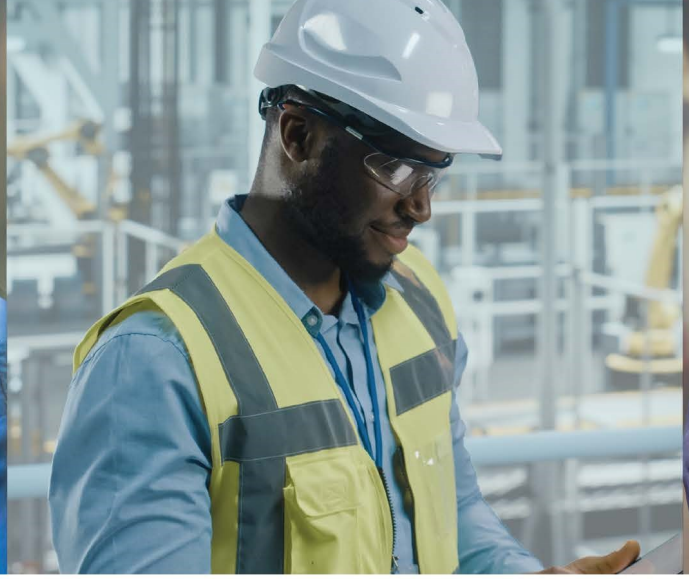




MAPEI

BENEFITS GUIDE

2025

superior benefits FOR YOU

For COBRA Participants

2025 MAPEI Benefits for COBRA Participants

Before enrolling, be sure you understand your benefit options:

1. Review your current benefit elections.
2. Decide what to keep and what to change.
3. Collect the information to add eligible dependents (see *page 3*).
4. Add/remove dependents and elect your benefits in the Oracle enrollment site.

As a COBRA participant, you are eligible to elect the following benefits during the enrollment period only. However, if you have a qualifying life event during the year, you may be able to change your elections and add or remove dependents (see page 3).

Contents

Important Information

This benefits summary provides selected highlights of the MAPEI Corporation employee benefits program beginning January 1, 2025 through December 31, 2025. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at MAPEI Corporation. All benefit plans are governed by master policies, contracts, and plan documents available from the Benefits Team at benefits@mapei.com.

Any discrepancies between any information provided through this summary and the actual terms of such policies, contract, and plan documents shall be governed by the terms of such policies, contracts, and plan documents. MAPEI Corporation reserves the right to amend, suspend, or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

This *Benefits Guide* also serves as the 2025 Summary of Material Modifications to supplement the MAPEI Summary Plan Description.

You have the right to request and receive a paper copy of any benefits-related documents free of charge by contacting the Benefits Team at benefits@mapei.com or **954-246-8888**.

Benefits at a Glance and Contacts

Please review the following summary of benefits. For questions or more information, contact the Benefits Team at **benefits@mapei.com** or the call centers and websites below. The benefits are summarized on the next pages.

Benefits at a Glance and Contacts		
Benefits	**Administrator**	**Contact**
Medical Enroll in or waive coverage.	**Florida Blue** Plan #65143	**800-664-5295** **floridablue.com**
Prescription Drugs Included with the medical benefits.	**RxBenefits** Plan #RXBMAPE	**800-334-8134**
Telemedicine Access online doctors.	**Revive Health** (formerly SwiftMD)	**833-794-3863** **Passcode: MAPEI19** **swiftMD.com**
Dental Benefits Enroll in or waive coverage.	**Delta Dental** Plan #22430	**800-521-2651** **deltadentalins.com**
Vision Benefits Enroll in or waive coverage.	**EyeMed** Plan #1051430	**866-939-3633** **eyemed.com**
COBRA Continuation of Coverage Available after employment ends.	**HealthEquity**	**888-678-4861** **Mybenefits.wageworks.com**

Medicare Notice

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D notice on page 16 for details and state contact information beginning on page 13.

Dependent Eligibility

If you enroll, you can enroll your legal spouse and eligible dependents up to age 26 in the medical, dental, and vision plans.

Dependent children are your:

- Naturally born child(ren).
- Dependent child(ren) of your spouse.
- Stepchild(ren).
- Child(ren) who you or your legal spouse have adopted or who are placed with you for adoption.
- Child(ren) for whom legal guardianship has been awarded to you or your spouse, or for whom you are required to provide coverage under a *Qualified Medical Child Support Order* (QMCSO) or other court or administrative order.
- Unmarried child(ren) of any age who become mentally or physically disabled before reaching the benefit-eligibility-age limit. You must provide medical certification that the child became disabled before reaching the benefit-eligibility-age limit. They must also be dependent on you for support.

