Arkema Inc. Pre-65 Retiree Medical Plan Summary Plan Description

(including Prescription Drug and the Health Savings Account)

Contains addendums for Arkema, Bostik, R&H and DuPont

Effective January 1, 2021

Contents

Disclaimer Note
This summary plan description describes certain benefits as they apply to eligible retirees. Specific details that apply to eligible retirees of Arkema Inc. and Bostik, Inc. are included in addendums to this SPD. 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 (along with the applicable addendum) 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. Pre-65 Retiree Medical Plan (which includes Prescription Drug and the Health Savings Account), effective January 1, 2021. It describes the benefits as they apply to eligible retirees of Arkema Inc. (the Company). Some provisions of the plan that are specific to eligible Arkema Inc. retirees and eligible Bostik, Inc. retirees are described in the applicable addendums. 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 (along with the applicable addendum) 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 retirees. 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 the *Arkema Benefits Online* website at **benefits.myplansconnect.com/Arkema** for more benefits information.

Keep this 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 benefit programs with this document for future reference.

Eligibility and Enrollment

This booklet includes important information about your participation in the Arkema Inc. Pre-65 Retiree Medical Plan (the "plan" or "retiree medical plan"), including when to enroll, when you can make election changes, and when coverage ends. Additional information about eligibility, cost of coverage and paying for coverage is included in the attached addendums for eligible retirees of Arkema Inc., Bostik, Inc., DuPont, and Rohm and Hass.

Eligibility

Retirees who meet the service requirement for retirement (see the attached addendum) and retire from active service are eligible to elect healthcare coverage under the Arkema Inc. Pre-65 Retiree Medical Plan.

If you do not retire from active service, or if you retire from active service without meeting the service requirement, you will not be eligible for post-retirement medical coverage, even if you are eligible to receive a vested accrued retirement benefit under the Arkema Inc. Retirement Benefits Plan at a future retirement date. You may, however, continue medical coverage under COBRA for up to 18 months.

A retiree who is covered by a collective bargaining agreement is eligible to participate only if the applicable labor contract provided for retiree coverage incorporates medical coverage and prescription drug coverage, and if the retiree meets the eligibility requirements or as set forth in the collective bargaining agreement.

Service and Age Requirements

Please see the attached addendum for a description of the service and age requirements that pertain to you as retiree of Arkema Inc., Bostik, Inc., DuPont, or Rohm and Hass.

Your Eligible Dependents

You may also elect coverage for your eligible dependents who were covered under the active plan prior to retirement, including:

- Your lawfully married spouse, including your common-law spouse in states where such relationships are recognized.
- Your child(ren) until the end of the month in which they turn age 26.
- Your disabled child(ren), regardless of their age, provided they became disabled before age 26 while covered under the plan.
- Any other child(ren) for whom you are considered the legal guardian as defined by a court order or when a court order requires health insurance for the child(ren) for example, Qualified Medical Child Support Order (QMCSO), until the date stated in the order but in no event beyond the end of the month in which they reach age 26.

Your children are your:

- Natural children,

- Stepchildren,
- Legally adopted children, and
- Children who are placed in your home for adoption.

Please Note: If you die, your eligible spouse may continue to elect coverage while still eligible. If you have a dependent child at the time of our death, that child may also continue coverage until they are no longer eligible. If your spouse remarries, the new spouse will not be eligible for coverage.

Disabled Child(ren)

You must provide written proof of your child's disability to the Claims Administrator within 31 days after the date eligibility would otherwise end and as requested thereafter. This eligible dependent must still meet all other eligibility qualifications for coverage to be continued.

Qualified Medical Child Support Order

Any child of a plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the plan. In general, a QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant is eligible under the plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. A dependent child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process. For a description of Arkema procedures for a QMCSO, free of charge, 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.lifeworks.com Access Code: ING105
Email: qdroprocessing@lifeworks.com
Phone: (844) 208-7192
Fax: (844) 886-8539
Mail: P.O. Box 534277
St. Petersburg, FL 33747

Note: You can only add dependents that were eligible to be covered under the plan when you retired.

Enrollment

You may enroll in retiree medical coverage immediately upon your retirement, you may defer your initial enrollment once and begin participating at any time up to age 65, or you may waive coverage.

Annual Open Enrollment

If you are a current retiree, you may enroll for coverage, change your coverage level, or defer or waive coverage during an annual Open Enrollment period, which is held each fall for the following plan year. Coverage for you and your eligible dependents will begin on January 1 and remain in effect through December 31. You may only make changes in your election during the year if you have a change described in the section *Making Changes During the Year* For more information, see *Making Changes During the Year* on page 5.

If You and Your Spouse Worked for the Company

If you and your spouse are both retirees of the Company, you each have the option of enrolling separately as a "retiree," or one retiree may enroll as a dependent of the other retiree. You may not be covered both as a retiree and as a dependent at the same time. Only one of you may enroll your eligible children. If you enroll as a dependent, you can use that as your one time deferral and later enroll as a retiree.

If Your Spouse or Dependent Child(ren) Work for Arkema

If your spouse or dependent child is an active employee of Arkema, they may not be covered under the retiree plan and should enroll in the medical plan for active employees.

If You Don't Enroll

If you are a new retiree and you do not enroll for, waive, or defer coverage for yourself or your dependents within 31 days of your retirement date, you will default to defer coverage. For more information, see *If You Defer Coverage* below.

If you are a current retiree and actively participating in the plan and you do not make an election during Open Enrollment, you will automatically be re-enrolled in your current plan at your current coverage level. The coverage will be subject to any plan design or contribution changes for the following year.

You will not be able to make changes to your coverage (unless you have deferred coverage) or enroll your dependents for coverage until the next Open Enrollment, which applies to the next calendar plan year. For information about making changes to your coverage during the year, see *Making Changes During the Year* on page 5.

If You Waive Coverage

If you waive coverage, you will not be able to enroll for Arkema pre-65 retiree medical coverage in the future.

If You Defer Coverage

You can choose to defer coverage at the time of your retirement. If you choose to defer, you can enroll for coverage at a later date until you turn age 65. You can also elect coverage at the time of

retirement and later defer coverage. Note that you only have one opportunity to defer coverage, whether it is at the time of your retirement or at a later date.

When Coverage Begins

You may enroll in retiree medical coverage immediately upon your retirement or you may defer your initial enrollment and begin participating at any time up to age 65. Your coverage will be effective on the first day of the month following your enrollment**. Because this is the Pre-65 Retiree Medical Plan, if you do not enroll in coverage before you reach age 65, you will lose your right to retiree medical coverage.**

Coverage elected during the annual Open Enrollment period becomes effective for you and your dependents on January 1 and remains in effect through December 31. See *Enrollment* on page 3.

Your dependent's coverage will begin on the later of:
- The date your coverage begins if you enroll the dependent at that time
- The date specified in a Qualified Medical Child Support Order (QMCSO).

If you waive coverage for yourself or a dependent, you cannot later enroll yourself or that dependent in the plan. If your dependent is also a retiree, they have the ability to be covered as a dependent and then come back and be covered as a retiree.

Coverage Levels

If you enroll for pre-65 retiree medical coverage, you must choose from one of these coverage categories:
- Retiree,
- Retiree plus spouse or common-law spouse in states where permitted,
- Retiree plus child(ren),
- Retiree plus family, or
- No coverage.

Cost of Coverage

Please see the attached addendum for details about the cost of coverage as it pertains to you as retiree of Arkema Inc. or Bostik, Inc.

Paying for Coverage

Please see the attached addendum for details about paying for coverage as it pertains to you as a retiree of Arkema Inc. or Bostik, Inc.

Making Changes During the Year

You can drop or waive coverage for yourself or your dependents at any time. However, once you drop or waive coverage for yourself or a dependent, you cannot reenroll yourself or that dependent

unless that dependent is also eligible as a retiree on their own. If you deferred coverage and lose other coverage, you may enroll yourself and your dependents. See Loss of Other Coverage below.

Acquiring a New Dependent

If you are enrolled in the Pre-65 Retiree Medical plan as a retiree you may enroll your new spouse and/or stepchild within 31 days of your marriage and a new child within 31 days of his or her birth, adoption or placement for adoption. If your spouse is not enrolled in the plan, you may enroll him or her in the plan when you enroll a child due to birth, becoming your stepchild, adoption or placement for adoption. In the case of marriage, coverage will begin on the date of the qualifying event. In the case of birth, adoption or placement for adoption, coverage is retroactive to the date of birth, adoption or placement for adoption.

Loss of Other Coverage

If you have deferred enrollment in Arkema's medical plans for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in coverage under this plan without waiting for the next Annual Enrollment period, provided you request enrollment within 31 days after your other coverage ends.

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,
- If you are rehired by the company, you must move to the active medical plan as of your rehire date. You can return to the retiree medical plan if you leave the company again and are still eligible. If you are covering a dependent, that dependent must also move with you,
- The date coverage for your benefit class is canceled,
- The end of the month upon which you cancel your coverage if you are voluntarily canceling it while remaining eligible, or
- The date of your death,
- The end of the month in which you reach the age of 65.

Your dependent's coverage will end on the last day of the month for any of the following reasons:

- If you fail to make any required contribution toward the cost of your dependent's coverage when due,
- Your coverage ends,
- Your dependent no longer meets the definition of a dependent,
- You cancel your dependent's coverage if you are voluntarily canceling it while remaining eligible,
- Your dependent becomes covered as an employee or a retiree unless otherwise provided under applicable law,
- Your dependent becomes eligible for like benefits under this or any other group plan offered by your employer,
- Your eligible dependent(s) goes on active duty in the armed forces of any country,
- The end of the month in which your death occurs (if your dependent does not elect independent coverage under the Arkema Pre-65 Retiree Medical Plan),
- Your dependent reaches the age of 65, or
- You reach the age of 65.

Your covered spouse and dependents may be able to continue your Company medical coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) (see page 88 for details).

How the Medical Plan Works

The Arkema Inc. Pre-65 Retiree Medical Plan provides you the choice between two medical options, administered by Aetna, which include the:

- Aetna Choice POS II (PPO Option) — a preferred provider organization (PPO), and
- Aetna CDHP with HSA Option – a consumer driven health plan (CDHP) with health savings account (HSA).

Prescription drug coverage is provided with both benefit options and is administered by Express Scripts.

This document summarizes the coverage provided under the retiree medical plan and prescription drug plan. Decisions regarding what treatment is appropriate (for example, level and duration of care) are always at the discretion of the patient and his or her attending physician, regardless of what the medical option will pay.

In-Network Providers

Aetna has contracted with participating providers to offer medical services at negotiated, discounted fees. Under the PPO and CDHP options, you always have the freedom to choose any medical provider. However, when you use in-network providers, you generally save on out-of-pocket expenses.

Aetna manages and selects the group of healthcare professionals and facilities in its network. You can access an in-network provider listing based on your home ZIP code as follows:

- Call Aetna Member Services at 1-800-238-3488, or
- Log in to **www.aetna.com** to Find a Provider using the online provider directory.

Important Note:

When receiving orthopedic or bariatric surgery, you will be required to receive care at an Aetna Institute of Quality (IOQ) to receive care at the in-network rate.

If you do not receive care through an Aetna IOQ, the Arkema medical plans will not pay any benefits for bariatric surgery or related care, and the plans will cover certain orthopedic surgery procedures involving hip, knee, spine and neck procedures and related care at the out-of-network rate (60% after you meet the deductible). Please **contact Aetna member services at the number on the back of your ID card** for information regarding the specific orthopedic and bariatric surgery procedures impacted by the above requirements prior to scheduling a surgery.

Please note: This requirement does not apply if you are enrolled in the Out-of-Area medical plan, however the Out-of-Area Plan will no longer be available after December 31, 2021.

Out-of-Network Providers

Services performed by out-of-network providers are paid up to the recognized charge as determined by Aetna. You are responsible for paying any amount the provider charges in excess of the recognized charge in addition to any calendar year deductible and coinsurance. However, coverage may be different in emergency situations.

PPO Option

If you elect the PPO Option, you may choose to receive care from any licensed medical provider or hospital. Under the PPO, the option pays a percentage of your cost after you meet the deductible, except for services where copays apply. The percentage of coinsurance you pay differs depending on whether you use an in-network or out-of-network provider. When you use an in-network provider, your costs are generally less because of the coinsurance difference and because in-network providers have agreed to provide services at negotiated, discounted fees.

If you use an in-network provider, you do not need to submit claim forms. In addition, your in-network provider handles pre-certification for hospital admissions.

If you receive care from an out-of-network provider, you need to pay the expense out-of-pocket and you will need to submit a claim form to receive reimbursement for a covered expense. In addition you must also pre-certify hospital admissions, certain outpatient services, and many other services. It is your responsibility to obtain this pre-certification from the Claims Administrator before receiving care. Failure to pre-certify may result in a reduction in benefits. For more information about pre-certification, see *Pre-certification* on page 18, and for more information about claims filing, see *How to File A Claim*, on page 65.

CDHP with HSA Option

If you elect the CDHP with HSA Option, you may choose to receive care from any licensed medical provider or hospital without a referral. Under the CDHP, you pay for the cost of your care until you reach your annual deductible. You can use a debit card and have that payment deducted directly from your HSA. After you reach the annual deductible, the option pays a percentage of your cost. The percentage of coinsurance you pay differs depending on if you use an in-network or out-of-network provider. When you use an in-network provider, your costs are generally less because in-network providers have agreed to provide services at negotiated, discounted fees, and because of the coinsurance difference that applies after you have reached the annual deductible.

If you use an in-network provider, you do not need to submit claim forms. See *How an HSA Works* on page 73 for more information about your payment options with the HSA. In addition, your in-network provider handles pre-certification for hospital admissions. If you receive care from an out-of-network provider, you need to pay the expense out-of-pocket and submit a claim form to receive reimbursement for a covered expense after you have reached your deductible. You must also pre-certify hospital admissions and certain outpatient services. Failure to pre-certify may result in a reduction in benefits. For more information about pre-certification, see *Pre-certification* on page 18,

and for more information about checking the status of a claim, see *How to Check the Status of a Claim*, on page 78.

In 2021, when you actively enroll in this plan and if you are not covered by other health insurance or enrolled in Medicare, you have the option of establishing an HSA. You can contribute to this account, up to $3,600 if you cover only yourself or up to $7,200 if you cover any dependents under the CDHP; if you're age 55 or older at any time during 2021, you can contribute an additional $1,000 catch-up contribution. The maximum annual contribution to the Health Savings Account is set by the IRS annually and is subject to change.

You can use this account to pay for medical expenses now and in the future tax-free, as your HSA rolls over from year to year and earns tax-free interest. If you use this account for anything other than a qualified medical expense, you will be subject to income tax on the amount you withdraw and may be subject to excise taxes as well. Your HSA account may also be invested through Fidelity. Contact them at 1-800-541-3716 to learn more about investing your HSA money.

Out-of-Area Plan

Through December 31, 2021, if you live in an area that is not considered within Aetna's service area, you may participate in the Out-of-Area Plan. This plan offers the same coverage as the PPO, but offers in-network coverage even for care and services received outside the Aetna network. The Out-of-Area Plan is discontinued effective December 31, 2021. To determine if you qualify for the out-of-area program please contact Aetna Member Services at 1-800-238-3488 or call the Arkema Benefits Center at 1-800-406-9823, Monday to Friday, 9 a.m. to 6 p.m. Eastern time. Retirees who do not actively enroll in another medical option effective January 1, 2022, will be enrolled in the Aetna PPO plan at the same coverage tier they were enrolled in under the Out-of-Area Plan.

