire or during Open Enrollment, you must wait until the next Open Enrollment in the fall to enroll, unless you have a qualified status change or become entitled to a HIPAA special enrollment rights during the year. For more information, see *Making Changes During the Year* on page 5.

# When Coverage Begins

If you are a new employee enrolling during the year, coverage will begin as of your first active date of employment. However, you must enroll in the plan to receive benefits. See *Enrollment* on page 2.

If you enroll during the Open Enrollment period, coverage will begin on January 1 and remain in effect through December 31. See *Enrollment* on page 2.

## Important Note about Coverage

According to IRS regulations, you will lose (forfeit) any money remaining in your FSA account for a calendar year, if you have received reimbursement for all of your eligible expenses attributable to that year but have money left in your FSA account. For more information, see the *Use It or Lose It* section on page 8.

# Paying for Coverage

Participation in the Health Care, Limited and Dependent Care FSAs is completely voluntary. You pay for all contributions to your FSA accounts on a pre-tax basis (subject to IRS code regulations), that is, before federal — and, in most cases, state — income taxes and FICA taxes are withheld. Pre-tax contributions reduce your taxable income and increase your take-home pay. As a result, earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the benefit programs will normally be greater than any eventual reduction in Social Security benefits.

You pay no taxes on the contributions to the FSA Plan *or* the amounts reimbursed from the FSA Plan for your eligible expenses. Expenses that you have reimbursed through the Health Care, Limited and Dependent Care FSA Plan may not be deducted on your income tax return.

Arkema pays all administrative costs. Each year, you can elect how much you want to contribute to your FSA account for the upcoming plan year (subject to plan limits).

For the Health Care FSA or Limited FSA, you can contribute from a minimum of $120 up to the IRS maximum per calendar year, which is $2,750 for 2021.

For the Dependent Care FSA, you can contribute from a minimum of $120 up to the IRS maximums per calendar year. For 2021, the maximums are $5,000 in total for married individuals who file joint tax returns; those filing separately can contribute up to $2,500 each.

For 2021, the American Rescue Plan Act (ARPA), signed into law on March 11, 2021, increased pre-tax contribution limits for the Dependent Care FSA. The increased annual limits for pre-tax contributions increased to $10,500 for single taxpayers and married couples filing jointly, and to $5,250 for married individuals filing separately. This temporary increase to the limits ends on December 31, 2021.

These maximums are subject to change by the IRS annually.

It's important to estimate your expenses carefully before you decide how much to contribute to your account because you can't:

- Receive a refund of any unused balance,
- Transfer amounts between the Health Care FSA, Limited FSA and the Dependent Care FSA, or
- Carry funds over from one year to the next.

# Making Changes During the Year

## Mid-Year Election Change Events

In general, the elections you choose when you are first enrolled in the FSA remain in effect for the remainder of the plan year in which you are enrolled. Elections you make at annual Open Enrollment generally remain in effect for the following plan year.

Federal law prevents employers from allowing employees to change their FSA Plan elections during the year, except in certain circumstances. Generally, you may make such a change only if you experience a qualified status change that affects eligibility for coverage under the FSA Plan, or in certain other limited situations. You must make any qualified status changes to your coverage within 31 days of the change in status.

Please note that in order to change your benefit elections due to a qualified status change, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.).

Qualified status changes that allow you to change your FSA Plan election include:

- Marriage, divorce, or annulment,
- Birth, death, adoption or placement for adoption of a child,
- Any event that changes your employment status or the employment status of your spouse or dependent, such as terminating or starting employment, the beginning or ending of an unpaid leave, or change of employment classification (for example, part-time to full-time or vice versa) that causes a loss or gain of coverage,
- Your child gains or loses eligibility for your coverage,
- Your dependent spouse or child dies,
- Eligibility of an employee, spouse, or dependent for COBRA, or
- Events such as the loss of other coverage that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of Medicaid or State Child Health Insurance Program (CHIP) coverage or eligibility for state premium assistance.

Except for election changes due to a HIPAA and or Medicare/CHIP special enrollment, your change in coverage must be "due to and consistent with" your qualified status change. In addition, your status change must cause a gain or loss of eligibility in the program or another employer's plan, and your new election must correspond with the event. To satisfy the federally required "consistency rule," your qualified change in status and corresponding change in coverage must meet both of the following requirements:

- **Effect on eligibility.** For your Health Care FSA or Limited FSA, the qualified change in status must affect eligibility for coverage under the FSA Plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.

For your Dependent Care FSA, the qualified change in status must affect the amount of dependent care expenses eligible for reimbursement. For example, if your child reaches age 13, his or her dependent care expenses are no longer eligible for reimbursement.

- **Corresponding election change.** The election change must correspond with the qualified change in status. For example, you may change or begin contributions to your Health Care, Limited or Dependent Care FSA if you have or adopt a child or a child is placed with you for adoption. Arkema will determine whether a requested change is due to and consistent with a qualified change in status.

You may make a qualified status change by calling the Arkema Benefits Center at 1-800-406-9823.

### Other Permitted Dependent Care FSA Changes

There are a few additional cases where you may be able to change your Dependent Care FSA election during the year, as follows:

- If your dependent care provider reduces or increases the number of hours worked, you may make a corresponding change to your Dependent Care FSA election. For example, if your child starts school, causing a reduction in the number of hours he or she is in the care of a dependent care provider, you may decrease your Dependent Care FSA election.
- If you change your dependent care provider mid-year and there is a significant change in your expenses, you may change your Dependent Care FSA contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) significantly raises or lowers their rates mid-year, you may increase or decrease your contributions. For this purpose, "relative" means an individual related to you by blood or marriage.

### If You Need to Make a Change

You must contact the Arkema Benefits Center within 31 days of the change (or 60 days in the event of a CHIP change). Otherwise, your next opportunity to make changes will be the next Open Enrollment period or when you have a qualified change in status, whichever occurs first. FSA Plan participation changes that you are permitted to make will be made prospectively, as of the date the Arkema Benefits Center receives the notification (and the change is permitted).