For more information, please contact your local HR Team, email the Benefits Team at **benefits@mapei.com**, or call **954-246-8888.**

Changing Elections after You Enroll

The elections you make cannot be changed until the next Open Enrollment unless you have a *qualifying life event* as defined by the IRS. These include:

- Marriage, divorce, or legal separation.
- Loss of eligibility by a dependent.
- Losing or gaining other health coverage (you or a dependent).
- The birth, adoption, guardianship, or placement for adoption of a child.
- Change in your child's dependent status.
- Death of a spouse or dependent.
- Qualification by the Plan Administrator of a child support order for medical coverage.
- Entitlement to Medicare or Medicaid.

You have 30 days following a qualifying event to make changes to your benefit elections. You are required to provide documentation to verify the qualifying event.

Your benefit change or election will begin retroactive to the event date.

If you miss the 30-day deadline, you cannot enroll new dependents or change benefit elections until the next Open Enrollment or qualifying event.

Medical Benefits

You have two medical plan options. Both offer the same coverage and include prescription drug benefits through Express Scripts and Rx Benefits. Compare the differences on how the plans cover in-network expenses in the following table. See the *Medical Plan Terms to Know* on page 5 for definitions.

- **Plan 3769** has deductibles and higher copays for some services, but premiums are lower for covering dependents compared to Plan 3748.
- **Plan 3748** features no deductibles in-network and lower copays for some services but higher premiums compared to Plan 3769.

Refer to the *Summary of Benefits Coverage* (SBC) and your Employee Benefits at MAPEI App for more information on coverage, including on how out-of-network expenses are covered. Contact Member Services 24/7 at **800-664-5295** for questions.

Comparing Medical Plan Options
What You Pay for In-Network Expenses

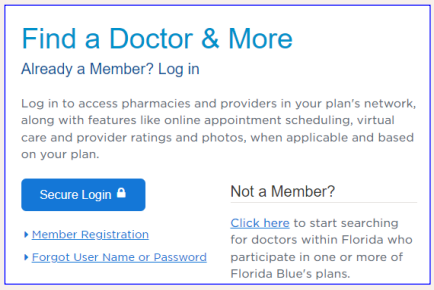
Plan Features	Plan 3769	Plan 3748
Annual Deductible (CYD) Individual Family	 $ 750* $1,500*	 $0 $0
Coinsurance (where applicable)	10%	0%
Annual Out-of-Pocket Maximum Individual Family	 $2,500 $5,000	 $2,000 $4,000
Preventive Care	$0	$0
Doctor's Office Copays/Visit Primary Care Physician (PCP)	$35	$25
Doctor's Office Copay/Visit Specialist Maternity	 $70 $35	 $50 $30
Telehealth Revive Health (formerly SwiftMD)	$0	$0
Urgent Care Facility Copay/Visit	$70	$50
Emergency Room Copay/Visit	$350	$300
Diagnostic Facility Copays (new for 2024) Outpatient Lab Facility X-Ray	 $25 $50	 $25 $50
Major Imaging Services Copays (CT/PET/MRI)	$125	$75
Inpatient Hospital Copays	10% after deductible	$250

*The deductible only applies to durable medical equipment, orthotics/prosthetics, outpatient surgeries, and inpatient hospitalization. Office visits, labs, x-rays, and prescription drugs do not have a deductible!

To Find Network Providers

Go to **floridablue.com** and click on *Find a Doctor and More* as shown in the box to the right. Then select the Blue Options Plan network.

You can also call **800-664-5295.**



For health screenings and blood work, be sure the lab is in-network. Quest Diagnostics is the preferred lab in Florida. If you are receiving lab services in any other state, please check the provider directory at **floridablue.com** for labs that are in your plan's network.

Medical Plan Terms to Know

Balance Billing: A charge billed by an out-of-network provider that is above the reasonable and customary cost of a particular healthcare service.

Coinsurance: Your share of the cost of a covered healthcare service, calculated as a percentage. For example, you generally pay 20% and the plan pays 80%, after meeting a deductible.

Copayment (Copay): A fixed amount charged for some healthcare services, after which the plan pays the remaining costs.

