DSM North America, Inc.

2019 Health Summary Plan Description

For Active Employees

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BRIGHT SCIENCE. BRIGHTER LIVING.

About This Health Summary Plan Description

This booklet is referred to as the “Health Summary Plan Description.” This Health Summary Plan Description (SPD) describes the various health care plans provided by DSM North America, Inc. (“DSM”) under its Consolidated Welfare Benefit Plan (the “Plan”) to eligible employees and their eligible dependents of the Plan’s Participating Companies. The term "health care plans" refers to the Medical (including prescription drug benefits), Dental and Vision Plans. This SPD describes the benefits in effect under the Plan as of January 1, 2019.

You should be able to find the answers to most of your questions relating to the health care plans within this SPD. However, if you would like additional information about the health benefits offered by DSM, call the DSM Benefits Center at 1-866-353-9740. DSM Benefits Center representatives are available Monday through Friday, 9 a.m. to 7 p.m., Saturdays 8 a.m. to 5 p.m. Eastern Time.

Important Notice

The benefit plans described in this SPD are established by DSM voluntarily and may be amended or terminated at any time by DSM, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., at any time, regardless of whether the individual is participating in the benefit plans at the time of amendment. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding. Effective January 1, 2011, benefits provided to a grandfathered group of eligible retirees and their eligible dependents are provided under the DSM Consolidated Retiree Welfare Benefit Plan and not under this Plan. Please refer to the separate SPD for the DSM Consolidated Retiree Welfare Benefit Plan for a description of those benefits.

Neither this SPD nor the policies and procedures contained herein constitute a contract. This means that no promise of any kind is intended by the benefits described in this SPD. Nothing in the SPD or the Plan gives or is intended to give any person the right to be retained in the employment of DSM or to interfere with the right of DSM to terminate the employment of any person. DSM has the discretion to amend or terminate the benefits at any time.

Each medical option also has a Summary of Benefits and Coverage (SBC) located on the DSM Benefits Website. The SBCs are based on templates required by the Affordable Care Act which are intended to standardize the description of medical options, so individuals can easily compare medical options. While the SBCs are concise “snapshots” of the options, they are not intended to take the place of your Summary Plan Description (SPD) or the official plan document. Nothing in an SBC makes you eligible for a medical option or any medical benefits unless the official plan document and SPD provide for such eligibility or benefits. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

Due to a federal law called the Affordable Care Act, you also will be able to purchase health coverage, for yourself and your family members through the Health Insurance Marketplace (otherwise known as an Exchange). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is “affordable” and provides “minimum value.” DSM believes that its Medical Plan provides a benefit option that is affordable and does provide minimum value. You will be given a notice at certain times which explains the coverage offered through Marketplace and the tax credit that may be available to you. You should review that notice carefully. You may request a copy of this notice from the Plan Administrator at any time and one will be provided free of charge.

Key Contacts

For Questions About …	Contact…	By calling…	Or visiting…
Eligibility and Enrollment	DSM Benefits Center	1-866-353-9740	*https:/my.adp.com/dsm*
Medical Benefits (excluding prescription drugs)	Horizon Blue Cross Blue Shield 3 Penn Plaza Newark, NJ 07105	**Member Services:** 1-800-355-2583 **Precertification (Medical Conditions):** 1-800-664-2583 **Precertification (Mental Health and Substance Abuse, through Horizon Behavioral Health):** 1-800-626-2212 **Provider Search:** 1-800-810-2583	*www.horizonblue.com/DSM*
Prescription Drug Benefits	Express Scripts, Inc. One Express Way St. Louis, MO 63121	1-866-851-0145	*www.express-scripts.com*
Dental Benefits	Delta Dental of North Carolina 343 E. Six Forks Road Suite 180 Raleigh, NC 27609	1-800-662-8856	*www.deltadentalnc.com*
Vision Benefits	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	1-800-877-7195	*www.vsp.com*
Wellness	Virgin Pulse	1-888-671-9395	*www.brighterliving.dsm.com*

Health Summary Plan Description

DSM offers health care benefits designed to help the eligible employees of its Participating Companies and their eligible dependents maintain their overall health. Eligible employees may enroll for coverage that is effective on their first day of active work regardless of preexisting conditions.

This SPD focuses on the following benefits, sometimes referred to as "health care benefits:"

- Medical, including prescription drug coverage
- Dental
- Vision

Be sure to see "About This Health Summary Plan Description" on page 1 for important information about your benefits and this SPD.

The Official Plan Documents Govern

This SPD describes the health care benefits currently in effect for the eligible employees of the Participating Companies (see "Additional Information," beginning on page 88, for a list of Participating Companies). This SPD supersedes any other SPD previously distributed.

The SPD is intended to give you an overall understanding of the Plan. This SPD is not meant to interpret, extend or change the Plan in any way. Every attempt has been made to ensure the accuracy of the information in this SPD. However, if there is a conflict between the contents of this SPD and the official Plan documents, the official Plan documents will always govern. If you have any questions regarding this SPD or the Plan, you should call the DSM Benefits Center at 1-866-353-9740.

In This SPD **See Page**

Eligibility and Enrollment

To be covered under the Plan for health care benefits, you must follow certain rules and procedures, such as enrolling in benefits within the required timeframes. You should also understand the rules for making and changing elections. The Plan also uses specific definitions that are important for understanding who is eligible for coverage. If you have questions about eligibility or enrollment, please call the DSM Benefits Center at 1-866-353-9740.

In This Section **See Page**

Eligibility and Enrollment for Health Benefits

This section explains the rules for eligibility and enrollment in the Medical (including prescription drug benefits), Dental and Vision Plans.

Eligible Employees

Eligible employees are those individuals classified in the sole discretion of a Participating Company as its U.S. nonbargained employees and Engineering Plastics Bargaining Unit employees regularly working 20 or more hours per week (see "Additional Information," beginning on page 88, for a list of Participating Companies).

Individuals who are classified by the Participating Company as temporary, seasonal or leased employees, independent contractors or interns are not eligible employees. Any employee who is covered by a collective bargaining agreement is an eligible employee only if such agreement specifically provides for coverage under the Plan.

An individual who is misclassified by the Participating Company, but who is later determined to have been an eligible employee, is not an eligible employee until the date that such determination is made and eligibility will only be prospective from the date the determination is made.

Eligible Dependents

If you are an eligible employee, your eligible dependent means:

- Your legal spouse, excluding common-law spouses, until you become legally separated or divorced. However, if your spouse is an eligible employee, that individual cannot be covered as both a spouse and an employee.
- Domestic partners (as defined in the following section)
- Your, your spouse's and/or your domestic partner's eligible children (as defined under "Eligible Children" on page 7)

Dependent Status

DSM may audit the eligibility of enrolled dependents at any time. It is your responsibility to keep DSM informed of changes in a dependents' status. Failure to remove ineligible dependents may result in you being required to pay for health care provided during the time when your dependents were not eligible for DSM's health benefits.

Misrepresentation or falsification of dependent proof records, misstating dependents on a benefit claim, or failure to notify DSM when a covered dependent is no longer eligible, is considered misrepresentation and falsification of records and is a serious disciplinary offense which could jeopardize your employment. The other penalties for providing incomplete, false, or inaccurate information include the denial of payment of benefits, loss of coverage and/or other legal action.

Domestic Partners

Domestic partners and their eligible dependents may enroll in the same medical, dental and vision coverage subject to the same participation rules as spouses and other dependent child(ren).

An individual and an eligible employee are domestic partners if the two individuals satisfy either of the following requirements:

- Have registered as domestic partners pursuant to the rules of a U.S. state or local governmental domestic partnership or civil union registry and such U.S. registration is currently valid.

- Are unmarried individuals of the same or opposite sex and are all of the following:
  - Engaged in a committed and exclusive relationship of mutual caring and support and intend to remain so indefinitely and provide DSM with the requested proof of such interdependence
  - At least eighteen (18) years of age and mentally competent to consent to a contract
  - Not the legal spouse of each other or any other person
  - Not previously married to each other
  - Not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside
  - Living together in the same residence, have lived together on a continuous basis for at least 12 months immediately prior to the date of enrollment and intend to do so indefinitely
  - Not involved in a domestic partnership with any other person and neither have had a different domestic partner in the last 12 months unless a previous domestic partnership terminated by death

If Both You and Your Spouse or Domestic Partner are Employed by DSM

Eligible dependent child(ren) may be covered by either employee, but not both. Also, spouses or eligible domestic partners who are both DSM employees cannot cover each other as dependents. In other words, no participant can be covered as both an employee and a dependent under the Plan.