Special Situations

Certain rules apply to ensure that you have coverage. Check with Aetna Member Services at 1-800-238-3488 for specific information.

- **In an Emergency:** When you have a medical emergency, seek care immediately. You will receive network benefits as long as you call Aetna Member Services at 1-800-238-3488 within 48 hours of the emergency.
- **While You Are Traveling in the US:** If you need care while you are traveling outside the network service area, contact Aetna Member Services at 1-800-238-3488 for guidance if it is not a medical emergency. Member Service Representatives may be able to guide you to a local facility that participates in the plan or otherwise direct you to appropriate care. If your care is pre-approved, you are assured of receiving network benefits. If you need emergency care, follow the procedures described above.
- **If Your Dependent Lives Outside the Network Service Area:** Your dependent will be covered only if he or she goes to providers in your network service area. In an emergency situation, the plan may cover care at the network level if you call Aetna Member Services at 1-800-238-3488 within the time limits specified by the plan. If the plan provider is not contacted, care is covered at the out-of-network level.

- **While You Are Traveling Outside the US on Personal Travel:** Under the PPO and CDHP, Aetna also covers non-emergency care (as out-of-network care). You would need to pay upfront for the care and get itemized receipts to submit to Aetna upon your return to the US. No need to contact Aetna while you are traveling. Simply call 1-800-238-3488 upon your return and provide them with the receipts (they should be translated to avoid any delays with payment). Aetna will determine medical necessity and process reimbursement, if approved.

Medical Coverage Overview

The following chart shows how benefits are covered through each medical option.

	PPO		CDHP	
Plan Provision	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network**
Annual Deductible	$600/person $1,200/family	$1,200/person $2,400/family	$1,600/ employee only coverage $3,200/all other coverage levels	$3,200/ employee only coverage $6,400/all other coverage levels
Out-of-Pocket Maximum	$2,500/ person Effective 1/1/2022, $3,000 $5,400/ family Effective 1/1/2022, $6,000	$5,000/ person $10,800/ family	$3,500/ employee only coverage Effective 1/1/2022, $4,000 $6,850/all other coverage levels Effective 1/1/2022, $8,000	$7,000/ employee only coverage $14,000/all other coverage levels
	(includes the deductible, coinsurance and copays; excludes prescription drug payments, pre-certification penalties and any amount exceeding recognized charges)		(includes the deductible, coinsurance and prescription drug payments; excludes pre-certification penalties and any amount exceeding recognized charges)	
Primary Care Physician Office Visits	$30 copay (no deductible)	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist Office Visits	$40 copay (no deductible)	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Teladoc General or Mental Health Visits	$0 copay; the plan pays 100% per visit, no deductible applies	N/A	$0 copay; the plan pays 100% per visit, after deductible is met	N/A

	PPO		CDHP	
Plan Provision	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network**
Teladoc Dermatology Visits	You pay the full cost of the visit before the deductible, approximately $75 You pay 20% coinsurance after the deductible; approximately $15	N/A	You pay the full cost of the visit before the deductible, approximately $75 You pay 20% coinsurance after the deductible; approximately $15	N/A
Urgent Care Center (excludes any non-urgent care provided)	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
X-rays and Lab Work (Lab work billed by the provider is subject to the applicable copay. Lab work billed by an independent network laboratory is covered at 100%.)	X-rays: Plan pays 80% after deductible Lab work: Plan pays 100% on outpatient basis, no deductible; 80% on inpatient basis after deductible	Plan pays 60% after deductible	Preventive screening: Plan pays 100% on outpatient basis, no deductible Diagnostic X-rays: Plan pays 80% after deductible All other diagnostic labs: Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive care **There are no Age or Frequency limits on preventive care under the plan: (for example)** ▪ Well-Child Exams/Immunizations (birth to age 18) ▪ Adult Physical (you, spouse or your dependents over age 18 are limited to one exam each calendar year) ▪ COVID-19 mandatory testing, COVID-19 vaccination ▪ Routine OB/GYN Exams ▪ Mammogram ▪ Routine Digital Rectal Exam/ Prostate-specific Antigen Test (men age 40 and over) ▪ Colorectal Cancer Screening ▪ Routine Eye Exams (every 24 months)	Plan pays 100% (no deductible, no copay) (There are no age and frequency limits on preventive care noted under the plan. Please see page 30 for a complete listing of covered care, and contact Aetna Member Services. There	Plan pays 60% after deductible	Plan pays 100% (no deductible)	Plan pays 60% after deductible

	PPO		CDHP	
Plan Provision	**In-Network**	**Out-of-Network[1]**	**In-Network**	**Out-of-Network**
▪ Routine Hearing Exams (every 24 months) Lab Work Associated with Preventive Care (e.g., Digital Rectal Exam/Prostate-specific Antigen Test, routine GYN, etc.)	are no age limitations.)			
Hospital Care/Surgery (Inpatient)	Plan pays 80% after deductible	60% after deductible; $250 per confinement	Plan pays 80% after deductible	Plan pays 60% after deductible
Orthopedic surgery facility[2]	Plan pays 80% after deductible as long as the patient uses an Aetna Institute of Quality (IOQ).[3]	If you don't use an Aetna IOQ facility, the facility charge and related care will be paid at 60% after the out-of-network deductible.	Plan pays 80% after deductible as long as the patient uses an Aetna Institute of Quality (IOQ).[3]	If you don't use an Aetna IOQ facility, the facility charge and related care will be paid at 60% after the out-of-network deductible.
Bariatric surgery facility[2]	Plan pays 80% after deductible as long as the patient uses an Aetna Institute of Quality (IOQ).[3]	If you don't use an Aetna IOQ facility, you will pay the full cost of the facility charge and related care.	Plan pays 80% after deductible as long as the patient uses an Aetna Institute of Quality (IOQ).[3]	If you don't use an Aetna IOQ facility, you will pay the full cost of the facility charge and related care.
Outpatient Surgical Facility Expenses	Plan pays 80% after deductible	60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Treatment ▪ Emergency room (No coverage for non-emergency visits)	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Ambulance service	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Allergy Treatment ▪ Allergy Testing and Injections	Covered at applicable doctor's office or specialist office visit copay	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
▪ Allergy Serums	Play pays 100%, no deductible, when no office	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible

Plan Provision	PPO		CDHP	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network
	visit is billed; otherwise, covered at applicable doctor's or specialist office visit copay			
Maternity				
▪ Prenatal maternity	100%, no deductible, no copay	Plan pays 60% after deductible	100%, no deductible, no copay	Plan pays 60% after deductible
▪ Office visits	$40 copay for first visit, then plan pays 100%	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
▪ Inpatient physician care for mother and baby (including nurse and/or midwife services)	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
	(Lab work and inpatient hospital covered same as all other regular lab work and inpatient hospital stays.)			
Infertility Treatment (Limited to diagnosis and treatment of underlying medical condition; maximum of six courses of treatment for Artificial Insemination and Ovulation Induction) $5000 maximum applies to ART benefits only.	Plan pays 80% after deductible for up to six cycles of artificial insemination and ovulation induction) All other advanced reproductive technology (ART) benefits are subject to a $5,000 lifetime maximum.[4]	Plan pays 80% after deductible for up to six cycles of artificial insemination and ovulation induction) All other advanced reproductive technology (ART) benefits are subject to a $5,000 lifetime maximum.[4]	Plan pays 80% after deductible for up to six cycles of artificial insemination and ovulation induction) All other advanced reproductive technology (ART) benefits are subject to a $5,000 lifetime combined in- and out-of-network maximum.[4]	Plan pays 80% after deductible for up to six cycles of artificial insemination and ovulation induction) All other advanced reproductive technology (ART) benefits are subject to a $5,000 lifetime combined in- and out-of-network maximum.[4]
Outpatient Short-Term Rehabilitation (speech, physical, and occupational therapy)	Plan pays 80% after deductible, up to 60 visits per year; combined in- and out-of-network	Plan pays 60% after deductible, up to 60 visits per year; combined in- and out-of-network	80% after deductible; up to 60 visits per year (combined in and out of network)	60% after deductible; up to 60 visits per year (combined in and out of network)
Chiropractic **(Maintenance care is not covered)**	Plan pays 80% after deductible, limited to 30 visits per year;	Plan pays 60% after deductible, limited to 30 visits per year;	Plan pays 80% after deductible; limited to 30 visits per year;	Plan pays 60% after deductible; limited to 30

Plan Provision	PPO		CDHP	
	In-Network	**Out-of-Network[1]**	**In-Network**	**Out-of-Network**
	combined in- and out-of-network	combined in- and out-of-network	combined in- and out-of-network	visits per year; combined in- and out-of-network
TMJ	Member cost-sharing is based on type and location of service; $5,000 lifetime maximum, combined in- and out-of-network	Plan pays 60% after deductible; $5,000 lifetime maximum, combined in- and out-of-network	Plan pays 80% after deductible; up to $5,000 lifetime maximum	Plan pays 60% after deductible; up to $5,000 lifetime maximum
Mental Health/Substance Abuse Treatment ▪ **Inpatient coverage**	Plan pays 80% after deductible	Plan pays 60% after deductible, $250 copay per confinement	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient coverage	$30 copay (no deductible)	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Penalty for failure to Pre-certify	—	$300	—	$300

[1]*Out-of-network benefits for the Out-of-Area Plan (Non-Union Passive Choice POS II Preferred and Non-Preferred Plans (Plan FA)) are the same as PPO in-network benefits. The Out-of-Area Plan is discontinued effective December 31, 2021.)*

[2] *If you reside more than 100 miles from an IOQ facility, you may be eligible for travel and lodging benefits. See* Institutes of Quality (IOQs) *on page 21 for details.*

[3] *This requirement does not apply to the Out-of-Area plan. (Plan ends on December 31, 2021.)*

[4] *Advanced reproductive technologies include treatments such as IVF, ZIFT, GIFT, ICSI, PGD and PGS.*

Recognized Charges

If you receive care from an out-of-network provider or facility, recognized charges (formerly reasonable and customary charges) will be used to determine the plan's liability. Recognized charges refer to the amounts providers charge for services and represent an acceptable range for the same or similar services or supplies within your geographic area. You are responsible to pay any charges in excess of recognized charges. These charges are in addition to any applicable annual deductibles, copays, or coinsurance under your medical option. In addition, the amounts you pay above recognized charges do *not* apply toward your out-of-pocket limit. To find out the recognized charges for a particular service or procedure, you may call Aetna Member Services at 1-800-238-3488 or use the Price-a-Procedure tool on **www.aetna.com**.

Recognized charges do not apply to services received from in-network providers. Recognized charges are applicable if you receive services from out-of-network providers.

Annual Deductible

A deductible is the amount that you and covered family members pay during a calendar year for covered medical expenses before the plan will pay benefits. The amount of the deductible depends on the plan you select, whether you elect individual or family coverage and whether you use in-network or out-of-network providers.

Retiree Medical Plan Option

If you participate in the…	Then the annual deductible is…
PPO	▪ $600 per person, $1,200 per family for in-network services ▪ $1,200 per person, $2,400 per family for out-of-network services
CDHP	▪ $1,600 in-network, $32000 out-of-network if you have retiree only coverage ▪ $3,200 in-network, $6,400 out-of-network if you have all other coverage levels

Under the PPO option, there is an annual retail-only prescription drug deductible of $50 per individual or $100 per family. After you meet the deductible, you will pay coinsurance for your eligible retail prescription drug expenses until you reach the prescription drug out-of-pocket maximum. You pay copays for your mail-order prescriptions, with no deductible, until you reach the prescription drug out-of-pocket maximum.

Family Deductible

Under the PPO Option, the family deductible limits the amount of covered expenses your family as a group must pay each year before the plan begins paying benefits. If you have family coverage and a member within your family meets the per person deductible, expenses for this member will be covered by the plan for the rest of the year. However, other covered family members must continue to pay for medical expenses until one other member or a combination of members (including the

one who met the individual deductible) meets the family deductible. Once the family deductible has been met, the plan will pay benefits for all family members for the rest of the year.

Under the CDHP Option, the family deductible limits the amount of covered expenses your family as a group must pay each year before the plan begins paying benefits. If you have family coverage, you must meet the entire family deductible—either through the expenses of one member or through the combined expenses of the family—before expenses will be covered by the plan for the rest of the year. Once the family deductible has been met, the plan will pay benefits for all family members for the rest of the year. Note that this is different from the PPO Option family deductible.

In- and Out-of-Network Deductibles

Your in- and out-of-network deductibles are combined. This means that all of your medical costs, whether in- or out-of-network, will count towards meeting your deductible. For example, if you incur $50 in charges using in-network services and $150 in out-of-network charges, your combined total towards your in- and/or out-of-network deductible would be $200.

Coinsurance

After you meet the annual deductible, the plan will begin to reimburse your medical provider a specific percentage of your covered medical expenses. Your coinsurance is the remaining percentage of covered expenses that you must pay — up to a specified annual out-of-pocket limit.

The PPO Option will generally pay 80% of most in-network care, and 60% of the recognized charges for most covered out-of-network medical expenses (including doctor visits and hospital stays). You will pay the remainder up to the annual out-of-pocket maximum plus any charges in excess of recognized charges.

The CDHP Option will generally pay 80% of most in-network care, and 60% of the recognized charges for most covered out-of-network medical expenses (including doctor visits and hospital stays). You will pay the remainder up to the annual out-of-pocket maximum plus any charges in excess of recognized charges.

Annual Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will have to pay each year toward the cost of covered medical expenses. Once you reach this maximum, the plan will generally pay 100% of eligible expenses for the rest of the year.

For the PPO Option, the annual in-network, out-of-pocket maximum in 2021 is $2,500 per person, and $5,400 per family. For 2022, these will be increased to $3,000 per person, and $6,000 per family. The out-of-network, out-of-pocket maximum in 2021 is $5,000 per person, and $10,800 per family. For 2022, these will also increase to $6,000 per person, and $12,000 per family. The in-network and out-of-network out-of-pocket maximums include the deductible, coinsurance and copays, and exclude prescription drug payments and any amount exceeding recognized charges and pre-certification penalties. For the PPO Option, qualified prescription drug retail and mail-order copays (excluding penalties and amounts exceeding recognized charges) will apply toward your

separate prescription drug in- and out-of-network out-of-pocket maximum, which is $1,500/person and $3,000/family.

If you have family coverage and a member within your family meets the annual per person out-of-pocket maximum, expenses for this member will be covered at 100% for the rest of the year, with some exceptions. However, other covered family members will continue to be subject to applicable plan copays and coinsurance until one other member or a combination of members meets the family out-of-pocket maximum. Once the family maximum has been met, the PPO will pay 100% of all covered medical expenses for all family members for the rest of the year, with some exceptions.

Even after you have met the out-of-pocket maximum, the PPO Option will not pay charges in excess of recognized charges or for pre-certification penalties, as applicable, for you or your covered dependents.

