This frequently asked questions document provides highlights of DSM's benefit program for U.S. non-bargained employees and Engineering Plastics Bargaining Unit employees. Plan administration and benefits are governed by official plan documents. In the event of a conflict between this document and the plan document, the plan document will govern. DSM reserves the right to terminate or amend any and all benefit programs.

Enrollment and Eligibility

1. **If I like the benefits I have today, do I need to do anything during annual enrollment, or will my benefits just continue as they are into next year?**

   Annual enrollment is your once a year opportunity to review your benefit choices and make sure that they continue to meet your family's needs. It is a good idea to take a fresh look at your medical plan choices and consider which plan meets your needs best.

   The enrollment period to select your **2023 benefits** is **Wednesday, October 26 through Wednesday, November 9, 2022**. If you already participate in the benefits program and do not change your current elections by the annual enrollment deadline, your 2022 elections will carry over to the 2023 plan year **except** for contributions made to flexible spending accounts (FSAs) and Health Savings Account (HSA). *If you wish to participate in an FSA or an HSA during the 2023 plan year, you must actively enroll during annual enrollment.*

   However, all employees enrolled in a DSM Medical Plan have annual enrollment required actions as follows:

   You are required to annually certify, if you cover your spouse/domestic partner (DP) in a DSM medical option, if your spouse/DP has access to coverage elsewhere. If you do not certify, DSM will assume that your spouse/DP is eligible for their employer's medical plan and you will be charged an additional $1,200 per year for medical coverage. Note: If you complete these actions and your spouse/DP has access to coverage elsewhere and you still cover him/her, you will be subject to the surcharge.

   You are required to annually certify whether you and/or your spouse/DP are a tobacco user. If you do not certify, DSM will assume you and your covered spouse/DP are tobacco users, and you will be charged a $300 surcharge for you and $300 more for your covered spouse/DP. Note: If you complete these actions and you and/or your spouse/DP are tobacco users, you will be subject to these surcharges as applicable.

2. **Since my spouse does not have medical coverage through his employer, am I automatically exempt from the spousal surcharge?**

   No. During annual enrollment, you must go online to the DSM Benefits Enrollment Website and indicate whether your spouse/domestic partner (DP) has access to other employer-based medical coverage. If you do not confirm (or if your spouse/DP has coverage through his/her employer), a $1,200 spousal surcharge will apply, and you will pay more for medical coverage. For more information, go to **www.myDSMbenefits.com** and click on the link for spousal surcharge.

3. **How do I enroll, change my benefits and complete my required actions?**

   You have three easy ways to enroll — online, via the smartphone app or by phone.

   - **DSM Enrollment Website**
     Enroll online at your convenience, any time of day or night.

   - **Download the smartphone app**
     Enroll for benefits on the go! Download the app called "ADP Mobile Solutions" and follow the log-in process using the same log-in details as the website. Note you must have already registered for the site and have your log-in credentials before you can use this app.

   - **DSM Benefits Call Center: 1-866-353-9740**
     Representatives are available to assist with questions or enrollment via phone on Monday - Friday from 9 a.m. to 7 p.m. and Saturday 8 a.m. to 5 p.m. ET. You can also email questions to **dsmbenefitscenter@adp.com**. Please allow 24-48 hours for a full email response. *NOTE: The email address is only for questions. Submissions of enrollment elections will be rejected.*

4. **What should I do if I forget my user ID and/or password to the DSM Benefits Website?**
   If you have not accessed the enrollment website in the last 6 months, a password reset will be required for security purposes.

   If you do not have your user ID, you can retrieve by going online to **DSM Enrollment Website** and clicking on "Forgot Your User ID/ Password." You will need to enter your date of birth and your DSM email address. If you do not have your own DSM email address, you can get your user ID by calling the DSM Benefits Center at 1-866-353-9740 between Monday - Friday from 9 a.m. to 7 p.m. and Saturay 8 a.m. to 5 p.m. ET.
5. **Will I receive Annual Enrollment information from DSM about current benefit options and changes?**
   We are continuing our commitment to "go green," which aligns with our company's core value of sustainability and our commitment that everything we do contributes to a more sustainable world. You can view your benefit options on our benefits website: **www.myDSMbenefits.com** and when you enroll for coverage via the **DSM Benefits Enrollment Website**, you will be able to view the premium costs for each plan and coverage level.

6. **What do I need to know about the tobacco surcharge?**
   During annual enrollment, you will be asked to certify whether you and/or your enrolled spouse/domestic partner has been a tobacco user in the past 6 months. If you are a tobacco user, then a $300 annual surcharge will be withheld from your paycheck with your other benefits deductions. If your spouse/domestic partner is also a tobacco user, then an additional $300 surcharge will be applied.

7. **What if I am not a tobacco user, do I still need to act?**
   All those who enroll into the DSM medical plan are required to certify their tobacco use during annual enrollment. If no action is taken, DSM will assume you (and your enrolled spouse/domestic partner are a tobacco user and the surcharge will apply).

8. **Why is DSM focusing on Tobacco use?**
   DSM cares about your health and the health of your family. We hope that this brings additional attention to the issue. Smoking harms nearly every organ of the body, causing many diseases and affecting the general health of smokers. DSM encourages you and your family to secure a better future by taking advantage of these resources to help you quit the tobacco habit and stop smoking:
   - Horizon Tobacco Cessation Program
   - Virgin Pulse Coaching Program
   - Express Scripts offers free tobacco cessation medications

9. **What resources are available to help me make the best decision for my 2023 benefits?**
   You can go to www.**myDSMbenefits.com** to:
   - Read about your benefit options, paying special attention to the changes coming next year and what to do to enroll.
   - If you are a smoker, learn about the Tobacco surcharge and smoking cessations resources DSM provides to help you quit.
   - Estimate how much you should contribute to a Flexible Spending Account (FSA) or Health Savings Account (HSA) and see your potential tax-savings with tools available through WageWorks and Health Equity
   - Watch a short video about the Health Savings Account, if you are considering enrolling in the Consumer Directed Health Plan (CDHP), to learn how the HSA can help you budget and save for eligible medical and prescription drug costs
   - Review Frequently Asked Questions (FAQ)

If you have questions about your benefits or the enrollment process, call the DSM Benefits Center at 1-866-353-9740, Monday - Friday from 9 a.m. to 7 p.m. and Saturday 8 a.m. to 5 p.m. ET. You can also email questions to DSM Benefits at dsmbenefitscenter@adp.com. Please allow 24-48 hours for a full email response.