Deductible: The out-of-pocket amount you pay for covered services, after which the plan pays or you and the plan share costs through coinsurance.

Employee Contribution Rate (Premium): The amount deducted from paychecks after enrolling in a plan.

Flexible Spending Accounts (FSA): Option to set aside before-tax or after-tax earnings up to an annual limit to pay for certain qualified expenses during a specific time period (usually a calendar year). There are two types of FSAs: the Healthcare FSA and the Dependent Care FSA.

In-Network Providers: Service providers who have contracted with an insurance company to provide services at discounted charges.

Inpatient Services: Provided to an individual during an overnight hospital stay.

Out-of-Network Providers: Service providers who are not members of an insurance company's network, meaning they do not charge the network-discounted prices.

Out-of-Pocket Maximum: A financial safety net that applies when eligible health plan expenses during the plan year reach a maximum dollar amount. Once the maximum is met, the plan pays any remaining eligible expenses for the rest of the calendar year at 100%, unless otherwise noted. Does not include premiums, charges above a defined Reasonable and Customary amount, or healthcare services the plan doesn't cover. There are separate maximums for in-network and out-of-network expenses.

Outpatient Services: Provided to individuals at a medical facility without an overnight hospital stay.

Premiums: See Employee Contribution Rate.

Primary Care Physician (PCP): A doctor who you would regularly see for your ongoing healthcare (e.g., a family doctor).

Reasonable and Customary: Refers to the normal, acceptable, or average amount charged for a healthcare service, treatment, or supplies for an appropriate level of care in the geographical location where the treatment, services, or supplies are provided.

Specialist Physician: A doctor specializing in a particular branch of medicine (e.g. , surgeon).

Prescription Drug Benefits

When you enroll in a MAPEI Blue Options medical plan, prescription drug benefits through Express Scripts and RxBenefits are included. Your share of the cost for medications depends on:

- The drug classification and
- Whether filled at a retail pharmacy, for a 30-day supply, or through the mail-order pharmacy or Smart90 program (Walgreens), for a 90-day supply.

RxBenefits
800-334-8134
7am to 8pm CT
Email:
CustomerCare@rxbenefits.com

Prescription Drug Classifications

Prescription medications have four classification tiers for pricing:

1. Generic
2. Preferred Brand-Name
3. Non-Preferred Brand-Name
4. Specialty

Saving Money
Ask your doctor or pharmacists to check if a generic is available for any brand-name drugs you are prescribed.

Retail Pharmacies

When your doctor prescribes medications in up to a 30-day supply, save money by filling your prescription at an Express Scripts in-network pharmacy. To find a network pharmacy near you, go to express-scripts.com and register, then click on *Find a Pharmacy*, or call **800-334-8134.**

Home Delivery and the Smart90 Program

You pay less when filling ongoing maintenance medications, such as for diabetes or high blood pressure, in 90-day supplies through the home-delivery pharmacy or Smart90 Program.

Home Delivery Pharmacy

As shown in the table below, one 90-day prescription for a maintenance medication prescription filled at the home-delivery pharmacy costs less than three 30-day fills at a retail pharmacy.

For example, in Plan 3748, a *preferred brand-name drug* would cost $120 if filled in *three* 30-day supplies at a retail pharmacy. The cost is $60 if filled in *one* 90-day supply through the home-delivery pharmacy.

3 Ways to Get Started with Home Delivery

1. **Online**: Login or Register.
2. **Mobile**: Choose home delivery using the Express Scripts mobile app.
3. **Ask Your doctor**: Ask your doctor to prescribe a 3-month supply for Home Delivery or Smart90.

That's a savings of $240 a year.

The Smart90 Program through Walgreens

Instead of home delivery, you can choose to fill your 90-day maintenance medications at a Walgreens pharmacy by calling RxBenefits.

Refrigerated Drugs
Home delivery will ensure that medications requiring refrigeration will be transported refrigerated.

Prescription Drug Benefits
In-Network Copays

Classification	Plan 3769		Plan 3748	
	Retail Pharmacy	Home Delivery Pharmacy	Retail Pharmacy	Home Delivery Pharmacy
Generic	$10	$20	$5	$10
Preferred Brand Name	$40	$80	$30	$60
Non-Preferred Brand Name	$60	$120	$50	$100
Specialty	$100	Not covered	$100	Not covered

How to Manage Your Prescriptions

Register at **express-scripts.com** to:

- Find in-network pharmacies.
- Manage your prescriptions.
- Price and compare medications.
- Connect with prescription specialists for help with chronic health conditions.
- Find information on your prescriptions.
- Set up home-delivery and automatic refills.
- View your claims and prescription history.
- Manage your account settings and payment methods.