For the CDHP Option, the annual out-of-pocket maximum for pre-65 retiree only coverage is $3,500 in-network and $7,000 out-of-network. For 2022, these will increase to $4,000 in-network and $8,000 out of network. The out-of-pocket maximum for all other coverage tiers is $6,850 in-network and $14,000 out-of-network. For 2022, these will increase to $8,000 in-network and $16,000 out-of-network. These amounts include your deductible, coinsurance payments and prescription drug payments, and exclude amounts exceeding recognized charges and all penalties.

If you have family coverage, you must meet the entire family out-of-pocket maximum before expenses for any member will be covered at 100% for the rest of the year.

Even after you have met the out-of-pocket maximum, the CDHP Option will not pay charges in excess of recognized charges or for pre-certification or other penalties, as applicable, for you or your covered dependents.

Pre-certification

Certain services, such as inpatient stays, certain tests, procedures and outpatient surgery require pre-certification by Aetna. Pre-certification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows the Claims Administrator to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to pre-certify services provided by a network provider. Network providers will be responsible for obtaining necessary pre-certification for you. Since pre-certification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to pre-certify services.

When you go to an out-of-network provider, it is your responsibility to obtain pre-certification from Aetna for any services or supplies on the pre-certification list below. If you do not pre-certify, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring pre-certification follows on the next page.

Important Note
Please read the following sections in their entirety for important information on the pre-certification process, and any impact it may have on your coverage.

The Pre-certification Process

Prior to being hospitalized or receiving certain other medical services or supplies there are specific pre-certification procedures that must be followed.

If you are responsible for pre-certification (going out of network), you or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to pre-certify the admission or medical services and expenses prior to receiving any of the services or supplies that require pre-certification pursuant to this summary plan description in accordance with the following timelines:

Pre-certification should be secured within the timeframes specified below. To obtain pre-certification, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your physician or the facility will need to call and request pre-certification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For outpatient non-emergency medical services requiring pre-certification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

The Claims Administrator will provide a written notification to you and your physician of the pre-certification decision. If your pre-certified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, the Claims Administrator will notify you, your physician and the facility about your pre-certified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. The Claims Administrator will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If pre-certification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how the Claims Administrator's decision can be appealed. You or your provider may request a review of the pre-certification decision pursuant to the *Claim Procedures/Complaints and Appeals/Dispute Resolution* starting on page 65 of this summary plan description.

Services and Supplies Which Require Pre-certification

Pre-certification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment
- Home health care
- Private duty nursing care
- Intensive Outpatient Programs for mental disorders and substance abuse
- Applied Behavioral Analysis
- Neuropsychological testing
- Outpatient detoxification
- Psychiatric home care services
- Psychological testing

How Failure to Pre-certify Affects Your Benefits

A pre-certification benefit reduction will be applied to the benefits paid if you fail to obtain a required pre-certification prior to incurring medical expenses. This means the Claims Administrator will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills. You will also be charged a pre-certification penalty of $300 if you are covered under the PPO or the CDHP with an HSA.

You are responsible for obtaining the necessary pre-certification from the Claims Administrator prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however you should verify with the Claims Administrator prior to the procedure, that the provider has obtained pre-certification from the Claims Administrator. If your treatment is not pre-certified by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered. Network providers are responsible for obtaining pre-certification on your behalf.

Please note: you are not required to obtain pre-certification for hospital coverage for a newborn and/or a mother for a period of least 48 hours after a normal vaginal delivery and 96 hours after a cesarean delivery. See "Newborns' and Mothers' Health Protection Act" on page 86 for more information.

Case Management

If you or a covered family member suffer from a serious or complex medical condition, you may require case management. Aetna will assign a case manager to:

- Assist you with authorizations and pre-authorizations,
- Work with you to arrange services you may need (for example, home healthcare upon discharge from the hospital, necessary medical equipment), and
- Help coordinate your care for covered services.

Institute of Excellence™ (IOE)

The IOE program coordinates solid organ, stem cell, and bone marrow and tissue transplant services. This is different than the Institute of Quality program noted below. Through the IOE network, you will have access to a provider network that **specializes in transplants**. See *What Is Covered* on page 26 for additional information.

Institute of Quality (IOQ)

When receiving **orthopedic or bariatric surgery**, you will be required to receive care at an Aetna Institute of Quality (IOQ) to receive care at the in-network rate. IOQs are facilities that have been selected for surpassing quality and efficiency standards and that show commitment to high-quality, cost-effective care. If you do not receive care through an Aetna IOQ, the Arkema medical plans will not pay any benefits for bariatric surgery or related care, and the plans will cover orthopedic surgery and related care at the out-of-network rate (60% after you meet the deductible).

If you reside more than 100 miles from an IOQ, you will be notified by Aetna if you are eligible to receive travel and lodging benefits to help with the cost of your trip. Once you are notified that you are eligible, you may arrange your travel based on your needs/preferences. You then have 180 days to submit the expenses for reimbursement. Below is a list of eligible expenses:

- **Lodging**: $50 per person for you and up to one travel companion; $100 total per night
- **Mileage**: Reimbursement at the IRS rate.
- **Eligible Modes of Transportation**:
  - Coach Class Airfare
  - Taxi
  - Bus
  - Train
  - Ferry
  - Shuttle

You must receive travel and lodging approval prior to your procedure before the plan will pay benefits. The maximum reimbursement for all travel and lodging expenses is $10,000.00 per episode of care.

Please note: This requirement does not apply if you are enrolled in the Out of Area medical plan if that plan is offered at your location.

Aetna's Online Health Resource

The Healthwise Knowledgebase offers Aetna members an additional resource to help them make informed healthcare decisions. It provides access to clinical information on health topics, medical tests and procedures, support groups and medications. The Healthwise Knowledgebase is designed to encourage informed healthcare decision-making, allowing you to better understand your treatment options. You can access the Healthwise Knowledgebase online at **www.aetna.com**.

Care Management

Aetna's In Touch Care Program reaches out to help you get personal care when you need it the most. Arkema medical plan participants, especially those managing a chronic condition or having a health event, can count on one-on-one attention from a nurse. You can get answers to health questions, support through a variety of digital resources and customized health action plans based on your needs and preferences, all at no extra cost.
Resources include:

- **Personal health record** — Organize and store your health history and information, plus get health alerts and notifications.
- **Health decision support** — Learn about your healthcare and treatment options.
- **Online programs** — Find dynamic health coaching programs that give you personalized support.
- **Health dashboard** — View your health information, and find entry points to health and wellness programs and resources.

For more information or to enroll, call Aetna Member Services at 1-800-238-3488. Note that you may also receive a call from Aetna inviting you to join the program if your submitted medical and prescription drug claims indicate that you may be eligible to participate.

The Beginning Right Maternity Program

Aetna offers a maternity management program to help members care for themselves and a new baby from trained experts. Some features of the program include:

- Nurse support with a nurse case manager to help manage health issues that could affect pregnancy,
- A due date calculator,
- A frequently asked questions section to answer all of your basic questions, broken down by the trimester they would occur in, and
- "How To" slide shows that demonstrate basic steps, such as how to hold your baby and how to breast feed your baby.

For more information, call Aetna Member Services at 1-800-238-3488.

Informed Health Line

The Informed Health Line allows members to call Registered Nurses, 24 hours a day, seven days a week. The Registered Nurses will assess, refer and transfer you to or from other Aetna medical programs. They also provide information and support for informed decision-making using the Healthwise Knowledgebase. You can also access educational materials through an audio library. Call the Informed Health Line at 1-800-556-1555, or access the Healthwise Knowledgebase online at **www.aetna.com**.

Health Advocate

Health Advocate services are available to you and your family at no cost to you. Through this service, you will be connected with your own "Personal Health Advocate," a trained professional, usually a registered nurse, who understands the "ins and outs" of the healthcare system and how to navigate it. Your Personal Health Advocate will help you with many of your healthcare issues, like care coordination, claims assistance, grievance advice, prescription drug issues and more.

Note that you and your family can use this benefit even if you waive medical plan coverage.
To find out more, call Health Advocate at 1-866-695-8622.

Teladoc

Teladoc provides you with access to doctors for phone or video consultations 24/7/365, quality care when you need it that's more convenient than urgent care or doctor's office visit, and an easy way to get care when you're on vacation, on a business trip or away from home. If you are enrolled in an Arkema medical plan, you (and your enrolled dependents) are eligible to use this program.

General Medicine
Teladoc can help when you need treatment for simple medical conditions, including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems
- Short-term prescription refills
- And more

Mental Health Visits

You can now use Teladoc to schedule an appointment with a licensed therapist from the comfort of your home. Establish an ongoing relationship with a provider by phone or video for issues like stress, anxiety, depression, grief, family issues, and more.

Dermatology Visits

You can also use Teladoc to connect with a licensed dermatologist who can treat on-gong or complex skin conditions like psoriasis, skin infections, rosacea, suspicious moles, and more. You pay the full cost of each visit before you meet the deductible, approximately $75. After you meet the deductible, you pay 20% coinsurance for each visit, approximately $15.

You pay $0 for general medicine and mental health visits if you are enrolled in the Aetna PPO. If you are enrolled in the CDHP with HSA, you will also see $0 copays for general medicine and mental health visits while the pandemic lasts. For dermatology visits, you pay the full cost of the visit before you meet your deductible under both plans; after you meet the deductible, standard coinsurance will apply for consultations.

To find out more, call Teladoc at 1-855-Teladoc (835-2362) or visit **Teladoc.com/Aetna**.

2nd.MD

2nd.MD provides you with access to expert medical advice from leading physicians and serves as a resource that helps you make the best possible decisions about your health whether you're dealing with back pain, a chronic condition, questioning surgery or facing a life-threatening illness. If you are enrolled in an Arkema medical plan, you (and your enrolled dependents) are eligible to use this program for free.

If you need more in-depth help or are already under the care of a doctor, call 2nd.MD when you:

- Are looking for a second opinion related to anything from a straightforward surgical procedure to a chronic condition or a serious illness
- Are questioning a diagnosis and/or treatment plan
- Have questions about a medical condition, test results or a personal health issue
- Need help managing your symptoms
- Want to find a family doctor or specialist

To find out more, call 2nd.MD at 1-866-410-8649 or visit **www.2nd.md/aetna**.

Livongo

The Livongo for Diabetes Program is designed to make living with diabetes easier. The program is offered at absolutely no cost to employees (and covered dependents) enrolled in an Arkema medical plan who are living with type 1 or type 2 diabetes. Through the program, you receive:

- A connected blood glucose meter
- Unlimited lancets and strips
- The support of a certified diabetes educator
- And more

And more Effective November 1, 2021, a **Livongo for Hypertension** program is available. The program is offered at no cost to employees (and covered dependents) enrolled in an Arkema medical plan who are living with hypertension or high blood pressure. Through the program those who participate will receive a connected blood pressure meter and support from a coach and other resources. Take advantage of this program to avoid the damage caused by high blood pressure.

Hinge Health

This program, effective November 1, 2021, is designed to help those who are dealing with back, knee, hip, shoulder, or neck pain by providing access to a no cost digital physical therapy program through Hinge Health.

Those who participate in the program receive a remote assessment by a doctor of physical therapy, exercise sensors and a tablet computer loaded with a therapy program for the participant to follow at home or work. Participants also have access to a coach for answers to day to day questions and support. The program cost is paid by the company and is not subject to the deductible or coinsurance. Participants are expected to return the tablet and sensors upon completion of the program.

Learn more about the program by calling 1-855-902-2777 or apply at: HingeHealth.com/MyArkema.

Aetna Transform Oncology Program

A cancer diagnosis can be confusing, challenging, and expensive. Cancer was a major diagnosis category for Arkema members and we want to help support those impacted employees and their families with the best resources available. Beginning January 1, 2022, Transform Oncology provides you with strategies for every step of the cancer journey so you can get the best quality care at a lower cost. If you or anyone covered by the medical plan receives a cancer diagnosis, Aetna One Choice may call to help you connect with personalized support, or you may contact an Aetna One Choice nurse at 1-800-238-3488.

Covered Medical Expenses

Here is a list of covered medical expenses for the PPO and CDHP Options. They include expenses for certain hospital and other medical services and supplies, and they must be for the treatment of an injury or disease. Contact Aetna Member Services at 1-800-238-3488 for more information or questions about covered medical expenses.

What Is Covered

The plan covers certain medical services and supplies that meet the plan's definition of covered health services. You are responsible for all applicable copays, deductibles and coinsurance. Coverage under this plan is non-occupational, which excludes treatment for accidents sustained while at work. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

- Charges for preferred care healthcare services or supplies furnished by:
  - Your preferred care provider,
  - A non-preferred care provider if approved by the Claims Administrator,
  - Any healthcare provider for an emergency condition when travel to a preferred care provider prior to treatment is not feasible, and
  - A non-preferred urgent care provider when travel to a preferred care provider for treatment is not feasible.
- Inpatient hospital expenses:
  - Room and board and other hospital services and supplies, and
  - Private room if requested by preferred care provider and approved by the Claims Administrator; if not approved, charge above the institution's semiprivate room rate will *not be* covered.
  - Note that inpatient admissions and admissions to a skilled nursing facility/convalescent facility must be pre-certified by the Claims Administrator.
- Outpatient hospital expenses for services and supplies.
- Outpatient surgical facility expenses:
  - Surgical center or hospital outpatient department charges for surgical procedure performed in the center or hospital; procedure must meet these tests:
    - Not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity, or involve any major blood vessels,
    - Can safely and adequately be performed only in a surgical center or hospital, and
    - Not normally performed in the office of a physician or dentist.
  - Services and supplies furnished by the center or hospital on the day of the procedure.
- Charges for mammograms (each calendar year for females age 40 or over).
- Charges made by a physician.
- Diagnostic lab work and x-rays.
- X-ray, radium and radioactive isotope therapy.
- Anesthetics and oxygen.
- Allergy testing and injections.
- Voluntary sterilization.

- Contraceptive drugs and devices.
- Bariatric surgery after pre-certification and through an Institute of Quality, including, but not limited to: lap band, gastric bypass, and sleeve gastrectomy.
- Medically necessary custom orthotics.
- Professional ambulance service to transport a person from the place where injured or stricken by disease to the first hospital where treatment is given.
- Gender affirming treatment including certain services and supplies for gender affirming (sometimes called sex change) treatment.
- Artificial limbs and eyes. See *What Is Not Covered* beginning on page 46 for excluded charges in connection with artificial limbs and eyes.

Important note: Just log into your **Aetna** website at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this **covered benefit,** including eligibility and medical necessity requirements. You can also call *Member Services* at the telephone number on the back of your I.D. card.

See *What Is Not Covered* beginning on page 46 for excluded charges in connection with artificial limbs and eyes.

Applied Behavior Analysis

Covered services include certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Coverage for applied behavior analysis services is based on the type of service and where it is received.

Important note:
Applied behavior analysis may require **pre-certification**. See the *How your plan works – Medical necessity, pre-certification* section.

Autism Spectrum Disorder

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Occupational (OT), physical (PT) and speech (ST) therapies associated with the diagnosis of autism spectrum disorder

Coverage for Autism spectrum disorder services is based on the type of service and where it is received.