Eligible Children

You can choose to cover your, your spouse's and/or your domestic partner's child(ren) up to age 26, regardless of their marital, financial or student status, or whether they reside with you. Children eligible to participate include:

- Biological child(ren)
- Adopted child(ren) and child(ren) placed with you for adoption
- Stepchild(ren)
- Foster child(ren)
- Any unmarried child who lives with you for whom you or your spouse or domestic partner is the court-appointed legal guardian and the appointment occurred before the child's 18th birthday
- Children for whom coverage is required under a Qualified Medical Child Support Order that applies to you

You also may cover your disabled dependent children age 26 and older who are unmarried, primarily dependent on you for financial support and who:

- Are incapable of self-support because of a physical or mental disability that began prior to age 26
- Were disabled and enrolled in this Plan immediately prior to age 26 or, with respect to a new employee, had other creditable coverage immediately before becoming eligible to participate in the Plan after age 26 and were enrolled as soon as they became eligible under this Plan
- Once enrolled in the Plan, remain enrolled continuously while disabled; and
- Do not have coverage available through their own employment

Since the disability must occur prior to age 26, a dependent cannot be added back onto the Plan if they are deemed disabled after already being dropped due to age requirements. Also, a

Creditable Coverage

Creditable coverage means most health coverage including, but not limited to: group health plan coverage, continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, individual health policies, Medicare, Medicaid and coverage under a state child(ren)'s health insurance program.

dependent child does not become re-eligible for the Plan if they are over the age of 26 and had subsequently lost eligibility for coverage due to a change in status, such as divorce.

About Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) that is issued by a court of competent jurisdiction or state agency and satisfies all of the following:

- Specifies your name and last known address and the child's name and last known address
- Describes the coverage to be provided, or the manner in which the type of coverage is to be determined
- States the period to which it applies
- Specifies each plan that it applies to
- Does not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan

If the Plan receives a QMCSO requiring it to provide health coverage for your child(ren), deductions for such coverage will be made directly from your paycheck. You will be notified if the Plan receives notice of a QMCSO that affects your Plan participation. You may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Who Is Not Eligible

The following individuals are not eligible dependents even if they satisfy the requirements described above:

- Anyone for whom you do not provide proof of dependent status acceptable to DSM within the time and in the manner required
- Anyone for whom you do not provide required information such as social security number, or tax ID number over the age of one.

Enrollment and Coverage Effective Dates

New Employees

If you are a newly eligible employee, you can access information explaining your benefit options and the cost of coverage by visiting www.mydsmbenefits.com. You must complete your enrollment ***within 30 days of the day you first become eligible***.

If you enroll within your first 30 days of eligibility, your coverage and that of your enrolled dependents will take effect on your date of hire or your first day of Active Work, and will stay in effect until you change your election, in accordance with Plan rules, or you cease to be eligible.

Ways to Enroll or Change Your Elections

You can enroll online through the DSM Benefits Website at *www.myDSMbenefits.com*, by calling the DSM Benefits Center at 1-866-353-9740, or by using the ADP mobile app.

Active Work

Active Work means that you are performing the substantial duties of your job at your regular work site and working your regularly scheduled hours.

When Enrolling Dependents

Social Security or ITIN (International Tax Identification Number) numbers are required for dependents age one and older to enroll for health coverage. Please make sure you have them handy when you make your elections. Failure to provide this information timely will cause your dependent's coverage to be terminated retroactively to the coverage effective date.

Default Coverage

If you do not enroll yourself and, if applicable, your eligible dependents, within your first 30 days of eligibility, you will be deemed to have elected Employee Only medical coverage under the CDHP and to have authorized DSM to deduct the required premium (as shown in the enrollment material) for that coverage on a pre-tax basis each pay period. You will not have any dental or vision coverage, and the tobacco surcharge will apply until you update your tobacco usage status. This deemed medical election cannot be changed until the next Annual Enrollment period unless you experience a Life Event, as described in "Changing Your Health Elections" on page 10, or you are eligible for special enrollment rights.

Action is Required: If you do not want any coverage under the Medical Plan, you must waive coverage within 30 days of the date you first become eligible. This request can be made online or by contacting the DSM Benefits Center.

****Note employees under the age of 26 and covered under another medical plan (such as a parent's plan), must waive coverage.***

Annual Enrollment

Each year during the Annual Enrollment period, you have the opportunity to change your elections effective for the following calendar year (January 1 – December 31). You are responsible for enrolling your dependents for coverage as well as providing any required documentation. See "Enrollment Documentation" on page 10 for more information.

If you do not elect to change your coverage during Annual Enrollment, your current medical (including prescription drug coverage), dental and vision elections will automatically carry over to the next Plan year, provided the coverage is still offered, you and your dependents remain eligible and any required documentation for your dependents is approved by DSM. Any elections for Flexible Spending Accounts or Health Savings Accounts will not carryover to a new plan year. Although your medical coverage may carry over to the next Plan year, any applicable surcharges will apply by default if you do not answer the applicable surcharge questionnaires each annual enrollment. DSM, at its discretion, may announce during Annual Enrollment that a new election is required for coverage to continue in the next year in which event your current elections will not roll over.

Benefit Options and Coverage Categories

Within each benefit plan (Medical, Dental and Vision) you may:

- Enroll in or waive coverage. For medical and dental coverage, more than one option is currently available.
- Elect from one of the following coverage categories:
  - Employee Only
  - Employee and Spouse/Domestic Partner
  - Employee and Child(ren)

– Family

You are not required to choose the same coverage category for each benefit.

Important Note About Family Coverage

Election of family coverage does not mean that everyone in your family is automatically covered, even if you have provided all needed documentation, such as the domestic partner affidavit. "Family" coverage means you wish to enroll yourself, your spouse/domestic partner and at least one other dependent. The only family members that will be covered are those whom you enroll who meet the Plan's definition of eligible dependent and for whom you have provided the required information (such as Social Security numbers) and/or proof of dependent status documents satisfactory to DSM, if required.

ID Cards

Once you enroll for coverage and your elections have been processed, you will receive ID cards for medical, prescription drug and dental benefits if you have a change in coverage categories or enroll for the first time. There are no ID cards for vision coverage.

Enrollment Documentation

During initial and Annual Enrollments, you must certify:

- Proof of dependent eligibility such as birth certificate, adoption certificate, marriage certificate, etc.
- Your child's disabled status, if he or she is over age 26
- Your domestic partner's eligibility status, as well as certain other documentation affirming you meet the eligibility criteria

This certification may be done online or by calling the DSM Benefits Center.

Note: DSM may audit eligibility records and may request additional documentation regarding dependent eligibility at other times during the year. During an audit, you may be required to provide proof of dependent eligibility. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be disenrolled from the Plan, retroactively (subject to the rules described in "Rescission of Medical Plan (Including Prescription Drug) Coverage" on page 14). Providing DSM with false or misleading information regarding a spouse/domestic partner or dependent child, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria may constitute misrepresentation. If DSM determines that misrepresentation has occurred, the company may terminate or suspend your coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action.

Changing Your Health Elections

Once you elect a Plan option or coverage category (Employee Only, Employee and Spouse/Domestic Partner, Employee and Child[ren],or Family), or decline coverage under a health care plan, ***you may only change your election or add or drop dependents during the Plan's Annual Enrollment period, except in limited circumstances***. Once the Annual Enrollment period ends, no further coverage changes can be made unless you experience a Life Event or are eligible for special enrollment rights, as defined in this section.

You may change your benefit coverage election if you experience a Life Event, as long as you make an election change consistent with that Life Event ***within 30 days following the event.*** For example, if you are covering yourself,get married and want to enroll your new spouse, you must make an election change within 30 days after the marriage to add your new spouse to your coverage.

All Life Event changes must be reported by visiting *www.myDSMbenefits.com*, or you may call the DSM Benefits Center at 1-866-353-9740.

Life Events

The following is a list of Life Events that may allow you to make a corresponding mid-year election change in the Medical, Dental and/or Vision Plans:

- Marriage
- Commencement or termination of a domestic partner relationship
- Divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible dependent
- Change in legal guardianship of a dependent
- Involuntary loss of other health coverage
- Death of your spouse/domestic partner 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 your hours of service resulting in working below an average of 20 hours per week
- Change in work status of your spouse/domestic partner that affects his/her eligibility for benefits
- Change in coverage election made by your spouse/domestic partner during his/her employer's Annual Enrollment period where the coverage period is different from yours
- Significant cost or coverage change in a health plan covering you or an eligible dependent
- Enrollment in or loss of Medicare or Medicaid coverage by you or any eligible dependent
- A change in your, or any covered eligible dependent's residence affecting eligibility for benefits

DSM will determine if the requested change is consistent with the Life Event and whether the Plan permits the election change. Contact the DSM Benefits Center if you have questions.

Reporting a Life Event Change

All Life Event changes must be reported to the DSM Benefits Center within 30 days of the event – ***even if you already have family coverage***. You may make changes online by visiting *www.myDSMbenefits.com*, you may use the ADP mobile app or you may call the DSM Benefits Center at 1-866-353-9740.

Enrolling New Family Members After a Life Event

If you have a Life Event, such as getting married or having a baby, and you want your new family member to be covered under the Plan, you must enroll your spouse/child(ren) within 30 days of the marriage or birth – ***even if you already have family coverage***.

Enrolling Newborn Children

A newborn child of an eligible employee on the date of the newborn's birth is ***not*** automatically enrolled in the Medical Plan. For coverage to begin at birth, the child must be enrolled in the Medical Plan within 30 days following his or her birth. If the newborn child is not enrolled in the Medical Plan within 30 days following birth and the child begins incurring covered expenses of his or her own, there will be no payment from the

Medical Plan for expenses of the newborn, and the employee will be responsible for all expenses of the newborn.