To meet IRS regulations and FSA Plan administration requirements, Arkema reserves the right at any time to request written documentation of the effective date of the change in status event. The Plan Administrator will determine whether a requested change is due to a qualified change in status and whether the requested change is on account of and consistent with the event. Your new election shall take effect prospectively only, but not earlier than the date of the change in status, except in the case of a new child as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## When Coverage Ends

In general, coverage under the plan will end at midnight on the last day of the month in which eligibility is lost. Coverage may also end for other reasons, such as:

- The end of the month for which your last contribution is made, if you fail to make any required contribution toward the cost of coverage when due,
- The date the plan is canceled,
- The date coverage for any group of employees you are part of is canceled, or
- The date your employment is terminated.

# How FSAs Work

The Arkema Inc. Flexible Spending Accounts Plan offers you convenient, tax-free ways to pay for eligible healthcare and dependent care expenses.

The amount of money you elect to have deducted from your pay and contributed to the FSA Plan to pay for eligible healthcare and/or dependent care expenses is critical, because any money that is not used by December 31st of the year in which the contributions were made will be lost. You will not receive a refund. For more information, see the *Use It or Lose It* section below.

## Receiving Your Reimbursement

Whenever you incur an eligible expense, you simply submit a claim for reimbursement, along with proof of your incurred expenses. For information on how to file your claims for reimbursement, see *Filing a Claim for Reimbursement* on page 19. If you enroll in the Health Care or Limited FSA, you will also receive a NetBenefits Access debit card to pay providers directly.

## Use It or Lose It

The Health Care, Limited and Dependent Care FSAs will reimburse only eligible expenses that you incur by December 31st for the year in which you participate. IRS regulations stipulate that you must use the full amount of money in your FSAs for expenses incurred during the applicable Plan Year. If you do not use the entire balance in your account by December 31st, the IRS requires you to forfeit the remaining funds. If by March 31st of the following year you do not file a final claim for FSA expenses incurred by December 31st in the year in which you made contributions to the FSA Plan, you will not be reimbursed for those expenses. Claims need to be received by Fidelity by March 31 (or postmarked by this date if sent via USPS), to be considered eligible for the prior year.

It is important to accurately estimate the amount of your contribution so that it does not exceed your actual healthcare and/or dependent care expenses, because any excess in the account at the end of the year cannot be returned to you and must be forfeited.

### HEART Act

The plan complies with the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), which allows certain employees in the U.S. military reserves who are called to active military duty for at least 180 days to take a taxable distribution of any funds remaining in their Health Care FSA to avoid forfeiting the unused funds at the end of the year. For more information on distributions under the HEART Act, contact the Arkema Benefits Center at 1-800-406-9823.

## The Health Care FSA versus the Health Care Tax Deduction

The federal government permits you to take a deduction on your income tax return for certain healthcare expenses. For most people, the Health Care FSA is a better way to gain tax advantages for healthcare expenses than the federal income tax deduction. This is because you must have expenses of at least 10% of your gross income to qualify for this tax deduction. In addition, with the Health Care FSA, you realize your savings throughout the year — there's no waiting until you file your income tax return.

In some cases, you may use both the healthcare tax deduction and the Health Care FSA — but not for the same expenses. In other words, if you are reimbursed for an expense out of the Health Care FSA, the amount you receive reduces the amount you can use to calculate the tax deduction. Likewise, any expenses used to qualify for a federal income tax deduction cannot be used as an eligible expense under your Health Care FSA.

Consult a tax advisor to determine which is better for you — the Health Care FSA, the healthcare tax deduction, or a combination of both.

## The Dependent Care FSA versus the Child Care Tax Credit

With respect to your Dependent Care FSA, the current tax laws provide two means of saving on dependent care expenses: dependent care assistance plans (such as the Dependent Care FSA) and the federal child care tax credit. The tax credit generally applies to the same expenses that are eligible for reimbursement through your Dependent Care FSA. You can take a tax credit on your federal income tax return. The amount of the credit depends on your adjusted gross income. Currently, the amount of the credit offsets your tax liability dollar-for-dollar, and the expenses covered by the credit are limited to a maximum of $3,000 for one dependent and $6,000 for more than one dependent. The credit equals a percentage of your dependent care expenses up to the maximum limit on expenses.

You can use either the Dependent Care FSA or the tax credit — but not both — for eligible expenses. More specifically, if you use the Dependent Care FSA for $5,000 of expenses for one child, you can save taxes on the full $5,000, but you eliminate your ability to use the tax credit. If, on the other hand, you are reimbursed $1,400 through the Dependent Care FSA for expenses for one child, you can only apply up to $3,600 to the tax credit. You must report the name and taxpayer identification number of the dependent care provider on your income tax return regardless of which method you use.

Because you will not be able to take advantage of the tax credit for amounts reimbursed through your Dependent Care FSA, you may wish to consider which of the two methods will save you more in tax dollars. Your individual tax situation will determine which approach is better for you. Consult a tax advisor to determine which is better for you — the Dependent Care FSA, the dependent care tax credit, or a combination of both.

If you claim a child care tax credit or use a dependent care assistance plan, you will be required to report the name, address, and TIN of the care provider on your federal income tax form.

Please note: The child care tax credit phase-out currently begins at $200,000 of adjusted gross income for single filers and heads of household. You cannot claim any of the credit if your income is more than $240,000. For joint filers, the credit currently begins to phase out at $400,000 and phases out completely at $440,000.

# Health Care or Limited FSA

You can receive reimbursements through the Health Care FSA for certain out-of-pocket medical, prescription drug, dental and vision expenses that are not reimbursed by any healthcare plan. Eligible expenses are reimbursed up to the total amount you elect when you enroll, regardless of the amount you have contributed at the time of your claim. For example, if your annual contribution is $1,000 but only $200 has been contributed to your account when you submit your claim, you can be reimbursed up to $1,000.

If you elect to participate in the Health Care FSA, you can make pre-tax contributions from $120 up to the IRS maximum of $2,750 for 2021. **Maximum annual contributions to the HCFSA and Limited Purpose FSA are subject to annual change based on IRS guidance.**

# Your Eligible Expenses

The Health Care FSA or Limited FSA reimburse you for any IRS-approved healthcare expenses not covered by your medical, dental or vision plan, such as deductibles and copays, eyeglasses, certain over-the-counter products and prescription drugs, and hearing aids, while you are an active employee with the Company. Your contributions can be used to cover eligible healthcare expenses that you, your spouse or your dependents incur. Your dependents do not have to be covered through Arkema's medical, dental or vision plans to be eligible for reimbursement under the Health Care FSA or Limited FSA. Plus, you may use the account for expenses incurred by anyone whom you claim as a dependent on your federal income tax return.