10. When can I change my benefits during the year?

Certain life events that happen during the plan year may allow you to make changes to some of your benefit elections. Examples of life events include:

- Marriage
- Commencement or termination of a domestic partner relationship*
- Divorce, annulment or legal separation
- Birth, adoption or placement for adoption of an eligible dependent
- Change in legal guardianship of a dependent
- Involuntary loss of other medical coverage
- Death of your spouse/DP or eligible dependent
- Change in dependent eligibility (for example, child reaches age limit)
- Change in your work status that affects your eligibility for benefits
- Change in work status of your spouse/DP that affects his or her eligibility for benefits
- Change in coverage election made by your spouse/DP during his/her employer's annual enrollment period where the coverage period is different from yours
- Receipt of a Qualified Medical Child Support Order
- Significant cost or coverage change in a health plan covering you or an eligible dependent*
- Significant change in dependent care costs or dependent care provider (for changes to the Dependent Care FSA) *
- Enrollment in or loss of Medicare or Medicaid coverage
- Any other change permitted by Internal Revenue Code 125 regulations

** Changes to the Health Care FSA or Limited FSA cannot be made mid-year for these events.*

Any benefit changes you make must be consistent with the qualifying life event. For example, if you give birth to a child, you can add the child to your medical plan – but you cannot drop coverage for your spouse. **You must notify DSM within 30 days of the event** by making the change online via the **DSM Benefits Enrollment Website** or by calling the DSM Benefits Center at 1-866-353-9740. If you do not make benefits changes online or contact the DSM Benefits Center within 30 days of the life event, you will not be able to change your benefits until the next annual enrollment period.

11. Are newborns automatically enrolled in benefits?

Newborns will not automatically be enrolled in benefits. You will need to enroll and submit proof of eligibility (such as a birth certificate) within 30 days of the date of birth, to enroll a newborn for coverage.

12. If my spouse's access to coverage changes during the year and the spousal surcharge no longer applies, or applies for the first time, can the spousal surcharge be changed?

Yes, you may go online to the **DSM Benefits Enrollment Website** and process the change. You must certify whether your spouse has other medical coverage through his/her employer. The spousal surcharge will then be added or cancelled on a go-forward basis, based on your response.

13. Will I receive new ID cards?

When you newly enroll in benefits, you will receive a new ID card from Blue Cross Blue Shield for Medical coverage, Express Scripts for prescription drug coverage and from Delta Dental for dental coverage. Delta Dental will also provide a new ID card if you change your dental election. Vision coverage does not require ID cards. WageWorks will send you a card only if you are newly enrolling in a Flexible Spending Account (FSA) or Health Savings Account (HSA) or if your Wageworks card has expired. If you currently have an FSA card, any HSA or Limited FSA contributions will be added to this card. Your existing card will be automatically loaded with your 2023 election effective January 1, 2023.

14. Do I need to provide supporting documentation for my dependents?

If enrolling a dependent in health coverage for the first time, you will be required to provide appropriate verification documentation, such as a birth certificate or marriage license, to confirm the dependent's eligibility for benefits coverage.

You also need to provide Evidence of Insurability (EOI) for certain optional life insurance coverage elections or to purchase "buy-up" long-term disability if newly enrolling. This can be done online once you complete the enrollment process, via the EOI "Needs Attention" message and link. This link will

connect you with the Prudential site to fill out the form online. You can also submit a paper form to Prudential and the form is located on the enrollment site in the Forms/ Documents section.

15. **What if my domestic partner (DP) is not subject to imputed income on medical and dental coverage?**
    Tax law requires that you be taxed on the full value of coverage for a domestic partner and his or her children, if applicable, minus the amount you pay for this coverage on an after-tax basis. Since tax requirements are complex, you should consult a tax professional for advice on your personal situation. If your domestic partner is not subject to imputed income, you must submit a completed tax status form to DSM by December 1, 2022 for the 2023 tax year. The form is located on the DSM Benefits Website under Resources. If you have questions, contact the DSM Benefits Center at 1-866-353-9740.

16. **How long do I have to earn the Wellness Incentive?**
    Incentives are earned from January 1 – December 31 and applied in the following plan year. You can log on to the Virgin Pulse website at **www.BrighterLiving.DSM.com** (or log in to the Virgin Pulse app) to view how much you have earned in rewards and discounts towards your 2023 benefit costs.

17. **Will the wellness incentive be reflected in my 2023 Benefits Summary during the annual enrollment period?**
    The incentive earned through September 30 will be viewable on the enrollment website during the annual enrollment process as a reduction to your premium, if you enroll in the PPO Plan. If you are a Consumer Directed Health Plan (CDHP) participant in 2023, your earned incentive will be deposited to your HSA in January.

    The benefits enrollment site will be updated in January to reflect your fully earned incentive and 2023 medical premiums, mirroring your paycheck. Remember you can continue to earn through the end of the year for additional discounts.

18. **Will the wellness incentive be reflected in my 2023 payroll?**
    The earned wellness incentive for you and your covered spouse will be viewable on your pay stub as a separate amount. Incentives earned before December 13 will be viewable on your first 2023 payroll. Incentives completed between December 14 and December 31 may be delayed until the second 2023 payroll. In January, the benefits enrollment site will be updated to reflect your fully earned incentive and 2023 medical premiums, mirroring your paycheck.

Medical and Prescription Drug Coverage

19. **What carrier administers DSM medical plan options (High Option PPO, Low Option PPO and Consumer Directed Health Plan)?**
    All medical plans are part of the national BlueCard PPO network and administered by Blue Cross Blue Shield.

20. **How can I find a doctor or hospital facility in the BlueCard PPO network?**
    The Blue Cross Blue Shield network has more than 900,000 physicians and health care professionals and 5,900 network hospitals nationwide. To find out if your doctor is in the BlueCard PPO network, visit horizonblue.com/DSM or call 1-800-810-2583.

