Arkema Inc. Vision Plan Summary Plan Description

Contents

Disclaimer Note
This summary plan description describes certain benefits as they apply to eligible employees. The attached addendum includes certain provisions that apply specifically to certain retirees who are eligible for this coverage 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 the 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. Vision Plan, effective January 1, 2021. It describes the benefits as they apply to eligible employees of Arkema Inc. (the Company) and for certain eligible retirees. Some provisions of the plan that are specific to eligible retirees are described in an addendum. The addendum is considered part of the SPD for those eligible for retiree vision coverage under the plan. 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 addendum, if applicable), the Certificate of Coverage for Group Vision Insurance, and in the official plan document, the Certificate of Coverage for Group Vision Insurance will govern.

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

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

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

Eligibility and Enrollment

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

Please note: If you are an eligible retiree, the information in the "Eligibility and Enrollment" section that follows does not apply to you, except for the "Your Eligible Dependents" section. Please refer to the addendum for specific details about Eligibility and Enrollment as it pertains to you.

Eligibility

You are eligible to participate in the vision plan if you are a regular, full-time employee or a regular, part-time employee of Arkema Inc. who works at least 20 hours per week.

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

Your Eligible Dependents

You may also elect coverage for your eligible covered dependents, including:

- Your lawfully married spouse, including your civil union or common-law spouse in states where such relationships are recognized;
- For California residents only, your domestic partner provided your partnership is either currently registered with the California Secretary of State, or is a legal union of two persons of the same sex, other than a marriage, that was validly formed in another jurisdiction.
- Your children until the end of the month in which they turn age 26;
- Your disabled children, regardless of their age, provided they became disabled before age 26 while covered under the plan;
- Any other child for which you are considered the legal guardian as defined by a court order or when a court order requires health insurance for the child to be supplied by the participant [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 the child reaches age 26;
- Your legally adopted children, including children who are placed with you for adoption until the end of the month in which they turn age 26;
- Your stepchildren who live with you until the end of the month in which they turn age 26.

Disabled Children

You must provide written proof of your dependent'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 program. 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 QMCSO Processing Center 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 the Company 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.morneaushepell.com Access Code: ING105
Email: qdroprocessing@morneaushepell.com
Phone: (844) 208-7192
Fax: (844) 886-8539
Mail: P.O. Box 534277
St. Petersburg, FL 33747

Enrollment

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

If you are a current employee, you may enroll for coverage, change your coverage level, or waive coverage during Open Enrollment, which is held each fall for the following plan year (January 1 through December 31). You may not enroll or change your coverage during the plan year – unless you experience a qualified status change or become entitled to HIPAA special enrollment rights. For more information, see *Making Changes During the Year* on page 6.

If You Are a New Hire

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

If you fail to enroll yourself or your dependents during the initial 31-day enrollment period or choose to waive coverage, you may not enroll for coverage until the following Open Enrollment

period unless you experience a qualified change in status or become entitled to HIPAA special enrollment rights. For more information, see *Making Changes During the Year* on page 6.

Annual Open Enrollment

If you are a current employee, you may enroll for coverage, change your coverage level, or waive coverage during the 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. According to IRS rules, you may only make changes in your election during the year if you have a qualified change in status or if you become eligible for HIPAA special enrollment event permitting a mid-year election change. For more information, see *Making Changes During the Year* on page 6.

If You and Your Spouse Work for the Company

If you and your spouse are both employed by the Company, you each have the option of enrolling separately as an "employee," or one employee may enroll as a dependent of the other employee. You may not be covered both as an employee and as a dependent at the same time. Only one of you may enroll your eligible children.

If You and Your Dependent Child(ren) Work for Arkema

If you and your dependent child(ren) are both employed by Arkema, you each have the option of enrolling separately as an "employee," or one employee may enroll as a dependent of the other employee. You may not be covered both as an employee and as a dependent at the same time.

If You Don't Enroll

If you are a new hire and you do not enroll for coverage within 31 days, you will not receive vision benefits.

If you are a current employee and you do not enroll during Open Enrollment, you will automatically be enrolled in the same vision coverage option in which you are currently enrolled at your current coverage level. However, the coverage will be subject to any plan design or contribution changes for the following year. If you waived coverage the previous year and do not enroll during the Open Enrollment period, you will waive coverage the following year, too.

You will not be able to make changes to your default coverage or enroll your dependents for coverage until the next Open Enrollment, which applies to the next calendar plan year – unless you have a qualified status change or if you become entitled to HIPAA special enrollment rights. For more information, see *Making Changes During the Year* on page 6.

If You Waive Coverage

If you waive coverage as a new hire or during Open Enrollment, you must wait until the next Open Enrollment in the fall to enroll, unless you have a qualified status change during the year or

if you become entitled to HIPAA special enrollment rights. For more information, see *Making Changes During the Year* on page 6.