Please note: Expenses incurred by dependents covered by Arkema's medical plan are not eligible if they are not dependents on your federal income tax return.

The Health Care FSA is not available to individuals who are enrolled in the CDHP or another "high deductible" medical plan. That's because your HSA is designed to reimburse you for eligible medical and prescription drug expenses. Instead of a Health Care FSA, you may use a Limited Flexible Spending Account (Limited FSA) for help paying eligible dental and vision expenses and post-deductible medical expenses.

A participant who elects to contribute to a Health Savings Account may only be reimbursed under the Limited FSA (please see "Limited FSA" on page 18).

Expenses eligible to be reimbursed from the Health Care Flexible Spending Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Certain unreimbursed healthcare expenses that may be covered under the Health Care FSA include, but are not limited to, the following:

- Abortion,
- Acupuncture (provider must recommend for a medical condition),
- Alcoholism treatment,
- Annual deductibles,
- Bandages,
- Breast reconstruction surgery (after a mastectomy),
- Chiropractic services,
- Obstetrical expenses,
- Copays and coinsurance for medical, dental, prescription drug or vision care,
- Christian science expenses,
- Cosmetic surgery necessary because of an accident or birth defect,
- Crutches,
- Dental examinations,
- Dentures,
- Diagnostic fees,

- Disabled dependent care expenses,
- Drug addiction services,
- Fertility enhancements,
- Hearing and unreimbursed vision care, including:
  - Eyeglasses and frames,
  - Hearing and eye examinations,
  - Contact lenses, including all necessary supplies and equipment,
  - Hearing aids and repairs,
  - Special telephone and television equipment for the deaf,
  - Braille books and magazines for the blind,
  - Guide dog or other animal or human guide used by a visually-impaired or hearing-impaired person, and
  - LASIK surgery and radial keratotomy,
- Insulin (which may be reimbursed without a prescription)
- Laboratory fees,
- Lead-based paint removal,
- Medical conferences (must include chronic illness of yourself, spouse, or dependent),
- Medical devices, including durable medical equipment and supplies,
- Nursing home,- the cost of a Nursing Home after a hospital stay or surgery is qualified. The cost of custodial care in a convalescent or nursing home (for example, long-term care) is not an FSA-qualified expense.
- Nursing services,
- Organ transplants,
- Other paramedical services,
- Over-the-counter items
- Over-the-counter drugs
- Oxygen,
- Prescription drugs, including vitamins and minerals prescribed by a qualified health care provider that are unavailable without a prescription and prescribed to treat a specific medical condition,
- Psychiatrist fees,
- Psychologist fees,
- Smoking-cessation programs and related prescription drugs,
- Special education programs for learning disabled,
- Special treatment programs (for example, a cardiovascular fitness program prescribed by a qualified health care provider),
- Sterilization,
- Surgical fees,

- Transportation necessary to obtain certain healthcare services (must be documented),
- Vasectomy,
- Weight-loss programs for treatment of obesity when diagnosed by a qualified health care provider for the treatment of a specified disease,
- Wheelchairs,
- Wigs purchased on qualified health care provider’s advice for mental health of a patient who has lost all hair from disease or treatment,
- X-rays,
- Any other charges not fully covered under any healthcare plan, such as amounts that exceed the reasonable and customary charge, and
- Any other expenses allowed by the IRS as a qualified healthcare expense, excluding expenses for long-term care.

## Ineligible Expenses

According to current IRS regulations, some items are not eligible for reimbursement from your Health Care FSA. For example, you cannot be reimbursed for:

- Cosmetic dentistry,
- Cosmetic surgery (unless the surgery is necessary because of an accident, birth defect, or reconstructive surgery after a mastectomy),
- Electrolysis or hair removal,
- Expenses incurred before you became eligible for the FSA or during any period you did not contribute to the FSA,
- Expenses reimbursed by any healthcare plan, including Medicare and Medicaid,
- Expenses that are not eligible for deduction on your federal income tax return,
- Expenses you actually claim as deductions on your federal income tax return,
- Exercise equipment, hot tubs, whirlpool baths, and swimming pools,
- Funeral or burial expenses,
- Household help,
- Insurance premiums,
- Long-term care expenses, including premiums for long-term care insurance,
- Marriage or family counseling for a non-medical reason,
- Maternity clothes or diaper services,
- Membership fees to a fitness club (unless deemed medically necessary by your provider),
- Nursing care for a normal, healthy baby,
- Premium contributions for healthcare coverage provided by the Company or for any other healthcare coverage, including COBRA premiums and Medicare,
- Programs to control weight or to maintain general health,
- Swimming lessons,
- Teeth whitening,

- Undocumented travel to or from your qualified health care provider's office or other medical facility, and
- Veterinary fees.

For a more information about eligible and ineligible expenses, you may also consult IRS Publication 502, under the sections addressing what medical expenses are and are not deductible for details regarding what are and are not eligible expenses: But use caution when referring to Publication 502, because it is meant only to help taxpayers determine their tax deductions, not describe the expenses that are reimbursable under a health FSA. For example, the publication states that you may get a deduction for expenses paid during the year. For purposes of your health FSA, you may be reimbursed generally only for expenses you incur during the year - no matter when you pay for them. (Expenses are incurred on the date you receive the healthcare services, that is, the date you see the doctor or other healthcare provider.) As another example, health insurance premiums, long-term care contracts and long-term care services are listed as deductible expenses in the publication; however, they generally are not reimbursable from your health FSA. Publication 502 is available from your nearest IRS office or by calling the IRS at 1-800-829-3676. You also may obtain a copy online by accessing **http://www.irs.gov**.

# When Participation Ends

Your participation in the Health Care FSA will terminate whenever one of the following events occurs:

- Your employment terminates for any reason, including retirement or death, or
- You fail to enroll during the Open Enrollment period to participate in the Health Care FSA for the following calendar year.

If your employment terminates during a calendar year, you will be eligible for reimbursement of eligible expenses incurred through your last day of employment, up to the total amount in your Health Care FSA.

If you have unused funds remaining in your account, you may continue contributing to the Health Care FSA under COBRA, but on an after-tax basis. If you contribute through COBRA, you will continue to be able to submit expenses for services incurred after you terminate employment through the end of the plan year, provided you continue to make the required contributions. For more information, see *Continuation of Coverage* on page 272.