21. **What happens if I go to an out-of-network provider?**
    With all medical options, you have flexibility to use any provider you choose for eligible services, but the level of benefits will be reduced, and you will likely pay more out of your pocket. You will also need to file your own claims when you use out-of-network providers

22. **What type of preventive care services are covered by the medical plans?**
    DSM Medical plans provide coverage for in-network preventive care at 100%. Most covered preventive services depend on your age and gender. For a list of preventive services, go to the Resources section on **www.myDSMbenefits.com.**

23. What are some key things to consider if I am thinking about choosing the Consumer Directed Health Plan (CDHP)?

- The Consumer Directed Health Plan is designed to encourage you to take a more active role in your health and includes a Health Savings Account (HSA). Tax-free dollars can be contributed to the HSA to pay for qualified medical and prescription drug expenses, including deductible and coinsurance amounts. Some of the dollars come from DSM (such as earned wellness incentives and employer contribution); additional dollars come from you. See www.myDSMbenefits.com for full information on the company contribution.
- You pay the lowest employee contributions (per paycheck costs) for coverage in the CDHP.
- You must meet the deductible for all prescription drug and non-preventive medical care before the plan pays a share of the cost. There are no copayments for services.
- Your deductible depends on who you cover: employee only, employee plus one dependent or employee plus two or more dependents.
- Once you meet the annual out-of-pocket maximum (combined for medical and prescription drugs), all covered in-network expenses are paid at 100% for the rest of the calendar year. An individual enrolled in Employee + 1 or Family coverage has a "per person" out-of-pocket maximum, which allows the individual to reach the out-of-pocket maximum sooner. For in-network care, the out-of-pocket maximum is $6,850 per person.

Use the Medical Coverage Decision Support Tool to help you compare medical options and choose the plan that is right for you. Go to **www.myDSMbenefits.com** to access the tool.

24. How do the deductible and out-of-pocket maximum work under the Consumer Directed Health Plan (CDHP)?

For the CDHP, your deductible for non-preventive care is based on the coverage tier that is elected and there is no "per individual" deductible. This means the CDHP will start paying expenses for an individual family member once the full deductible has been met. The deductible depends on who you cover:

- For employee only coverage, you meet the individual deductible ($1,500 in-network)
- If you also enroll your spouse/domestic partner or one child, you have a $3,000 in-network deductible before the plan pays
- If you enroll in family coverage (Employee + 2 or more dependents), you meet the full family deductible ($4,500 in-network)

25. What kind of services count toward the out-of-pocket maximum?

It depends on the plan you choose:

- If you enroll in the Consumer Directed Health Plan (CDHP), your out-of-pocket maximum includes all covered medical and prescription drug deductible expenses. Certain preventive medical services are covered at 100% with no deductible.
- With the High Option PPO and Low Option PPO, copays for in-network medical care as well as the deductible and coinsurance count toward the out-of-pocket maximum.
- All out-of-pocket covered prescription drug expenses count toward the separate prescription drug out-of-pocket maximum.

26. What should I do if I need medical care while traveling abroad?

The DSM Medical Plan extends coverage through Blue Cross Blue Shield Global Core, which provides global access to medical assistance services, doctors and hospitals. In most cases, you will be required to pay the provider up front and then submit your eligible claim to Blue Cross Blue Shield Global Core for reimbursement.

You can locate participating physicians and other health care professionals by visiting the Horizon website at **www.HorizonBlue.com/DSM**. To contact BCBS Global Core Service Center, call toll-free 1-800- 810-2583 or call collect 1-804-673-1177.

27. I may need an MRI or CT scan and understand they can be expensive. How can I get help finding a quality provider at a competitive price?

The cost for an MRI can range anywhere from $300 to $3,000, depending on the provider you use.

If you are enrolled in a DSM medical plan and need a diagnostic imaging service, such as an MRI or CAT scan, you can use the Horizon online Provider Directory to quickly and easily look up health care professionals to see if they participate in the BlueCard PPO network. Simply visit the Horizon website at **www.HorizonBlue.com/DSM,** or you call the customer service telephone number on the back of your ID card.

Once you and your doctor select an imaging facility, you may receive a phone call from AIM Specialty Health, a Horizon partner, regarding alternative imaging facilities that may provide a savings of $300 or more. You will only receive a phone call if you meet the following criteria:

- Exam is for MRI/CT
- There is a $300 cost differential
- Member is over 18 years of age
- Exam is for a non-cancerous diagnosis
- Search is within 60 miles of your residence

If you decide to go to the suggested provider, AIM will help you schedule your appointment with the new provider. There is no additional cost to you for this service.

28. I may need testing and treatment for a sleep disorder. Will I have to undergo testing in a lab?

Depending on your medical condition, you may undergo testing in a lab or in the convenience of your home. If you are in a DSM medical plan, your doctor should contact AIM Specialty Health's sleep management program to coordinate your care and treatment. During your treatment, AIM will review your care with your doctor or durable medical equipment provider quarterly during the first year and annually thereafter to ensure that you are receiving appropriate care and services.

29. Are injections for pain covered by the DSM Medical Plan?

Horizon Blue Cross Blue Shield does not cover spinal pain injections unless you are actively participating in ongoing conservative treatment with physical therapy, chiropractic care and/or a structured home exercise program. You should always try conservative treatment with physical therapy or chiropractic care before undergoing pain injections or surgery, which are more invasive treatments with potentially severe side effects. In general pain injections only relieve pain, whereas physical therapy or even chiropractic care can correct the mechanical conditions which underlie the pain. In a few situations, where there is evidence of nerve impingement (you are numb or weak in the leg) you should see a surgeon right away. Even if you have surgery or pain injections, physical therapy helps to improve and maintain the effect.

30. I need medical advice and can't get in to see my doctor for a few days. Can I use the Telehealth program (Horizon Care Online)?