When Coverage Begins

If you are a new employee enrolling during the year, coverage for you and your dependents will begin as of your first active date of employment. However, you must enroll in the plan to receive benefits. See *Enrollment* on page 3.

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

Coverage Levels

If you enroll in the vision plan, you must choose from one of these coverage categories:

- Employee,
- Employee plus spouse (or domestic partner for California residents only),
- Employee plus child(ren),
- Employee plus family, or
- No coverage.

Cost of Coverage

You pay the full cost of coverage. Your cost varies according to the coverage level you elect. Generally, your cost is deducted from your pay on a before-tax basis. 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

You pay the entire cost of your vision plan coverage, which is deducted from your paycheck on a pre-tax basis (subject to IRS code regulations), that is, before federal – and in most cases state – income taxes and FICA taxes are withheld. Your contributions are based on the group rates obtained by the Company. Pre-tax contributions reduce your taxable income and increase your take-home pay. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the benefit programs will normally be greater than any eventual reduction in Social Security benefits.

Imputed Income for Domestic Partner Benefits (California Only)

According to tax law, your taxes may be affected when you enroll your domestic partner in the vision plan, available only if you live in California. The cost of coverage for a domestic partner is the same as the cost for a spouse. The cost of coverage for a domestic partner's child(ren) is

the same as the cost for a dependent child. If your domestic partner [and his or her child(ren)] qualifies as your dependent under section 152 of the Tax Code, your contributions for domestic partner coverage will be taken *before* taxes are withheld and there will be no tax implications for you. To enroll a domestic partner as a tax dependent, you must complete a Declaration of Tax Status. This form is available from your local Human Resources representative.

If your domestic partner [and his or her child(ren)] does not qualify as your dependent under section 152 of the Tax Code, the value of any coverage for your domestic partner [and/or his or her child(ren)] is considered "imputed income" and will be shown on your pay statement and Form W-2. You will pay taxes on the amount of imputed income. The value is calculated by determining the excess of the fair market value (FMV) of the coverage over the after-tax amount you paid for the coverage. The Company will consider dependents of your domestic partner as your tax dependents under the Tax Code. You must notify your local Human Resources representative if they are not your tax dependents.

Contact your personal tax advisor for more information.

Making Changes During the Year

Mid-Year Election Change Events

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

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

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

Qualified status changes that allow you to change your vision plan election include:

- Marriage, divorce, or annulment,
- Entrance into or termination of a domestic partnership whereby your domestic partner is or was considered a tax dependent (for California residents only),
- Birth, adoption or placement for adoption of a child,
- Any event that changes your employment status or the employment status of your spouse, such as terminating or starting employment, the beginning or ending of an unpaid leave, change in worksite, or change of employment classification (for example, part-time to full-time or vice versa) that causes a loss or gain of coverage,

- Your spouse acquires or loses coverage through his/her employer,
- Your child gains or loses eligibility for your coverage because of age,
- Your covered spouse or child dies,
- A significant increase or decrease of your or your spouse's costs of benefit coverage,
- A change in your place of residence that causes a loss of coverage
- Eligibility of an employee, spouse, or dependent for COBRA, or
- Events such as the loss of other coverage that qualify as special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of Medicaid or State Child Health Insurance Program (CHIP) coverage or eligibility for state premium assistance.

For enrollment opportunities due to the Medicaid/CHIP eligibility change, you will have 60 days — instead of 31 — from the date of the Medicaid/CHIP eligibility change to request enrollment.

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

- **Effect on eligibility.** The qualified change in status must affect eligibility for coverage under the vision plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.
- **Corresponding election change.** The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the vision plan, you may cancel vision coverage only for that dependent. Arkema will determine whether a requested change is due to and consistent with a qualified change in status.

If you experience a qualified status change, you must inform the Arkema Benefits Center of your new election and provide proof of the change upon request within 31 days of the change or you will lose your right to change your election until Open Enrollment. Your new election shall take effect prospectively only, but not earlier than the date of the change in status, except in the case of your new child birth, adoption, or placement of adoption as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

Other Permitted Changes

In some instances, you can make changes to your vision coverage for other reasons, such as mid-year events affecting your cost or coverage, as described below. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Cost Changes

If there is a significant increase or decrease in the cost of coverage under a vision option offered through the Arkema vision plan, you may be permitted:

- To change your corresponding election coverage,
- In the case of a significant increase in cost, revoke your existing election and elect coverage under another option providing similar coverage (if no alternative similar coverage is available, you may revoke your election with respect to such coverage), or
- In the case of a significant decrease in the cost of a plan during the year, you may enroll in that plan, even if you declined to enroll in that plan earlier.