Need Help? Call an Rx Plan Specialist

Discuss your prescriptions with a plan specialist at **800-334-8134**, Mon-Fri, 7am-pm CT for:

- Plan benefits.
- If the plan covers a drug.
- How to start home delivery.
- How to get Prior Authorization.
- Answers to benefit questions.
- Status on claims.
- Finding network pharmacies.
- Help with specialty medications.
- Pharmacy information.

Prescription Drug Terms to Know

Brand-Name Drugs: A patented drug sold by a manufacturer and known by its trademark name. A manufacturer of a brand-name drug can make that drug without any competition. Example: “Advil.”

Formulary (Drug List): Lists brand-name and generic prescription drugs covered by the plan, showing its pricing tier for how much it costs. A copy of the formulary is available on the Express Scripts website at express-scripts.com.

Generic Drugs: Generic drugs have the same intended use, dosage, effects, risks, safety, and strength as their brand-name counterparts.

Home-Delivery Pharmacy: Pharmacies that fill ongoing medications in 90-day supplies generally at a discount compared to filling the same prescription in three 30-day fillings at an in-network retail pharmacy.

Prior Authorization: Indicates that approval from the insurance company is needed before your doctor can prescribe certain medications.

Specialty Drugs: Are high-cost prescription medications used to treat complex, chronic conditions such as cancer, rheumatoid arthritis, and multiple sclerosis.

Step Therapy: Requires you to try one or more similar, lower-cost drugs to treat your condition before the plan will pay for the prescribed drug.

Telemedicine through ReviveHealth

After your medical plan begins, register with ReviveHealth (formerly SwiftMD) for 24/7 access to board-certified doctors by phone or videoconference. Get diagnoses and prescriptions to treat non-emergency health situations. No copays or cost to you. MAPEI pays for the membership for you and dependents enrolled in a MAPEI medical plan.

ReviveHealth
833-794-3863
Group Code: MAPEI19
SwiftMD.com

Here are some of the health issues to discuss with a Revive Health doctor from home, office, or on the road:

- Allergies
- Arthritis pain
- Back pain/injury
- Cold sores
- Congestion
- Fever
- Flu
- Headache
- Insect bites/stings
- Conjunctivitis or pink eye
- Diarrhea
- Earache
- Lyme disease
- Nasal congestion
- Rashes
- Respiratory congestion
- Sinusitis

Connect with ReviveHealth 24/ 7

- Call toll free at **833-794-3863** and enter group passcode **MAPEI19**.
- Set up an appointment.
- Receive a call back within 30 minutes after scheduling your appointment.

Survey Shows High Satisfaction among MAPEI Employees

- 96% satisfied with the consult received from a ReviveHealth doctor.
- 99% would use again.

For more information go to SwiftMD.com**.** To download the app, scan the codes below with your phone's camera or from your app store.

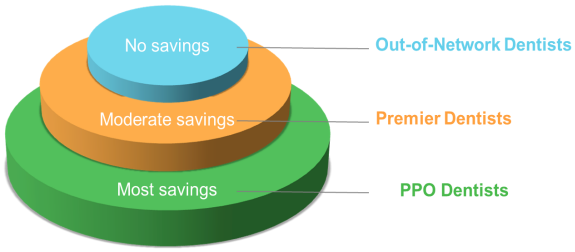
Dental Benefits

Delta Dental
800-521-2651
deltadentalins.com

You can enroll in either the **High Plan** or the **Low Plan** through Delta Dental. Use any licensed dental provider. However, Delta Dental dentists charge discounted rates through two provider networks:

- **Providers in the PPO network** offer the biggest savings.
- **Providers in the Premier network** are the next best option as they offer moderate discounts. However, in the Low Plan, you pay the co-insurance plus any difference between the PPO network providers' contracted fee and the Premier providers' contracted fee.

Non-Network Providers are not contracted with Delta Dental and bill without any discounts. This means they accept the amount Delta Dental pays as full payment and you pay the non-network co-insurance percentage plus the difference between what the PPO network dentist would have charged for the same procedure and what the non-network dentist bills (referred to as "balance billing").