# Dependent Care FSA

The Dependent Care FSA is a voluntary benefit program designed to help you pay, on a pre-tax basis, the expenses of hiring someone to care for your eligible dependents while you (and your spouse, if you are married) work or are actively looking for work. If you elect to participate in the Dependent Care FSA, you can make pre-tax contributions of between $120 and the IRS maximum of $5,000 per family in 2021. The amount of before-tax Dependent Care expenses reimbursed during the taxable (calendar) year by all plans, including this plan, that qualify as dependent care plans under Code section 129 may not exceed $5,000 ($10,500 when adjusted by ARPA) or $2,500 ($5,250 when adjusted by ARPA) if you are a married employee filing a separate federal income tax return). If your spouse is also participating in a dependent care FSA, the total before-tax contributions between the two plans (yours and your spouse's) cannot exceed $5,000.When determining whether you should participate in the Dependent Care FSA, you should first verify that your dependents qualify for the Dependent Care FSA, and that you expect to have eligible expenses during the year. Then, you should estimate your monthly dependent care expenses, keeping in mind that if you enroll in the Dependent Care FSA, the amount you request to have set aside each month cannot exceed the smaller of the following amounts:

- Your monthly earned income (net wages), or
- Your spouse’s monthly earned income (net wages) if you are married.

Please note that if your spouse is incapable of self-care or is a full-time student, your spouse will be deemed to have earned $250 per month (up to $3,000 per year) if there is one qualified dependent, and $500 per month (up to $6,000 per year) if there are two or more qualified dependents. However, even if your spouse's assumed income is $6,000 for the year, you are still limited by the IRS' $5,000 (or ARPA-adjusted $10,500) maximum dependent care FSA benefit.

In return for favorable tax treatment, federal tax laws require the Dependent Care FSA to pass certain nondiscrimination tests. The tests are designed to ensure a fair mix of participation. If the tests are not passed, it may be necessary to decrease the amount that certain employees can contribute to the Dependent Care FSA. You will be notified if this applies to you.

## Additional Eligibility Rules for the Dependent Care FSA

The dependent care FSA can be used only for reimbursement of eligible expenses for qualified dependents, as defined by the Internal Revenue Code (IRC).

Eligible expenses are those expenses that you incur to provide care for:

- a child whom you can claim as a dependent on your federal tax return, and who
  - lives with you more than half the year, and
  - is under age 13; or
  - a dependent who is physically or mentally unable to care for himself or herself, regardless of age, who lives with you for more than half the year; or
- a spouse who is physically or mentally unable to care for himself or herself, and who lives with you for more than half the year.

If you are married, your spouse must be gainfully employed for you to be eligible to participate in the Dependent Care FSA. If your spouse does not work, he or she must be actively looking for work, a full-time student, or incapable of self-care for you to be eligible.

If you are divorced, you may qualify for reimbursement for your children only if the following conditions are met:

- You are the custodial parent,
- The child has been in your or your ex-spouse's custody for more than half the year, and
- The child receives more than half of his or her support from you and/or your ex-spouse.

You are not required to claim your child as a dependent for other tax purposes to be eligible for the Dependent Care FSA as a divorced parent. If you are the non-custodial parent, your child is not an eligible dependent under the Dependent Care FSA. If you are divorced or separated and you share custody of the child, the child is an eligible dependent under the Dependent Care FSA if you have custody of the child for the greater portion of the year.

According to IRS rules, same-sex domestic partners are not recognized as eligible dependents, unless the same-sex domestic partner is your legal dependent for federal income tax purposes. You must sign an affidavit stating that the same-sex domestic partner is a tax-qualified dependent. Expenses incurred by children of same-sex domestic partners are typically not eligible for reimbursement since a dependent must not be a qualifying child of any other taxpayer, such as a domestic partner.

## Your Eligible Expenses

Eligible expenses under the Dependent Care FSA are those costs for care of your dependents only if you are a single employed parent or an employed parent whose spouse is also employed, actively looking for work, a full-time student or incapable of self-care.

Eligible expenses include costs for the following:

- Care at licensed nursery schools or day camps, (excluding most expenses for grades kindergarten and above or overnight camps). To qualify, the school or center must comply with state and local laws and receive a fee for its services if it cares for seven or more children,
- Payment to a housekeeper who is primarily responsible for providing day care,
- Payment to someone who provides care in your home, as well as related taxes you pay on that person's behalf,
- Care provided at an adult day care facility (but not expenses for an overnight nursing home facility),
- Day care provided by before-school or after-school programs,
- Day care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes, or your child under age 19,
- Household services related to the care of an eligible dependent who lives with you, and
- Any other qualified dependent care expense as defined by the Internal Revenue Code.

## Ineligible Expenses

Eligible dependent care expenses do not include:

- Care for a child 13 or older, unless physically or mentally unable to care for himself or herself,
- Amounts paid for the care of a person in a nursing home or convalescent facility,
- Amounts paid to your spouse or child under the age of 19 for day care services (for example, you cannot be reimbursed for payments to one of your teenage children to care for your younger children),
- Cost of food, clothing, shelter, insurance, medical treatment, or vacations of a qualified dependent,
- Payment for care that is not necessary for you to work (for example, a babysitter while you go to the movies),
- Education expenses for any child in or beyond kindergarten,
- Items you intend to claim as a credit for federal tax purposes,
- Expenses for services that have not yet been provided (for example, prepaid day care expenses),
- Overnight camp expenses,
- Expenses you incur while you are not contributing to the Dependent Care FSA, and
- Any other Dependent Care expense that does not qualify under the Internal Revenue Code.

For a complete list of eligible and ineligible expenses and an explanation of any federal limits, call 1-800-TAX-FORM (1-800-829-3676) and request IRS Publication 503: Child and Dependent Care Expenses. This publication is also available on the IRS website at http://www.irs.ustreas.gov/. Note that reference to this publication is for general guidance only. This SPD and the governing documents of the Plan will determine which expenses are eligible and which are ineligible.

If you do not participate in the Dependent Care FSA, you may qualify to claim eligible child and dependent care expenses as a tax credit on your federal income tax return. The method that will produce the greatest tax savings for you — the tax credit or participation in the Dependent Care FSA — depends on your personal situation. You may want to consult your personal tax advisor for guidance before you enroll in the Dependent Care FSA.

