Important DSM Health Plan Notices

For the 2022 Plan Year

The following are some of the notices that are required to be distributed to new and/or existing enrollees in a DSM group health plan. Please share these notices with your spouse/domestic partner. These notices are very important, and you should review them carefully. Please refer to your applicable Summary Plan Description (SPD) for further information regarding your health benefits, including other required notices. You should also review the SBCs (Summary of Benefits and Coverage) that are available to you online summarizing the various medical benefit options. If you have any questions, please contact the DSM Benefits Center at 1-866-353-9740, Monday - Friday, 9:00 a.m. to 7:00 p.m. ET. You can also email questions to DSMbenefitscenter@adp.com, but please allow up to 48 hours for an email response.

Important: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug Program gives you more choices about your prescription drug coverage. Please see page 3 of this Notice for more details.

The Women's Health and Cancer Rights Act of 1998

As a participant in or beneficiary of one of the medical options offered under the DSM Consolidated Welfare Benefit Plan (the "Plan"), DSM is required to inform you, on an annual basis, of your rights under the Women's Health and Cancer Rights Act of 1998. In 1998, the federal government enacted a law that mandates certain health coverage for breast reconstructive surgery in any health program that provides medical and surgical benefits for mastectomies.

If a covered person is receiving benefits in connection with a mastectomy and elects to have breast reconstruction along with that mastectomy, the policy must provide in a manner determined in consultation with the attending physician and the patient, coverage for the following:

- 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; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to deductibles and coinsurance to the same extent as for any other illness under your coverage. For further details, please refer to the DSM Medical SPD.

Notice of Special Enrollment Rights under the Health Insurance Portability and Accountability Act (HIPAA)

If you have declined or are declining medical coverage under one of the medical options offered under the DSM Consolidated Welfare Benefit Plan (the "Plan") for yourself or your dependents (including your spouse or domestic partner) because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other medical coverage ends (or after the employer stops contributing towards the other coverage). (This special enrollment right does not apply to retirees or terminated employees.)

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 dependents in the Plan's medical coverage. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, you may be able to enroll yourself and your dependents in the Plan's medical coverage (1) if your or your dependent's coverage under a Medicaid plan or a State Children's Health Insurance Program ("CHIP") plan terminates due to loss of eligibility for such coverage, or (2) if you or your dependents become eligible for premium assistance with respect to the Plan's medical coverage under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date of termination of such coverage or the date you or your dependent is determined to be eligible for such assistance, whichever is applicable.

To request special enrollment or obtain more information, call the DSM Benefits Center at 1 -866-353-9740. If you are already enrolled in medical coverage for yourself, you may change your own medical coverage election in connection with enrolling a dependent child or spouse (or domestic partner) under the above special rules.

In addition, during the COVID-19 National Emergency, the deadline for special enrollment rights may be suspended for up to one year but in no event more than 60 days after the end of the National Emergency. Nevertheless, to ensure coverage, it is best not to delay enrollment even during the National Emergency. If you would like more information about the extension, please call the DSM Benefits Center at 1-866-3539740.

IMPORTANT NOTICE FROM DSM ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

(*FOR THOSE ENROLLED OR ENROLLING IN A DSM MEDICAL OPTION AND WHO ARE ELIGIBLE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS*)

Please read this notice carefully and keep it where you can find it. This notice has information about the prescription drug coverage under the DSM Medical Plan which is part of the DSM Consolidated Welfare Benefit Plan (the "Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare the DSM coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about DSM's prescription drug coverage and Medicare's prescription drug coverage:

1. **You can get prescription drug coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **DSM has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the DSM coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (i.e., a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to your Current Coverage if you Decide to Join a Medicare Drug Plan?
Your coverage as an employee, or dependent coverage (including that of a spouse/domestic partner) of an active employee, will not be affected if you or your Medicare-eligible dependent enrolls in a Medicare prescription drug plan. However, if you and/or your dependent drop coverage with DSM and enroll in a Medicare prescription drug plan, you and/or your dependent will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you (or dependent, as applicable) are eligible for coverage at the time your reenrollment would be effective). In addition, the DSM coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage from DSM you must also drop your medical coverage.

If you (or a dependent or spouse) are covered under the Plan's medical options through COBRA and you (or your dependent or spouse) later elect to be covered under Medicare, your coverage under the DSM medical plan will be cancelled, if permitted by law. This means that Medicare will be the only source of medical and prescription drug benefits for you. In addition, once you cease to be covered under COBRA, you many not reinstate your COBRA coverage under the DSM medical plan.

As a result of these rules, before enrolling in a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to the DSM Health Summary Plan Description for more detailed information about coverage under the DSM medical options and when coverage terminates.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current DSM coverage and don't join a Medicare drug plan within 63 continuous days after your DSM coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or your Current Prescription Drug Coverage...
Contact the DSM Benefits Center (see below) for further information. You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through DSM changes. You also may request a copy of this notice at any time.