See "The Medical Plan," beginning on page 18, for the provisions with respect to Hospital/Physician charges for routine nursery and physician care to determine which charges are considered charges of the mother and which are considered charges of the newborn child.

Special Enrollment Rights

If you are declining medical coverage under one of the Plan's medical options for yourself or your dependents (including your spouse) because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your dependents in the Medical Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you 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).

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.

The term "placement", or being "placed", for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

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 under the above special rule. These rights do not always extend to domestic partners and their children, but an election change may be permitted if it qualifies as a Life Event change. Contact the DSM Benefits Center for details.

An employee or dependent who is eligible but not enrolled in the Medical Plan, may enroll in the Medical Plan if loss of eligibility for coverage is due to ***each*** of the following conditions:

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under DSM's Medical Plan was previously offered to the individual
- The coverage of the employee or dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not covered under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated
- The employee or dependent requests enrollment in the Medical Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions. Coverage will begin on the date of the event giving rise to the enrollment period

For purposes of these rules, a loss of eligibility occurs upon any of the following events:

- If the Plan is no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees)
- As a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death, termination of employment or reduction in the number of hours of employment or contributions towards the coverage were terminated
- When coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual)
- When coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual) and no other benefit package is available to the individual

Note: If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan), that individual does not have a Special Enrollment right and cannot enroll in the Plan as a result of the loss of that coverage.

To request a Special Enrollment or obtain more information, call the DSM Benefits Center at 1-866-353-9740.

When Coverage Ends

Medical (including prescription drug benefits), Dental and Vision Plan coverage will end as described in the following sections.

Employee Coverage

Employee coverage will terminate on the earliest of the following dates (except in certain circumstances where a covered employee may be eligible for continuation coverage). For a complete explanation of when continuation coverage is available under COBRA or the Uniformed Services Employment and Reemployment Rights Act [USERRA], what conditions apply and how to elect it, see “Continuing Coverage” beginning on page 102.

- The date the Plan or applicable benefit option is terminated
- The last day of the month the covered employee ceases to be in one of the eligible classes of employees. This includes termination of active employment (excluding covered employees on an approved leave of absence)
- Date of death for a covered employee
- The last day of the month in which your enrollment in the Plan ends
- The last day of the month for which the required contribution has been paid if the charge for the next month is not paid when due

This Plan complies with the Family and Medical Leave Act (FMLA). During any FMLA leave, DSM will maintain coverage under the Medical, Dental and Vision Plans on the same conditions as coverage would have been provided if the employee had been continuously employed during the entire leave period. If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for the employee and his or her covered dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Dependent Coverage

A dependent's coverage will terminate on the earliest of these dates (except in certain circumstances where a covered dependent may be eligible for continuation coverage). For a complete explanation of when continuation coverage under COBRA or USERRA is available, what conditions apply and how to elect it see “Continuing Coverage,” beginning on page 102.

- The date the Plan, the applicable benefit option or dependent coverage for benefits is terminated
- The date that the employee's coverage under the Plan terminates for any reason
- The date of a divorce, dissolution of domestic partnership, legal separation, or annulment from the employee, with respect to a covered spouse
- The last day of the month in which a child ceases to be an eligible dependent- except when a dependent turns age 26, in which case coverage ends the day before his/her 26 birthday
- The last day of the month for which the required contribution has been paid if the charge for the next month is not paid when due
- With respect to a child required to be covered under the terms of a qualified medical child support order, the date coverage terminates in accordance with such order

Termination for Cause

A person's coverage under the Plan will be terminated immediately upon discovery that a person has committed or participated in committing fraud against the Plan. Fraud against the Plan includes, but is not limited to:

- A person furnishing or who participated in furnishing fraudulent information to the Plan for the purpose of obtaining benefits under the Plan; for example, false health-related treatment claims
- Permitting improper use of his or her ID card
- Use of another person’s ID card under the Plan
- Prescription forgery, falsification or transfer of medication

Rescission of Medical Plan (Including Prescription Drug) Coverage

Notwithstanding the above, once your medical coverage is effective, it cannot be rescinded unless you or a covered dependent performs an act, practice or omission that constitutes fraud or unless you or a covered dependent makes an intentional misrepresentation of a material fact. A rescission is a cancellation, discontinuance or termination of medical coverage that has a retroactive effect. The Medical Plan will provide you at least 30 days advance written notice if your medical coverage will be rescinded. Any rescission of medical coverage is subject to the Claims and Appeals procedures, as described beginning on page 94.

For this purpose, the following are treated as intentional misrepresentation or fraud (unless prohibited by applicable law):

- Providing the employer, Plan Administrator or Medical Plan with false or misleading information regarding a spouse/domestic partner or dependent child (e.g., incorrect name or Social Security number)
- Enrolling an individual who does not satisfy the eligibility criteria
- Failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria (e.g., failing to drop a spouse within 30 days of a divorce)
- Filing or participating in filing a false or misleading claim for benefits
- Allowing your ID card to be used by an individual who is not enrolled in the Medical Plan, or

- Any other act, practice or omission that constitutes intentional misrepresentation or fraud as determined by the Plan Administrator (unless prohibited by applicable law)

However, the rescission rules described above do not apply in the following situations:

- If you fail to timely pay required premiums or other contributions towards the cost of your medical coverage, your medical coverage can be terminated retroactively
- If your medical coverage is terminated prospectively, or
- As otherwise permitted by law

Employee Contributions and Surcharges

You share the cost of your medical and dental coverage with DSM. Your Medical Plan contributions include the cost of prescription drug coverage. If you elect vision coverage, you pay the full cost of this benefit. Your share of the cost of your health benefits depends on the Plan option and coverage category you choose. Your health care contribution amounts are subject to change.

You pay your contributions for medical (including surcharges), dental and vision benefits through payroll deductions. Contributions for these health benefits for active employees are made on a before-tax basis (except for domestic partner coverage and coverage for the eligible dependents of a domestic partner). This means that the contributions you make each pay period are not counted as income for Social Security, federal income, and in most cases, state and local tax purposes. When you enroll for health benefits, you automatically authorize DSM to make the appropriate before-tax deductions.

If you are enrolled in the Medical Plan CDHP with Employee Only coverage by default, your contributions for this coverage will be taken from your pay automatically.

Spousal Surcharge: The required contributions for covering a spouse or domestic partner who has access to medical coverage from his/her employer (other than DSM) are higher than for those without access to other coverage. This is referred to as the Spousal Surcharge. This surcharge applies even if your spouse/domestic partner chooses not to enroll in that other coverage. If you enroll a spouse/ domestic partner, the spousal surcharge will apply, unless you provide an attestation that other coverage is not available. Remember that you are responsible for notifying DSM within 30 days after the date your enrolled spouse/domestic partner becomes eligible/ineligible for other coverage. It is your responsibility to indicate whether your spouse/domestic partner has other employer medical coverage by notifying the DSM Benefits Center.

Tobacco Surcharge: DSM assesses a surcharge for employees and spouses/ domestic partners enrolled in the DSM medical plan. Tobacco use is defined as any use of tobacco products, regardless of the frequency, within the past 6 months. Tobacco products include cigarettes, cigars, pipes and smokeless tobacco (i.e. chewing tobacco). Use of nicotine patches, nicotine inhalers or electronic cigarettes will not require an employee/spouse to pay the tobacco surcharge. There are options available to waive future surcharges by completing certain activities as defined by the DSM Brighter Living Wellness Program. More information is available by contacting the wellness provider or visiting myDSMbenefits.com.

Your required contributions for the PPO plans can also be reduced if you qualify for the wellness credit. See CDHP section for more information on how the wellness credit is applied for those who enroll in the CDHP plan. The wellness credit is also described on the Virgin Pulse website at www.brighterliving.dsm.com.

Social Security Taxes

Each year you pay Social Security taxes on a certain level of your earnings, called the taxable wage base. The before-tax dollars you use for health plan contributions are not considered part of your pay for Social Security tax purposes. As a result, your Social Security taxes may be reduced if your pay is below the taxable wage base after these before-tax dollars are subtracted from your total earnings. However, your savings on current taxes, by using before tax dollars to pay the required contributions, will normally be greater than any eventual reduction in Social Security benefits.

Contributions for Domestic Partners and Imputed Tax for Domestic Partners and their Dependents

Domestic Partners: If you cover a domestic partner (and children of the domestic partner, if applicable) for medical and/or dental (health) coverage, you will have an after-tax payroll deduction for the cost of benefits for these dependents. In addition, federal tax law requires that you be taxed on the full value of the cost of coverage for the domestic partner (and child[ren], if applicable), except in limited circumstances. This amount is equal to the full cost for one individual (approximately the COBRA cost for a single person). If you cover a domestic partner and a child of the domestic partner, this amount is equal to the full cost of family coverage (approximately the COBRA cost for family coverage) minus the full cost of coverage for one individual.

Although you do not have to pay the full cost of the coverage, you will be treated, for tax purposes, as if you received the amount subsidized by DSM for that coverage in your paycheck. This is referred to as “imputed income.” Each paycheck will show the amount of your imputed income and taxes will be withheld on that amount. Federal law requires that you pay taxes on the amount of these contributions, as do most states.