If you are enrolled in a DSM medical plan, you can contact a Telehealth doctor for help with a non-emergency medical problem. You can access doctors by telephone or computer conferencing 24 hours a day, 7 days a week. The telehealth doctors are U.S. board-certified and can diagnose and treat many medical issues, including cold and flu symptoms, migraines, allergies, pink eye, and stomach pains. Telehealth Doctors can now treat Behavioral Health conditions. Telehealth doctors can even prescribe medication. Please refer to **www.dsm.horizonblue.com/health-wellness/horizon-careonline** for service restrictions based on your state of residence.

If you are in the DSM PPO plan, your copay is only $5. If you are in the CDHP plan, you will be charged $5 up front, and the remaining balance will be charged to your credit card. Behavioral health costs are billed differently. Please see the Horizon Care Online flyer on myDSMbenefits.com for more details. Remember, you must use the key 'DSM' to ensure correct billing.

31. If I'm asked to participate in the Primary Nurse Health Management Program, what type of support can I expect?

The Primary Nurse Health Management Program helps participants receive professional support to manage acute and chronic conditions like diabetes, asthma and heart disease. The Primary Nurse Program also provides assistance with severe and complex care needs, including cancer, high risk pregnancies/NICU care, transplants and infusion therapy.

If selected to participate in this incentive-based program, you will be contacted by Horizon BCBS.

Spouses/DPs and qualified dependents are also eligible. The program is voluntary and offered at no additional cost to participants. You will also receive points in the Brighter Living Wellness program for your participation.

32. How and when do I pay for medical services or prescriptions under the Consumer Directed Health Plan?

- **When you visit the doctor or a hospital**, you generally pay nothing at the time of your service. Your medical provider will submit your claim to Blue Cross Blue Shield, and Blue Cross Blue Shield will process your claim – sending you an Explanation of Benefits (EOB) showing how much of the claim the plan paid and how much you owe to the provider. The doctor or hospital will then send you a bill. Your Explanation of Benefits can also be viewed at Blue Cross Blue Shield's website **www.HorizonBlue.com/DSM**. You can then use money from your HSA to pay your share of the cost, or you can use other funds and let your HSA grow for the future. In some cases, hospitals and providers may require you to pay at the time of service if a procedure needs to be performed. Remember that you can increase or decrease your HSA contributions throughout the year as your medical costs may change.
- **When you fill a prescription**, Express Scripts pharmacies know when you meet your deductible. You can use your HSA card to pay your share (or pay by other means such as by credit card).

33. How are prescription drug benefits covered under the medical plans?

You automatically have prescription drug coverage administered by Express Scripts when you elect DSM medical coverage. There are some important differences in prescription drug coverage based on the medical plan you choose:

- For the Consumer Directed Health Plan, you must **meet the medical plan's annual deductible for all non-preventive medical care and prescription drugs.** After you meet the deductible, you pay 20% for generics and preferred brand or 40% for non-preferred brand until you meet the out-of-pocket maximum.
- For the High Option and Low Option PPOs, you have copays of $15 for generic and $30 for preferred brand prescriptions and pay 30% coinsurance of the in-network cost for non-preferred brand drugs. Once you meet the out-of-pocket maximum for prescription drugs, the plan pays 100% of your cost for covered prescription drugs.
- For all options, certain preventive medications are covered at 100% with no copayment or deductible.

If you go to an out-of-network pharmacy, you will pay more out of pocket and you will be required to file a claim. See the online enrollment guide by visiting **www.myDSMbenefits.com** for more information on DSM's prescription drug coverage.

34. If my medication is listed on Express Scripts formulary, will it continue to be covered a preferred brand drug in 2023?

Express Scripts updates the formulary annually. Go to the Express Scripts website at **www.express-scripts.com** to verify that your medication continues to be covered on the formulary. You pay non-preferred brand costs for medications that are not listed on the formulary.

35. When can I use mail order for prescriptions?

Regardless of which plan you choose, you can order prescription maintenance medications for up to a 90-day supply through Express Scripts mail order (Home Delivery) program. Prescription maintenance medications are those drugs taken regularly for treating long-term chronic conditions such as asthma, diabetes, high cholesterol, hypertension, or arthritis. In most cases, your cost will be lower for mail order than purchasing your drugs at the local pharmacy, making mail order both convenient and cost-effective.

36. Do I have to use the mail order program to fill my maintenance medication?

You are not required to fill your maintenance prescriptions (typically for a 90-day supply) through mail order, but if you do not wish to use mail order, you are required to call Express Scripts at 1-866-851-0145 to opt out of mail order. In most cases, your cost will be lower for mail order than purchasing your medication at the local pharmacy. The name of the mail order program is called Home Delivery.

37. I satisfied the requirements for earning the 2023 wellness incentive by the wellness program

deadline. Will I have a lower contribution for my 2023 medical coverage?

- If you enroll in either the High Option or Low Option PPO, your earned incentive will lower your per paycheck contribution for medical coverage.
- If you enroll in the CDHP option and elect the Health Savings Account (HSA), your incentive will be deposited with your employer contribution in your HSA**.**
- If you do not enroll in a DSM Medical Plan, you can still earn 'PulseCash.' For more information on how to use PulseCash rewards, or how to transfer the funds to your personal account, visit the Virgin Pulse website at www.BrighterLiving.DSM.com.

38. My spouse also completed the requirements for earning the 2023 wellness incentive. Does this mean my 2023 contribution for DSM medical coverage will be even lower?

- If you and your spouse enroll in either the High Option or Low Option PPO, your spouse's incentive will reduce your per paycheck contribution for medical coverage even more.
- If you and your spouse enroll in the CDHP option and elect a Health Savings Account (HSA), your spouse's incentive will also be deposited with your employer contribution in your HSA**.**.
- If both you and your spouse earn the incentive during all four quarters and both enroll in a DSM medical plan, your incentive will total $1200 for the new plan year.

39. There are health care plans available in the marketplace and a government subsidy to help pay for medical coverage. Will I qualify for the subsidy?

Because DSM offers medical plans to employees that meet or exceed the requirements for affordable employee coverage and benefit value, you and your eligible dependents generally will not qualify for a government subsidy to help pay for medical coverage through the health insurance marketplace.

40. Where can I find more information about health care reform and how it may impact me?

You can visit **HealthCare.gov** and select "Get Answers" or call 1-800-318-2596 for information.