## When Participation Ends

Your participation in the Dependent Care FSA will terminate whenever one of the following events occurs:

- Your employment terminates for any reason, including retirement or death, or
- You fail to enroll during the Open Enrollment period to participate in the Dependent Care FSA during the following calendar year.

If your employment terminates during a calendar year, you will be eligible for reimbursement of eligible expenses incurred through your last day of employment, up to the amount of your contributions in your Dependent Care FSA.

If your employment terminates during a calendar year, you will not be permitted to make additional pre-tax contributions to your Dependent Care FSA. You will, however, be eligible for reimbursement of eligible expenses incurred prior to your actual termination up to the total amount in your Dependent Care FSA.

# Limited FSA

The Limited FSA allows you to put aside money on a pre-tax basis so that you can pay for certain eligible medical, dental and vision expenses that are not reimbursed by any other coverage you and your qualifying family members have.

Since you cannot be covered by a traditional Health Care FSA if you contribute to a Health Savings Account (HSA), a component of the Consumer Driven Health Plan (CDHP), you have the option to elect the Limited FSA. Unlike a traditional Health Care FSA, the Limited FSA can be used in addition to the HSA.

If you elect to participate in the Limited FSA, you can make pre-tax contributions of between $120 and the IRS maximum of $2,750 for 2021**. Maximum contributions to the HCFSA and Limited Purpose FSA are subject to annual change based on IRS guidance.**

## Your Eligible Expenses

Eligible expenses under the Limited FSA include costs for the following:

- eligible dental, vision and preventive care expenses not reimbursed by any other health plan
- qualified medical expenses, including coinsurance and copays, incurred after you have satisfied the CDHP deductible applicable to you, either the individual or family deductible, depending on your level of coverage.

## Unused Contributions

The Limited FSA will reimburse only eligible expenses that you incur by December 31st for the year in which you participate. IRS regulations stipulate that you must use the full amount of money in your Limited FSA for expenses incurred during the applicable Plan Year. If you do not use the entire balance in your account by December 31st, the IRS requires you to forfeit the remaining funds. If by March 31 of the following year you do not file a final claim for the Limited FSA expenses incurred by December 31, in the year in which you made contributions to the Limited FSA Plan, you will not be reimbursed for those expenses. Any funds remaining in your Account after that date will be forfeited. Claims need to be received by Fidelity by March 31 (or postmarked by this date if sent via USPS), to be considered eligible for the prior plan year.

## When Participation Ends

Your participation in the Limited FSA will terminate whenever one of the following events occurs:

- You are not enrolled in the Arkema CDHP and Arkema HSA,
- You are covered by a traditional health care FSA, including either the Arkema Health Care FSA or another health care FSA (e.g., through your spouse),
- You are covered by a non-high deductible health plan (e.g., through your spouse),
- Your employment terminates for any reason, including retirement or death, or
- You fail to enroll during the Open Enrollment period to participate in the Limited FSA for the following calendar year.

# Paying for Eligible Expenses

There are two ways to pay for eligible health care expenses with your Health Care FSA and Limited FSA: paying out of pocket and submitting a claim for reimbursement, and paying directly using your NetBenefits Access debit card. You do not receive a debit card for the Dependent Care FSA; you must pay for dependent care expenses out of pocket and submit a claim for reimbursement.

The NetBenefits AccessCard is a special-purpose Visa card that provides an easy, automatic way to pay for qualified medical expenses and certain other expenses such as vison and dental expenses. The card provides electronic access to the amounts set aside in your spending accounts.

You can use your card to pay for qualified medical expenses at eligible merchants and service providers that accept Visa debit cards for payment. The eligible amount of the purchase will be deducted — automatically — from the appropriate account based on the type of merchant, expense type and available balance in the account. If you have multiple account balances stored on your NetBenefits AccessCard, a predetermined hierarchy based on the type of merchant is used to apply the different expense types to the appropriate account.

Internal Revenue Service (IRS) regulations allow you to use your NetBenefits AccessCard in participating pharmacies, mail-order pharmacies, discount stores, and supermarkets that can identify FSA-eligible items at checkout and accept Visa prepaid benefit cards.

You may also use your card to pay a hospital, doctor, dentist, or vision provider that accepts Visa prepaid benefit cards. For FSA, auto-substantiation technology is used to attempt to electronically verify the transaction's eligibility according to IRS rules.

The IRS requires that every FSA card transaction be substantiated. If your transaction cannot be auto-substantiated, you may be asked to submit receipts to verify that your expenses comply with IRS guidelines. Each receipt must show: the merchant or provider name, the service received, or the item purchased, the date and the amount of the purchase.

If you do not submit a receipt in a timely manner, Fidelity may restrict the use of your FSA balance(s) on your NetBenefits AccessCard until your previous usage can be substantiated.

If you have not substantiated debit card transactions by the end of the year following the year in which they occurred, the amount of the unsubstantiated claims will be added onto your taxable income at the end of the year and reported on your W2.

# Filing a Claim for Reimbursement

Fidelity is the Claims Administrator for the Flexible Spending Accounts Plan.

## Health Care FSA

When you or an eligible family member incur a healthcare expense and are covered under Arkema's medical, prescription drug, dental or vision plans, you must first file a claim for reimbursement with the appropriate plan (in most cases the insurance company and provider will handle this). The balance that is unpaid by the medical plan (up to your full Health Care FSA contribution amount for the year) can then be submitted to your Health Care FSA for reimbursement. Fidelity will determine if your claim is eligible for reimbursement. If it is eligible, Fidelity will reimburse you up to your total annual contribution amount, if appropriate.

## Limited FSA

When you or an eligible family member incur an expense and are covered under Arkema's medical, prescription drug, dental or FSA/Limited  FSAs, you must first file a claim for reimbursement with the appropriate plan (in most cases the insurance company and provider will handle this). The balance that is unpaid by the medical plan (up to your full Limited FSA contribution amount for the year) can then be submitted to your Limited FSA for reimbursement. Fidelity will determine if your claim is eligible for reimbursement. If it is eligible, Fidelity will reimburse you up to your total annual contribution amount, if appropriate.