Prior to enrolling your domestic partner and his/her eligible child(ren), if applicable, for medical and dental coverage, call the DSM Benefits Center at 1-866-353-9740 to obtain the current premium amounts on which income will be imputed. This taxable income will appear on your W-2 form. If you determine that your domestic partner does meet the definition of a dependent under the Internal Revenue Code and you do not wish to be taxed on imputed income, you may submit an affidavit stating that he or she is a tax dependent each year. This affidavit must be submitted to DSM payroll and benefits by December 15th, before the beginning of the Plan year for which it is to be effective.

When filing your tax return, you may wish to consult with your tax advisor regarding the dependency status of your domestic partner and/or child(ren) of your domestic partner and its impact on imputing income for their benefits coverage. Since these tax requirements are complex, you should consult a tax professional for advice on your personal situation.

The Medical Plan

Your health is important to you and it's important to DSM. That's why DSM offers competitive, comprehensive benefits under the Medical Plan. DSM's medical coverage is designed to help make a major illness or injury easier to handle financially as well as to provide coverage for minor medical issues.

Key Terms

Turn to page 54 for definitions of key terms used in this section.

You have a choice of three medical options administered by Blue Cross Blue Shield (BCBS): the High Option PPO, the Low Option PPO and the Consumer Directed Health Plan (CDHP).

All three medical options use the Blue Cross Blue Shield network of providers and allow you to choose between in-network and out-of-network providers. Out-of-pocket costs are lower when in-network providers are utilized. All the options include prescription drug coverage, administered by Express Scripts.

In This Section **See Page**

The Medical Plan at a Glance

This section summarizes the basic facts of the Medical Plan.

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Employee only Employee + 1 Family (Employee + 2 or more dependents)	 $350 $700 $1,050	 $700 $1,400 $2,100	 $1,050 $2,100 $3,150	 $2,100 $4,200 $6,300	 $1,500 $3,000 $4,500	 $3,000 $6,000 $9,000
Out-of-Pocket Maximum* Employee only Employee + 1 Family (Employee + 2 or more dependents)	 $1,850 $3,700 $5,550	 $3,700 $7,400 $11,100	 $2,850 $5,700 $8,550	 $5,700 $11,400 $17,100	 $4,500 $9,000** $12,700**	 $9,000 $18,000 $25,400
Lifetime Benefit Maximum	Unlimited					
What the Medical Plan Pays* **						
Preventive Care (as defined by the Plan)	100%	70% after deductible	100%	60% after deductible	100%	60% after deductible
Office Visits • Primary Care • Specialist	100% after: $20 copay $40 copay	70% after deductible	100% after: $20 copay $40 copay	60% after deductible	80% after deductible	60% after deductible
Coinsurance – for many covered services	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Health Savings Account	N/A		N/A		DSM contributes to your HSA: $250 employee only $500 employee + spouse/domestic partner or child $750 employee + 2 or more dependents *(prorated if you enroll after January 1st)*	

** Shows deductible reflected in the out-of-pocket maximum for all options.*

***The out-of-pocket maximum is limited to $6,850 for only in network care for each individual in the CDHP*

****For out-of-network expenses, the amount paid by the plan is based on the Allowance. If the amount charged by the provider is more than the Allowance, you are responsible for 100% of that excess.*

All the options provide prescription drug benefits, although coverage under the CDHP works differently than under the PPO options. More information on prescription drug coverage is contained in "Prescription Drug Benefits," beginning on page 57.

Please note that the information in the above summary is not meant to be a complete description of the benefits. Certain requirements, exclusions and limitations may apply. Please refer to the rest of this SPD for further details.

Medical Benefits

The Medical Plan features three BCBS options to provide medical benefits. The options are:

- High Option PPO
- Low Option PPO
- Consumer Directed Health Plan (CDHP)

You may also waive medical coverage.

Within each option, the following coverage categories are available:

- Employee Only
- Employee plus Spouse/Domestic Partner
- Employee plus child(ren)
- Family (Employee plus Spouse/ Domestic Partner and Child(ren))

See “Eligibility and Enrollment,” beginning on page 5, for more information. Also, see page 15 for information on the spousal surcharge.

Preexisting Conditions

The Medical Plan does not have any preexisting condition limitations. This means you and your eligible dependents are eligible for covered expenses to treat an illness or injury that you had when you joined the plan.

CDHP Option and the Health Savings Account

The Consumer Directed Health Plan (CDHP) can be used in connection with a tax advantaged account called a Health Savings Account (HSA). HSAs were designed to work with the CDHP to help you:

- Pay for expenses incurred before you meet your deductible
- Pay for qualified medical expenses that are not otherwise reimbursable by the CDHP
- Save for future qualified medical expenses on a tax-free basis

It is your responsibility to confirm if you are eligible to set up an HSA and, therefore, to receive a contribution from DSM. Remember that to open an HSA, you must meet the requirements imposed by the IRS which include that you not have other disqualifying coverage. You can also make additional contributions to your HSA on a pre-tax basis through payroll deduction, up to the IRS limits which are set each year and communicated in the enrollment material. You do not pay certain taxes on the money you and DSM contribute, when it goes into your HSA account and use it for eligible expenses.

Currently, DSM contributes the following amounts to the HSA accounts of DSM employees established with the trustee identified in the enrollment material. These amounts are subject to change in future years. Note that to be eligible for the contribution, you must be a DSM employee enrolled in the CDHP as well open and qualify for a Health Savings Account in the applicable Plan year; individuals enrolled in the CDHP under COBRA are not eligible for the HSA contribution.

Medical Coverage Tier	Annual Amount DSM Contributes
Employee Only	$250
Employee Plus Spouse/Domestic Partner or Child	$500
Employee Plus 2 or more Dependents	$750

Note: The amounts are prorated if you and/ or your dependents enroll in coverage and open an HSA account after January 1.

Funds are available in the HSA once they have been contributed, not sooner like with an FSA. You can only be reimbursed from the HSA for expenses that are incurred after the date you actually establish the HSA account. If you qualify for the Wellness Incentive and open a Health Savings Account, your full incentive will be contributed to this account.

Health Savings Account features:

- You "own" your HSA; your account is portable.
- Contributions to an HSA can be made by you, DSM, or both.
- Contributions (subject to limits) and earnings are tax-free under federal and many state income tax laws.
- In order to remain within IRS limits, your contributions will be reduced by the DSM contributions to your account, as well as any potential wellness credit (regardless of whether you actually earn it)
- Withdrawals (to pay for qualified medical expenses, as determined by the IRS) are tax-free under federal and many state income tax laws.
- You do not forfeit funds that you do not use by year end. Instead, HSA funds remaining in your account will roll over to the following year.

Note: The HSA is not part of the Medical Plans or any other plan sponsored by DSM, and it is not governed by ERISA.

For more detailed information, refer to the DSM Benefits Website at www.myDSMbenefits.com.

How Coverage Works

All options are administered by BCBS and provide benefits for the same covered expenses. Keep in mind, the Medical Plan only covers certain preventive care and medically necessary assessment, diagnosis and treatment of certain conditions.

BCBS has a Preferred Provider Organization (PPO) network of doctors, hospitals and other health care providers who have agreed to offer care at negotiated rates. When you enroll in one of the three Medical Plan options, you may choose between having your health care provided by either in-network or out-of-network providers. Your out-of-pocket costs will generally be lower when you use in-network providers. There is no need to select a primary care physician and no referrals are needed to see a network specialist. In-network providers have agreed to charge negotiated, fixed fees; you won't have to pay charges above your plan copay or coinsurance, as long as you receive care In-Network.

About Preventive Care

Reimbursement for eligible claims will be made based on whether services are billed by your provider as preventive (routine) or diagnostic (non-routine). Note that certain preventive benefits have age and frequency limits.

You and the Medical Plan will each pay a portion of your covered expenses. The amount of covered expenses that you pay depends in part on which Medical Plan option you enroll in, the type of service provided, whether you choose an in-network or out-of-network provider and whether you have satisfied any required deductible.

Generally, coverage for eligible services that you receive when you use ***in-network*** providers is:

- **For covered preventive care,** 100% for all options
- **For all other covered care,** 90% of the negotiated fee after the deductible in the High Option PPO, 80% of the negotiated fee after the deductible in the Low Option PPO and 80% of the negotiated fee after the full deductible has been met for the applicable coverage tier for the CDHP Option

For some types of care you have the flexibility to receive care outside the network and receive a lower level of benefits after you meet the deductible. Out-of-network coverage is generally 70% of the allowance after the deductible in the High Option PPO, 60% of the allowance after the deductible in the Low Option PPO, and 60% of the allowance after the full deductible has been met for the applicable coverage tier for the CDHP Option.

You are responsible for paying the difference between the total service charge and the allowance, in addition to your coinsurance amount.