Convalescent Facility Expenses

Convalescent facility expenses for the following services and supplies while confined to convalesce from a disease or injury, up to 120 days per calendar year:

- Room and board, including charges for services such as, general nursing care made in connection with room occupancy; does *not* include private room board and room charge over the institution's semiprivate room rate,
- Use of special treatment rooms,
- X-ray and lab work,
- Physical, occupational or speech therapy,
- Oxygen and other gas therapy,
- Medical supplies, and
- Other medical services usually given by a convalescent facility; does *not* include private or special nursing or physician's services.

Note that admissions to a skilled nursing facility/convalescent facility must be pre-certified by the Claims Administrator. See *What Is Not Covered* beginning on page 46 for excluded charges in connection with convalescent facilities.

Home Care Expenses

Covered expenses include charges made by a home health care agency for home health care, and the care:

- Is given under a home health care plan;
- Is given to you in your home while you are homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
- Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under this plan if you had a hospital stay.
- Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a physician and directly related to an active treatment plan of care established by the physician. All of the following must be met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a hospital or residential treatment facility, or receiving outpatient services outside of the home.
  - You are homebound because of illness or injury.
  - The services provided are not primarily for comfort or convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.

Benefits for home health care visits are covered up to 60 visits per year combined in- and out-of-network. Each visit by a nurse or therapist of up to 4 hours, and each visit by a behavioral health professional of up to 1 hour, is one visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:
- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note that home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations shown in See *What Is Not Covered* beginning on page 46.

Limitations

Unless specified above, *not* covered under this benefit are charges for:
- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care.

Important Reminders

The plan does not cover custodial care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Note that home health care and Private Duty Nursing/Skilled Nursing Care must be precertified by the Claims Administrator. See *What Is Not Covered* beginning on page 46 for excluded charges in connection with home care expenses.

Skilled Nursing Care

Covered expenses include charges provided by a R.N., L.P.N. or nursing agency for outpatient skilled nursing care if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a Calendar Year in excess of 60 visits per year combined in- and out-of-network. Each visit by a nurse or therapist of up to 4 hours is one visit. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

Limitations
Unless specified above, not covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a hospital or health care facility.
- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

Note that home health care and Private Duty Nursing/Skilled Nursing Care must be pre-certified by the Claims Administrator. See *What Is Not Covered* beginning on page 46 for excluded charges in connection with skilled nursing expenses.

Preventive Services

As part of Arkema's philosophy of prevention and wellness and in compliance with federal mandates, most in-network preventive exams will be covered at 100%, with no copay or deductible required. Please advise your provider when you have an appointment for preventive care services that your plan will pay 100%. Your provider can also contact Aetna to confirm what the plan covers at 100%. Following is the list of routine preventive services that are covered at 100%.

As of January 1, 2021, all age and frequency limits have been removed from preventive services under the plan.

For more details on the preventive care services covered under your Arkema medical plan, log in to your **www.aetna.com** account and search for any of the services listed below under "Finding Care & Pricing."

Routine Physical Exams

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk human papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam. For covered newborns, an initial hospital checkup.

Preventive Care Immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well Woman Preventive Visits

- Well woman preventive exam office visit to your physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
- Preventive care breast cancer (BRCA) gene blood testing by a physician and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive Screening and Counseling Services

Obesity and/or healthy diet counseling
Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Misuse of Alcohol and/or Drugs
Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

Use of Tobacco Products
Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits;

Tobacco cessation prescription and over-the-counter drugs
Eligible health services include FDA- approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

Sexually Transmitted Infection Counseling

Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

HIV Prevention

Eligible health services include pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

Genetic Risk Counseling for Breast and Ovarian Cancer

Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine Cancer Screenings

- Mammograms
- Prostate specific antigen (PSA) tests

- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Skin cancer screening (contact Aetna member services to ensure your preventive screening is covered if your dermatologist codes your scheduled screening with a diagnosis and it is denied as a result)
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network provider who is an OB, GYN or OB/GYN.

Prenatal Care

You can get the following care at your physician's, PCP's, OB's, GYN's, or OB/GYN's office:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

Comprehensive Lactation Support and Counseling Services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support provider.

Breast Feeding Durable Medical Equipment

Eligible health services include renting or buying durable medical equipment you need to pump and store breast milk as follows:

Breast Pump

- Renting a hospital grade electric pump from the hospital while your newborn child is confined in a hospital.
- The buying of:
  - An electric breast pump (non-hospital grade). Your plan will cover this cost once every three years, or

- A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pumps may be purchased at one of the participating DME suppliers shown below and they will submit a claim for the member.

DME National Providers	Phone Number	Website	Primary Products	Other Products	Mail Order
A+ Breast Pumps by Yummy Mummy	1-855-879-8669	www.yummymummystore.com/	Breast pumps and supplies	No	Yes
A Pumping Essentials	1-866-688-4203	www.pumpingessentials.com	Breast pumps/accessories	No	Yes
A Breast pump and More	1-855-786-7296	www.abreastpumpandmore.com/	Breast pumps and supplies	No	Yes
Aeroflow Inc.	1-888 345-1780	www.aeroflowinc.com	Breast pumps, catheters, incontinence, standard mobility, pediatrics, respiratory, sleep apnea, wound care.	No	Yes
Genadyne Biotechnologies	1-888-809-9750	www.lucinacare.com	Breast pumps/accessories	No	Yes

Breast Pump Supplies and Accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family Planning Services – Female Contraceptives

- Counseling services - Eligible health services include counseling services provided by a physician, PCP, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Devices - Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a physician during an office visit.
- Voluntary sterilization - Eligible health services include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

If you have any questions about whether a procedure is considered preventive care, or frequency and age limitations, please call Aetna Member Services at 1-800-238-3488.

See *What Is Not Covered* beginning on page 46 for excluded charges in connection with preventive care services.

Hearing Exams

Charges for one audiometric (hearing) exam per 24-month period, performed by a certified otolaryngologist or otologist or an audiologist who either is legally qualified in audiology or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of applicable licensing requirements and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

See *What Is Not Covered* beginning on page 46 for excluded charges in connection with routine hearing exams.

Hospice Care

Covered hospice care services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

Room and board

- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Psychological and dietary counseling
- Pain management and symptom control

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
  - -Physical and occupational therapy
  - -Medical supplies
  - -Outpatient prescription drugs
  - -Psychological counseling
  - -Dietary counseling

Note that inpatient hospice care and home health care must be pre-certified by the Claims Administrator. See *What Is Not Covered* beginning on page 46 for excluded expenses in connection with hospice care.

Infertility Services

Basic Infertility Expenses
Charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

Even though not incurred for treatment of an illness or injury, covered expenses will include expenses incurred by an eligible covered female for infertility if all of the following tests are met:

- A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or an infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Booklet.

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist, subject to all the exclusions and limitations of the Arkema Medical Plan.

- Covered services include the following infertility services provided by an infertility specialist:
  - Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
  - Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination
- If oral/injectable prescription drugs are covered under the medical benefit, include below.
  - Oral and injectable prescription drugs used:
    - To stimulate the ovaries
    - Primarily for treating the underlying cause of infertility
- Infertility covered services may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, a "cycle" is defined as:
  - An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination
  - An artificial insemination cycle with or without injectable medication to stimulate the ovaries
- You are eligible for these covered services if:
  - You or your partner have been diagnosed with infertility
  - You have met the requirement for the number of months trying to conceive through egg and sperm contact
  - Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's infertility clinical policy

Aetna's National Infertility Unit: The first step to using your comprehensive infertility covered services is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with

determining eligibility for benefits. They can also help your provider with pre-certification. You can call the NIU at 1-800-575-5999.

Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.

Advanced Reproductive Technology (ART) Expenses

To be eligible for ART benefits under the Arkema Medical Plan, you must meet the requirements above and:

- First exhaust the infertility services benefits. Coverage for ART services is available only if infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your physician to Aetna's infertility case management unit.
- You or your partner have been diagnosed with infertility
- You have met the requirement for the number of months trying to conceive through egg and sperm contact
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's infertility clinical policy

Covered ART Benefits

Advanced reproductive technology (ART)**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by an ART **specialist**:

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)
- Oral and injectable prescription drugs used:
    - To stimulate the ovaries
    - Primarily for treating the underlying cause of infertility

Aetna's National Infertility Unit: The first step to using your ART covered services is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and can give you information about our infertility Institutes of Excellence™ facilities. They can also help your provider with pre-certification. You can call the NIU at 1-800-575-5999.

Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as:
    - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
    - Other gonadotoxic therapies
    - Removing the uterus
    - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's infertility clinical policy.

Premature ovarian insufficiency

If your infertility has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

Short-term Rehabilitation

Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.

- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
    - Significantly improve, develop or restore physical functions you lost as a result of an acute illness, injury or surgical procedure, or
    - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
    - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure, or
    - Improve delays in speech function development caused by a gross anatomical defect present at birth.
    - Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.
- Habilitation therapy services
  - Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).
- Eligible health services include habilitation therapy services your physician prescribes. The services have to be performed by:
  - A licensed or certified physical, occupational or speech therapist
  - A hospital, skilled nursing facility, or hospice facility
  - A home health care agency
  - A physician
- Habilitation therapy services have to follow a specific treatment plan, ordered by your physician.
  - Outpatient physical, occupational, and speech therapy
  - **Eligible health services include:**
    - Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
    - Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.
    - Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development. (Speech function is the ability to express thoughts, speak words and form sentences).

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

See *What Is Not Covered* beginning on page 46 for excluded expenses in connection with short-term rehabilitation.

Durable Medical and Surgical Equipment

Rental of durable medical and surgical equipment, or instead of rental:

- Initial purchase of such equipment if the Claims Administrator determines that long-term care is planned and that such equipment either cannot be rented or is likely to cost less to purchase than to rent,
- Repair of purchased equipment, and
- Replacement of purchased equipment if the Claims Administrator determines that it is needed due to a change in the person's physical condition, or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in this SPD. The Claims Administrator reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the Claims Administrator.

Prosthetic Devices

- Internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect.
- Instruction and incidental supplies needed to use a covered prosthetic device.
- First prosthesis needed that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:
  - Internal body part or organ; or
  - External body part.
- Replacement of a prosthetic device if:
  - The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
  - It is likely to cost less to buy a new one than to repair the existing one; or
  - The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

See *What Is Not Covered* beginning on page 46 for excluded expenses.

Institute of Excellence (IOE)

Transplant Services

Eligible health services include transplant services provided by a physician and hospital.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

CAR-T and T-Cell receptor therapy for FDA approved treatments

Network of Transplant Facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility Aetna designates to perform the transplant you need
- A Non-IOE facility

Your cost share will be lower when you get transplant services from the IOE facility Aetna designates to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.
The National Medical Excellence Program® will coordinate all solid organ, bone marrow and CAR-T and T-Cell therapy services and other specialized care you need.

Important Note:

If there is no IOE facility for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an IOE facility in another one of our networks. If you don't get your transplant services at the IOE facility Aetna designates, your cost share will be higher.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

See *What Is Not Covered* beginning on page 46 for excluded expenses in connection with the IOE program.

Mouth, Jaws and Teeth

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a physician, a dentist and hospital:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to injury.
  - Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of orthodontic treatment after an injury.

See *What Is Not Covered* beginning on page 46 for excluded expenses in connection with the mouth, jaws and teeth.

Emergency Room Providers

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physicians services;
- Hospital nursing staff services; and
- Radiologists and pathologists services.

Please contact your physician after receiving treatment for an emergency medical condition.

Note that, with the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses. No other plan benefits will pay for non-emergency care in the emergency room. See *What Is Not Covered* beginning on page 46 for excluded expenses in connection with emergency room and urgent care providers.

Urgent Care Providers

Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition. Charges to evaluate and treat an urgent condition (not an emergency) by an urgent care provider; you must contact your primary care provider after treatment.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

If you visit an urgent care provider for a non-urgent condition, the plan will not cover your expenses. See *What Is Not Covered* beginning on page 46 for excluded expenses in connection with emergency room and urgent care providers.

Treatment of Mental Disorders

Eligible health services include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:

- Inpatient room and board at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
    - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
    - Individual, group and family therapies for the treatment of mental health
    - Other outpatient mental health treatment such as:
        - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
        - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
        - Skilled behavioral health services provided in the home, but only when all the following criteria are met:
            - You are homebound
            - Your physician orders them
            - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
            - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications

- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation
- Peer counseling support by a peer support specialist
- A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by Aetna. Peer support must be supervised by a behavioral health provider.

Please Note: Inpatient care, partial hospitalizations and outpatient treatment must be pre-certified by the Claims Administrator. Refer to ***Pre Certification*** on page 18 for more information.

The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Please Note: The plan does not cover certain services. Please contact Aetna Member Services at 1-800-238-3488 to confirm whether or not your service will be covered.

Treatment of Alcoholism and/or Substance Abuse

The Claims Administrator coordinates your treatment by behavioral health providers for substance abuse treatment. In addition to meeting all other conditions for coverage, the treatment must be supervised by a physician or licensed provider.

Please Note: Inpatient care, partial hospitalizations and outpatient treatment must be pre-certified by the Claims Administrator. Refer to ***Pre Certification*** on page 18 for more information.

- In-Patient Treatment:
  - Room and board, up to the institution's semiprivate room rate, and
  - Necessary services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent.
  - Treatment in a hospital for the medical complications of substance abuse.
  - "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
    Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.
- Partial Confinement Treatment:
  - Charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse.
- Outpatient Treatment:

- Charges for partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse.
  The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility

Please Note: The plan does not cover certain services. Please contact Aetna Member Services at 1-800-238-3488 to confirm whether or not your service will be covered.

Experimental or Investigational Services, Supplies and Drugs

Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

Clinical trial therapies (experimental or investigational)

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a provider in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Gene-based, cellular and other innovative therapies (GCIT)

These services are subject to pre-certification and must be provided by a **physician**, **hospital** or other **provider**. GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.

- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:
You must get GCIT **covered services** from the GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

Medical Emergency

A medical emergency is a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy,
- Serious impairment to bodily function,
- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

You must notify Aetna Member Services at 1-800-238-3488 within 48 hours of your emergency room visit to receive the network level of benefits. If you use the emergency room for anything other than what is considered a medical emergency, there are no benefits payable from your plan.

What Is Not Covered

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in *What Is Covered* beginning on page 26. The plan does not cover certain services, some of which are listed below. Please contact Aetna Member Services at 1-800-238-3488 to confirm whether or not your service will be covered.

General Exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

- The provision of blood to the **hospital**, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected. This cosmetic services exclusion does not apply to medically necessary panniculectomy/apronectomy when panniculus hangs below the level of the pubis and chronic intertrigo is documented as recurring over 3 months while receiving appropriate medical treatment.

Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered service

Custodial care

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care except as covered under oral and maxillofacial treatment.

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Early intensive behavioral interventions

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Educational services

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)) unless related to mental health treatment
  - Job training
  - Job hardening programs
  - Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs).

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, or fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hospice

- The following are not covered hospice services:
  - Funeral arrangements
  - Pastoral counseling
  - Financial or legal counseling including estate planning and the drafting of a will
  - Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
    - Sitter or companion services for you or other family members
    - Transportation
    - Maintenance of the house

Infertility

- The following are not covered infertility services:

- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
    - Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
    - Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
    - Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.
    - Treatment for dependent children, except for fertility preservation as described above.
    - Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.