Any change in the cost of your vision coverage that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Coverage Changes

Curtailment or Loss of Coverage

If your coverage under a vision option is significantly curtailed or ceases entirely, you may revoke your elections and elect coverage under another vision option providing similar coverage. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for vision coverage. This could occur, for example, if the Company eliminates your vision option, if the vision option is no longer available where you live, or other reasons determined by the Company.

Addition to or Improvement in Coverage

If the Company adds or significantly improves a vision option during the year, and you had elected a benefit option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved vision option.

Special note regarding domestic partner coverage (California only): The events qualifying you to make a mid-year election change described in this section also apply to events related to a qualified domestic partner. However, IRS rules generally do not permit you to make a mid-year change "on a *pre-tax* basis" for such events unless they involve a *tax* dependent.

Changes in Coverage under Another Employer Plan

If your spouse's or dependent's employer's vision plan allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the vision plan. For example, if your spouse elects family coverage during his or her employer's open enrollment period, you may drop your coverage under your vision option. You may need to provide proof of the event and the effective date of the event.

Medicare or Medicaid Entitlement

You may change an election for vision coverage mid-year if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your vision coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding vision coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act (FMLA)

You may drop vision coverage mid-year when you begin an unpaid leave, subject to the provisions of the FMLA. If you drop coverage or if you fail to make payments for benefit coverage during your FMLA leave, when you return from the FMLA leave, you have the right to be reinstated to the same elections you made prior to taking your FMLA leave. See *Continuing Your Coverage During an Approved Leave of Absence* on page 30 for more information.

Judgment, Decree or Order (including QMCSOs)

If a judgment, decree or order (including QMCSO) requires the vision plan to provide coverage under any of the benefits described herein, dependent children may also include any child for whom you are required to provide medical coverage under a QMCSO. In general, QMCSOs are orders under state law requiring a parent to provide health care support to a child – for example, in case of separation or divorce. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who do not reside with you. However, children who are no longer eligible, as defined by the Vision Plan eligibility rules, due to their age for example, cannot be added under a QMCSO.

If a QMCSO requires the vision plan to provide vision coverage to such a child, then the vision plan automatically may change your election to provide coverage for that child. In addition, you may make corresponding changes to your elections under other Company benefits, to the extent permitted by the Internal Revenue Code.

If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child if you provide proof to the vision plan that such other person actually provides the coverage for the child.

You may obtain a copy of the Company's procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

When Coverage Ends

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

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

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 (if dependent child is age 26 or older),
- Your eligible dependent(s) goes on active duty in the armed forces of any country, or
- Your dependent child reaches the maximum age limit.

You may be able to continue your Company vision coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) (see page 20 for details).

How Your Plan Works

The Arkema Inc. Vision Plan is designed to meet your and your family's needs for routine eye care and eyewear. The vision plan offers you a network of vision care providers from which to choose. Each time you need services, you can decide whether to use an in-network or out-of-network provider. Both options cover you for many basic services, including eye exams, lenses, frames and contact lenses, but you pay less when you use an in-network provider. Vision benefits are provided through an insurance contract with HM Life Insurance Company as administered by Davis Vision.

- If you use an in-network provider, you receive a higher coverage level than if you visit an out-of-network provider. In general, you pay a copayment for eye exams and lenses, and the plan covers the rest. For frames and contact lenses, the plan pays up to a certain amount. You do not need to file a claim form.
- If you go to an out-of-network provider, you will pay the provider directly and then submit a claim form and your receipts to the plan. The plan will then reimburse you up to the allowable expense for each covered service.

To find a network provider, call Davis Vision at 1-800-999-5431 to access the interactive voice response unit, which will supply you with the names and addresses of the network providers nearest you. You may also access the website at **www.davisvision.com** and utilize the "Find a Provider" feature. Your ID/Login is your Personnel Number, or you can log in using Arkema's Client Code, 2006.

Your Benefits

Here is a look at how some commonly used services are covered under the vision plan. For information on how services not listed may be covered, contact Davis Vision at 1-800-999-5431.

Plan Provision	In-Network	Out-of-Network	Frequency
Comprehensive Eye Examination	You pay $10 copayment	Plan reimburses up to $35	Once per Calendar Year
Frames*	$130* maximum allowance $180* maximum allowance at Visionworks locations only	Plan reimburses up to $60	Choice of one pair of eyeglasses (frames and spectacle lenses) or contact lenses per 12-month period
Spectacle Lenses			
▪ Single	You pay $20 copayment	Plan reimburses up to $25	Choice of one pair of eyeglasses (frames and spectacle lenses) or contact lenses per 12-month period
▪ Bifocal	You pay $20 copayment	Plan reimburses up to $40	
▪ Trifocal	You pay $20 copayment	Plan reimburses up to $55	
▪ Lenticular	You pay $20 copayment	Plan reimburses up to $55	