# Dependent Care FSA

After you pay for an eligible dependent care expense, you must submit a claim for reimbursement. Fidelity will determine if your claim is eligible for reimbursement. If it is eligible, Fidelity will reimburse you up to the balance in your account at the time you submit the claim. For example, if you have contributed $200 to your account, Fidelity will reimburse you up to $200. If you submit a claim for $200, but only have $150 in your Dependent Care FSA at the time your claim is received, you will receive a reimbursement check for $150. The unpaid balance of your claim will be paid automatically as soon as additional contributions are made through your subsequent payroll deductions. Fidelity will not reimburse you for dependent care expenses you have paid in advance, until you actually receive the prepaid services, or for expenses with a service date before your coverage effective date or after your coverage terminates.

## Filing a Claim for Reimbursement

If you need to file a claim, you can submit the claim either via the online portal, or using a Reimbursement Request Form (accessible from the online portal).

To file a claim and request reimbursement, visit the online portal and click on "Accounts," then select "File a Claim" under the "I Want To" dropdown. Select the account you would like to use, then choose whether you would like to send the reimbursement to yourself (via check or direct deposit, depending on your account preferences), or to someone else via check.

Along with your claim, you must upload a receipt which includes:

- Merchant name and information
- Type(s) of service,
- Date(s) of service,
- Cost of service(s), and
- Whether the transaction is a copay.

**Note**: You can upload documents in JPG, JPEG, PNG, GIF or PDF. The total size limit is 8MB.

After you upload the receipt, provide the following claim details:

- Start and end date of service
- Dollar amount charged
- Provider name
- Service category
- Type of service
- Recipient name
- Whether or not you drove to receive your product/service, and how many miles

Once you have entered all of the claim details, agree to the Terms and Conditions and hit the submit button to submit your claim.

You must file claims for eligible expenses by March 31 of the year following the year in which you incur the eligible expenses. For example, if you have an expense in July 2021, you have until March 31, 2022, to file the claim for reimbursement. Claims need to be received at Fidelity by March 31, 2022.

If your participation in the Health Care FSA. LFSA or Dependent Care FSA ends for any reason, you may submit claims for any eligible expenses you incurred while you were participating in the FSA. You must file claims by March 31 of the following year for eligible expenses incurred through the date your participation ended.

Mail your claims to:

Fidelity Flexible Spending and Reimbursement Accounts Service

P.O. Box 1703

Fargo, ND 58108

## How to Check the Status of a Claim

To check the status of a claim or your account, you can log on to Fidelity's member website at **www.netbenefits.com**. When you access the website, you can:

- View FSA claim payments and account balance information,
- View who is covered.
- Access the list of items approved by the IRS for FSA reimbursement,
- Obtain FSA claim forms,
- Obtain FSA claim office mailing addresses, and
- Contact Fidelity.

## If Your Claim Is Denied

If your claim is denied in whole or in part, Fidelity will notify you of the denial in writing, within 90 days after you filed, unless special circumstance require an extension of time for processing. If there is an extension, Fidelity will notify you of the extension and the reason for the extension within the initial 90-day period. The notice will:

- Explain the reason for denial,
- Indicate the portion of the plan document upon which the decision was made,
- Include the claims and appeals procedures,
- Provide a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and
- Include a statement informing you of the right to bring a civil action under ERISA.

You can view your denial notice in the "Statements" section of your account, or under the "Message Center" tab.

To appeal the denial, you must write to Fidelity at the spending account claims address within 180 days of the date you are advised of Fidelity's denial. In your correspondence, you should explain why you think your claim should be covered and include any documents or additional information that is relevant to your appeal. You or your authorized representative may review all pertinent documents and submit issues, comments, documents, records, and other information in writing.

Fidelity will review the request and notify you in writing within 60 days of receiving your appeal. In some cases, Fidelity may require up to 120 days to review your claim. You will be notified if an extension is necessary, within the initial 60-day period. Fidelity's decision shall be final and binding upon you and all other persons or entities involved.

# Additional Rules That Apply To This Plan

The following rules apply to this plan.

## Your HIPAA Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents.

### About Your Privacy and Security

HIPAA also imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, or PHI, includes virtually all personally identifiable health information held by any health plan, whether received in writing, in an electronic medium, or as an oral communication.

The Company has implemented policies and practices to appropriately protect the privacy and security of your PHI. PHI that you provide will be handled in accordance with the Company's HIPAA privacy policy. For more information, see *Compliance With HIPAA Privacy and Security Regulations* on page 34.

## Qualified Medical Child Support Order (QMCSO)

The plan will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, it is reviewed by the Company for validity. If it is found to be valid, the Company will notify the Arkema Benefits Center. The Arkema Benefits Center will then coordinate the addition of the dependent to the participant's healthcare coverage. Coverage under the plan pursuant to a medical child support order will not become effective until the Company determines that the order is a QMCSO. If you have any questions regarding a QMCSO, please contact the QMCSO Processing Center at the information shown below.

QMCSO Administration Services personnel at the QMCSO Processing Center are available to assist through the process. Employees, custodial parents, state agencies and/or their legal representatives may contact us using the following:

Website: https://qdro.morneaushepell.com Access Code: ING105
Email: qdroprocessing@morneaushepell.com
Phone: (844) 208-7192
Fax: (844) 886-8539
Mail: P.O. Box 534277
St. Petersburg, FL 33747
Circumstances That May Result in Denial, Loss or Forfeiture of Benefits

Under certain circumstances, plan benefits may be denied or reduced from those described in this booklet. For instance, claims can be denied for reasons including the following:

- Loss of eligibility under the plan,
- Charges incurred prior to your effective date of coverage,
- Reaching the maximum benefits provided under the plan,
- Amendment to the plan,
- Employee, dependent or provider not responding to a request for additional information needed to process the claim or appeal,
- Incomplete claims submission, or
- Charges incurred after your coverage has ended.

# How to Reach Your FSA Plan Service Provider

Here is how you can reach your FSA plan service provider:

| *Plan* | *Telephone Number* | *Website Address* |
| --- | --- | --- |
| **Fidelity**<br>**(Group Number: 76543)** | 1-833-299-5089 | **www.netbenefits.com** |

# Continuation of Coverage

Under federal law — the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) — you may be eligible to continue contributing to your Health Care FSA through the end of the plan year in which you leave Arkema. Your COBRA contributions must be made on an after-tax basis and will be subject to an additional 2% administrative fee. You can then request reimbursement for eligible expenses incurred through the earlier of the end of that plan year, or the date your COBRA contributions stop. If you are age 65 or older, you cannot continue to participate through COBRA.