Jaw joint disorder

- Non-surgical treatment of jaw joint disorder (TMJ)

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
    - Sheaths
    - Bags
    - Elastic garments
    - Support hose
    - Bandages
    - Bedpans
    - Syringes

- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-prescription drugs and medicines

- Outpatient prescription or non-prescription drugs and medicines provided by the employer or through a third party vendor contract with the employer.

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses.

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as covered under the plan.

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States.

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine

- Services given by providers that are not contracted with Aetna as telemedicine providers
- Services given when you are not present at the same time as the provider
- Services including:
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF).This also includes:
  - Counseling, except as specifically provided in the Eligible health services under your plan – Preventive care and wellness section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)

- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Additional Exclusions

Preventive Care and Wellness

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician's direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Hospital and Facility Care

Outpatient surgery and physician surgical services

- The services of any other physician who helps the operating physician
- A stay in a hospital
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
    - Sitter or companion services for either you or other family members
    - Transportation
    - Maintenance of the house

Outpatient private duty nursing

See description of outpatient and inpatient skilled nursing care regarding coverage of nursing services.

Emergency Services and Urgent Care

- Non-emergency care in a hospital emergency room facility
- Non-urgent care in an urgent care facility(at a non-hospital freestanding facility)

Behavioral health treatment

Services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Family planning services - other

- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility

Maternity and related newborn care

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health /substance use disorders conditions

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Paraphilia’s
- Tobacco use disorders and nicotine dependence, except as described in the Coverage and exclusions – Preventive care section

- Pathological gambling, kleptomania, pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor function
- Specific developmental disorders of speech and language
- Other disorders of psychological development

Obesity

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the Eligible health services under your plan – Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery (Bariatric surgery is covered under covered services)
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Treatment of infertility, except as otherwise covered

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.

- Thawing of cryopreserved (frozen) eggs, embryos or sperm.
- The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
- The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Obtaining sperm from a person not covered under this plan for ART services.

- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.

Specific Therapies and Tests

Acupuncture

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Short-term rehabilitation services

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided to treat delays in development and/or chronic conditions. Examples of covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Autism Spectrum Disorder
  - Down syndrome
  - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a home health care agency.
- Services provided by a physician, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist.

Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Other Services

Ambulance services

- Fixed wing air ambulance from an out-of-network provider

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described under clinical trial therapies (experimental or investigational).

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies).

Durable medical equipment (DME)

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered under the plan.

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Vision Care

Adult vision care

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Vision care services and supplies

- Your plan does not cover vision care services and supplies, except as described under the plan.

- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Outpatient Prescription Drugs

- Preventive contraceptives
- Brand-name prescription drug forms of contraception in each of the methods identified by the FDA

Prescription Drug Plan

If you elect coverage in any of the Aetna retiree medical plan options offered by Arkema, you and your eligible dependents are automatically enrolled in the Express Scripts prescription drug plan. You do not pay a separate contribution for prescription drug benefits and you do not have to complete a separate enrollment election to receive this coverage.

Through this plan, you may purchase prescription drugs at retail pharmacies in the Express Scripts pharmacy network or the Express Scripts Pharmacy. Under the PPO Option, when you visit a participating pharmacy, you will pay coinsurance for your medication. If you visit a non-participating pharmacy, you pay 100% of retail cost and submit a claim for reimbursement to Express Scripts. If you use the mail-order service, you pay applicable copays until the annual deductible is met. The prescription drug plan will reimburse you for the participating pharmacy cost of the prescription drug less the member coinsurance. For the PPO Option, there is an annual deductible of $50 per individual or $100 per family that applies to retail purchases only. The plan will pay 100% of eligible expenses for the rest of the year when you meet the retail and mail order prescription drug out-of-pocket maximum ($1,500 per person or $3,000 per family in- and out-of-network). Note that only qualified prescription drug expenses will apply toward your out-of-pocket maximum. All penalties and amounts exceeding recognized charges will be excluded.

Under the CDHP Option, when you visit a participating or non-participating pharmacy or use the mail-order service, you will pay 100% of the cost of your medication, until you reach the annual deductible (combined medical and prescription drug), unless the prescription is preventive. After you reach the annual deductible, you will pay coinsurance when you visit a participating pharmacy or use the mail-order service; if you visit a non-participating pharmacy, you pay 100% of retail cost and submit a claim for reimbursement to Express Scripts. The prescription drug plan will reimburse you for the participating pharmacy cost of the prescription drug less the member coinsurance. Note that only qualified prescription drug expenses will apply toward your out-of-pocket maximum. All penalties and amounts exceeding recognized charges will be excluded.

Compound prescriptions deemed not cost-effective or clinically appropriate will not be covered by the PPO Option or the CDHP Option.

Here's an overview of the prescription drug plan.

	PPO		**CDHP**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$50/person $100/family Applies to Retail Only		No separate prescription drug deductible; prescription drug costs are counted toward the combined medical and prescription drug deductible	
Annual Out-of-Pocket Maximum *(excludes penalties and amounts exceeding*	$1,500/person $3,000/family		No separate prescription drug out-of-pocket maximum; prescription drug costs are counted toward the combined medical and prescription drug out-of-pocket maximum	

	PPO		CDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
recognized charges)				
Retail (up to 30-day supply) *You must meet the deductible before you pay coinsurance for eligible expenses ‡*				
Generic*	20% coinsurance, minimum $10	You pay 100% of the retail cost and submit a claim for reimbursement. The plan will reimburse you For the participating pharmacy cost of the prescription drug less the member coinsurance. Note that any amounts in excess of the participating pharmacy cost will not be reimbursed.	20% coinsurance, minimum $10‡	You pay 100% of the retail cost and submit a claim for reimbursement. The plan will reimburse you for the participating pharmacy cost less member coinsurance. Note that any amounts in excess of the participating pharmacy cost will not be reimbursed.
Brand-Name Formulary	20% coinsurance, minimum $30		20% coinsurance, minimum $30‡	
Brand-Name Non-Formulary	20% coinsurance, minimum $60		20% coinsurance, minimum $60‡	
Mail-Order (up to 90-day supply)* *You must meet the deductible before you pay coinsurance for eligible expenses ‡*				
Generic*	$20 copay	Not available	$20 copay‡	Not available
Brand-Name Formulary	$60 copay	Not available	$60 copay ‡	Not available
Brand-Name Non-Formulary	$120 copay	Not available	$120 copay ‡	Not available

* *If a generic drug is available and you purchase a brand-name (formulary or non-formulary) drug, you will pay the applicable retail coinsurance or mail-order copay, plus the difference in cost between the brand-name and generic drug.*

** *Certain maintenance medications must be filled through mail order.*

‡ *Through the CDHP, preventive drugs including certain vitamins, vaccines, weight loss agents, fluoride preparations, and cholesterol-lowering drugs that are prescribed by your medical care provider are covered at 100%. For a complete list, visit Arkema Benefits Online at* ***benefits.myplansconnect.com/Arkema****.*

To see a directory of participating pharmacies, log on to the Express Scripts website at **www.express-scripts.com**. When visiting for the first time, you will have to register. After you have registered for the site, you will be able to search for a participating pharmacy in your area. You can also contact Express Scripts by calling 1-800-363-8952**.**

Deductible

For the PPO Option, there is an annual prescription drug deductible that applies to retail purchases only of $50 per person, $100 per family, separate from the medical deductible. For the CDHP with HSA Option, prescription drug costs are counted toward the combined medical and prescription drug deductible. Once you reach the deductible, you will pay coinsurance for medications until you reach the out-of-pocket maximum.

If you get a brand-name drug when a generic is available, amounts paid in excess of the brand-name drug coinsurance, will not apply towards the deductible or out-of-pocket maximum. Nor will amounts in excess of the participating pharmacy cost when using a non-participating pharmacy apply.

Out-of-Pocket Maximum

For the PPO Option, there is an annual prescription drug out-of-pocket maximum of $1,500 per person, $3,000 per family, separate from the medical out-of-pocket maximum. For the CDHP with HSA Option, prescription drug costs are counted toward the combined medical and prescription drug out-of-pocket maximum.

The following example shows the difference in how the prescription charges are applied to the out-of-pocket maximum:
Terry fills a prescription for her daughter's qualified, generic medication each month which costs $25.00.

Prescription cost each month	Amount applied to PPO out-of-pocket max	Amount applied to prescription out-of-pocket max in PPO	Amount applied to combined CDHP and prescription out-of-pocket max
January - $25; deductible not yet met	$0	$25	$25
February - $25; deductible not yet met	$0	$25	$25
March - $20; deductible met	$0	$20	$20
April - $20; deductible met	$0	$20	$20

For both the CDHP and PPO, only qualified prescription drug expenses will apply toward your out-of-pocket maximum. All penalties and amounts exceeding recognized charges will be excluded. Once you reach the out-of-pocket maximum, the prescription drug plan will begin paying 100% of your costs for medications for the rest of the year.

If you get a brand-name drug when a generic is available, amounts paid in excess of the brand-name drug coinsurance, will not apply towards the deductible or out-of-pocket maximum. Nor will amounts in excess of the participating pharmacy cost when using a non-participating pharmacy apply.

Mandatory Generic Drug Program

In the PPO Option and CDHP with HSA Option, after the annual combined deductible has been met, if you purchase a brand-name formulary or brand-name non-formulary drug when a generic alternative is available, you will pay your brand-name drug coinsurance, plus the difference in cost between the brand-name and generic drug.

For example, if you fill a prescription for a brand-name drug that costs $200, and a generic equivalent is available that costs $100, you will pay $40 for the coinsurance, plus $100 for the difference in cost between the two drugs ($140 total). Note that you will never pay more than the full retail cost of the brand-name drug.

Brand and Generic Drugs

The brand name of a drug is the product name under which the drug is advertised and sold. Generic drugs are sold under generic names. They are similar to brand name drugs but they cost less. By law, generic drugs must have the same active ingredients and are subject to the same US Food and Drug Administration (FDA) standards for quality, strength, and purity as their brand name counterparts. Under the prescription drug plan, generic drugs will cost you less than brand name drugs, so ask your doctor to prescribe generic drugs whenever appropriate. Keep in mind, if a generic drug is available and you purchase a brand-name drug, you will pay the 20% coinsurance, plus the difference in cost between the brand-name and generic drug.

Your Express Scripts prescriptions will be filled with a generic drug, unless your doctor specifically requests a brand-name drug and writes "dispense as written" on your prescription.

Mandatory Mail-Order for Maintenance Medications

If you take medication on an ongoing basis, for example, for an ulcer, high cholesterol, blood pressure or diabetes, you are required to order your maintenance prescription drugs and refills through The Express Scripts Pharmacy® to receive full benefits. With the mail-order service, you save money because you pay less than you would at a retail pharmacy.

Through the PPO Option and CDHP Option, you are allowed to get the first prescription and one refill (if needed) at a retail pharmacy before you have to use the mail order service in order to continue receiving benefits. For the PPO Option or the CDHP Option after you have met the deductible, if you continue to purchase the medication at a retail pharmacy on the third fill and beyond, you will pay 100% of the total cost of the prescription.

The first time you use The Express Scripts Pharmacy® for a prescription, you must provide the pharmacy with an original new prescription from your doctor. The mail service pharmacy, under federal law, cannot accept transferred prescriptions or refill existing prescriptions from another pharmacy (mail or retail).

If you have questions about whether a specific prescription is covered by the mandatory mail program, please contact Express Scripts at 1-800-363-8952.

SaveOn Specialty Program

If you are enrolled in the PPO plan, your Express Scripts prescription drug coverage will feature SaveonSP, a specialty pharmacy copay assistance program. With SaveonSP, you will not pay a copayment for select specialty drugs. Prescriptions will be filled through Accredo, Express Scripts' specialty mail pharmacy. Please note participation in the program is mandatory if you require select

specialty drugs. Express Scripts will notify you if your prescription is part of the program and will provide information on how to enroll.

If you do not enroll and fill your specialty drugs through SaveonSP, you will pay significantly higher costs for these medications. The costs for these specialty pharmacy drugs are considered non- essential health benefits and fall outside the out-of-pocket limits. The cost (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximum.

Ordering New Prescriptions

Ask your doctor to prescribe your medication for 90 days (if the intended use is for at least 90 days) and, if applicable, have it noted that it can be refilled up to three times (for a maximum prescription length of 12 months per prescription). The Express Scripts mail-order service cannot refill a prescription more than one year after the date of the prescription.

Refilling Your Medication

A few simple precautions will help ensure you don't run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip or on your medication container. Or reorder when you have less than 14 days of medication left.

Refilling By Mail
Use the refill and order forms provided with your medication and mail them with your copayment.

Refilling Online
Log on to **www.express-scripts.com**. Have your member ID number and prescription (Rx) number on hand.

Refilling By Phone
Call 1-800-4REFILL (1-800-473-3455) to use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

Delivery of Your Medication

Your prescriptions are sent to you via the U.S. postal service or by United Parcel Service (UPS). New prescriptions are usually sent within 10 business days and refills usually within five business days. If the mail service pharmacy has questions about your prescription, they will contact your physician, and your prescription may be delayed. Note that if they cannot reach your physician, your prescription order will be returned to you unfilled.

Your medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages and other important details.

For an additional fee, your order will be shipped by an expedited service offered in your area. This option must be chosen when you make the order, and it cannot be applied after an order has already been processed.

Rx Savings Solutions Program

Beginning January 2022, you and your family members enrolled in an Arkema medical plan will have access to Rx Savings Solutions, a program and tool to identify cost savings opportunities for prescriptions. When you register for this benefit, you will have access to tools to help you understand and identify the lowest-price option for any prescription. You can search and compare prices and other options before being prescribed a new medication. This program is available at no cost to you. Once you've registered, if a prescription savings opportunity is available, Rx Savings Solutions will reach out to you.

For Aetna PPO plan participants with certain specialty medications, Rx Savings Solutions will direct you to SaveonSP for information on how to receive these medications at no cost to you. To find out more and register for the program, visit rxsavingssolutions.com/solutions/members or call 1-800-268-4476.

Covered Prescription Drugs

If you have questions about whether a specific drug is covered, log onto **www.express-scripts.com** to check the formulary or contact Express Scripts at 1-800-363-8952.

100% Covered Preventive Prescription Drugs under the CDHP with HSA

Preventive drugs such as vitamins, vaccines, weight loss agents, fluoride preparations, and cholesterol-lowering drugs that are prescribed by your medical care provider are covered at 100% under the CDHP with HSA Option, before the combined annual deductible. For a complete list, visit Arkema Benefits Online at **benefits.myplansconnect.com/Arkema**.

If Your Prescription Is Denied

If your claim is denied in whole or in part, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. See page 66 — *If Your Claim Is Denied by Aetna or Express Scripts*.

How to File a Claim

PPO and CDHP with HSA In-Network

If you participate in the PPO Option or the CDHP with HSA Option and visit an in-network provider, you do not have to submit a claim form. You simply present your ID card and pay your copay at the time of service. If you participate in the PPO Option, you will also pay your copay at the time of service. If you participate in the CDHP with HSA Option, you will pay nothing at the time of service, but will pay after your bill is processed by the Claims Administrator. Your in-network provider will handle the claims filing process.