Plan Provision	In-Network	Out-of-Network	Frequency
Additional Lens Options			
▪ Basic Polycarbonate	You pay $30† copayment	Not Covered	Once per 12 month period
▪ UV Coating	You pay $15 copayment	Not Covered	
▪ Tint (fashion, sun or gradient or plastic)	You pay $12 copayment	Not Covered	
▪ Scratch-resistant coating	Covered in full	Not Covered	
▪ Standard anti-reflection	You pay $35 copayment	Not Covered	
▪ Premium anti-reflection	You pay $48 copayment	Not Covered	
▪ Photochromic glass	You pay $20 copayment	Not Covered	
▪ Plastic photosensitive	You pay $65 copayment	Not Covered	
▪ Intermediate vision	You pay $30 copayment	Not Covered	
▪ Blended invisible bifocals	You pay $20 copayment	Not Covered	
▪ Polarized	You pay $75 copayment	Not Covered	
▪ High-index (thinner and lighter)	You pay $55 copayment	Not Covered	
▪ Standard progressive additional multifocal**	You pay $45 copayment	Not Covered	
▪ Premium progressive additional multifocal**	You pay $90 copayment	Not Covered	
▪ Ultra progressive additional multifocal**	You pay $140 copayment	Not Covered	
Scratch Protection Plan – Single Vision Lenses	You pay $20 copayment	Not Covered	
Scratch Protection Plan – Multifocal Lenses	You pay $40 copayment	Not Covered	
Contact Lenses			
▪ Conventional	$130†† maximum allowance	Plan reimburses up to $110	Choice of one pair of eyeglasses (frames and lenses) or contact lenses per 12-month period
▪ Disposable	$130†† maximum allowance	Plan reimburses up to $110	
▪ Medically necessary (with prior approval)	Covered in full with prior approval	Plan reimburses up to $200	
Low Vision Program			
▪ Comprehensive evaluation	$300 maximum allowance per evaluation; $100 maximum	$300 maximum allowance per evaluation; $100 maximum	Once every 60 months (including four follow-up visits)

Plan Provision	In-Network	Out-of-Network	Frequency
	allowance per follow-up visit	allowance per follow-up visit	
▪ Low vision aids	$600 maximum allowance per aid; $1,200 lifetime maximum allowance for all aids	$600 maximum allowance per aid; $1,200 lifetime maximum allowance for all aids	

* *No copay for Premier selection of frames from "Davis Vision's Collection" in most in-network provider offices. When selecting a frame from a network provider's own collection or from a provider (such as an in-network retail center) who does not have "Davis Vision's Collection", a $130 credit will be applied to your purchase or $180 credit at a Visionworks location. An additional 20% discount will be applied toward any remaining frame cost.*

† *No charge for children up to age 19, monocular patients, and patients with prescriptions of +/- 6.00 or greater.*

** *If unable to adapt to progressive addition lenses, conventional bifocals will be supplied at no additional charge; however, the copayment will not be refunded.*

†† *No copay for plan-supplied standard, soft, daily-wear, disposable or planned replacement contact lenses in lieu of eyeglasses. A $130 credit will be applied toward contact lenses from the provider's own supply (which may or may not apply toward fitting/follow-up care fees). When receiving services from an in-network center the credit will be applied toward the purchase of contact lenses and fitting/follow-up fees. Where required by state, the full credit may be applied toward the contact lenses only. Medically necessary contact lenses will be covered in full with prior approval. (Disposable contact lens wearers will receive four multi-packs of lenses. Planned replacement contact lens wearers will receive two multi-packs of lenses.)*

A one-year unconditional breakage warranty is provided for all eyeglasses completely supplied by Davis Vision when broken glasses are returned.

Replacement Contact Lenses By Mail

Free membership and access to a mail order replacement contact lens service, Davis Vision Contacts, provides a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, contact 1-855-589-7911 or visit the Davis Vision Contact website at **www.davisvisioncontacts.com**.

Laser Vision Correction Services

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons (please note that some providers have flat fees equivalent to these discounts).

For more information, contact 1-855-502-2020 or visit the Davis Vision website at **www.davisvision.com** or direct website at **www.qualsite.com**.

What Is Covered

Covered expenses include charges made by a provider for the following vision care services (Benefits payable vary depending upon which provider renders the service):