Allowance

An amount determined by the plan as the least of the following amounts:

- The actual charge made by the provider for the service or supply
- For an in-network provider, the amount that the provider has agreed to accept for the service or supply
- For an out-of-network provider, the amount determined as 250% of the amount that would be reimbursed for the service or supply under Medicare

If you use both in-network and out-of-network providers:

- In-network care will count toward ***both*** the in-network and out-of-network deductibles and the out-of-pocket maximums

- Out-of-network care will count toward ***both*** the in-network and out-of-network deductibles and the out-of-pocket maximums

Using In-Network vs. Out-of-Network Providers

Each time you need care, you can choose an in-network provider or an out-of-network provider. In-network providers agree to charge for services based on fees negotiated in advance with BCBS. These fees are generally less than those charged by out-of-network providers. Your cost for services is based on this overall lower cost. In addition, when you use In-Network providers, you will not have to pay any charges above the negotiated fee.

Finding an In-Network Provider

For assistance in finding an in-nnetwork provider, you can call BCBS at 1-800-810-2583 or visit the BCBS Website at www.horizonblue.com/DSM.

When treatment is received from out-of-network providers, the deductible must be met before the plan will make any payment. In addition, the plan will generally pay a lower percentage of covered expenses billed by out-of-network providers than it would have paid had an in-network provider been used. You are responsible for all charges in excess of the allowance.

Using In-Network Providers

Using an in-network facility for services such as X-rays, mammograms and lab work can help you save money. Even if your doctor is in-network, there is no guarantee that he or she will refer you to an in-network provider for other services. It is your responsibility to talk with your doctor about using providers in the BCBS network.

ID Cards

When you enroll for the first time, BCBS will mail you up to two ID cards for you and any covered dependents (one card if you enroll in Employee Only coverage, two if you enroll any dependents, regardless of how many). You may request additional ID cards from BCBS or print a temporary one from the BCBS website at http://www.horizonblue.com/dsm.

About Copays (High Option PPO/Low Option PPO)

General practitioners, internists, family practice doctors, OB/GYNs and pediatricians are generally considered primary care physicians and their office visits are usually covered under the $20 copay.

Cardiologists, dermatologists, and other providers whose main practice is in a specific area of care are generally considered specialists and their office visits require a $40 copay.

The CDHP Option does not have copays.

Using the Medical Plan Options

You use the High and Low Option PPOs the same way. The CDHP works differently. The following are some key points to keep in mind when using your medical coverage.

Deductibles

When services are obtained from in-network or out-of-network providers, the Medical Plan pays a percentage of most covered medical expenses after you pay a portion of these expenses each year. The portion you must pay first each year is called the annual deductible. Each Medical Plan option has an annual deductible for employee only, employee plus one dependent and family (employee plus two or more dependents) coverage.

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Employee only	$350	$700	$1,050	$2,100	$1,500	$3,000
Employee + 1	$700	$1,400	$2,100	$4,200	$3,000	$6,000
Family (Employee + 2 or more dependents)	$1,050	$2,100	$3,150	$6,300	$4,500	$9,000

Whether you receive treatment from in-network or out-of-network providers, all eligible charges that go toward meeting your annual deductible are added together to satisfy both the in-network and out-of-network deductibles.

How Deductibles Work Under the PPO Options

For the High Option PPO and the Low Option PPO, if you have employee plus one or family coverage, there is an individual deductible equal to the employee only deductible.

The ***individual deductible*** is the amount you pay for each person's covered expenses (excluding any required copays) each calendar year before the plan begins to make payments.

*The **deductible for employee plus one coverage*** is the maximum you would have to pay in deductibles for you and a covered dependent each calendar year. You pay the expenses for each covered person until that person's expenses have reached the individual deductible amount.

*The **family deductible*** is the maximum you would have to pay in deductibles for all covered family members each calendar year. You pay the expenses for each covered family member until that person's expenses have reached the individual deductible amount. However, if the amount you pay toward the deductibles of all covered family members combined reaches the family deductible, you do not need to pay any more toward deductibles for the remainder of the year.

Note: No covered person may satisfy more than his/her individual deductible in meeting the family deductible.

In-Network Family Deductible Example for the PPO Options

Let's say your family of four is covered under the High Option PPO and you use both in-network and out-of-network providers in a given calendar year.

As a result of services you receive from in-network providers, you satisfy your entire $350 in-network individual deductible by March 1st. By June 1st of the same calendar year, your spouse satisfies $300, one of your children satisfies $200, and your other child satisfies $200.

The Medical Plan would begin reimbursing your in-network covered expenses after March 1st because you satisfied your $350 individual deductible. After June 1st, the plan will begin reimbursing your eligible dependents' in-network covered expenses because, together, they have satisfied the other $700 of the family deductible. In this example, even though your individual eligible dependents did not each satisfy their $350 deductible, together, you have all met the $1,050 family deductible. However, no more than $350 of any one family member's expenses counts toward the satisfaction of the family deductible.

Note: Amounts used to satisfy the in-network deductible may also apply to satisfying the out-of-network deductible.

Family Deductible in Case of Accidents

For the PPO options, if two or more covered members of your family (including you) have covered expenses from the same accident, only one individual deductible must be satisfied for those expenses during the total time benefits are payable for that accident.

How Deductibles Work for the CDHP Option

For the CDHP Option, deductibles are based on the coverage tier you elect and there is no "per individual" deductible. The CDHP will start paying benefits for an individual family member once the full deductible for the coverage tier elected has been met. There is no individual deductible. For example, if you elect employee plus one or family coverage, **you must meet the entire deductible** for that coverage tier before the Plan pays benefits other than covered in-network preventive care expenses. Prescription drug costs count toward the deductible (and are subject to the deductible). There are no copays under the CDHP.

*The **deductible for employee plus one coverage*** is the maximum you would have to pay in deductibles for you and a covered dependent each calendar year. You pay the expenses for each covered person until your combined expenses meet the deductible amount.

*The **family deductible*** is the maximum you would have to pay in deductibles for all covered family members each calendar year. You pay the expenses for each covered family member until your combined expenses meet the deductible amount.

In-Network Family Deductible Example for the CDHP Option

Let's say your family of four is covered under the CDHP Option and you use both in-network and out-of-network providers in a given calendar year.

As a result of services you receive from in-network providers, including minor surgery, you satisfy $2,500 of the family deductible by May 1st, including $400 in prescription drugs. (You must meet the entire family deductible before the CDHP begins paying a portion of non-preventive covered expenses, including prescription drugs.) By September 1st of the same calendar year, you satisfy an additional $500 of the deductible, your spouse satisfies $700, one of your children satisfies $600, and your other child satisfies $200. Note that this family could use money in their HSA to help pay for these expenses.

The Medical Plan would begin reimbursing you and your covered dependents in-network covered expenses after September 1st because you and your family have satisfied the family deductible.

Note: Amounts used to satisfy the in-network deductible may also apply to satisfying the out-of-network deductible.

Out-of-Pocket Maximums

All Medical Plan options have calendar year out-of-pocket maximums. The out-of-pocket maximum limits how much you have to pay for covered medical expenses during the year. Each Medical Plan option has an out-of-pocket maximum for employee only, employee plus one dependent and family (employee plus two or more dependents) coverage. The annual deductible counts toward reaching the out-of-pocket maximum.

Whether you receive treatment from in-network or out-of-network providers, all out-of-pocket amounts are added together to satisfy both the in-network and out-of-network out-of-pocket maximums, as shown in the following table.

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Maximum						
Employee only	$1,850	$3,700	$2,850	$5,700	$4,500	$9,000
Employee + 1	$3,700	$7,400	$5,700	$11,400	$9,000*	$18,000
Family (Employee + 2 or more dependents)	$5,550	$11,100	$8,550	$17,100	$12,700*	$25,400

* An individual enrolled in Employee +1 or Family coverage in the CDHP will have a "per person" out-of-pocket maximum. An individual will be able to reach the annual out-of-pocket maximum for in-network care once he or she has incurred expenses of $6,850.

Expenses That Do Not Count Toward the Out-of-Pocket Maximum

The following expenses will not count toward the satisfaction of the out-of-pocket maximums and will not be eligible for 100% reimbursement even if out-of-pocket maximums are satisfied:

- Prescription drug copays do not apply to the High Option PPO and the Low Option PPO medical out-of-pocket maximum as they apply to the separate prescription drug out-of-pocket maximum (the medical and prescription drug out-of-pocket maximum together will not exceed the amount permitted under the Affordable Care Act)

- Expenses which are not eligible under the plan
- Expenses which exceed the out-of-network allowance

How Out-of-Pocket Maximums Work Under the PPO Options

For the High Option PPO and the Low Option PPO, if you have employee plus one or family coverage, there is an individual out-of-pocket maximum equal to the employee only out-of-pocket maximum.

The ***individual out-of-pocket maximum*** is the most you have to pay for each person's in-network covered expenses during the calendar year, with the exception of certain expenses described in this section. If an individual's expenses reach this maximum, the plan will pay 100% of any additional covered expenses that person has for the rest of the calendar year.

*The **out-of-pocket maximum for employee plus one coverage*** is the most you have to pay for in-network covered expenses for you and a covered dependent each calendar year with the exception of certain expenses described in this section. You pay the expenses for each covered person until that person's expenses have reached the individual out-of-pocket maximum amount.