PPO and CDHP with HSA Out-of-Network

If you visit an out-of-network provider in the PPO Option or CDHP with HSA Option, you may have to pay for your care at the time of your visit. If you participate in the PPO Option or if you have reached the CDHP with HSA Option annual deductible and are receiving benefits from the plan, you may still pay with your debit card. But you will then need to submit a claim form to the Claims Administrator. In some cases, your doctor will handle the claims filing process for you and then bill you directly. If you need to file a claim, claim forms are available by:

- Visiting the *Arkema Benefits Online* website at **benefits.myplansconnect.com/Arkema**,
- Calling Aetna Member Services at 1-800-238-3488, or
- Visiting **www.aetna.com**.

Fill out the claim form and send it to the address on your medical ID card. You should also keep complete records of the expenses of each person because they may be required when a claim is made. You should keep:

- Names of providers who furnish services,
- Dates expenses are incurred, and
- Copies of all bills and receipts.

Filing a Claim

You must submit your completed claims to the appropriate Claims Administrator as soon as possible after services are received.

All retiree medical claims must be submitted to the Claims Administrator in writing within 90 days after the date of the claim. It must give proof of the nature and extent of the claim. To request a claim form, please call Aetna at 1-800-238-3488. You may also access Aetna's website at **www.aetna.com**.

If, through no fault of your own, you are not able to meet the deadline for filing a claim with the Claims Administrator, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered by the Claims Administrator if they are filed more than 24 months after the deadline.

For prescription drug claims, all claims must be submitted to the prescription drug Claims Administrator within 12 months from the prescription dispensing date. You may access the Express Scripts website at **www.express-scripts.com**. To request a Direct Member Reimbursement Form, please call Express Scripts Member Services at 1-800-363-8952.

The chart below contains contact information on filing claims.

Type of Claim	**Claims Administrator**
Medical (Group Number: 885667)	Aetna Life Insurance Company PO Box 981106 El Paso, TX 79998-1106
Prescription Drug (Group Code: Arkema1)	Express Scripts PO Box 14711 Lexington, KY 40512

There are different claim filing procedures depending on your medical option. Note that claims must be filed within 24 months of the date of the service or your claim will not be eligible for reimbursement. Aetna and Express Scripts generally processes claims as soon as possible after receipt of the claim form and any necessary medical documentation.

Explanation of Benefits Statements

After your medical claim is processed for claims involving a balance due by you, other than your copay, the Claims Administrator will send you an Explanation of Benefits (EOB) statement outlining:

- The provider's charge for the service rendered,
- Provider name,
- Date of service,
- The benefit paid by your medical option, and
- What you need to pay, if anything.

Please read your statement carefully because it will verify that the claim was processed correctly. The statement also will inform you of any claim denial.

If Your Claim Is Denied By Aetna or Express Scripts

When a claim comes in, you will receive a decision on how you and the plan will split the expense. The Claims Administrator will also explain what you can do if you think they got it wrong.

Claims are processed in the order in which they are received.

Claim Procedures

Notice	Requirement	Deadline
Submit a claim	You should notify and request a claim form from Arkema.	Within 15 working days of your request.

	The claim form will provide instructions on how to complete and where to send the form(s).	If the claim form is not sent on time, the Claims Administrator will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (claim)	A completed claim form and any additional information required.	No later than 90 days after you have incurred expenses for covered benefits. The Claims Administrator won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send notice and proof as soon as reasonably possible. Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	Written proof must be provided for all benefits. If any portion of a claim is contested by the Claims Administrator, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of Claims and Communication of Claims Decisions

You or your provider are required to send the Claims Administrator a claim in writing. You can request a claim form from the Claims Administrator and they will review that claim for payment to the provider.

There are different types of claims. The amount of time that the Claims Administrator has to tell you about their decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent Care Claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service Claim

A pre-service claim is a claim that involves services you have not yet received and which the Claims Administrator will pay for only if they precertify them.

Post-service Claim

A post service claim is a claim that involves health care services you have already received.

Concurrent Care Claim Extension

A concurrent care claim extension occurs when you ask the Claims Administrator to approve more services than they already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent Care Claim Reduction or Termination

A concurrent care claim reduction or termination occurs when the Claims Administrator decides to reduce or stop payment for an already approved course of treatment. They will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from the Claims Administrator or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If the Claims Administrator upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time the Claims Administrator has to tell you about their decision.

The Claims Administrator may need to tell your physician about their decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the hospital.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (Claims Administrator)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (Claims Administrator)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*The Claims Administrator has to receive the request at least 24 hours before the previously approved health care services end.

Adverse Benefit Determinations

The Claims Administrator pays many claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes they pay only some of the claim. And sometimes they deny payment entirely. Any time they deny even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if the Claims Administrator rescinds your coverage entirely.

If the Claims Administrator makes an adverse benefit determination, they will tell you in writing.

The Difference of a Complaint and an Appeal

A Complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. The Claims Administrator will review the information and provide you with a written response within 30 calendar days of receiving the complaint. They will let you know if more information is needed to make a decision.

An Appeal

You can ask the Claims Administrator to re-review an adverse benefit determination. This is called an appeal. You can appeal to them verbally or in writing.

Appeals of Adverse Benefit Determinations

You can appeal an adverse benefit determination. The Claims Administrator will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like considered.

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell the Claims Administrator if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form stating that you are allowing someone to appeal for you. You can get this form by contacting the Claims Administrator. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent Care or Pre-service Claim Appeals

If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out a form.

The Claims Administrator will provide you with any new or additional information that they used or that was developed to review your claim. They will provide this information at no cost to you before giving you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before the Claims Administrator tells you what their final decision is.

Timeframes for Deciding Appeals

The amount of time that the Claims Administrator has to tell you about their decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time they have to tell you about their decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (Claims Administrator)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of Appeals Process

In most situations you must complete the two levels of appeal with the Claims Administrator before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- The Claims Administrator does not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
    - The rule violation was minor and not likely to influence a decision or harm you.
    - The violation was for a good cause or beyond their control.
    - The violation was part of an ongoing, good faith exchange between you and the plan.

External Review

External review is a review done by people in an organization outside of Aetna or Express Scripts. This is called an external review organization (ERO).

You have a right to external review only if:

- The claim decision involved medical judgment.
- The Claims Administrator decided the service or supply is not medically necessary or not appropriate.
- The Claims Administrator decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If the claim decision is one for which you can seek external review, it will be stated in the notice of adverse benefit determination or final adverse benefit determination sent to you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

- You must submit the Request for External Review Form:
- To the Claims Administrator
- Within 123 calendar days (four months) of the date you received the decision from them
- And you must include a copy of the notice from the Claims Administrator and all other important information that supports your request.

You will pay for any information that you send and want reviewed by the ERO. The plan will pay for information we send to the ERO plus the cost of the review.

The Claims Administrator will:

- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow the contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date they receive your request form and all the necessary information.
- The Claims Administrator will stand by the decision that the ERO makes, unless they can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?

The Claims Administrator will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your provider must call the Claims Administrator or send a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your provider states that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations

Your provider states that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of the time the Claims Administrator gets your request.

Recordkeeping

The Claims Administrator will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

The plan does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Health Savings Account

The Health Savings Account (HSA) is a tax-advantaged savings vehicle available to individuals who elect the Consumer Driven Health Plan (CDHP). The Health Savings Account allows you to put aside money so that you can pay for current and future qualified medical expenses, including long-term care, COBRA and Medicare premiums. Your account can also pay for non-qualified medical expenses, although reimbursement for such expenses are subject to federal, state, and local taxes, as applicable, and in most cases a penalty tax.

The money in your HSA can be used to help pay for out-of-pocket healthcare costs incurred by you and/or your eligible dependents. Expenses incurred by individuals who are not dependents for tax purposes are not eligible for tax-free reimbursement.

Participating in an HSA

You are eligible to establish and contribute to the Health Savings Account if you are enrolled in the Arkema CDHP option, and:

- Are not be covered by other health insurance (this rule does not apply to specific injury insurance and accident, disability, dental care, vision care, long-term care),
- Are not enrolled in Medicare, and
- Are not claimed as a dependent on someone else's tax return.

Therefore you cannot contribute to a Health Savings Account if you or a family member participates in a traditional Health Care Flexible Spending Account, you are enrolled in Medicare, or have other non-high deductible health plan coverage (such as through your spouse's employer plan). However, if you have access through your spouse's employer plan, you may be eligible to participate in a Limited Purpose Health Care Flexible Spending Account, which is designed specifically for individuals who participate in a high deductible health plan. A Limited Health Care Flexible Spending Account reimburses only eligible dental, vision and qualified medical expenses incurred after you meet your Consumer Driven Health Plan deductible. Note that you do not have access to a Limited Health Care Flexible Spending Account through the Arkema Retiree Medical Plan.

Please Note: It's up to you to make sure that you meet the tax requirements to establish and contribute to the Health Savings Account. Neither Arkema nor the Claims Administrator has the information or the responsibility to monitor your status. You should consult with a tax professional for information about your personal tax situation.

How an HSA Works

You can make a tax-free withdrawal up to the balance available in your account to cover qualified medical expenses. You may also use your account to pay for non-qualified medical expenses, although withdrawals for such expenses are subject to federal, state, and local taxes, as applicable, and in most cases a penalty tax.

Any unused balance in your account at year-end is carried forward to the next calendar year, even if you do not participate in the CDHP option next year.

You must meet certain tax requirements to establish and contribute to the Health Savings Account. Below is a general summary of some Health Savings Account features.

- Generally anyone who is covered by a high deductible health plan (as defined in Internal Revenue Code Section 223) may establish a Health Savings Account.
- Amounts contributed to the Health Savings Account belong to you and are completely portable.
- Every year the money not spent would stay in the Health Savings Account and earn interest tax-free, just like an IRA.
- Unused amounts in the Health Savings Account remain available for later years.
- Funds can be withdrawn from the Health Savings Account for either qualified medical or other expenses. If the amount withdrawn is used for qualified medical expenses, then the withdrawal is tax free. If the amount withdrawn is used for expenses other than qualified medical expenses, the amount withdrawn will be taxed and, for individuals who are not disabled or over age 65, subject to a 20% tax penalty.
- Although Arkema is facilitating your establishment and continued participation in an HSA, responsibility for meeting all the tax rules is yours. For example, to avoid taxation and possible penalties, it's up to you to make sure that any withdrawal you take from the Health Savings Account is for a qualified medical expense. Neither Arkema nor the Claims Administrator will monitor your distribution requests for tax compliance—it's up to you to do this and keep necessary tax records.
- Additionally, just like an IRA, it's your responsibility to confirm your eligibility to contribute to a Health Savings Account under the tax rules. For example, if you have other medical coverage (i.e., through your spouse's employer) that is not High Deductible Health Plan coverage, then you should not establish and contribute to the Health Savings Account. Also, if you have another Health Savings Account, you will have to make sure that your total contributions do not exceed the IRS limits.
- Before making any decision, you should carefully consider whether or not you want to establish a Health Savings Account (assuming you are eligible to do so) and, if so, whether you want to use the Health Savings Account product that Arkema is making available or another trustee's Health Savings Account (which might have different features, for example, other investment options).

Whenever you incur an eligible expense, you may pay for your expenses directly using your HSA debit card, or you may submit a claim for reimbursement, along with proof of your incurred expenses. Reimbursement goes directly to you, not the provider. For information on how to file your claims for reimbursement, see *Filing a Claim for Reimbursement* on page 65.

If during the year you do not use all of the funds in your HSA, the money remains in your account and rolls over to the following year to be used for future healthcare expenses.

Contributions

You contribute to your HSA, up to $3,600 for 2021 with individual coverage and up to $7,200 for 2021 with family coverage. Participants age 55 and older may contribute an additional $1,000 in

2021. You make contributions directly to the Health Savings Account Administrator as long as you meet the tax requirements to contribute to a Health Savings Account. If you establish an HSA after January 1 or change your coverage level under the CDHP option because of a qualified status change, your maximum contribution will be prorated based on the number of full months remaining in the calendar year and your level of coverage under the CDHP option. You are responsible for ensuring you stay within IRS contributions limits for the HSA.

Regardless of whether you continue to contribute, you may continue to withdraw from your unused account balance for qualified and non-qualified medical expenses.

Withdrawals

In general, you may withdraw from your Health Savings Account for qualified medical expenses on a tax-free basis for yourself, your spouse, and your qualifying family members.

Your qualifying family members include any person who qualifies for tax-free health plan benefits, including any of the following individuals:

- Your legal spouse
- Your child up to age 19 or age 24 if a full time student
- Any person you could have claimed as a dependent on your return

Withdrawals for individuals not qualifying for tax-free health plan benefits and services and items other than qualified medical expenses are subject to federal, state and local taxes, as applicable, and an additional 20% penalty unless the withdrawal occurs after you reach age 65, are disabled or die.

You may pay for HSA-qualified expenses using your HSA debit card, rather than filing a claim for reimbursement. However, if you do not use your debit card to pay for an expense, you may file a claim through Aetna and be reimbursed up to your account balance at that time.

For guidelines on qualified medical expenses under Internal Revenue Code Section 213, see IRS PUBLICATION 502. However, some items listed in this publication are not reimbursable under the Health Savings Account (e.g. premiums, except for certain premiums at age 65 or older). For Health Savings Account specific requirements under IRC Section 223, see IRS Publication 969. IRS publications are available at **www.irs.gov** or by calling the IRS at 1-800-829-3676. You may also check with the Health Savings Account Administrator if you have questions about reimbursable expenses.

Your Tax-Free Eligible Expenses

The expenses eligible for tax-free reimbursement under the HSA are the same as the Health Care FSA. Certain healthcare expenses that may be for eligible for reimbursement under the HSA include, but are not limited to, the following:

- Abortion,
- Acupuncture,
- Alcoholism treatment,
- Alternative medicine,

- Annual deductibles,
- Bandages,
- Breast reconstruction surgery (after a mastectomy),
- Chiropractic services,
- Obstetrical expenses,
- Christian Science practitioners,
- COBRA premiums,
- 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,
- Founder's Fee,
- Health premiums while you are receiving unemployment insurance,
- Hearing and unreimbursed vision care, including:
  - Eyeglasses and frames (including prescription sunglasses),
  - 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,
- Medicare premiums, other than Medicare supplemental plan premiums,
- Nursing home,
- Nursing services,
- Organ transplants,
- Other paramedical services,
- Out-of-pocket expenses for medically necessary services not reimbursed by medical and dental plans,
- Over-the-counter items as permitted under applicable law or regulation
- Oxygen,
- Prescription drugs, including vitamins and minerals prescribed by a doctor that are unavailable without a prescription and prescribed to treat a specific medical condition,
- Psychiatrist fees,

- Psychologist fees,
- Retiree medical plan premiums if HSA owner is 65 or older (except for Medicare supplemental insurance),
- 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 physician),
- 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 physician for the treatment of a specified disease,
- Wheelchairs,
- Wigs purchased on doctor'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 recognized 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 tax-free reimbursement from your HSA. For example, you cannot be reimbursed tax-free 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 opened the HSA,
- 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,
- Health club membership dues,
- Health plan premiums,
- Household help,
- Insurance premiums other than premiums for COBRA, Medicare (but not Medicare supplemental), long term care and premiums paid while receiving unemployment compensation,
- 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,
- Nursing care for a normal, healthy baby,

- Over-the-counter drugs that are not for medical care, including:
  - Deodorants,
  - Face creams, moisturizers, eye creams, wrinkle reducers,
  - Hair removal treatment and waxes,
  - Mouthwashes, teeth whitening kits, powders, and
  - Vitamins (pre-natal vitamins are eligible),
- Programs to control weight or to maintain general health,
- Swimming lessons,
- Teeth whitening,
- Undocumented travel to or from your doctor's office or other medical facility,
- Veterinary fees, and
- Weight loss programs (unless you have a letter from your treating physician indicating medically necessary.