- Eye examination, including the following procedures:
  - Case history
  - Entrance distance acuities
  - External ocular examination including slit lamp examination
  - Internal ocular examination
  - Tonometry
  - Distance refraction – objective and subjective
  - Binocular coordination and ocular motility evaluation
  - Evaluation of pupillary function
  - Biomicrosopy
  - Gross visual fields
  - Assessment and plan
  - Advice on matters pertaining to vision care
  - Form completion – school, motor vehicle, etc.
- Fitting of eyeglasses and follow-up adjustments
- Materials:
  - Premier Collection frames and the following lenses as provided through Davis Vision:
    - Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions
    - Prescription sunglasses with grey glass #3 lenses (in lieu of dress eyeglasses)
    - Oversized lenses
    - Cataract lenses
    - Contact lenses
  - Optional in-network items:
    - Progressive addition multifocal lenses (invisible bifocals)
    - Photochromic lenses (single vision or multifocal)
    - Scratch resistant coating
    - Standard anti-reflective coating
    - Premium anti-reflective coating
    - Blended invisible bifocal lenses
    - Ultraviolet coating
    - Polycarbonate lenses (no charge for children up to age 19, monocular patients, and patients with prescriptions of +/- 6.00 or greater)
    - High index lenses
    - Plastic photosensitive lenses
    - Polarized lenses
    - Intermediate vision lenses Fashion, sun, gradient or solid tint
  - Frames and lenses from out-of-network providers or from network providers' own collections
  - Medically necessary contact lenses for keratoconus, if approved by Davis Vision
- Low vision program (subject to prior approval by Davis Vision):

- Comprehensive low vision evaluation when needed
- Follow-up visits
- Low vision aids

What Is Not Covered

The plan does not cover certain services, some of which are listed below. Please contact Davis Vision to confirm whether or not your service will be covered. Benefits will not be paid for:

- Services or supplies not recommended by a provider.
- Periodic vision examinations, except as provided for in the chart on page 11.
- Eye examinations required by an employer as a condition of employment.
- Services or materials provided in connection with special procedures, such as orthoptics and visual training, or in connection with medical or surgical treatment.
- Lenses that do not provide vision correction.
- Charges for the replacement of lost or stolen lenses or frames.
- Sickness or injury covered by a Workers' Compensation act or other similar legislation.
- Charges incurred as a direct or indirect result of war (declared or undeclared).
- Charges incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
- Services or supplies furnished before the effective date of the plan or after your coverage ends.
- Services or supplies that are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.
- Any medical treatment rendered outside the United States or Canada.
- Services rendered by practitioners who do not meet the definition of provider.
- Expenses covered by:
  - Any other group insurance.
  - A health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.
- Any expenses covered by any union welfare plan or governmental program or a plan required by law.
- Experimental or investigational procedures.
- Services not covered under the plan.
- Cosmetic surgery or treatment, as determined by the plan.
- Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior notification was not sent to Davis Vision.
- Medically necessary contact lenses prescribed for a covered person affected with keratoconus for which prior notification was not sent to Davis Vision.

Note: Coverage for contact lenses is in conjunction with the contact lens fitting/evaluation. They are not separate components.

If the patient receives Davis Vision Collection (plan) contact lenses, the fitting/evaluation is always covered in full as outlined in the benefit description.

If the patient receives non plan also known as Dr. supplied contact lenses, the cost of the fitting/evaluation is added to the cost of the materials. The contact lens allowance is then applied to that total cost. Any amount over the allowance amount is an OOP charge to the patient.

Additional Rules That Apply To This Plan

The following rules apply to this plan.

Your HIPAA Rights

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

About Your Privacy and Security

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

The Company has implemented policies and practices to appropriately protect the privacy and security of your PHI. PHI that you provide will be handled in accordance with the Company's HIPAA privacy policy. For more information, see *Compliance with Privacy Regulations* on page 41.

Circumstances That May Result in Denial, Loss or Forfeiture of Benefits

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

- Loss of eligibility under the plan,
- Charges incurred prior to your effective date of coverage,
- Reaching the maximum benefits provided under the plan,
- Amendment to the plan,
- Employee, dependent or provider not responding to a request for additional information needed to process the claim or appeal,
- Misuse of the plan ID card or other fraud,
- No coverage for certain services due to use of out-of-network providers, or
- Incomplete claims submission.

Qualified Medical Child Support Order (QMCSO)

The plan will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, it is reviewed by the Company for validity. If it is found to be valid, the Company will notify the Arkema Benefits Center. The Arkema Benefits Center will then coordinate the addition of the dependent to the participant's health care coverage. Coverage under the plan pursuant to a medical child support order will not become effective until the Company determines that the order is a QMCSO. If you have any questions regarding a QMCSO, please contact the Arkema Benefits Center at 1-800-406-9823.

How To Reach Your Vision Plan Service Provider

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

Plan	*Telephone Number*	*Website Address*
Davis Vision	1-800-999-5431	**www.davisvision.com** (General Login Code: 2006)

Note: When calling Davis Vision, you will need to provide your Personnel Number which is your number on your paystub.

Continuation of Coverage

You may be able to continue coverage under the vision 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 employees and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events").

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the federal law. In some states, state law continuation provisions may also apply to the insurers offering benefits under the plan. For more information, please contact the COBRA Administrator at the address shown in *Contacting the COBRA Administrator* on page 29, or call the Arkema Benefits Center.