Health Savings Accounts

41. What vendor administers the Health Savings Account (HSA)?

HealthEquity administers the HSA and the bank where your account resides. Once the account is established, you will go manage your account and invest your money using the HealthEquity website.

42. How do I use the Health Savings Account (HSA) with the Consumer Directed Health Plan (CDHP)?

You can use your HSA anytime – up to the amount in your account at the time – to pay for eligible medical and prescription drug expenses. The decision to use the account or pay with other money is yours each time you receive care.

43. If I newly elect the CDHP during annual enrollment and establish an HSA, when do my HSA contributions begin?

As long as you agreed to the Terms & Conditions when you enrolled during annual enrollment and HealthEquity approves your request to set up an account, contributions will begin with your first paycheck in January. Be sure to respond to all additional requests for information from HealthEquity during your account set-up to ensure you receive the DSM contribution and any earned incentive credits.

44. When do I begin to earn interest on my HSA funds?

Contributions to your HSA account earn interest at nominal money-market rates when you have $1,000 or more in your account. The interest rate goes up and down with changes in the market. When you have $1,000 or more in your account, you can also invest in funds through HealthEquity.

45. What happens if I do not use all the funds in my HSA at the end of the plan year?

Any unused balance remains in your account. This means any unused dollars you or DSM contributes can be used for eligible health care expenses during the current plan year, or in future years. If you leave DSM, you take your HSA with you and use it for eligible expenses at any time.

46. Are there fees associated with opening and maintaining an HSA?

No. If you are a CDHP participant and enroll in the HSA you must elect to receive electronic statements (opt out of receiving paper statements) to avoid paying service fees. DSM pays any fees while you are actively employed. After you leave DSM, or if you set up an HSA with a bank on your own, fees may apply.

47. If I enroll in the Consumer Directed Health Plan (CDHP), do I have to open an HSA?

You are not required to open an HSA. However, if you do not qualify or if you do not elect HSA (even with a $0 contribution), you will not be able to receive the DSM HSA contribution of $500 (employee only coverage), $750 (employee plus spouse/domestic partner), or $1,000 (employee plus child or employee plus two or more dependents). The amount is pro-rated if you are a new hire and enroll after January 1. It is important to budget for the CDHP deductible in case you need care during the year – and the HSA offers a way to save tax-free dollars. The money is there if you need it, and it remains in your account if you do not use it.

48. Can anyone open an HSA?

You may open and contribute to an HSA and receive its tax advantage if:

- You enroll in the Consumer Directed Health Plan (CDHP),
- You **are not enrolled** in other meaningful medical coverage, such as another employer's plan, which may include your spouse's flexible spending account, or a plan sponsored by the military or the U.S. government, for example, Medicare* (unless your other plan meets the government definition of a high deductible plan), and
- You are not claimed as a dependent on another person's tax return.
- You have a street address. You cannot have a P.O. Box so you will need to identify your physical address.
- You pass the Patriot Act vetting process known as the Customer Identification Process (CIP).

** You may set up an HSA if you are Medicare-eligible. However, if you enroll in Medicare, (even Part A) you **cannot** open an account.*

49. How do I set up my Health Savings Account now that I am enrolled?

HealthEquity will mail you a Welcome Kit to confirm your account is open. You should then visit **www.HealthEquity.com** to designate your HSA beneficiaries, enter your personal address and elect to receive electronic statements.

50. Can I pay my dependents' eligible medical expenses with my Health Savings Account?

Expenses for most dependents are eligible to be reimbursed by a Health Savings Account. In addition, you may be able to pay your dependent's expenses using money from your HSA even if your dependent does not qualify as a tax dependent on your tax return form. Go to **www.HealthEquity.com** for information. You can find qualifying tests that can help you determine if your child or domestic partner's expenses are eligible under the HSA.

51. Who can contribute to the HSA account?

Both you and DSM can contribute to your HSA once it is opened. DSM will contribute to your HSA when you enroll in the Consumer Directed Health Plan (CDHP). DSM's contribution is based on the dependents you choose to cover and if you and/or your spouse earned the wellness incentive. The contribution will be deposited into your HSA account in early 2023. Together, DSM and your contributions cannot exceed the IRS-determined annual maximum for the account. In order to ensure you do not exceed the IRS allowed contribution, DSM will reduce your maximum contribution amount by any potential employer contribution and wellness incentive.

52. How much can I contribute to my HSA during 2023?

You can make before-tax contributions from your pay. Your maximum contributions when combined with DSM's can be up to:

- $3,850 for employee only coverage
- $7,750 if you enroll dependents

You can make changes to your contribution amount any time during the year; you do not need a qualified life event to make changes. However, you may not change your election amount to less than what you have already contributed. To make mid-year changes to your contributions, visit the **DSM Benefits Enrollment Website**.

53. Can I take my HSA funds with me if I leave DSM?

Yes, you can take your account with you if you leave DSM. If you have a Health Savings Account (HSA) with a balance, HealthEquity will send you a letter with details on what services you will still receive, criteria for continuing to make contributions, and the monthly maintenance fee. The options available to you will be to keep the HSA open, transfer to another HSA custodian/account, or close the HSA.

54. What if I am currently enrolled in the CDHP, but decide to enroll in a PPO plan for 2023, can I continue to use my HSA?

If you enroll in a PPO in 2023, you will no longer be eligible to contribute to an HSA in 2023. However, if there is a remaining balance in your HSA, you will be able to continue to submit eligible expenses to the account for reimbursement.

55. Can I use money in my HSA for expenses other than health care expenses?

Yes, you can withdraw money from your HSA for any reason. However, if you use the money for expenses that do not meet government rules for qualified HSA expenses, the money will be taxable as income and you will pay a tax penalty (generally about 20%). It is important to always save all your receipts. For more information, visit **www.HealthEquity.com**.

Dental

56. How can I find a network dentist?

To find a network dentist, go to **www.deltadentalnc.com** and select either the Delta PPO or Delta Premier Network. If you participate in either dental option, you can be treated by dentists in either network. Both networks offer discounts to Delta Dental members, with Delta PPO network offering the best discount.