You will receive notification of your COBRA rights if your employment terminates and you are eligible to continue your Health Care FSA.

IRS regulations do not allow you to continue participating in the Dependent Care FSA through COBRA.

## 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**.

All notices and other communications regarding COBRA and the Arkema Inc. Health Care FSA should be directed to the COBRA Administrator at:

WageWorks, Inc.

P.O. Box 650407

Dallas, TX 75265-0407

1-877-924-3967

## FSA Continuation While on Military Leave

You may only continue to participate in the Health Care FSA for the first six months of military leave. After six months, you may continue contributing to the Health Care FSA through COBRA until the end of the plan year. You must remit monthly after-tax contributions directly to the COBRA Administrator within 60 days or your account will be cancelled.

## FSA Continuation While on an Approved Leave of Absence

If you take an approved leave of absence due to your own illness or injury, or a leave that qualifies under the Family and Medical Leave Act, you may only continue to participate in the Health Care FSA provided that you maintain your monthly contributions.

If your leave of absence is paid, your contributions will continue to be deducted from your paycheck on a pre-tax basis. If your leave is unpaid, you must remit your monthly contributions on an after-tax basis directly to Health Equity/WageWorks, our direct billing administrator.

If your approved leave of absence expires and you fail to return to work, you will have the right to continue your participation in the Health Care FSA by making after tax contributions until the end of the plan year through COBRA.  As long as you continue to contribute, you will have access to your full annual election.

## FSA Continuation While Disabled

Your participation in the Health Care and/or Dependent Care FSA ends on the day your long-term disability commences. Health Care FSA participation may continue through COBRA until the end of the plan year if you make contributions to the account on an after tax basis if, for example, you have made more contributions to the account than you have claimed.

# Administrative Information

This section of the booklet includes administrative information, as well as information required to be provided by the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, you are entitled to receive a clear and accurate description of your benefits. Therefore, the information in this section complements the material in the other sections so that together they provide a complete Summary Plan Description, as defined by ERISA. The Dependent Care FSA Account is not subject to the requirements of ERISA.

## Plan Sponsor

Arkema Inc.
Health and Welfare Benefits Department
900 First Avenue
King of Prussia, PA 19406-1308

## Plan Name

Arkema Inc. Flexible Benefits Plan, of which the FSA Plan is a component plan.

## Plan Number

501

## Plan Type

Welfare plan providing FSA benefits

## Plan Year

January 1 through December 31

## Employer Identification Number

23-0960890

## Plan Administrator

Arkema Inc.
Health and Welfare Benefits Department
900 First Avenue, Building 4
King of Prussia, PA 19406-1308

The Plan Administrator is responsible for the general administration of the FSA plan, and will be the fiduciary to the extent not otherwise specified in this document or in an insurance contract or administrative services agreement. The Plan Administrator has the discretionary authority to construe and interpret the provisions of the FSA plan and make factual determinations regarding

all aspects of the FSA plan and its benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the FSA Plan, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

The Plan Administrator may designate other organizations or persons to carry out specific fiduciary responsibilities in administering the FSA Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the FSA Plan, including the processing and payment of claims under the plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the FSA Plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the FSA Plan to the extent an insurer or administrator is not empowered with such responsibility.

The Plan Sponsor will administer the FSA Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated. Except to the extent superseded by laws of the United States, the laws of the Commonwealth of Pennsylvania will be controlling in all matters relating to the FSA Plan.

## Benefits Administrator

Arkema Benefits Center
P.O. Box 9740
Providence, RI 02940
1-800-406-9823
Monday to Friday, 9 a.m. to 6 p.m. Eastern time

## Claims Administrator

Fidelity Flexible Spending and Reimbursement Accounts Service

P.O. Box 1703

Fargo, ND 58108

## Agent for Service of Legal Process

Arkema Inc.
Arkema Legal Department
900 First Avenue
King of Prussia, PA 19406-1308

## Plan Funding and Type of Plan Administration

The FSA plan is unfunded. Benefits are provided under a group insurance contract entered into between Arkema and the Claims Administrator. Claims for benefits are sent to the Claims Administrator who is responsible for paying claims, not the Plan Sponsor. However, the Claims Administrator and the Company share responsibility for administering the plan.

## Future of the Plan

While the Plan Sponsor intends to continue the plan indefinitely, the Plan Sponsor reserves the right to amend, modify, suspend, or terminate any plan, or any benefit coverage, in whole or in part, at any time without prior notice. For example, the Plan Sponsor reserves the right to amend or terminate covered expenses, benefit copays, lifetime maximums, and reserves the right to amend a plan to require or increase employee contributions. The Plan Sponsor also reserves the right to amend a plan to implement any cost control measures that it may deem advisable. The Plan Sponsor may make any such amendment, modification, suspension, or may terminate the plan. The Plan Sponsor's decision to change or terminate any of the plans may be due to changes in the federal or state laws governing benefits, the requirements of the Internal Revenue Code or ERISA, or for any other reason.

Any amendment, termination or other action by the Plan Sponsor with respect to the plan will be by a duly adopted resolution of the Board of Directors or may be made by any person duly authorized to take such action on behalf of the Board. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination will reduce the amount of any benefit otherwise payable under the plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the plan will terminate unless the plan is continued by a successor to the Program Sponsor.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the Plan Sponsor to the extent permitted under applicable law, unless otherwise stated in the plan.

## Your Employment

Your eligibility or your right to benefits under the Arkema Inc. FSA Plan should not be interpreted as a guarantee of employment. The Company's employment decisions are made without regard to the benefits to which you are entitled upon employment.

This SPD provides detailed information about the plan and how it works. This SPD does not constitute an expressed or implied contract or guarantee of employment.

## Your Legal Rights

As a participant in the FSA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all program participants shall be entitled to the following information.

## Receive Information about Your Plan and Benefits

You have the right to examine, without charge, at the Plan Administrator's office, all documents governing the FSA Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the FSA Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and most recent Summary Plan Description. The Administrator may make a reasonable charge for the copies.