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

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

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

Qualifying Events that Result in Loss of Coverage	**Maximum Continuation Period**		
	Employee	**Spouse**	**Child(ren)**
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee becomes entitled to Medicare as a retiree	N/A	36 months	36 months
Employee or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse divorce	N/A	36 months	36 months

Employee and domestic partner terminate domestic partnership (for California residents only)	N/A	36 months	36 months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 months*	36 months*
Child(ren) no longer qualifies as a dependent	N/A	N/A	36 months

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

Qualifying Events

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

If you should die, become divorced, terminate your domestic partnership (for California residents only), or become entitled to Medicare, your covered dependents whose health coverage under the plan would be reduced or terminated may continue vision coverage under the plan for up to 36 months. Also, your covered children may continue vision coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

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

Special Rules for Domestic Partners (for California residents only): Although domestic partners and their eligible dependent children are generally not considered qualified beneficiaries for purposes of legal entitlement to COBRA continuation coverage, Arkema does make COBRA coverage available to covered domestic partners and their eligible dependent children who meet the requirements for eligibility under the Plan. Accordingly, eligible dependents for purposes of receiving COBRA coverage as described in this section also include domestic partners and their dependent children. If you have enrolled your domestic partner and his or her eligible dependent children for coverage under the Plan and you terminate your domestic partnership, you must notify the Plan Administrator in writing within 60 days of the event. Your domestic partner and his or her eligible dependent children will thereafter be eligible to elect to receive COBRA continuation coverage under the Plan as described in this section.

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

Your Duties

Under the law, an active employee or a family member of an active employee has the responsibility to inform the COBRA Administrator of a divorce, or a child losing dependent status under the vision 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 employee 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 the driver's license or birth certificate showing the child(ren)'s age [in the case of a child(ren) becoming too old for coverage];
- Entitlement to Medicare – a letter from the Social Security Administration indicating the employee 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* on page 29. This notice must be provided within 60 days from the date of the divorce, or child losing dependent status (or if later the date coverage would normally be lost because of the event). If you or a family member fails to provide this notice to the COBRA Administrator during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage.

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

Arkema's Duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occur that will result in a loss of coverage:
- The employee's death or termination (for reasons other than gross misconduct),
- A reduction in the employee's hours of employment, or
- Notification of an employee's entitlement to Medicare.

Electing and Paying for COBRA Continuation Coverage

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

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

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

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

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

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

Separate Elections

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

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

Limited Second Election Period. The Trade Reform Act of 2002 created a special COBRA right applicable to employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of 65% (increased to 80% for a certain period of time) of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. Notwithstanding the foregoing, however, this election may not be made more than six months after the date the individual's group health plan coverage ends. Note that an individual receiving a government (COBRA) subsidy may not be eligible to receive this tax credit during that same month. If you have questions about the Trade Reform Act provisions or if you qualify or may qualify for assistance under the Trade Reform Act of 2002, you may contact the Plan Administrator for additional information or you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Reform Act of 2002 is also available at **https://www.dol.gov/agencies/eta/tradeact**

Cost

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

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

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

Duration of COBRA

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

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

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

COBRA coverage can end before any of the above maximum periods for several reasons. See the *Early Termination of COBRA* section below for more information.

Additional Qualifying Events

Under the law, in order to receive an extension of continuation coverage, a former employee or family member of a former employee has the responsibility to inform the COBRA Administrator of the death of an employee, divorce, a child losing dependent status under the vision plan, or entitlement of an employee to Medicare which occurs after an employee's termination of employment or reduction in hours.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days from the later of (1) the date of the second qualifying event, or, if later, (2) the date on which the qualified

beneficiary would have lost coverage because of the event under the terms of the plan (if it had occurred while the qualified beneficiary was still covered under the plan as an active participant).

Written notice of the additional qualifying event must be provided to the COBRA Administrator. This notice should be mailed or hand-delivered to the COBRA Administrator at the address listed in *Contacting the COBRA Administrator* (page 29) and must include the following information:

- The name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event;
- The signature, name and contact information of the individual sending the notice.

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

- Death – A copy of the death certificate.
- Divorce – A copy of the divorce decree.
- Child no longer qualifying as a dependent – A copy of a driver's license or birth certificate showing the child's age (in the case of a child becoming too old for coverage.
- Entitlement to Medicare – A letter from the Social Security Administration indicating the employee is entitled to Medicare benefits.

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

Special Rules for Disability

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

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

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

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

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

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

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

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

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

Early Termination of COBRA Continuation Coverage

COBRA continuation of health coverage for any person may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following 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 or otherwise) under another group health plan;
- 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.);
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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**.

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. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, 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**. For more information about the Marketplace, visit **www.HealthCare.gov**.