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. If you are Medicare-eligible or close to becoming Medicare-eligible, you will receive a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable 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 maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 29, 2021
Name of Entity/Sender:	DSM North America, Inc.
Contact--Position/Office:	DSM Benefits Center
Address:	P.O. Box 22489 Louisville, KY 40252
Phone Number:	1-866-353-9740

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

This notice applies to services provided on or after January 1, 2022.

This notice does not apply to separate dental and vision coverages or to the extent not required by law.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your health plan using the contact information on the back of your health ID card. You may also contact the Employee Benefits Security Administration as follows:

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

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 the claims administrator for your medical plan using the number on the back of your ID card.

NOTICE OF PRIVACY PRACTICES
Revised Effective: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DSM Services USA, Inc. (and other members of its controlled group, such as subsidiaries and divisions), as the sponsor of various group Plans ("Plan Sponsor"), is required by law to take steps to ensure the privacy of your personally identifiable health information and to provide you with this Notice of Privacy Practices ("Notice"). This Notice is provided to you as a covered person under one or more of the Plans sponsored by DSM that provide medical, retiree medical, prescription, dental, vision, health FSA and EAP benefits under DSM Consolidated Welfare Benefit Plan and the DSM Retiree Consolidated Welfare Benefit Plan (the "Plan.")

A federal law, known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires the Plan to maintain the privacy of your protected health information ("PHI"). PHI encompasses substantially all "individually identifiable health information" which is transmitted or maintained by the Plan, regardless of its form. PHI includes medical information relating to your physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you. However, PHI does not include all health information that may be maintained by DSM or its benefit plans. For example, PHI does not include health information maintained by DSM in its capacity as an employer, such as drug testing results, sick leave requests and related physician notes and medical information used for processing Family Medical Leave Act (FMLA) requests. Further, PHI does not include health information that is used or maintained by DSM ' non-health benefit plans, such as workers' compensation, life insurance, accidental death and dismemberment (AD&D) and short and long term disability benefits. If health information is not PHI, then the health information is not protected by HIPAA and is not covered by this Notice.

DSM and the Plan understand that your PHI is personal and private, and both are committed to maintaining the privacy of your PHI. This Notice summarizes the Plan's legal duties and privacy practices with respect to PHI. In particular, it describes the ways in which the Plan may use or disclose your PHI. It also describes the Plan's obligations to you and your individual rights regarding the use and disclosure of your PHI. HIPAA requires the Plan to provide this Notice to you and to comply with its terms.

If you are enrolled in a fully-insured health plan or an HMO, you may also receive a notice from the insurer/HMO about their privacy practices.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The following categories describe the different ways that the Plan may use and disclose your health information, without your authorization. For each category, the Notice outlines the uses or disclosures included in the category, but not every use or disclosure within a category can be listed.

For Treatment. The Plan may use and disclose your PHI to provide, coordinate or manage your health care treatment and any related services provided to you by health care providers. This includes the coordination or management of your health care by a health care provider. For example, the Plan may use and disclose your PHI to describe or recommend treatment alternatives and to provide information about health-related benefits and services that may be of interest to you and generic prescription drug alternatives.

For Payment. The Plan may use and disclose your PHI to make coverage determinations and provide payment for health care services you have received. These activities include determining your eligibility for benefits under the Plan (including coordination of benefits or the determination of cost sharing amounts); processing your claims under the Plan; resolving subrogation and reimbursement rights; billing, claims management and collection activities; obtaining payment under stop-loss and excess loss insurance policies; reviewing health care services you receive for Plan coverage, medical necessity and appropriateness; and conducting utilization review activities (including precertification, preauthorization, concurrent review and retrospective review activities). For example, the Plan may disclose your health information to a third party (for instance, a medical reviewer) when necessary to resolve the payment of a claim for health care services that have been provided to you.

For Health Care Operations. The Plan may use and disclose your PHI for administration and operations, including quality assessment and quality improvement activities; underwriting, premium rating and other activities relating to the creation, renewal or replacement of a health insurance or health benefits contract or a stop-loss or excess loss insurance contract; conducting or arranging for medical assessments, legal services and auditing functions (including fraud and abuse detection and compliance programs), and other administrative activities such as customer service and HIPAA compliance. For example, the Plan may disclose health information to potential health insurance carriers to obtain a premium bid from the carrier.

Each of the plans subject to this Notice may share health information between them to carry out Treatment, Payment or Health Care Operations.

Special Protection for Genetic Information. The Plan is not permitted to use or disclose your genetic information for underwriting purposes, which includes (1) determining whether you are eligible for benefits; (2) determining the premium for coverage; (3) determining whether you are

subject to a pre-existing condition exclusion; and (4) other activities related to the creation, renewal or replacement of the coverage provided under the Plan.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN SPECIAL SITUATIONS

Outlined below are other situations in which the Plan may use or disclose your PHI without your authorization. Uses or disclosures may be performed by the Plan or any business associate on behalf of the Plan.