Examples

Here are examples of how dental charges apply for both the Low Plan and the High Plan. They are for illustration only and do not apply any maximums or deductibles.

Example 1: Low Plan Claim For Crown (Major Service)	Most savings	Some savings	No savings
	Delta Dental PPO	Delta Dental Premier	Non-Network
Dentist submits claim	$1,400	$1,400	$1,400
Dentists accepts as full payment	$745	$1,009 ($745*)	$1,400 ($745*)
Plan pays	Plan pays 50% of $745 = $372.50	Plan pays 50% of $745 = $372.50	Plan pays 50% of $745 = $372.50
You Pay	**You pay $372.50** ($745 - $372.50 =)	**You pay $636.50** ($1,009 - $372.50 =)	**You pay $1,027.50** ($1,400 - $372.50 =)

Example 2: High Plan Claim For Crown (Major Service)	Most savings	Some savings	No savings
	Delta Dental PPO	Delta Dental Premier	Non-Network
Dentist submits claim	$1,400	$1,400	$1,400
Dentist accepts as full payment	$745	$1,009	$885
Percentage paid by plan	Plan pays 50% of $745 = $372.50	Plan pays 50% of $1,009 = $504.50	Plan pays 50% of $885 = $442.50
You pay	**$372.50** ($745 - $372.50 =)	**$504.50** ($1,009 - $504.50 =)	**$957.50** ($1,400 - $442.50 =)

*Premier network providers are reimbursed based on the PPO network contracted fee.

Dental Benefit Terms to Know

Deductible: Applies to Basic and Major Services for the calendar year. Does not apply to Preventive Care or Orthodontia expenses.
Annual Benefit Maximum: The plan's dollar limit per person for covering eligible dental expenses.
Preventive and Diagnostic Services: The plans cover exams and cleanings, including bitewing x-rays two times a calendar year.
Basic Services: Such as fillings, simple extractions, denture repair/reline/rebase, root canal (endodontics)
Major Services: Such as dentures, bridges, crowns, inlays, implants, onlays, and cast restorations.

Finding Network Providers

To find network dentists, go to **deltadentalins.com** and click on **Find a Dentist**. Enter your address and ZIP code and select either network from the drop-down menu.

Comparing Dental Plan Options

You and the plan share dental expenses up to each plan's maximum benefit for the year (in- and out-of-network charges combined). After that, you pay the full discounted network cost for dental expenses for the rest of the calendar year.

The **High Plan** offers better benefits but costs more per paycheck. The **Low Plan** is an option to consider if you do not need a lot of dental work. Compare the benefits in each plan in the table.

Dental Benefits at a Glance (Plan #22443)
What You Pay (except where noted otherwise)

Plan Features	High Plan			Low Plan		
	PPO Network	**Premier Network**	**Non-Network**	**PPO Network**	**Premier Network**	**Non-Network**
Deductible Individual/Family	You pay $50/$150	You pay $50/$150	You pay $50/$150	You pay $50/$150	You pay $50/$150	You pay $100/$300
Annual Benefit Maximum	Plan pays up to $2,250 per person	Plan pays up to $2,250 per person	Plan pays up to $2,250 per person	Plan pays up to $1,000 per person	Plan pays up to $1,000 per person	Plan pays up to $1,000 per person
Preventive and Diagnostic	You pay 0%	You pay 0%	You pay 0%	You pay 0%	You pay 0%*	You pay 20%*
Basic Services	You pay 20%	You pay 20%	You pay 20%	You pay 20%	You pay 20%	You pay 50%
Major Services	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 50%	You pay 60%
Orthodontia	Adults and children Plan pays 50% up to $1,500 lifetime maximum			Children only up to age 19 Plan pays 50% up to $1,000 lifetime maximum		

*In the Low Plan, Delta Dental only pays Premier dentists up to a contracted amount regardless of what they bill you. This means you would be responsible for any amount billed by the Premier dentist above the