The ***family out-of-pocket maximum*** is the most you have to pay for all in-network covered family members for the year with the exception of certain expenses described in this section. If the total amount you pay for covered expenses of all covered family members combined reaches the family out-of-pocket maximum, the plan will pay 100% of your family's additional covered expenses for the rest of the calendar year.

Note: No covered person may satisfy more than his/her individual out-of-pocket maximum in meeting the family out-of-pocket maximum. Once you reach the out-of-pocket limit, you will still pay copays for some services.

Family Out-of-Pocket Maximum Example for the PPO Options

Let's say your family of four is covered under the High Option PPO, which has a $5,550 family out-of-pocket maximum for in-network care and your family has met the annual deductible, which counts toward the maximum. Here's an example showing how you might reach that limit.

As a result of services you receive from in-network providers, your individual out-of-pocket costs for covered expenses reach $1,850. This is the most an individual family member can contribute toward the family out-of-pocket maximum for In-Network expenses under the High Option PPO.

Meanwhile, your other family members have accumulated out-of-pocket costs for covered expenses from In-Network providers of $950, $1,750, and $1,000. This brings the family's total out-of-pocket costs for In-Network covered expenses to $5,550 – the family out-of-pocket maximum for the option.

Once your family reaches the in-network family out-of-pocket maximum of $5,550, the plan begins paying 100% of the cost for covered services received from in-network providers, other than applicable copays, for the rest of the calendar year. This applies even for the three family members in this example who had not yet reached their individual out-of-pocket maximums under the plan.

How Out-of-Pocket Maximums Work Under the CDHP Option

For the CDHP Option, if you have employee plus one or family coverage, you must meet the entire out-of-pocket maximum for employee plus one or family coverage (as applicable) before the Plan pays 100% of any additional covered expenses for the remainder of the calendar year other than covered preventive care. Prescription drug costs count toward the out-of-pocket maximum. There are no copays.

If you have employee plus one coverage, the ***out-of-pocket maximum for employee plus one coverage*** is the most you have to pay for covered expenses for you and a covered dependent each calendar year with the exception of certain expenses described in this section. You pay the expenses for employee plus one until the expenses for employee plus one is reached then the plan pays 100% of any additional covered expenses for the remainder of the calendar year.

If you have family coverage, the ***family out-of-pocket maximum*** is the most you have to pay for all covered family members for the year with the exception of certain expenses described in this section. If the total amount you pay for covered expenses of all covered family members reaches the family out-of-pocket maximum, the plan will pay 100% of your family's additional covered expenses for the remainder of the calendar year.

Family Out-of-Pocket Maximum Example for the CDHP Option

Let's say your family of four is covered under the CDHP, which has a $12,700 family out-of-pocket maximum for in-network care and your family has met the annual deductible, which counts toward the maximum. Here's an example showing how you might reach that limit.

As a result of services you receive from in-network providers, your individual out-of-pocket costs for covered expenses reach $6,850. Meanwhile, your other family members have accumulated out-of-pocket costs for covered expenses from in-network providers of $2,350, $2,450, and $1,050. This brings the family's total out-of-pocket costs for in-network covered expenses to $12,700 – the family out-of-pocket maximum for the option. Note that this family could use money in their HSA to help pay for these expenses.

Once your family reaches the in-network family out-of-pocket maximum of $12,700, the plan begins paying 100% of the cost for covered services received from in-network providers for the remainder of the calendar year.

Lifetime Benefit Maximum

Except in limited circumstances, all Medical Plan options have an unlimited lifetime maximum for all covered medical expenses paid under these options for you and each of your eligible dependents. There are specific lifetime benefit maximums that apply to infertility treatment, wigs and hospice care. See "Important Information on Certain Covered Expenses," beginning on page 36, for more information. The Medical Plan (including prescription drug benefits) will be administered in accordance with the Patient Protection and Affordable Care Act which requires that no lifetime maximum apply to essential health benefits.

Managing Your Health Care

The plan uses several programs designed to provide or improve your quality of care while effectively managing costs, as described in the following sections.

Precertification

The precertification program is designed to improve delivery of care and help ensure that you and your dependents receive the most appropriate treatment while avoiding unnecessary costs. The program is not intended to restrict or deny your access to medical treatment or take the place of your own physician's medical advice. Rather, it is intended to certify necessary and effective treatment and to suggest alternative treatment approaches or facilities where appropriate.

BCBS precertifies care for all inpatient services, except for mental health/substance abuse treatment. Horizon Behavioral Health precertifies care for applicable mental health/substance abuse treatment. Precertification is not a guarantee of coverage or payment.

What You Need to Know About Precertification

You, your physician, or a family member may make required certification calls. However, you are ultimately responsible for satisfying the plan's certification requirements. (Emergency care is not subject to precertification.)

If BCBS or Horizon Behavioral Health denies your request for precertification when it is required and you choose to receive this care anyway, the plan may not cover any of the expenses related to your hospital stay or course of treatment. You can request a review of a denial of precertification by calling BCBS at 1-800-664-2583 (for medical benefits), or by calling Horizon Behavioral Health at 1-800-626-2212 (for mental health and/or substance abuse benefits). If you receive care that is subsequently deemed not medically necessary, you will not be eligible for benefits under the plan related to that care, regardless of whether you have requested precertification.

Precertification does not guarantee that expenses are covered under the plan.

Precertification for Medical Conditions (Except Mental Health/Substance Abuse)

Certain hospital and other facility-related charges, such as skilled nursing care admissions or hospice care, must be precertified by BCBS. If your attending physician is an in-network provider, he or she is responsible for obtaining precertification from BCBS for your care. If your attending physician is an out-of-network provider, you are responsible for calling BCBS and obtaining precertification from BCBS for your care.

The precertification phone number is printed on your BCBS ID card. For admissions outside the U.S., call BCBS at 1-800-664-2583 or 1-804-673-1177. BCBS must receive the request for precertification at least five business days or as soon as reasonably possible before the admission is scheduled to occur.

The following care must be precertified:

- Care in advance of a scheduled hospital stay
- Before the end of a certified length of stay in a hospital if continued inpatient hospital confinement is needed
- Before extending any maternity stay beyond 48 hours for a non-cesarean delivery or beyond 96 hours for a cesarean section, even if the stay was previously certified
- Inpatient hospital/facility admissions (excluding emergency admissions), including rehabilitation facilities
- Home Health Care services
- Skilled Nursing Facility services
- Private Duty Nursing (private duty nursing does not require precertification, but BCBS will review for medical necessity before paying a claim)
- Bariatric surgery
- Hospice Care (inpatient only)
- Home Infusion Therapy
- Synagis and its administration – does not require prior authorization but can be subject to a back end claim review*
- Durable Medical Equipment – rental or purchase over $500
- Transplant services
- Inpatient cardiac catheterizations
- Cosmetic Reconstructive Surgery

- All Possible Cosmetic or Plastic procedures
- Sinus (Nasal) Surgery – does not require prior authorization but can be subject to a back-end claim review*
- Pain injections- do not require prior authorization but can be subject to a back-end review*
- Infertility Procedures such as: In-vitro Fertilization, Gamete Intra Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT)

**A back-end claim review involves a post service medical necessity review by Claim/Medical Policy. The services are reviewed using the Horizon Uniform Medical Policy or other criteria. The PPO and Indemnity plan also have the option for a voluntary predetermination process which reviews the requests before services are performed*

After BCBS is notified, they determine:

- Medical necessity and appropriateness of the hospital admission or other medical care
- Anticipated length of stay
- Appropriateness of health care alternatives, like home health care or other outpatient or out-of-hospital care

Certification program medical professionals, in consultation with your physician, review your recommended treatment to help ensure that it is medically necessary, appropriate and effective.

BCBS notifies you or your provider, by phone, of the outcome of BCBS' review. If BCBS authorizes a hospital or other facility admission, the authorization is valid for the:

- Specified provider
- Named attending physician
- Specified admission date
- Authorized length of stay
- Diagnosis and treatment plan

Note: Emergency care is not subject to precertification.

Precertification for Mental Health and Substance Abuse

Horizon Behavioral Health precertifies all inpatient mental health and substance abuse treatment, including residential treatment center confinements when medically necessary. You may contact Horizon Behavioral Health at 1-800-626-2212.

After Horizon Behavioral Health is notified, they determine:

- Medical necessity and appropriateness of the admission
- Anticipated length of stay from admission date
- Appropriateness of health care alternatives, such as outpatient or out-of-hospital care

Although you are not required to precertify mental health and substance abuse treatment provided on an outpatient basis, by calling Horizon Behavioral Health prior to receiving treatment, you can ensure that your care is medically necessary and provided by the most appropriate provider.

Continued Stay Review

Continued stay review is the process by which BCBS determines (based on discussions with your physician and the facility regarding your course of treatment) whether a continued hospital admission is necessary.

You, your provider or BCBS may initiate a continued stay review of any hospital admission. BCBS may contact your provider or facility to discuss the following:

- Medical necessity and the necessity for continued hospitalization
- The anticipated length of continued hospitalization
- The appropriateness of health care alternatives

BCBS will notify your physician or facility of the outcome of their review. BCBS will confirm in writing the outcome of their review that resulted in a denial and/or any newly authorized lengths of stay in the denial.