Disclosure to You or Your Personal Representative. The Plan may disclose your PHI to you or your personal representative.

Disclosure to the Plan Sponsor. The Plan, or an HMO or insurer of benefits under the Plan, may disclose your PHI without your written authorization to the Plan Sponsor for plan administration purposes. The Plan Sponsor agrees not to use or disclose your health information other than as permitted or required by the plan document(s) for the Plan and by applicable law. In particular, your health information will not be used or disclosed for employment decisions, and genetic information will not be used for underwriting.

Disclosure to a Business Associate. Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may pay your health care provider's claims through an electronic claims processing system maintained by one or more of its business associates. In doing so, the business associate will obtain, maintain, use and disclose your PHI so it can perform this service. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information as required under HIPAA.

Public Health Activities. The Plan may use or disclose your PHI for public health activities, such as:

- Disclosure to a person subject to the jurisdiction of the Food and Drug Administration ("FDA") in connection with activities related to the quality, safety or effectiveness of FDA-regulated products.
- Disclosure to report births and deaths.
- Disclosure to report reactions to medications, problems with health related products or to notify a person of recalls of medications or products the person may be using.
- Disclosure to a public health authority for the purpose of preventing or controlling disease, injury or disability, or to report child abuse or neglect.
- Disclosure, if authorized by law, to a person who may have been exposed to or be at risk of contracting or spreading a communicable disease.

Abuse or Neglect. The Plan may disclose your PHI to an appropriate government authority authorized by law to receive reports of child abuse, neglect or domestic violence, including a social services or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect or domestic violence. However, the Plan will only disclose your PHI in these situations, if (1) the disclosure is required by law; (2) you agree to the disclosure; or (3) it reasonably believes that the disclosure is necessary to prevent serious harm to you or other potential victims. The Plan will notify you of a disclosure for abuse or neglect purposes if doing so will not place you at further risk of such harm.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for certain activities authorized by law including audits; civil, administrative, or criminal investigations; inspections; licensure or other activities necessary for appropriate oversight of the health care system.

Judicial and Administrative Proceedings. In certain limited situations, the Plan may disclose your PHI in response to a valid court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if it receives satisfactory assurances that the party seeking the information has tried to inform you of the request or to obtain a qualifying protective order to safeguard the information requested.

Required by Law. The Plan will use or disclose your PHI where required to do so by federal, state or local law. It may also disclose your PHI to the Department of Health and Human Services regarding HIPAA compliance.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan may also disclose PHI to a funeral director, as necessary to allow the funeral director to carry out his or her duties.

Organ and Tissue Donation. If you are an organ donor, the Plan may disclose your PHI as necessary to facilitate organ or tissue donation, including transplantation.

Research. The Plan may disclose your PHI to researchers without your authorization if their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI and the researchers have provided certain necessary representations regarding the research.

Serious Threat to Health or Safety. The Plan may use or disclose your PHI, consistent with applicable law and standards of ethical conduct, if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or, in certain cases, when the information is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply and if you are a member of the Armed Forces, the Plan may disclose your PHI (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military service. The Plan may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities for the conduct of lawful intelligence, counter-intelligence and national security activities and to authorized federal officials for the provision of protective services to the President or others that are authorized by law.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, the Plan may

disclose your PHI to the institution or official if the information is necessary for (1) the provision of health care to you, (2) your health and safety or the health and safety of other inmates, the officers, employees, or others at the correctional institution, (3) law enforcement on the premises of the correctional institution, or (4) the safety and security of the correctional institution.

Workers' Compensation. The Plan may disclose your PHI as necessary to comply with Workers' compensation laws and other similar legally established programs that provide benefits for work-related injuries or illness without regard to fault.

Law Enforcement Purposes. The Plan may disclose your PHI, in certain situations, to law enforcement officials, including: (1) when directed by a court order, subpoena, warrant, summons or similar process; (2) if necessary to identify or locate a suspect, fugitive, material witness or missing person; and (3) if necessary to report information about the victim of a crime in limited circumstances where the victim is unable to provide consent.

OTHER USES AND DISCLOSURES

To use or disclose your PHI for any reason other than those described in this Notice, the Plan must obtain your written authorization. Specifically, it must obtain your written authorization (1) in certain situations to use or disclose psychotherapy notes about you, (2) to market (or allow other parties to market) products or services to you if that marketing involves receipt by the Plan of financial remuneration, and (3) to sell your PHI to a third party in exchange for remuneration (except in cases of mergers or acquisitions). If you sign an authorization form, you may revoke your authorization by submitting a request in writing. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by the authorization. However, uses and disclosures by the Plan that occurred prior to your revocation will remain valid.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have several important rights with regard to your PHI, summarized below. In many cases, you can exercise these rights by contacting the claims administrator for the applicable benefit option. You may also contact the Privacy Official for additional information and to exercise any of these rights.