57. Will I receive a Delta Dental ID card?

Yes, you will receive a dental ID card if this is your first time enrolling or you change your Delta Dental Plan through DSM.

58. What is the advantage of using a network dentist?

There are important benefits to using network dentists:

- You have access to negotiated discounts.
- Network dentists will file claims for you.
- If your dentist is not in the PPO network, he or she may bill you more than the reasonable and customary (R&C) charge, and you are responsible for paying the difference between the R&C charge and the amount billed by your dentist.

Vision

59. Do I have to enroll separately for vision coverage?

Yes. DSM provides a Vision Plan administered by VSP, that you can enroll in during annual enrollment.

60. Will I receive an ID card for vision?

No. An ID card is not required to receive services. If you would like an ID card, you can print one by logging in to your account on the VSP website at **www.vsp.com** and clicking on 'My Member Vision Card'.

61. How can I find a VSP Signature Provider?

To find a VSP Signature Provider, visit **www.vsp.com.**

62. What is the allowance for frames and lenses?

The allowance is $160 for both frames and contact lenses.

63. Do I have to file a claim form for vision services?

If you visit an in-network provider, you do not have to fill out or submit claim forms. Simply tell the provider you are a VSP member and they will validate your benefit coverage and submit your claims for payment.

If you decide not to see a VSP provider, you'll typically pay more out of your pocket and you will need to file claims yourself. Claim form and instructions on how to file the claim are located at **www.vsp.com**.

Flexible Spending Accounts (FSAs)

64. How much can I contribute to a Flexible Spending Account (FSA)?

If you enroll in a Flexible Spending Account, the minimum you can contribute is $100.

- You may set aside up to $2,850 annually in a Health Care FSA or Limited FSA.
- You may contribute up to $5,000 or up to $2,500 for married couples filing separately, in a Dependent Care FSA annually.

Your contributions come out of your pay before taxes are withheld. Use the FSA tool available through WageWorks for help deciding how much to contribute to an FSA. You can access the tool from **www.myDSMbenefits.com.**

Remember, you can carry over up to $570 of your unused FSA balance remaining at the end of 2022. This will help you avoid losing unused money at the end of the year. Expenses incurred from January 1 through December 31 will be reimbursed.

65. If, at the end of 2022, I have unused money to carry over, can I still elect to contribute the IRS maximum to my Health Care FSA for 2023?

Yes. You can elect the maximum contribution limit and carry over up to $570 of your unused balance. Employees who decline Health Care FSA participation during Annual Enrollment and have a rollover benefit will be limited to spend that account balance during the next plan year

66. Are there any changes to the Flexible Spending Accounts for 2023?

Some employees who meet the IRS definition of highly compensated ($130K annual salary) will be limited to $2,500 in contributions. This is an important step to ensure our Plan passes Non-Discrimination testing on an annual basis. You may wish to consider this in your tax planning.

Effective 1/1/2021, if you decline FSA participation during Annual Enrollment and you have a balance in your account, you will only be allowed to carry over up to $570 for one plan year. Example, those who enroll in 2022 and carryover to 2023 plan year, but make no active election in 2023, will be allowed to use their funds through 12/31/2023, but any remaining balance as of 1/1/2024 would be forfeited, if not claimed.

67. If I do not use my full account balance, what happens to the money?

You can carry over up to $570 of your balance into the new plan year. Any unused amount over $570 will be forfeited. Employees who decline Health Care FSA participation during Annual Enrollment and have a rollover benefit will be limited to spend that account balance during the next plan year

68. May I change my contributions during the year?

You cannot make changes unless you have a life event (such as marriage) and the change in your contributions is consistent with your life event. Visit **www.myDSMbenefits.com** for more about making changes to benefit elections during the year.

69. How does the WageWorks Health Care Card work if I am enrolled in the HSA and Limited FSA?

When an employee has an HSA and a Limited FSA (LFSA), the balance in both accounts is loaded to one Health Care Card.

When the member swipes the card at the point of sale, the system looks first to the LFSA. If the claim is for Vision or Dental, the transaction will debit the balance in the LFSA. If it is for Medical, the transaction will debit the HSA balance. If the balance in the LFSA is not enough to pay the entire transaction, the balance in the LFSA will be exhausted first and then the remaining amount will be debited from the HSA.

70. How does the WageWorks Health Care Card work if I am enrolled in a PPO plan?

For employees enrolled in the DSM PPO plan who elected the Health Care Flexible Spending Account (FSA), all medical and prescription drug claims incurred on or after January 1 will be automatically applied to your Health Care FSA once the claims have been processed by Horizon BCBS and Express Scripts. That means any remaining claim balances that are your responsibility will be applied to your FSA. The claim reimbursement is deposited to your bank account on record at HealthEquity. If there is not a bank account on record, then a check is issued. This feature will save you time. If you do not wish for these claims to be automatically applied to your Health Care FSA, you must go to the HealthEquity site to turn this of. Visit www.HealthEquity.com.

71. Can I use my Health Care FSA for over-the-counter medications?

You cannot use your account for non-prescribed drugs other than insulin. Over-the-counter medications, such as aspirin, ibuprofen or fiber, herbal and vitamin supplements, unless required for treatment of a specific medical condition, will not be reimbursable unless you have a prescription from your doctor.

72. Can I contribute to a Health Care FSA if I enroll in the Consumer Directed Health Plan (CDHP)?

If you enroll in the CDHP, you can enroll in a Limited FSA and contribute up to $2,850 before-tax a year **for eligible dental and vision expenses only**. You can carry over up to $570 of your unused FSA balance into the new plan year. You should use your HSA for eligible medical and prescription expenses. Any unused funds in your HSA will remain in your account.

73. How can I elect the Limited FSA if I waived DSM medical coverage and I am enrolled in my spouse's High Deductible Health Plan?

The LFSA will not show on the DSM Benefits Website if you waive medical; the LFSA only shows when you elect the DSM CDHP medical option. If you are enrolled in your spouse's High Deductible Health Plan and want to elect to contribute to the LFSA, contact the DSM Benefits Center at 1-866-353-9740.