What Else to Know

- **Expanded Coverage for Expecting Mothers:** Offers one additional exam and one cleaning or scaling and root planing during the plan year because pregnant women are at a higher risk for tooth decay and gum disease. Let your dentist know if you are pregnant for these extra benefits.
- **Teledentistry:** Connect online with a Delta Dental dentist through videoconference or receive a photo assessment for a dental issue.
- **Cost Estimator Tool:** Avoid surprises. Log in to **deltadentalins.com** and set up an online account to use the Cost Estimator Tool for personalized estimates on how much you'll pay for your next dentist visit. You can also ask your dentist for a pre-determination of benefits from Delta Dental before your treatment begins to learn how much the plan will cover.
- **Hearing Benefits:** As a Delta Dental participant, you have special pricing on hearing aides through Amplifon. Savings average 66% off retail hearing aid prices plus a year of follow-up. To learn more, go to **amplifonusa.com/deltadentalins** or call **888-779-1329**.
- **LASIK Benefits:** Get discounts averaging 35% on LASIK eye surgery through QualSight. Visit **qualsight.com/-delta-dental** or call **855-248-2020** for more information.

Vision Benefits

Everyone needs to take care of their eyes as good vision is important to your health. If you enroll in the EyeMed Vision Plan, benefits are available for eye exams, lenses, frames, contacts, and more.

EyeMed
866-939-3633
eyemed.com

Saving Money with Eye360 and PLUS Providers

You can use any vision care professional you choose. However, as shown in the table below, you pay less when using providers who are members of the EyeMed network, with additional savings available when using PLUS Providers, as found at **eyemed.com**.

PLUS Provider

See the EyeMed vision care services summary for additional benefits and details on coverage.

Vision Care Benefits at a Glance
All services in the table are available once during the calendar year.

Plan Features	In-Network	Out-of-Network
Eye Care Exam	**PLUS Providers:** Plan pays 100%. **Other Providers:** Plan pays 100% after $10 copay. **Retinal Imaging:** You pay up to $39.	**Plan reimburses** up to $40. **Retinal Imaging** is not covered.
Frames $0 copay	**PLUS Providers:** Plan pays up to a $180 allowance plus 20% off the balance over the allowance. **Other Providers:** Plan pays up to $130 allowance; plus 20% off the balance over the allowance.	**Plan reimburses** up to $65.
Standard Plastic Lenses	**Plan pays:** • 100% after your $25 copay for single vision, bifocal, trifocal, lenticular, and standard progressive lenses • $55-$200 for premium progressive lenses	**Plan reimburses**: • Up to $30, single vision • Up to $50, bifocal • Up to $70, trifocal/lenticular • Up to $50, all progressives
Lens Options	**You pay copays as follows:** • $45 for standard anti-reflective coating • $57-$85 for premium anti-reflective coating • $75 for photochromatic (non-glass) • $40 for standard polycarbonate • $0 for standard polycarbonate (up to age 19) • $15 for scratch coating and tints • $0 for UV treatment • 20% off retail for all others	**Plan reimburses** up to: • Up to $23 • Up to $23 • Not covered • Not covered • Up to $20 • Not covered • Up to $8 • Not covered
Conventional Contacts	$0 copay; 15% off balance over $150 allowance.	**Plan reimburses** up to $75 for conventional and disposable contacts and up to $300 for Medically Necessary contacts.
Disposable Contacts	$0 copay; Plan pays $150 allowance, you pay balance over the allowance.	
Medically Necessary Contacts	$0 copay; Plan pays 100%.	
Contact Lens Exams and Fitting	**Standard:** Plan pays up to $40; contact lens fit and two follow-up visits. **Premium:** 10% off retail price	Not covered

Welcome Packet

If you are enrolling in the vision plan for the first time, you will receive a welcome packet with two ID cards, a benefit summary, and recommendations for eight providers near your home. Register on the EyeMed website or download the mobile app to access or print ID cards at any time or download the ID card to your phone.

Sample EyeMed ID card.

Use this link, **https://member.eyemedvisioncare.com/member/en**, or scan the QR code to register on the EyeMed website. Download the app and take advantage of the many services and discounts available to you and your covered family members.

What's on the EyeMed Mobile App?

In the app, you can check your benefits and eligibility, track claims, find special offers, locate network providers, including PLUS Providers, get answers to FAQs, and access interactive vision guides. You can download it from the Apple Store or Google Play.

Does EyeMed Offer Additional Discounts?

Extra savings are available at participating in-network providers, including 40% off an additional pair of eyeglasses and 20% off non-prescription sunglasses and accessories. Log in to **eyeglass.com** for details.

For discounts on LASIK laser vision correction, call **800-988-4221** to find a US Laser Network provider.