Predetermination of Benefits

A predetermination of benefits can be initiated by your provider, who must contact BCBS on your behalf before you have a non-emergency surgery. A predetermination is not a guarantee of benefit payment, but a determination of medical necessity for the treatment or service under consideration. Precertification of the treatment or service may also be required by BCBS. Refer to "Precertification for Medical Conditions (Except Mental Health/Substance Abuse)" beginning on page 28 for more information.

If your physician recommends non-emergency surgery, he or she would need to call BCBS at the phone number on the back of your ID card to initiate a predetermination of benefits. He or she may also mail the predetermination request to:

Horizon Blue Cross Blue Shield of New Jersey
Attn: Claim Policy Implementation – Predetermination
P.O. Box 220
Newark, NJ 07101-1740

When a request for predetermination is received, BCBS will:

- Request your physician provide written documentation for review
- Determine the medical necessity of the elective procedure and notify you and your surgeon. BCBS will generally provide a response within 30 days. You should discuss the BCBS determination with your surgeon before undergoing surgery

Predetermination is not required for benefit payment. If you do not request predetermination, the usual plan benefits will be paid based on the information submitted after the surgery. If you request predetermination and the actual surgery differs from the descriptions submitted by the surgeon for predetermination, benefits will be based on the actual surgery performed.

*The out of pocket maximum is limited to $6,850 for only in-network care for each individual in the CDHP

Primary Nurse Case Management Program

This Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ) program is built to give you the education, care and services you may need when faced with a complex medical situation or support and resources you may need for an acute or chronic condition. Trained case managers are fully licensed health care professionals and registered nurses. Your Primary Nurse will periodically contact you to discuss your medical situation and work with your doctors and other caregivers to help you or covered dependents manage your medical needs. Chronic conditions include Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Heart Failure, and Diabetes. This voluntary program is free and available to all members. To learn more or enroll, call 1-888-621-5894 and select option 2.

Note: Horizon Primary Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your doctor's care. Always speak with your doctor before starting an exercise program or diet.

Covered Expenses

The following chart outlines how benefits are paid under the Medical Plan. Note that in-network benefits are based on negotiated fees and out-of-network benefits are based on the allowance. Refer to "Important Information on Certain Covered Expenses" beginning on page 36 for more specific information on some of the items in the following chart.

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited[1]		Unlimited[1]		Unlimited[1]	
Deductible						
Employee only	$350	$700	$1,050	$2,100	$1,500	$3,000
Employee + 1	$700	$1,400	$2,100	$4,200	$3,000	$6,000
Family (Employee + 2 or more dependents)	$1,050	$2,100	$3,150	$6,300	$4,500	$9,000
Out-of-Pocket Maximum						
Employee only	$1,850	$3,700	$2,850	$5,700	$4,500	$9,000
Employee + 1	$3,700	$7,400	$5,700	$11,400	$9,000	$18,000
Family (Employee + 2 or more dependents)	$5,550	$11,100	$8,550	$17,100	$12,700	$25,400
Health Savings Account	N/A		N/A		DSM contributes to your HSA: $250 employee only $500 employee + spouse/domestic partner $750 employee + child or family (employee + 2 or more dependents) *(prorated if you enroll after January 1st*	

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physician Office Visits [2]						
Primary physician office visit	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible	80% after deductible	60% after deductible
Specialist physician office visit	100% after $40 copay	70% after deductible	100% after $40 copay	60% after deductible	80% after deductible	60% after deductible
Urgent care center office visit	100% after $20 primary/ $40 specialist copay	70% after deductible	100% after $20 primary/ $40 specialist copay	60% after deductible	80% after deductible	60% after deductible
Preventive Care						
Well-child care/immunizations (to age 18) [3]	100%, no deductible	70% after deductible (deductible waived to age 5)	100%, no deductible	60% after deductible (deductible waived to age 5)	100%, no deductible	60% after deductible
Routine physicals/ immunizations (one per calendar year, age 18 and older)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Well-woman exams including Pap tests (one per calendar year)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Mammograms (one baseline, ages 34-49; one per calendar year, age 40 and older)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Prostate cancer screenings (one per calendar year, age 50 and older)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Colonoscopies or sigmoidoscopies (one per calendar year, age 50 and older)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Digital Rectal Exam (one per calendar year, age 40 and older)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Routine hearing exams (one per calendar year)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Skin Cancer Screenings	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible
Lung Cancer Screenings (if you are 55 or older and have smoked for more than 30 years)	100%, no deductible	70% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Laboratory Services [2]						
Performed in physician's office or outpatient non-hospital facility	100%; copay applies if physician charges for non-routine office visit	70% after deductible	100%; copay applies if physician charges for non-routine office visit	60% after deductible	80% after deductible	60% after deductible
Performed in inpatient or outpatient hospital facility	90% after deductible; 100% if preventive	70% after deductible	80% after deductible; 100% if preventive	60% after deductible	80% after deductible	60% after deductible
X-ray Services [4]						
Performed in physician's office or outpatient non-hospital radiology facility	100%; copay applies if physician charges for non-routine office visit	70% after deductible	100%; copay applies if physician charges for non-routine office visit	60% after deductible	80% after deductible	60% after deductible
Performed in inpatient or outpatient hospital facility	90% after deductible; 100% if preventive	70% after deductible	80% after deductible; 100% if preventive	60% after deductible	80% after deductible	60% after deductible
Allergy Testing and Treatment [2]						
Performed in physician's office or outpatient non-hospital facility	100%; copay applies if physician charges for non-routine office visit	70% after deductible	100%; copay applies if physician charges for non-routine office visit	60% after deductible	80% after deductible	60% after deductible
Performed in inpatient or outpatient hospital facility	90% after deductible;	70% after deductible	80% after deductible;	60% after deductible	80% after deductible	60% after deductible
Hospital Coverage [2]						
Inpatient (including physician visits and consultations)[5]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Surgery [5]						
Physician's Office	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Inpatient Facility Services [5]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgical Facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Physician Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Surgeon's Fees	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Second Surgical Opinion	100% after $20 primary/ $40 specialist copay	70% after deductible	100% after $20 primary/ $40 specialist copay	60% after deductible	80% after deductible	60% after deductible
Outpatient/Preadmission Testing						
Primary physician office visit	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible	80% after deductible	60% after deductible
Specialist physician office visit	100% after $40 copay	70% after deductible	100% after $40 copay	60% after deductible	80% after deductible	60% after deductible
Outpatient Facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Room						
For medical emergencies	100% after $100 copay (waived if admitted)	100% of covered amount after $100 copay (waived if admitted)	100% after $100 copay (waived if admitted)	100% of covered amount after $100 copay (waived if admitted)	80% after deductible	80% after deductible
For non-medical emergencies	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Ambulance						
For medical emergencies	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
For non-medical emergencies	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Infertility Care [6]						
Initial office visit	100% after $20 primary/ $40 specialist copay	70% after deductible	100% after $20 primary/ $40 specialist copay	60% after deductible	80% after deductible	60% after deductible
All other covered expenses	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Family Planning						
Vasectomy/Tubal Ligation	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Short-Term Rehabilitation Services						
Short-term Therapies [7]						
Performed in provider's office or outpatient non-hospital facility	100% after $40 copay	70% after deductible	100% after $40 copay	60% after deductible	80% after deductible	60% after deductible

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Performed in inpatient or outpatient hospital facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physical Therapy (60-visit maximum per calendar year)[8]						
Performed in provider's office or outpatient non-hospital facility	100% after $30 copay	70% after deductible	100% after $30 copay	60% after deductible	80% after deductible	60% after deductible
Performed in inpatient or outpatient hospital facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chiropractic Care (30-visit maximum per calendar year)[8]	100% after $30 copay	70% after deductible	100% after $30 copay	60% after deductible	80% after deductible	60% after deductible
Maternity (unless covered as preventive care)						
Initial visit to confirm pregnancy	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible	80% after deductible	60% after deductible
All subsequent physician's charges for pre- and postnatal visits and delivery[5]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Special Services						
Skilled Nursing Facility (60-day maximum/ calendar year) [5, 8]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Home Health Care (100 visit maximum/ calendar year) [5, 8]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospice Care (180-day lifetime maximum) [5, 8]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Private Duty Nursing (240-hour maximum/ calendar year) [5, 8]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment[5]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
External Prosthetics	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Dialysis Services	90% after deductible	0% Out of Network not covered	80% after deductible	0% Out of Network not covered	80% after deductible	0% Out of Network not covered
Mental Health & Substance Abuse						
Inpatient[5]	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient—office visit	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible	80% after deductible	60% after deductible
Outpatient—other	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

	High Option PPO		Low Option PPO		Consumer Directed Health Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
All Other Covered Expenses						
Other Covered Expenses	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible

[1] *Except in limited circumstances, such as infertility treatment.*

[2] *Services such as infusion therapy (chemotherapy, in-network dialysis and IV therapies) are subject to deductible and coinsurance.*

[3] *Frequency based on American Academy of Pediatrics recommendations and other applicable guidelines under the Patient Protection and Affordable Care Act.*

[4] *Advanced radiology, such as CAT/ PET scans, MRIs and nuclear radiology, are subject to deductible and coinsurance.*

[5] *Precertification required.*

[6] *$15,000 lifetime benefit maximum applies on a combined basis for all in- and out-of-network care received under all DSM medical options.*

[7] *Includes speech, occupational and cognitive therapy (30 visits/calendar year each).*

[8] *Combined in- and out-of-network.*

***Remember**: For out-of-network care, you are responsible for 100% of the charges that exceed the allowance.*

Important Information on Certain Covered Expenses

To be covered by the Medical Plan, the expense must be medically necessary. Further, the plan does not pay benefits for all expenses that are medically necessary – only those that are covered expenses. The covered expenses for all Medical Plan options are the same, as described in the following sections. **Unless specifically noted below, all benefits are paid according to the chart under "Covered Expenses," beginning on page 31.**

Ambulance Benefits

For medical emergencies, in- and out-of-network ambulance benefits are covered subject to the in-network deductible and coinsurance. Ambulance services for non-medical emergencies are not covered.