Life and Accidental Death & Dismemberment (AD&D) Insurance

74. Do I have to enroll to have basic life and AD&D coverage?

No. DSM provides basic life and basic AD&D automatically at no cost to you. Eligible employees receive basic life and basic AD&D insurance coverage equal to two times your annual base pay. Both life and AD&D insurance are offered through Prudential.

75. What optional life insurance options are available to me?

You can choose optional coverage for additional protection for your family.

Optional Life Insurance	Benefit	Maximum Benefit	Guarantee Issue Amount
For you	1 to 6 times annual base pay rounded up to the nearest $1,000	$1,000,000	Lesser of 3x annual base pay and $300,000
For your spouse/domestic partner	$10,000 increments	$150,000	$50,000
For your children	$5,000 increments	$25,000	Not applicable

76. Does life insurance create extra taxable income for me?

Current tax law requires you to pay income tax (imputed income) on the value of your basic life insurance benefit over $50,000. Any basic life insurance coverage over $50,000 will be reported as taxable income to you on your W-2 form.

77. Is Evidence of Insurability required for optional life insurance?

You will need to provide evidence of insurability (EOI) if you are increasing the amount of your life insurance or enrolling for the first time (other than as a new hire). For any coverage that requires EOI, you will have the option to complete the forms directly through the annual enrollment system at the time of election. You can also still print the EOI form from the DSM Benefits Website.

For you

As a new hire: You may enroll for optional life insurance up to the lesser of 3 times pay or $300,000, without providing EOI.

After your initial eligibility period (such as during the annual enrollment period): *To add or increase optional life insurance, you must provide EOI to elect coverage.*

For your spouse/domestic partner (DP)

For new hires: You may enroll for optional life insurance coverage up to $50,000 for your spouse/DP without providing EOI.

After your initial eligibility period (such as during the annual enrollment period): *Your* spouse/DP must provide EOI if you wish to enroll in or increase the level of optional life coverage for your spouse/DP.

Coverage subject to EOI does not become effective until approved by the insurer and you do not pay for the additional coverage until it is approved. Learn more about age reduction and restrictions by visiting **www.myDSMbenefits.com.**

78. What is AD&D?

AD&D, or Accidental Death and Dismemberment Insurance, provides benefits for covered loss of life, limb, hearing or sight as a result of an accident. Dependents may also be insured. Generally, the plan pays the full coverage amount selected for loss of life. For other covered losses, the plan may pay the full coverage amount or a percentage of the coverage amount depending on the type of loss.

AD&D is not applicable to DSM Engineering Plastics Bargaining Unit employees.

79. What optional AD&D is available to me?

You may purchase optional AD&D insurance for yourself. If you elect optional AD&D insurance, then you may purchase optional AD&D insurance for your family. Your spouse/DP, and/or children's benefit is based on a percentage of your benefit, subject to certain maximums. This chart shows optional AD&D coverage choices:

Optional AD&D Insurance	Benefit	Maximum Benefit
For You	Increments of $25,000	$1,000,000
For your family:		
Spouse/domestic partner benefit	50% of employee benefit if no children are covered; 40% with child coverage	$100,000
Child benefit	10% of employee benefit if spouse/domestic partner is covered; 15% if no spouse/domestic partner coverage	$25,000

See age reduction and restrictions by visiting **www.myDSMbenefits.com.**

Disability Insurance

80. How do I elect short-term disability? The company provides you with short-term disability at no cost to you. *

Your coverage will begin on the third month anniversary of your first day of active work as an eligible employee, provided you are actively at work on that anniversary date. Otherwise, your coverage will begin on your first full day of active work after completing the three-month eligibility period. Short-term disability (STD) pays 100% of pre-disability earnings for up to 13 weeks, and then pays 70% of pre-disability earnings for up to another 13 weeks; however, if you have less than one year of service, the first four weeks are paid at 100% and the next 22 weeks are paid at 60%. If you are a new hire, you become eligible for this benefit three months from your date of hire (provided you are actively at work on that date).

***** *DSM Engineering Plastics Bargaining Unit employees are eligible for Weekly Income Benefits instead of STD coverage. Check with your local Human Resources representative for more information***.**

81. What is the difference between core long-term disability and buy-up long-term disability insurance?

Core long-term disability (LTD) insurance is provided at no cost to all eligible employees. DSM pays the full cost of this coverage. Core LTD coverage replaces 60% of your monthly base pay up to a maximum benefit of $10,000 per month.

"Buy-up" LTD benefits offer additional protection you can choose to purchase. "Buy-up" LTD replaces additional base pay, for a total of 70% of your monthly base pay up to maximum benefits of $15,000 per month.

LTD benefits generally continue up to age 65 as long as you meet the definition of disability and other policy requirements.

Disability benefits may be reduced by income and benefits you receive from other sources.

*******DSM Engineering Plastics Bargaining Unit employees are not eligible for LTD coverage.*

82. When will my disability benefits begin?

When you have been absent from work for five consecutive calendar days for an illness or injury, you must contact Matrix Absence Management (1-877-202-0055) to report your absence and file for short-term disability benefits. After 16 weeks of disability, DSM will send you a package to apply for long-term disability benefits through Prudential. If eligible, the LTD benefits begin after you have exhausted all your short-term disability benefits - which is 26 weeks. It is important to apply for LTD benefits before your STD benefits end, as it takes several weeks to review the information and more information may be required from your doctor.

83. What is my employee status when I am disabled?

When on short-term disability, you are considered an active employee. When on long-term disability, you are no longer considered an active employee.

84. Do pre-existing condition limitations apply to LTD?

Yes, pre-existing condition limitations do apply. You will not be eligible for LTD benefits for a pre-existing condition if you received medical treatment, consultation, care of services (including diagnostic measures), or took prescribed medicines, or followed treatment recommendations for that condition in the three-month period just before your coverage under the LTD plan became effective. Likewise, you will not be eligible for LTD benefits for a pre-existing condition if you had symptoms of which an ordinarily prudent person would have consulted a health care provider in the three months before your coverage under the LTD plan becomes effective. This pre-existing condition limitation is effective during the first 12 months you are insured under the DSM LTD plan. See the DSM Long Term Disability Summary Plan Description for more information about the LTD pre-existing condition limitation.