This list is subject to change based on IRS rules; the examples above are a guide and not meant to be an official list. For more information about eligible expenses, see IRS Publication 969. IRS publications are available at **www.irs.gov** or by calling the IRS at 1-800-829-3676. You can also access a list of eligible expenses on the Arkema Benefits Online website at **benefits.myplansconnect.com/Arkema**, or by using the Aetna Navigator **www.aetna.com**. The determination of what may be a qualified medical expense is subject to change by the IRS.

As a Health Savings Account owner, you are responsible for verifying whether funds are appropriately used for qualified medical expenses and for maintaining appropriate records. You should consult with a tax professional for information about your personal tax situation.

How to Check the Status of a Claim

To check the status of a claim or your account, you can log on to Aetna Navigator at **www.aetna.com**. When you access the website, you can:

- View HSA claim payment and account balance information,
- View who is covered,
- Access the list of items approved by the IRS for HSA reimbursement,
- Use the Estimate the Cost of Care tools to help you plan for anticipated healthcare costs, and
- Contact Aetna Member Services.

Coordination of Benefits

Arkema's retiree medical plan is designed to coordinate with other coverage. In the event you or your dependents are covered by more than one group plan (defined below) benefits paid could be duplicated. This section explains the retiree medical plan's coordination of benefits provision, which guards against duplicative coverage and overpayments.

If you or your dependent has two sources of medical coverage, the retiree medical plan coordinates benefits with the other plan so that the *total* amount paid by both plans is not greater than the "payable expense" for the service. The payable expense is the amount the retiree medical plan would normally pay in absence of other coverage.

How Coordination of Benefits Works

- The Claims Administrator will determine its normal benefit under your medical option,
- The Claims Administrator a will subtract the benefit you receive from the primary payer (see *Which Plan Pays First* on page 79*)* from the payable expense of the medical service, and
- The Claims Administrator will pay the difference between the payable expense and the benefit you receive from the primary payer, up to the Claims Administrator's normal benefit under the medical option.

The most the Claims Administrator will pay would be its normal benefit under your medical option under the Arkema Inc. Pre-65 Retiree Medical Plan. The Arkema Inc. Pre-65 Retiree Medical Plan will not pay any benefits until you have met applicable deductibles. Remember, the secondary plan pays benefits only after the primary plan pays, or denies, the claim.

Group plan means any of the following that provides medical benefits or services:

- Group, blanket or franchise insurance coverage, other than school accident and sickness policies,
- Service plan contracts, group or individual practice or other prepayment plans (such as PPOs),
- Coverage under any labor-management trustee plans, union welfare plans, employer organization plans or retiree benefit organization plans,
- Governmental program or coverage required or provided by law (including any motor vehicle "no fault" coverage), with the exception of Medicare and Medicaid, or
- No-fault, self-insured, and underinsured motorist automobile insurance or healthcare benefit paid through settlement of a lawsuit.

A group plan does not include any personal policy you may have.

To obtain all the benefits for which you are eligible, claims should be filed with each of your sources of coverage.

Which Plan Pays First

When a claim is made, the *primary* plan pays its benefits without regard to any other plan. Then, the *secondary* plan adjusts its benefits so that the total benefit will not be greater than 100% of the payable expense. To determine whether the Arkema Inc. Pre-65 Retiree Medical Plan or another group plan is the primary payer, the following rules apply:

- If one plan does not have a coordination of benefits provision, that plan will pay benefits first,
- The plan that covers the person as a retiree will pay benefits in full before the plan that covers the person as a dependent, except as otherwise provided pursuant to the Medicare Secondary Payer rules,
- For dependent child(ren)'s expenses, if the dependent is covered under both parents' plans and the parents are not divorced or separated, the plan of the parent whose birthday (month and day) occurs earlier in the calendar year will pay first, regardless of which parent is older. When parents have the same birthday (month and day), the plan of the parent who has been covered longer under the plan will pay first,

- When parents are not married or are separated/divorced, the plan covering the dependent child(ren) of the parent with custody will pay benefits first, unless there is a court decree directing otherwise:
  - When one parent has remarried, the plan covering the dependent child(ren) of the step-parent will pay benefits first before the plan of the parent without custody,
  - If the above two situations do not apply, then the plan of the parent not having custody of the child(ren) shall pay first, and
  - When parents have joint custody, the birthday rule that applies to dependents whose parents are not divorced or separated shall apply here; provided, however, that if one parent has financial responsibility for the medical or other healthcare expenses of the child(ren), then the plan covering the dependent child(ren) of the parent who has financial responsibility for the dependent child(ren) will pay first.
- The plan that covers a person as an employee, or the employee's dependent, will determine its benefits before those of a plan covering a person as a laid-off or retired employee, or as that employee's dependent, provided however, if one of the plans at issue does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored, or
- The plan that covers a person as an employee, participant or subscriber (or as that person's dependent) will determine its benefits before those of a plan covering the person under COBRA or state law; provided, however, if one of the plans at issue does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The Arkema Inc. Pre-65 Retiree Medical Plan is always secondary to:
  - Any medical payment, PIP or No-Fault coverage under any automobile policy available to you.
  - Any plan or program which is required by law.

If these rules do not decide which plan's benefits are payable first, the plan that has covered the person for the longest time will be *primary*.

When this plan is *secondary*, the coordination of benefits feature ensures that the total benefits paid will not be more than the "payable expense" (this means any medically necessary, recognized charge that is covered).

This plan always pays secondary to:
- Any medical payment, PIP or No-Fault coverage under any automobile or premises coverage available to you.
- Any plan or program which is required by law.

All Covered persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

How Your Retiree Medical Coverage Coordinates with Medicare

Since coverage under this plan terminates at age 65, it is not likely that a participant will have coverage under this plan and coverage under Medicare. However, in the event that you, your spouse or dependent child are covered under this plan and become eligible for Medicare, this plan treats you as enrolled in Medicare (Medicare Parts A, B, and D). As a result, Arkema coordinates benefits as if you are receiving these Medicare benefits — even if you're not.

In addition, when you become eligible for Medicare, Medicare becomes the primary payer of benefits. This means that Medicare pays benefits first. Then, the Arkema Inc. Pre-65 Retiree Medical Plan pays the difference between what Medicare paid and what the Arkema Inc. Pre-65 Retiree Medical Plan would have paid if it were the only coverage available (in other words, if Medicare did not exist). Arkema Inc. will pay second even if your provider does not participate in Medicare. This means that the Plan will determine how much it will pay, based on what Medicare would have paid even if Medicare does not pay a portion of the cost. These provisions also apply to your Medicare-eligible dependents.

Please Note: If you and/or a covered dependent are eligible for Medicare and do not apply for Medicare coverage, or if your provider does not accept Medicare, the Medicare benefits that would have been paid will still be considered before Plan benefits are determined (if Medicare is the primary payer). Therefore, even if you do not elect Medicare Part B, or if your provider does not accept Medicare, benefits for the Medicare-eligible individual will be provided on a Medicare-primary basis. This will increase your payment responsibility.

Coordination of Benefits with Medicare Parts A and B Based on ESRD Entitlement

Medicare pays secondary to this Plan during the first 30 months that you (or your covered dependents) are entitled to Medicare based on end-stage renal disease (ESRD). After 30 months, Medicare is considered primary and will pay first for all Medicare-covered services. This coverage pays second. Refer to the section above for details about coordination of benefits after the 30-month period.

Coordination of Benefits with Medicare Part D

Enrolling in a Medicare prescription drug plan is required once you are eligible. To enroll, you must have Medicare Part A and Part B. It's important to note that Retiree Medical Plan does not coordinate benefits with Medicare Part D. You and/or your dependents cannot have prescription drug coverage under both the Arkema Inc. Retiree Medical Plan and a Medicare prescription drug plan. If you enroll in a Medicare prescription drug plan, your and your dependents' medical and prescription drug coverage under the Arkema Inc. Retiree Medical Plan will be discontinued (even if all of your covered dependents are not eligible for Medicare).

Subrogation and Right of Recovery

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's rights of subrogation and reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured

motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

No payment of benefits should be made to you or made on your behalf to any provider as a result of an injury, illness or condition. If you accept such payment, funds will be deemed to be in a constructive trust.

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of

the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting coverage or benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence or acts.

Cooperation

As a condition of plan participation, you agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator or its designee for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting coverage or benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Refund of Overpayments

If a benefit payment is made by the plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the plan has the right to require the return of the overpayment. The plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the plan.

This right does not affect any other right of recovery the plan may have with respect to overpayments.

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 identifiable health information held by any health plan, whether received in writing, in an electronic medium, or as an oral communication.
Arkema 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 Arkema's HIPAA privacy policy. For more information, see *Compliance with Privacy Regulations* on page 100.

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, is to be forwarded to the QMSCO processing center reviewed by Arkema for validity. 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. Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent. If you have any questions regarding a QMCSO, 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.lifeworks.com Access Code: ING105
Email: qdroprocessing@lifeworks.com
Phone: (844) 208-7192
Fax: (844) 886-8539
Mail: P.O. Box 534277
St. Petersburg, FL 33747

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with child birth 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 limits Arkema's ability to use individuals' genetic information in deciding eligibility and contributions for group health plan benefits.

How to Reach Your Medical Plan Service Provider

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

Plan	Telephone Number	Website Address
Aetna (Group Number: 885667)	1-800-238-3488	**www.aetna.com**
Express Scripts (Prescription Drug Coverage) (Group Code: Arkema1)	1-800-363-8952	**www.express-scripts.com**

Continuation of Coverage

Your spouse and dependents may be able to continue coverage under the retiree medical plan under certain conditions.

COBRA Continuation

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer retirees' 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"). Also, you may be eligible for COBRA upon company bankruptcy.

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* (page 92) or call the Arkema Benefits Center.

Continuation coverage under COBRA is provided subject to your eligibility for coverage. The Company 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**	
	Spouse	**Child(ren)**
Retired employee dies (if continued retiree medical coverage is not available to the dependent)	36 months	36 months
Retired employee and spouse/domestic partner divorce/terminate domestic partnership	36 months	36 months
Retired employee becomes entitled to Medicare*	36 months	36 months
Child(ren) no longer qualifies as a dependent	N/A	36 months

** Continuation period depends on when the employee/retiree becomes entitled to Medicare*

Qualifying Events

If you should die, or become divorced, your covered dependents whose health coverage under the plan would be terminated may continue health coverage under the plan for up to 36 months. Also, your covered dependents may continue health coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

If a retiree becomes eligible for Medicare and as a result the spouse and any eligible loses coverage, the covered dependents whose health coverage terminated may continue health coverage under the plan for up to 36 months.

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

Your Duties

Under the law, you or your family member has the responsibility to inform the COBRA Administrator of a divorce, legal separation in a state that recognizes legal separation, or a child(ren) losing dependent status under the retiree medical plan. This notice must be provided within 60 days from the date of the divorce or a child(ren) losing dependent status (or, if later, the date coverage would normally be lost because of the event) and include the following information:

- The name of the retiree who is or was covered under the plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- 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:

- Death — A copy of the death certificate.
- Divorce — A copy of the divorce decree
- 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 becoming too old for coverage).
- Entitlement to Medicare — A letter from the Social Security Administration indicating the retiree is entitled to Medicare benefits.

The notice should be mailed or hand-delivered to the COBRA Administrator at the address listed in *Contacting the COBRA Administrator* (page 92). This notice must be provided within 60 days from the date of the divorce, legal separation 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 your family member that they have the right to choose continuation coverage. If your 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, legal separation, or a child losing dependent status, then the family member 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 you or your family member) if any of the following events occur that will result in a loss of coverage:

- Your death, or
- Notification of your 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, your family member must elect continuation coverage within 60 days from the date your family member would lose coverage because of one of the events described earlier, or, if later, 60 days after the COBRA Administrator provides your family member with notice of your family member's right to elect continuation coverage. A 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 retiree 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 your family member chooses continuation coverage, the Company is required to give your family member coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated retirees or family members. This means that if the coverage for similarly situated family members is modified, your family member's coverage will be modified. "Similarly situated" refers to a current retiree 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.

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 dependent child(ren) is entitled to elect continuation coverage, even if the spouse does not elect COBRA. . Similarly, at annual enrollment, a spouse or dependent child(ren) on COBRA may elect different coverage than the coverage the retiree elects, and a dependent child on COBRA can elect different coverage than a spouse on COBRA. A retiree 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.

Cost

Continuing Pre-65 Retiree Coverage: Qualified Beneficiaries will be required to pay the full cost of covering any eligible dependents. In addition, there is a 2% administrative fee, making your payment a total of 102% of the cost of coverage.

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

Duration of COBRA

The law requires that your family member be afforded the opportunity to maintain continuation coverage for 36 months.

Early Termination of COBRA Continuation Coverage

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

- 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.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee, retiree or otherwise) under another group health plan not offered by the Company 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.
- 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.)
- The plan sponsor terminates all group health coverage for all retirees.

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, the Company 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 and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the retiree 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 (but only after any preexisting condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage (after exhaustion or satisfaction of any pre-existing condition limitation). The Company, 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.

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

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 a retiree or the COBRA Administrator if you are a former retiree, in writing immediately at the address listed below.

All notices and other communications regarding COBRA and the Arkema Inc. Pre-65 Retiree 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**.

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.

Plan Sponsor

Arkema Inc.
Benefits Department
900 First Avenue
King of Prussia, PA 19406

Plan Name

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

Plan Number

501

Plan Type

Welfare plan providing retiree medical benefits

Plan Year

January 1 through December 31

Employer Identification Number

23-0960890

Plan Administrator

Arkema Inc.
Benefits Department
900 First Avenue
King of Prussia, PA 19406

The Plan Administrator is responsible for the general administration of the medical 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 medical plan and make factual determinations regarding all aspects of the medical plan and its benefits, including the power and discretion to determine the rights or eligibility of retirees and any other persons, and the amounts of their benefits under the medical 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 medical 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 medical 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 retirees or other persons entitled to benefits under the medical plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the medical plan to the extent an insurer or administrator is not empowered with such responsibility.

The Plan Sponsor will administer the medical 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 state of Pennsylvania will be controlling in all matters relating to the Arkema Inc. Pre-65 Retiree Medical Plan.