Right to Inspect and Copy. With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a "designated record set" or "DRS." The DRS is the group of records maintained by or on behalf of the Plan and contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Plan, and any other records which are used by the Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal or administrative proceedings, and information maintained by the Plan Sponsor that duplicates information maintained by a Plan third-party administrator in its DRS. If you request a copy of your PHI contained in a DRS, the Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing. In most cases, you must use a specific form, which you can request directly from the Privacy Official.

The Plan must provide you with access to the PHI contained in a DRS in the form and format you request. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Plan and you must agree on the electronic form or format in which it will be produced. If you exercise your right to access your PHI, the Plan will respond to your request within 30 days. If the Plan is unable to respond within 30 days, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request. The Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have and the right to file a complaint with the Plan or with the Department of Health and Human Services. If the Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Plan will notify you of where to direct your request.

Right to Amend. If you believe that your PHI in a DRS is incorrect or incomplete, you may request that the Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. In most cases, you must use a specific form, which you can request directly from the Privacy Official. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond.

In limited situations, the Plan may deny your request to amend your PHI. For example, the Plan may deny your request if (1) the PHI was not created by the Plan (unless the person who created the information is no longer available to make the amendment); (2) the Plan determines the information to be accurate or complete; (3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of your right to submit a statement of disagreement and of your right to file a complaint with the Plan or with the Department of Health and Human Services.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain types of disclosures of your PHI made by the Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; or (3) disclosures pursuant to an authorization.

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months or two calendar years. This time period may not be longer than six [6] years prior to the date of the request. The Plan must respond to your request within 60 days. If it cannot do so, it may have a one-time 30-day extension by providing you with a

written explanation for the delay and the date by which it will respond to your request. The Plan will provide the first accounting you request in any 12-month period free of charge. The Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI that the Plan uses or discloses about you in certain situations. However, it is not required to agree to your request. The Plan has determined that approving these requests would generally interfere with the resolution of benefit claims and, therefore, a restriction request will only be approved in special and compelling circumstances in the sole discretion of the Plan.

With respect to a health care provider, you have a right to request that the provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service fee which you (or another person acting on your behalf) has paid the health care provider in full outside of the Plan.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about health matters in a specific manner or specific location. You must make your request in writing and specify how and/or where you wish to be contacted (such as by mailings to a post office box). In most cases, you must use a specific form, which you can request from the Privacy Official. The Plan will consider and attempt to accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to request a paper copy of this Notice, even if you previously received this Notice electronically. Any such request should be submitted to the Privacy Official at the address provided below.

Personal Representatives. You may exercise your HIPAA rights though a personal representative. The representative must produce appropriate evidence of his or her authority to act on your behalf. Examples of acceptable authority include (1) a power of attorney, notarized by a notary public, (2) a court order of appointment as conservator or guardian and (3) a parent of an unemancipated minor. The Plan may deny access to PHI to a personal representative, including a parent of an unemancipated minor, if the denial is in the best interest of the individual.

NOTICE OF A BREACH OF UNSECURED PHI

The Plan and its business associates are required to maintain the privacy and security of your PHI. The goal is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, an unauthorized use or disclosure of your PHI could occur. These incidents are referred to as “breaches.” If a breach affects you and is related to unsecured PHI, the Plan or its business associate will notify you of the breach and the actions taken to mitigate or eliminate the exposure to you.

CHANGES TO THIS NOTICE

The Plan reserves the right to change, at any time, its privacy practices and this Notice. If revised, a revised copy of the Notice will be distributed to you and posted on the applicable website. Unless otherwise provided, the revised Notice will be effective for all PHI that the Plan maintains at the time of the revision, as well as PHI it creates or receives in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint to the Plan or the Secretary of the Department of Health and Human Services. DSM will not retaliate against you for filing a complaint with the Plan or with the Department of Health and Human Services. To submit a complaint to the Plan, you must submit the complaint in writing to the Privacy Official using the address below. To submit a complaint to the Department of Health and Human Services, you should follow the procedures described on the website for the Office for Civil Rights of the Department of Health and Human Services at http://www.hhs.gov/ocr/privacy/hipaa/complaints. The contact information for the Office of Civil Rights is also located on this website.

CONTACT INFORMATION

All requests, submissions required to be in writing, inquiries and questions with respect to your privacy rights, complaints and this notice should be directed to:

HIPAA Privacy Official
DSM North America, Inc.
c/o Benefits Department
45 Waterview Blvd.
Parsippany, NJ 07054
Phone: (973) 257- 8368