85. Will I need to provide evidence of insurability to enroll in LTD?

For new hires, Evidence of Insurability (EOI) is not required for disability coverage.

After your initial eligibility (such as during the annual enrollment period), if you are currently enrolled in core LTD and want to enroll in "buy-up" LTD, you will be required to provide EOI. Your increased coverage will not become effective until your EOI is approved by Prudential. You will have the opportunity to complete the EOI application directly through the enrollment site during Annual Enrollment. You may also print the EOI form found on the Resources page at **www.myDSMbenefits.com** and send the completed form to Prudential per the instructions at the top of the form.

Employee Assistance Program (EAP)

86. What is the Employee Assistance Program (EAP)?

The EAP is a program designed to identify and assist employees in resolving personal matters. You can receive counseling and referrals through the Magellan Behavioral Health EAP for matters such as:

- Family or marital problems
- Conflicts at work
- Job stress
- Adoption assistance
- Child or adult care
- Emotional difficulties like depression
- And much more

87. How do I use the EAP?

Sometimes a telephone call is all it takes to get the help you need. Contact Magellan 24 hours a day/7 day a week at 1-800-523-5668 or visit www.MagellanAscend.com and register as a new user. You will need to enter the phone number above (without the "1") and name of our company, DSM, when registering. You can receive up to 5 free counseling sessions.

Legal Services

88. What does the Legal Services Plan cover?

The plan allows you and eligible dependents access to a wide variety of legal services and advice through network and non-network attorneys. Most services obtained through network attorneys are covered in full. The legal services plan is administered through MetLife Legal.

Legal services available through this program include:

- Advice and Consultation
- Identify Theft
- Family Law
- Consumer Protection
- Immigration
- Debt Matters
- Real Estate Matters
- Defense of Civil Lawsuits
- Traffic and Criminal Matters
- Document Preparation
- Will and Estate Matters

89. Once enrolled, how do I use the legal services?

If you think you may have a legal issue, call MetLife Legal Plans and a customer service representative can help you find a plan attorney near your home or workplace. Simply contact that attorney for an initial consultation to determine next steps. Visit the MetLife Legal Plans website (enter access code LEGAL),

or call 1-800-821-6400, Monday-Friday, 8am-8pm EST.

Home-Auto-Umbrella Insurance

90. What is Home-Auto-Umbrella Insurance?

Farmers provides the opportunity to buy personal home, auto, and umbrella insurance at discounted rates.

You can purchase coverage for:

- Homeowners (except in California and Florida)
- Renters
- Condominium
- Dwelling fire
- Auto
- Boat
- Motor home
- Umbrella liability

These benefits are not payroll deducted. Farmers offers a variety of flexible payment options at no extra cost. You can enroll or change your election anytime during the year. Visit **www.myDSMbenefits.com** for contact details and more information.

91. Is Home-Auto-Umbrella insurance cheaper than insurance I could buy on my own?

It may be less expensive because it is offered at discounted rates. It is important to compare the cost and coverage features with other options you have when you make a choice.

Pet Insurance

92. What does Pet Insurance cover?

Veterinary Pet Insurance through Nationwide provides coverage to help you cover the costs of your veterinary care expenses. Choose from 2 levels of reimbursement: 70% or 50% and use any vet, anywhere. There are no networks and no pre-approvals are needed. Coverage is offered for dogs, cats, birds, rabbits, reptiles and other exotic pets.

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93. How do I sign up for Pet Insurance?

For more information, visit the Nationwide website or call 1-877-738-7874. You can enroll at any time and you will be direct billed for premiums.

Retirement Savings

94. How do I enroll in the DSM USA Defined Contribution Plan?

When you join DSM, you are automatically enrolled in the Plan if you take no action. Your contributions are automatically deducted from your paycheck on a before-tax basis. You may change your contribution amount at any time by visiting **www.401k.com** or by contacting Fidelity at 1-800-835-5095.

Note: DSM Engineering Plastics Bargaining Unit employees are eligible for the DSM Engineering Plastics Bargaining Employees' Incentive Savings Plan.

95. I was automatically enrolled in the plan at 4% of my base pay as a new hire. Will my contribution percentage continue at 4% each year?

If you elect to save less than 10% of your base pay, Fidelity automatically enrolls you in the automatic increase program. Your savings percentage will increase by 1% each year until you reach the plan maximum, currently 10%. If you do not wish to participate in the plan and/or the automatic enrollment program, you must log in to your account at **www.401k.com** and select the Contributions tab, click on the

"Annual Increase Program" and select "Unenrolling from the Annual Increase Program" and then click on "Change Annual Increase Election." Fidelity can also assist with this process by calling them at 1-800-835-5095.

100. Does DSM make contributions to my account?

Yes. DSM provides a 100% company match for the first 4% of total pay that you save in the Plan.

DSM also makes a separate, additional contribution equal to 4% of total pay for employees who are not eligible for a pension benefit, even if you do not participate in the plan. Therefore, DSM's total contribution will be up to 8% of total pay.

101. When do I have ownership in my account?

You are always 100% vested in the contributions you make to the plan as well as any matching employer contributions. Employees who are not eligible for a pension benefit are fully vested in the additional 4% Company contributions after three years of service.

102. What happens to my account if I leave DSM?

If you leave DSM for any reason, your vested account goes with you to reinvest, or you may be able to leave it where it is in the Plan to continue growing on a tax-deferred basis. Please see the plan documents for vesting rules and distribution options, call Fidelity at 1-800-835-5095, or go to **www.401k.com**.

103. What if I do not want to have contributions deducted from my bonus?

If you do not want contributions deducted from your bonus, you should change your contribution rate to zero with enough time for it to be effective before your bonus is paid. After the bonus is paid, you may change your contribution rate back to your prior election.

104. Are there any resources available to help me with retirement planning?

There are many tools on Fidelity website to assist you with a variety of retirement-related topics. Call 1-800-603-4015 to speak with a Fidelity Workplace Specialist to receive an in-depth analysis of your retirement plan, or take the **Fidelity Financial Wellness Check-up**. In under 10 minutes, you will know what steps you should take to make the most of your retirement planning. You will also earn points in our wellness program when participating.