Benefits Administrator

Arkema Benefits Center
P.O. Box 9740
Providence, RI 02940
1-800-406-9823

Claims Administrators

The following benefits are self-insured by Arkema and benefits are paid directly out of the general assets. Arkema has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured benefits:

Medical Claims Administrator

Aetna Life Insurance Company of America
151 Farmington Ave.
Hartford, CT 06156
1-800-238-3488

Prescription Drug Administrator

Express Scripts
P.O. Box 14711
Lexington, KY 40512
1-800-363-8952

Billing Administrator and COBRA Administrator

Health Equity/Wage Works
P.O. Box 226101
Dallas, TX 75222
1-877-722-2667

QMCSO Administration Services for Children Covered under a Qualified Medical Child Support Order (QMCSO)

Website: https://qdro.lifeworks.com Access Code: ING105
Email: qdroprocessing@lifeworks.com
Phone: (844) 208-7192
Fax: (844) 886-8539
Mail: P.O. Box 534277
St. Petersburg, FL 33747

Agent for Service of Legal Process

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

Program Funding and Type of Program Administration

The retiree medical plan is self-insured. 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.

Arkema's general assets shall be the sole source of self-insured benefits under the plan if no fund is established. Unless otherwise required by applicable law, Arkema assumes no liability or responsibility for payment of such benefits beyond that which is provided in the plan, and each participant or other person who claims the right to any payment with respect to such benefits under the plan shall not have any right, claim or demand therefore against Arkema or any employee or retiree, officer or director of Arkema.

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 retiree 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 Legal Rights

As a participant in the medical 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 medical 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 medical 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 medical 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 Group Medical Care Coverage

You have the right to continue medical care coverage for yourself, your spouse or dependents if there is a loss of coverage under the medical 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 medical plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Program Fiduciaries

In addition to creating rights for medical plan participants, ERISA imposes duties upon the people who are responsible for the operation of retiree benefit plans. The people who operate your medical plan, called "fiduciaries" of the medical 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 a medical 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 medical plan documents or the latest annual report from the medical plan and this is not placed in the mail to you 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 medical 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 medical 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, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**. You may also contact 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

Arkema has certain obligations regarding the privacy and security of your medical 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"), such 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)

Arkema may only use and disclose PHI and e-PHI it receives from the medical plan 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 PHI and e-PHI in connection with payment, treatment and healthcare operations.

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

Arkema 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 medical plan, 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 retiree benefit plan of the Company.
- Report to medical plan, 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 and e-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 medical plan available to the Secretary of HHS for purposes of determining compliance by the medical plan.
- If feasible, return or destroy all PHI and e-PHI received from the medical plan 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 medical plan must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- 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.

Arkema 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 Inc. Pre-65 Retiree Medical and Prescription Drug 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:

- Sr. Vice President — Human Resources, Communications and Site Services
- Sr. Director — Compensation, Benefits & M&A
- Manager — Health & Welfare Benefits
- Specialist — Benefits & HRMS
- Associate 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 Arkema for the Plan.

If Arkema 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 Arkema established for purposes of privacy compliance, up to and including dismissal from employment. Arkema 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 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.

Cardiac Rehabilitation Therapy
Treatment to rehabilitate the heart muscle after a heart attack or heart surgery.

Chiropractic Care
Treatment to adjust the segments of the spinal column.

Companion
This is a person whose presence as a companion or caregiver is necessary to enable an NME patient:

- To receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis, or
- To travel to and from the facility where treatment is given.

Convalescent Facility
This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N., and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24-hour a day nursing care by licensed nurses directed by a full-time R.N.,
- Is supervised full-time by a physician or R.N.,
- Keeps a complete medical record on each patient,
- Has a utilization review plan,
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders, and
- Makes charges.

Copay/Copayment
This is a fee, charged to a person enrolled in the PPO Option, which represents a portion of the applicable expense.

Custodial Care
This means services and supplies primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);

- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting a patient;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Durable Medical and Surgical Equipment
This means equipment, and the accessories needed to operate it, that is:
- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to persons who do not have a disease or injury,
- Not for use in altering air quality or temperature, and
- Not for exercise or training.

Not included is equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids, and telephone alert systems.

Emergency Admission
One where the physician admits the person to the hospital right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
- That requires confinement right away as a full-time inpatient, and
- For which, if immediate inpatient care was not given could, as determined by the Claims Administrator, reasonably be expected to result in:
  - Serious jeopardy to the person's health,
  - Serious impairment to bodily function,
  - Serious dysfunction of a body part or organ, or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care
This means the treatment given in a hospital's emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- Serious jeopardy to the person's health,
- Serious impairment to bodily function,

- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Medical Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- Serious jeopardy to the person's health,
- Serious impairment to bodily function,
- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational
Except as provided for under the clinical trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

Home Healthcare Agency
This is an agency that:
- Mainly provides skilled nursing and other therapeutic services,
- Is employed with a professional group which makes policy; this group must have at least one physician and one R.N.,
- Has full-time supervision by a physician or an R.N.,
- Keeps complete medical records on each person,
- Has an administrator, and
- Meets licensing standards.

Home Healthcare Plan
This is a plan that provides for continued care and treatment after discharge from a hospital. The care and treatment must be:

- Prescribed in writing by the attending physician within seven days from the hospital discharge, and
- An alternative to staying in the hospital.

Hospice Care
This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.

Hospice Care Agency
This is an agency or organization that:

- Has hospice care available 24-hours a day,
- Meets any licensing or certification standards set forth by the jurisdiction where it is located,
- Provides:
  - Skilled nursing services,
  - Medical social services,
  - Psychological and dietary counseling, and
- Provides or arranges for other services which will include:
  - Services of a physician,
  - Physical and occupational therapy,
  - Part-time home health aide services which mainly consist of caring for terminally ill persons, and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - One physician,
  - One R.N.,
  - One licensed or certified social worker employed by the agency, and
- Establishes policies governing the provision of hospice care,
- Assesses the patient's medical and social needs,
- Develops a hospice care program to meet those needs,
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency,
- Permits all area medical personnel to utilize its services for their patients,
- Keeps a medical record on each patient,
- Utilizes volunteers trained in providing services for non-medical needs, and
- Has a full-time administrator.

Hospice Care Program
This is a written plan of hospice care, that:

- Is established by and reviewed from time-to-time by:
  - A physician attending the person, and
  - Appropriate personnel of a hospice care agency.
- Is designed to provide:

  - Palliative and supportive care to terminally ill persons, and
  - Supportive care to their families,
- Includes:
  - An assessment of the person's medical and social needs, and
  - A description of the care to be given to meet those needs.

Hospice Facility
This is a facility, or distinct part of one, that:
- Mainly provides inpatient hospice care to terminally ill persons,
- Charges its patients,
- Meets any licensing or certification standards set forth by the jurisdiction where it is,
- Keeps a medical record on each patient,
- Provides an ongoing quality assurance program, this includes reviews by physicians other than those who own or direct the facility,
- Is run by a staff of physicians; at least one such physician must be on call at all times,
- Provides, 24-hour a day nursing services under the direction of an R.N., and
- Has a full-time administrator.

Hospital
This is an institution that:
- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services,
- Is supervised by a staff of physicians,
- Provides 24-hour a day R.N. service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Institute of Excellence (IOE)
A hospital or other facility that has contracted with Aetna to give services or supplies to an IOE patient in connection with specific transplants, procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants, procedures for which it has signed a contract.

Institute of Quality (IOQ)

IOQs are facilities that have been selected for surpassing quality and efficiency standards and that show commitment to high-quality, cost-effective care.

L.P.N.
This means a licensed practical nurse.

Mental Disorder
This is an illness commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes, but is not limited to:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Medically Necessary
A service or supply furnished by a particular provider is necessary if the Claims Administrator determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved. To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition,
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition, and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the Claims Administrator will take into consideration:

- Information provided on the affected person's health status,
- Reports in peer reviewed medical literature,
- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data,
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment,

- The opinion of health professionals in the generally recognized health specialty involved, and
- Any other relevant information brought to the Claims Administrator's attention.

In no event will the following services or supplies be considered to be necessary:
- Those that do not require the technical skills of a medical, a mental health or a dental professional,
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility,
- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge
This is the maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under the plan.

Network Provider
This is a healthcare provider that has contracted to furnish services or supplies for a negotiated charge, but only if the provider is included in the directory as a network provider for:
- The service or supply involved; and
- The class of employees to which the individual belongs.

Non-Occupational Illness
A non-occupational illness is an illness that does not:
- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- Is covered under any type of Workers' Compensation law, and
- Is not covered for that illness under such law.

Non-Occupational Injury
A non-occupational injury is a bodily injury that does not:
- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an injury that does.

Non-urgent Admission
One that is not an emergency admission or an urgent admission.

Payable Expense
The amount the Arkema medical plan would normally pay in absence of other coverage.

Physician
A duly licensed member of a medical profession who:
- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where the Claims Administrator is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

R.N.
This means a registered nurse.

Recognized Charge

The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The recognized charge depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	The reasonable amount rate
Services of hospitals and other facilities	The reasonable amount rate
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Recognized charge does not apply to involuntary services.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP provider. NAP providers are out-of-network providers and third party vendors that have contracts with us but are not network providers. Except for involuntary services, when you get care from a NAP provider your out-of-network cost sharing applies.

Special terms used

- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the facility **provider** with a reasonable profit. For **hospitals** and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an out-of-network provider, unless that out-of-network provider is an assistant surgeon for your surgery
  - Not available from a network provider
  - Emergency services
- We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service

  Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:

  - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate may also exclude other payments that CMS may make directly to hospitals or other providers. It also may exclude any backdated adjustments made by CMS.

- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For DME, our rate is 75% of the rates CMS establishes for those services or supplies.

For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.

- "Reasonable amount rate" means your plan has established a reasonable rate amount as follows:

Service or supply	Reasonable amount rate
Professional services	85th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically: We update our systems with these changes within 180 days after receiving them from FAIR Health If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable If the alternative data source does not contain a value for a particular service or supply, we will base the recognized charge on the Medicare allowed rate.
Inpatient and outpatient charges of hospitals	The facility charge rate (FCR) rate
Inpatient and outpatient charges of facilities other than hospitals	The facility charge rate (FCR) rate

Our reimbursement policies

The plan reserves the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service

- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice

The views of physicians and dentists practicing in the relevant clinical areas

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits

Aetna has online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on Aetna Navigator®. Aetna's secure member website at **www.aetna.com** may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

for the Geographic Area where the service is furnished.

Residential Treatment Facility (Mental Disorders)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient's illness and risk;

- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An R.N. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a physician.

Room and Board Charges
Charges made by an institution for room and board and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

Semi-private Rate
This is the charge for Room and Board that an institution applies to the most beds in its semiprivate rooms with two or more beds. If there are no such rooms, the Claims Administrator will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
- Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
- Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
  - Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
    - The Joint Commission on Accreditation of Health Care Organizations;
    - The Bureau of Hospitals of the American Osteopathic Association; or
    - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Terminally Ill
This is a medical prognosis of six months or less to live.

Urgent Admission
A hospital admission by a physician due to:
- The onset of or change in an illness; or
- The diagnosis of an illness; or
- An injury.
- The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider
This is:
- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Charges for its services and supplies.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
  - Has contracted with Aetna to provide urgent care; and
  - Is, with Aetna's consent, included in the directory as a network urgent care provider.

It is not the emergency room or outpatient department of a hospital.

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician and is neither:

- An emergency room; nor
- The outpatient department of a hospital.

Addendum to the Arkema Inc. Pre-65 Retiree Medical Plan Summary Plan Description (for eligible Arkema Inc. retirees)

Effective December 31, 2021

This addendum is part of your Arkema Inc. Pre-65 Retiree Medical Plan Summary Plan Description (SPD), and details plan provisions that are specific to your retiree medical insurance coverage. It is part of the plan document and should be kept with your 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.

Disclaimer Note
This addendum describes certain benefits as they apply to eligible Arkema Inc. retirees. 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 reserves the right to terminate, suspend, withdraw, amend or modify any of the plans at any time and for any reason.

Eligibility
The following age and service requirements must be met to be eligible for Pre-65 retiree medical coverage:

- You must have at least 10 years of service and retire from Arkema at or after age 55. Years of service for this purpose are defined under the retirement plan.

Cost of Coverage
You pay a portion of the cost of coverage. Your cost varies according to the coverage level you elect, your years of service with Arkema, and the amount by which the cost exceeds the Cap, as described under *Paying for Coverage* below. You will be billed monthly by Arkema's direct billing administrator, Health Equity/WageWorks. In addition to the cost of coverage, you are also responsible for any applicable deductibles, copays, coinsurance, non-covered items and/or charges in excess of the recognized charges, as appropriate.

Paying for Coverage
Arkema announced in 2003 that the Company's future annual contribution toward the cost of your medical coverage is capped once the total cost, or full premium, of the plan reaches 150% of the average total cost per participant under the plan for the year ended December 31, 2003 (the "Cap"). The Cap is $8,300 per year. As the Cap has been reached, the

Company's contribution towards the cost of your coverage is frozen at the Company's percentage contribution (based on your years of service) multiplied by the Cap. Any increases or decreases in the premium will be reflected in the amount you pay. Each year, you will be notified of the cost of coverage for the following year.

Addendum to the Arkema Inc. Pre-65 Retiree Medical Plan Summary Plan Description (for eligible Bostik, Inc. retirees)

Effective December 31, 2021

This addendum is part of your Arkema Inc. Pre-65 Retiree Medical Plan Summary Plan Description (SPD), and details plan provisions that are specific to your retiree medical insurance coverage. It is part of the plan document and should be kept with your 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.

Disclaimer Note
This addendum describes certain benefits as they apply to eligible Bostik, Inc. retirees. 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 reserves the right to terminate, suspend, withdraw, amend or modify any of the plans at any time and for any reason.

Eligibility
To be eligible for Pre-65 retiree medical coverage, you must have been hired before August 1, 2015, and retired from active service at age 55 or older with a minimum of 10 years of service with Bostik, Inc.

Cost of Coverage
The cost of coverage is shared by Arkema and the retiree. Your cost varies according to the coverage level you elect. You will be billed monthly by Arkema's direct billing administrator, Health Equity/WageWorks. Each year, you will be notified of the cost of coverage for the following year.

In addition to the cost of coverage, you are also responsible for any applicable deductibles, copays, coinsurance, non-covered items, and/or charges in excess of the recognized charges, as appropriate.

Addendum to the Arkema Inc. Pre-65 Retiree Medical Plan Summary Plan Description

Effective December 31,2021

This addendum is part of your Summary Plan Description (SPD), and details Plan provisions that are specific to your coverage. It is part of the Plan document and should be kept with your 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.

Disclaimer Note
This addendum 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.

Who Is Eligible
For former DuPont and Rohm & Haas employees, eligibility information is listed below. Please note that this section of the addendum supersedes the Service and Age Requirement section of the Arkema Pre-65 Retiree Medical Plan SPD.

Grandfathered participants of the following plans who became a participant of the Arkema plan have the extended Early Retirement Eligibility rules outlined below:

DuPont	The first day of the month coincident with or next following the participant's attainment of age 50 and 15 years of service.
Rohm & Haas	The first day of the month coincident with or next following the participant's attainment of age 50 and 5 years of service.

Cost of Coverage
The cost of coverage is shared by Arkema and the retiree. Your cost varies according to the coverage level you elect. You will be billed monthly by Arkema's direct billing administrator, Health Equity/WageWorks. Each year, you will be notified of the cost of coverage for the following year.

In addition to the cost of coverage, you are also responsible for any applicable deductibles, copays, coinsurance, non-covered items, and/or charges in excess of the recognized charges, as appropriate.