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

All notices and other communications regarding COBRA and the Arkema Inc. Vision Plan should be directed, as discussed above, to the COBRA Administrator at:

Health Equity/WageWorks, Inc.
P.O. Box 650407
Dallas, TX 75265-0407
1-877-924-3967

Continuation of Coverage While on Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your vision coverage. Your vision coverage will continue for up to 24 months from the start of your Extended Military leave as long as:

- You give the Company advance notice (with certain exceptions) of the leave,
- Your total leave, when added to any prior periods of military leave from the Company, does not exceed five years (with certain exceptions), and
- You continue to make contributions for coverage.

If you are on military leave for six months or less, you can continue to make contributions at the active employee rate through payroll deductions. After six months, you will be offered the opportunity to continue your healthcare coverage for an additional 18 months through COBRA. You will be required to pay up to 102% of the entire amount (including both Company and employee contributions) necessary to cover an employee who does not go on military leave.

If you take a military leave and you do not elect the extended coverage, your coverage under the Arkema Inc. Vision Plan will be terminated. Immediately upon your timely return to work, your benefits will be reinstated with no waiting period.

If you are on military leave for less than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase continuation coverage for the remaining months, up to a total of 24 months from the beginning of your Extended Military leave.

For more information about continuing coverage, see *COBRA Continuation* on page 20.

You may maintain active dental coverage for yourself and your dependents at active employee rates for up to six months through payroll deductions. After six months, you must remit monthly contributions directly to the COBRA Administrator. If you are a reservist called to active duty, you are automatically covered by military health benefits and you may elect to enroll your dependents in TRICARE, a separate federal health plan for dependents. When there is dual coverage of dependents under TRICARE and the Arkema Inc. Vision Plan, the Arkema Inc. Vision Plan is considered the primary coverage.

Continuation of Coverage While on an Approved Leave of Absence

If you take an approved leave of absence that qualifies under the Family and Medical Leave Act (FMLA), you may continue vision coverage for you and your eligible dependents at active rates as long as you continue to pay your portion of the cost for your benefits during the leave.

If your leave of absence is paid, the cost of your vision coverage will continue to be deducted from your paycheck on a pre-tax basis.

If you take an unpaid leave of absence that qualifies under FMLA, you will be directly billed for your monthly contributions by Health Equity/WageWorks. You also have the option to suspend your vision coverage during the leave. If you lose any group health coverage during an FMLA

leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

Continuation of Coverage While Disabled

If you become disabled and eligible for long-term disability benefits, while covered under the vision plan, you may continue vision coverage for you and your eligible dependents under COBRA if you satisfy the Social Security Administration's definition of disabled. Please contact Health Equity/WageWorks for more information. You will be directly billed for your monthly contributions by Health Equity/WageWorks.

Filing a Claim

You do not need to file a claim if you use an in-network provider. To receive benefits for care obtained from an out-of-network provider through the vision plan, you must file a claim form.

If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each 12-month benefit cycle. All claims must be received within 365 days from the date the expenses were incurred. To request a claim form, visit the Davis Vision website at **www.davisvision.com** or call 1-800-999-5431.

Appeals

The plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act (ERISA) of 1974.

If you have any questions regarding how to file or appeal a claim, contact the appropriate Claim Administrator listed in the ERISA Information section.

Initial Benefit Determination

The plan recognizes three categories of claims:

Pre-Service Claims: The Plan Administrator will notify you of the Claims Administrator's determination, whether adverse or not, within a reasonable period of time, but not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information.

If the claim is improperly filed, the Claims Administrator will notify you as soon as possible, but not later than five (5) days after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service Claims: Claims involving the payment or reimbursement of costs for vision care that has already been provided.

For post-service vision claims, the plan has up to 30 days to evaluate and respond to claims for benefits covered by ERISA. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims: Claims where the plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments.

Concurrent care claims may fall under either of the other two category of claims, depending on when the claim is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Claim Is Denied

If your claim is denied, the Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination.
- References to the specific plan provisions on which the benefit determination is based.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Your Right to Appeal

Coverage decisions are based on members' benefits and the information submitted with their claims. Member Services Representatives (MSR) can provide more information about how your

coverage was applied and answer any questions you may have about your benefits. To reach a representative, please call 1-800-999-5431.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that Davis Vision, Inc. relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

If after speaking with an MSR you feel that the coverage decision was not correct, the patient or an authorized representative may appeal or grieve the decision by following the steps below.

Procedures for Appealing an Adverse Benefit Determination

To appeal or grieve a coverage decision, please send a written explanation of why you feel the coverage was incorrect to the address below. Information may also be provided to a member services representative over the phone. Please include with the explanation:

- The patient's name, relationship to member, address and telephone number,
- Your Davis Vision, Inc. identification number, and
- If applicable, the name of the healthcare professional or facility that provided the service, including the date and description of the service(s) provided, and the charge(s).