Regular Eye Exams Matter

Regular eye exams can help detect early signs of serious health conditions, such as:

- Diabetes
- High blood pressure
- Some cancers, and more

Early Eye Exams for Children

An early exam is important as one in four children have vision problems. Discuss with your eye doctor.

Legal Notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial

1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840, TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 or 603-271-5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 or 1-866-608-9422
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 Email: HIPPcustomerservice@dmas.virginia.gov
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269, (307) 777-7656, or (866) 571-0944

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

Important Notice to Employees from MAPEI Corporation about Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the MAPEI Corporation medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2025. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2025 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with MAPEI Corporation and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by the MAPEI Corporation prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the MAPEI Corporation plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop MAPEI Corporation coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the MAPEI Corporation plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with MAPEI Corporation and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this MAPEI Corporation coverage changes, or upon your request.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Credible Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have a maintained credible coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

For more information about this notice or your prescription drug coverage, contact:
MAPEI Benefits Team
MAPEI Corporation
1144 East Newport Center Drive, Deerfield Beach, FL 33442
(954) 246-8888
January 1, 2025

Notice of Special Enrollment Rights for Health Plan Coverage

As you know, if you have declined enrollment in MAPEI Corporation's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that

you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

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

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the MAPEI Corporation group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (954) 246-8888.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (954) 246-8888.

Marketplace/Exchange Notice

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than **9.02% for 2025** of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed **9.02% for 2025** of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact (954) 246-8888.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: MAPEI Corporation	4. Employer Identification Number (EIN): 36-3369327	
5. Employer address: 1144 E. Newport Center Drive	6. Employer phone number: (954) 246-888	
7. City Deerfield Beach	8. State: FL	9. Zip code: 33442
10. Who can we contact about employee health coverage at this job? Benefits Team		
11. Phone number (if different from above)	12. Email address: benefits@mapei.com	

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to:** All benefits eligible employees.
- Eligible employees are: Employees who regularly work 30 or more hours each week.
- **With respect to dependents:** Documents must show employee/dependent relation and date of document. A list of required documents will be provided.
- **Eligible dependents are:** Legal spouses, natural, adopted, step-children, children under legal guardianship and any child who is named in a Qualified Medical Support Order (QMCSO) as defined under federal law up to age 26, or older primarily supported by employee and incapable of self-sustaining employment by reason of mental or physical handicap.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Michelle's Law Notice – Extended Dependent Medical Coverage During Student Medical Leaves

The MAPEI Corporation plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school – or change in school enrollment status (for example, switching from full-time to part-time status) – starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, as soon as the need for the leave is recognized to MAPEI Corporation. In addition, contact *your child's health plan* to see if any state laws requiring extended coverage may apply to his or her benefits.

MAPEI Corporation HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by MAPEI Corporation health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: *Medical, Dental, and Vision*. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's Duties with Respect to Health Information about You

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not MAPEI Corporation as an employer — that's the way the HIPAA rules work. Different policies may apply to other MAPEI Corporation programs or to data unrelated to the Plan.

How the Plan May Use or Disclose Your Health Information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan May Share Your Health Information with MAPEI Corporation

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to MAPEI Corporation for plan administration purposes. MAPEI Corporation may need your health information to administer benefits under the Plan. MAPEI Corporation agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources, Benefits, Compliance, Payroll, and/or Finance are the only MAPEI Corporation employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and MAPEI Corporation, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to MAPEI Corporation, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to MAPEI Corporation information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that MAPEI Corporation cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by MAPEI Corporation from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other Allowable Uses or Disclosures of Your Health Information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

COBRA Continuation Coverage General Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Benefits Team via email at benefits@mapei.com; MAPEI Corporation, 1144 East Newport Center Drive, Deerfield Beach, FL 33442.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Benefits Team via email at benefits@mapei.com; MAPEI Corporation, 1144 East Newport Center Drive, Deerfield Beach, FL 33442.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage after My Group Health Plan Coverage Ends?

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

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

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

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Benefits Team via email at benefits@mapei.com; MAPEI Corporation, 1144 East Newport Center Drive, Deerfield Beach, FL 33442.

Summary of Material Modifications [or Summary of Material Reductions]

This enrollment guide constitutes a [Summary of Material Modifications (SMM)] OR [Summary of Material Reductions (SMR)] to the [insert full name and year of SPD] Summary Plan Description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.