You have the right to receive a summary of the FSA Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

## Continue Health Care FSA Coverage

You have the right to continue Health Care FSA coverage for yourself (or in the event of your death, coverage for your spouse and/or dependents) if there is a loss of coverage under the FSA Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the FSA Plan for the rules governing your COBRA continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for Health Care FSA Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your Health Care FSA Plan, called "fiduciaries" of the Health Care FSA Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for an FSA benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the FSA plan documents or the latest annual report from the FSA plan and this is not placed in the mail or given to you within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the FSA plan's decision or lack thereof concerning the qualified status of a medical

child support order, you may file suit in federal court. If it should happen that FSA plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your plan, you should contact the Arkema Benefits Center or the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
1-202-219-8776

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA at 1-866-275-7922 or by visiting the EBSA website at **http://www.dol.gov/ebsa**.

# Compliance With HIPAA Privacy and Security Regulations

The Company has certain obligations regarding the privacy and security of your health information according to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), and as HIPAA and the HIPAA regulations were amended by the American Recovery and Reinvestment Act of 2009 ("ARRA"), a group health plan must: (i) restrict the use and disclosure of protected health information ("PHI"), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce.

## Permitted Use and Disclosure of Protected Health Information (PHI)

The Company may only use and disclose PHI and e-PHI it receives from the FSA/Limited FSA as permitted and/or required by, and consistent with the HIPAA Privacy regulations found at 45 CFR Part 164, Subpart A and the HIPAA security regulations set forth in 45 CFR Part 164, Subpart C. This includes, but is not limited to, the right to use and disclose participant's Protected Health Information and e-PHI in connection with payment, treatment and healthcare operations.

The FSA/Limited FSA will disclose PHI and e-PHI to the Company only upon receipt of a certification by the Company that the plan documents have been amended to incorporate all the required provisions as described below:

The Company agrees to:

- Not use or further disclose the information other than as permitted or required by the plan documents or as required by law.
- Ensure that any agents, including a subcontractor, to whom it gives PHI and e-PHI received from the FSA/Limited FSA, agrees to the same restrictions and conditions that apply to the Company with respect to such information.
- Not to use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company.
- Report to the FSA/Limited FSA, any use or disclosure of the information that is inconsistent with the uses or disclosures provided for, of which the Company becomes aware.
- Make available PHI and e-PHI in accordance with individuals' rights to review their PHI.
- Make available PHI and e-PHI for amendment and incorporate any amendments to PHI and e-PHI consistent with the HIPAA rules.

- Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules.
- Make its internal practices, books and records relating to the use and disclosure of protected information received from the FSA/Limited FSA available to the Secretary of HHS for purposes of determining compliance by the FSA/Limited FSA.
- If feasible, return or destroy all PHI and e-PHI received from the FSA/Limited FSA that the Company still maintains in any form. The Company will retain no copies of PHI and e-PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible, but the FSA/Limited FSA must limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.
- Notify a participant or participants of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a “Breach”) without unreasonable delay in a report which includes the following information:

  (1) the names of the individuals whose PHI was involved in the Breach;

  (2) the circumstances surrounding the Breach;

  (3) the date of the Breach and the date of its discovery;

  (4) the information Breached;

  (5) any steps the impacted individuals should take to protect themselves;

  (6) the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

  (7) a contact person who can provide additional information about the Breach.

The Company will cooperate with you in the investigation of, and response to, the Breaches it reports to you. For this purpose, the term “Breach” means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

## Security Agreements of the Company

As a condition for obtaining e-PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, “Security Incident” shall mean successful unauthorized access to, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

- Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

## Separation of the Company and Arkema FSA Plan

The following employees or classes of employees or other persons under the control of the Company shall be given access to PHI and e-PHI:

- Vice President — Human Resources and Communications
- Sr. Director — Compensation, Benefits and M&A
- Manager — Health & Welfare Benefits
- Sr. Health & Welfare Benefit Analyst
- Assistant General Counsel
- General Counsel

The access to and use of PHI by the individuals described above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Company for the Plan.

If the Company or any other person(s) responsible for monitoring compliance determines that any person described above, has violated any of the restrictions of this section, then such individual shall be disciplined in accordance with the policies of the Company established for purposes of privacy compliance, up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

If you have a concern and feel your privacy rights have been violated, you should contact Arkema Inc. Corporate Human Resources Services at 1-215-419-7349.You may also submit a written complaint to the U.S. Department of Health and Human Resources or go to their website at www.hhs.gov for the address and more information.

## PHI Not Subject to This Section

Notwithstanding the foregoing, the terms of this section shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations; provided however that paragraph 4 above shall apply if and only if e-PHI beyond enrollment, disenrollment, summary health information, and authorized disclosures is obtained by the Company, and the Company adopts the literal interpretation of 45 CFR 164.314(b)(1), which would apply paragraph 4 unless the only e-PHI obtained is enrollment, disenrollment, summary health information, or authorized disclosures.

## Definitions

All capitalized terms within this section not otherwise defined by the provisions of this section shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

# Glossary of Terms

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply.

**Authorized Representative**

A person who can contact the plan on your behalf to help with claims, appeals or other benefit issues. If you choose to use an authorized representative, you must submit a written letter to the plan stating the following: The name of the authorized representative, the date and duration of the appointment and any other pertinent information. In addition, you must agree to grant your authorized representative access to your Protected Health Information. This letter must be signed by you to be considered official.

**COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985. Federal legislation requiring employers to allow former employees and/or their covered dependents to continue healthcare coverage under certain circumstances when coverage would otherwise end.

**Coinsurance**

The percentage of medical, dental or vision expenses you pay after you meet your annual deductible. For instance, if your medical plan option pays 80% of eligible expenses, you pay the other 20% — your coinsurance would be 20%.

**Copayment (copay)**

The set dollar amount you pay for certain eligible expenses such as qualified health care provider's office visits. After you pay the copay, your medical, dental or FSA/Limited FSA pays the remainder of the eligible expense.

**Deductible**

The amount of charges for covered services that each covered person (or a family) must satisfy each calendar year before the medical, dental or FSA/Limited FSA begins to pay benefits.

**Explanation of Benefits (EOB)**

The statement you receive after a medical, dental or vision claim is processed that describes the expenses submitted, any exclusion or deductible and the benefits paid, if any. Note that you also receive a Health Care FSA EOB after you submit a Request for Reimbursement Form.

**Family and Medical Leave Act (FMLA)**

The Family and Medical Leave Act entitles you to take up to a 12-week leave of absence to care for a spouse, child, or parent or if you have a serious health condition and are unable to perform the substantial and material duties of your job.