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
  - Constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate.
- A review in which the named fiduciary consults with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit

determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental).
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

Send written appeals to:

Davis Vision, Inc.
Attention: Complaints and Appeals
PO Box 791
Latham NY 12110

Members must file an appeal or grievance within 180 days of the date of the explanation of benefits notification of coverage decision. Davis Vision, Inc. will respond in writing to appeals within 60 calendar days.

The Claims Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:
- The specific reason(s) for the adverse benefit determination.
- References to the specific plan provisions on which the benefit determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If you have completed the appeals process without satisfaction, you may have the right to bring civil action under section 502 (a) of ERISA. Federal, state and local government programs, church plans, and individual policies are not regulated by ERISA.

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 19406-7699

Plan Name

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

Plan Number

501

Plan Type

Welfare plan providing vision 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 19406-7699

The Plan Administrator is responsible for the general administration of the vision 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 vision plan and make factual determinations

regarding all aspects of the vision plan and its benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the vision 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 vision 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 vision plan, including the processing and payment of claims under the plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the vision plan, and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the vision plan to the extent an insurer or administrator is not empowered with such responsibility.

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

Benefits Administrator

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

Claims Administrator

Davis Vision, Inc.
175 East Houston Street
San Antonio, TX 78205

Agent for Service of Legal Process

Arkema Inc.
Legal Department
900 First Avenue
King of Prussia, PA 19406-7699

Program Funding and Type of Program Administration

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

Future of the Plan

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

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

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

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

Your Employment

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

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

Please note: If you are an eligible retiree, the information under "Your Employment" above does not apply to you.

Your Legal Rights

As a participant in the vision 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 vision 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 vision 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 vision 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 Vision Care Coverage

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

Prudent Actions by Program Fiduciaries

In addition to creating rights for vision plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your vision plan, called "fiduciaries" of the vision 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 vision benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the vision plan documents or the latest annual report from the vision plan and this is not placed in the mail or given to you within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the vision 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 vision plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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

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

Compliance With HIPAA Privacy and Security Regulations

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

Permitted Use and Disclosure of Protected Health Information (PHI)

The Company may only use and disclose PHI and e-PHI it receives from the vision 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 Protected Health Information and e-PHI in connection with payment, treatment and healthcare operations.

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

The Company agrees to:

- Not use or further disclose the information other than as permitted or required by the plan documents or as required by law.
- Ensure that any agents, including a subcontractor, to whom it gives PHI and e-PHI received from the vision 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 employee benefit plan of the Company.
- Report to the vision 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.

- 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 vision plan available to the Secretary of HHS for purposes of determining compliance by the vision plan.
- If feasible, return or destroy all PHI and e-PHI received from the vision 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 vision plan must limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.
- Notify a participant or participants of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

  (1) the names of the individuals whose PHI was involved in the Breach;
  (2) the circumstances surrounding the Breach;
  (3) the date of the Breach and the date of its discovery;
  (4) the information Breached;
  (5) any steps the impacted individuals should take to protect themselves;
  (6) the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and
  (7) a contact person who can provide additional information about the Breach.

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

Security Agreements of the Company

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

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

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

Separation of the Company and Arkema Inc. Vision Plan

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

- Vice President – Human Resources and Communications
- Sr. Director – Compensation, Benefits and M&A
- Manager – Health & Welfare Benefits
- Sr. Health & Welfare Benefits Deputy General Counsel
- General Counsel

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

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

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

PHI not Subject to this Section.

The terms of this section will 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 the 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 to "Security Agreements of the Company," 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

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

Allowance
The flat dollar amount payable under the plan for eye examinations, the fitting of eyeglasses or materials received and/or purchased by the participant.

Coinsurance
The percentage of eligible expenses you pay, other than the deductible.

Copayment
The amount a participant is required to pay to the provider prior to an eye examination or toward the cost of materials.

Covered Expense
An expense for eye examinations, the fitting of eyeglasses or materials, incurred by a participant for which benefits are payable under the plan.

Disabled
The inability of a person to perform the substantial and material duties and functions of his or her occupation or any other gainful occupation.

Effective Date
The date the participant becomes covered under the plan.

Participant
An eligible employee, retiree or COBRA participant as defined by the plan.

Materials
Frames and lenses provided to a participant for ophthalmic correction.

Non-Participating Provider
Providers of optometric services who have not entered into a contract with Davis Vision.

Participating Provider
Providers of optometric services who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a scheduled fee basis.

Provider
A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the state in which the services are provided. There are two types of providers: participating providers and non-participating providers. Refer to these definitions for further information.

Usual and Customary Charge
The portion of a charge made by a provider for eye examinations, the fitting of eyeglasses or materials which does not exceed the lesser of:

- The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area, or
- The usual charge the provider most frequently makes to patients for the same service.