Air ambulance benefits are subject to the in-network deductible and coinsurance.

Bariatric Surgery

Bariatric surgery for morbid obesity is covered when deemed medically necessary by BCBS and is subject to the applicable deductible and coinsurance.

A procedure is considered medically necessary if you must satisfy the criteria established under the BCBS medical policy on surgery for morbid obesity and your procedure(s) must be preauthorized.

Clinical Trials

To the extent required by federal law, the Plan covers "routine patient costs" for items and services incurred by a "qualified individual" in connection with participation in an "approved clinical trial." "Routine patient costs" include all items and services that would be covered typically under the Plan for individuals who are not otherwise participating in a clinical trial.

It does not include the following items and services:

- The investigational items, devices or services themselves;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If the approved clinical trial is only offered outside the patient's state of residence, the Plan will cover routine patient costs of services and items which are provided by out-of-network providers. Otherwise, the Plan is not required to provide benefits for routine patient costs if the services are provided by an out-of-network provider unless the Plan would otherwise cover such services by out-of-network providers.

To be a "qualified individual," you must meet two requirements. First, you must be eligible to participate in an approved clinical trial (defined below) according to the trial protocol. Second, your attending physician must determine that your participation in the trial is appropriate, or you must provide medical and scientific information establishing that you meet the eligibility standards of the trial protocol and that your participation in the trial is appropriate.

An "approved clinical trial" is a phase I, II, III or IV clinical trial that is (1) conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition (i.e., likely to lead to death unless the course of the disease or condition is interrupted) and (2) is any one of the following:

- Federally-funded by one or more government agencies or entities designated in Section 2709(d)(1)(a) of the Public Health Service Act;
- Conducted under an investigational new drug application reviewed by the FDA; or
- Is a drug trial that is exempt from the investigational new drug application requirements.

NOTE: If one or more network providers are participating in the approved clinical trial, you must use the network provider for the approved clinical trial provided he or she will accept you as a patient.

Diabetic Education Benefits

For the High Option PPO and the Low Option PPO, in-network diabetic education benefits, when rendered at a provider's office, are covered at 100% after the required copay ($20 for primary care physicians and $40 for specialists). For the CDHP Option, in-network diabetic education benefits are covered, subject to the applicable deductible and coinsurance. Out-of-network diabetic education benefits are covered for all options, subject to the applicable deductible and coinsurance. Any diabetic education services performed in a facility setting are subject to the applicable deductible and coinsurance. Diabetic education that qualifies as preventive care is covered under the preventive care provisions of the plan.

Home Health Care

Covered expenses include charges billed by a Home Health Care Agency for the following medical services and supplies provided under the terms of a home health care plan established and approved in writing by a licensed physician who certifies that the patient would require confinement in a hospital or Skilled Nursing Facility, if he/she did not have the care and treatment stated in the Home Health Care Plan:

- Part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse
- Part-time or intermittent services of a Home Health Aide
- Physical, occupational and speech therapy
- Medical supplies
- Administration of drugs and medicines lawfully dispensed only on the written prescription of a physician

- Laboratory services, but only to the extent that such charges would have been considered covered expenses had a person required confinement in a hospital or Skilled Nursing Facility

Home Health Care coverage will not include care or treatment which is not stated in the home health care plan, services of a person who is a member of your or your eligible dependent's family or who normally lives in your or your eligible dependent's home, or any period when the person receiving Home Health Care is not under the continuing care of a physician.

Home Health Care benefits are limited to 100 visits per calendar year combined for in- and out-of-network services. Precertification of Home Health Care services is required (see "Precertification" beginning on page 27 for more information).

Hospice Care

Hospice care is an alternative to the traditional approach of caring for a terminally ill patient. Instead of focusing on a cure for an illness, hospice services are designed to lessen suffering and to enable the patient to live through the last phases of an incurable disease as fully and comfortably as possible while maintaining dignity, self-awareness and self-respect. "Terminally ill" means a prognosis of six months or less to live as diagnosed by a physician.

Covered expenses include charges made due to terminal illness for the following Hospice Care services provided under a Hospice Care program:

- Hospice facility charges for semiprivate room and board and other medically necessary services and supplies
- Hospice facility charges for services provided on an outpatient basis
- Fees charged by a physician for professional services
- Fees charged by a psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the death of the person who had been receiving covered Hospice Care
- Charges for pain relief treatment including drugs, medicines and medical supplies

A Hospice Care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families and provides palliative and supportive medical, nursing and other health services through home or inpatient care during the terminal illness.

A Hospice Facility must be accredited by the National Hospice Organization and meet standards established by BCBS. Charges ***not*** eligible under the Hospice Care program include charges for:

- Services of a person who is a member of your or your eligible dependent's family or who normally resides in your or your eligible dependent's home
- Any period when the person receiving Hospice Care is not under the care of a physician
- Services or supplies not listed in the Hospice Care program
- Services or supplies that are primarily to aid the person receiving Hospice Care in daily living
- More than three bereavement counseling sessions

Covered hospice benefits also include a lifetime maximum benefit of 10 days of respite care for an eligible caregiver of a plan participant receiving hospice care.

There is a 180-day combined lifetime benefit maximum for In- and out-of-network hospice benefits. Hospice care requires precertification (see "Precertification" beginning on page 27).

Hospital Coverage

The Medical Plan covers the same types of hospital services and supplies whether treatment is received at an in-network or out-of-network hospital. However, the level of coverage is generally higher when using an in-network hospital.

All inpatient hospital admissions must be precertified, except for medical emergencies (see "Precertification" beginning on page 27).

Covered expenses include:

- **Room and Board** at the negotiated semiprivate rate for in-network hospitals or at an out-of-network hospital's most common semiprivate rate. If you stay in a private room, you will have to pay any additional charges associated with the private room. Also covered are other general services and activities needed for the care of registered bed patients, including general nursing services
- **Outpatient Hospital Expenses** including charges billed by a free-standing surgical facility and charges billed by a hospital emergency room or urgent care center for emergency services or emergency care. For the High Option PPO and the Low Option PPO there is a required emergency room copay (the emergency care copay is waived if the patient is admitted to the hospital). For the CDHP, coverage is subject to the applicable deductible and coinsurance
- **Routine Nursery Charges**, including hospital physician's charges, are billed as part of a mother's hospital stay. In the event that a newborn child requires non-routine medical care and charges for that care are billed separately, those charges will be subject to the applicable deductible and coinsurance. (See "Enrolling Newborn Children" on page 11 for information on enrolling newborn children for medical coverage)

Routine and Non-Routine Nursery Charges

Routine Nursery Charges are for medical care provided as part of a newborn baby's hospital stay.

Non-Routine Nursery Charges are for medical care provided as treatment for conditions that have a specific diagnosis. Non-routine care of a newborn child is subject to the applicable deductible and coinsurance.

Other covered hospital expenses include:

- Intensive care
- Inpatient hospital physician, anesthesiologist, radiologist and pathologist charges
- Drugs and medicines furnished by and administered during an inpatient hospital confinement
- Charges billed by a facility licensed to furnish mental health and/or substance abuse treatment
- Licensed ambulance service to or from the nearest hospital where the needed medical treatment can be provided
- Anesthetics and their administration
- Treatment in an inpatient or outpatient facility for accidental injury to sound, natural teeth

Infertility

Coverage for the diagnosis and treatment of infertility, including but not limited to:

- Diagnosis and diagnostic tests
- Surgery (i.e. Laparoscopy, Hysteroscopy, etc.)
- Artificial Insemination
- In-Vitro Fertilization (IVF)
- Embryo Transfer
- Gamete Intra-Fallopian Transfer (GIFT)
- Intracytoplasmic Sperm Injection (ICSI)
- Zygote Intra-Fallopian Transfer (ZIFT)

There is a maximum lifetime benefit of $15,000 per person for all in- and out-of-network infertility treatment received under all options combined. See "Prescription Drug Benefits," beginning on page 56, for information on prescription drug benefits related to infertility. Please note that this infertility lifetime maximum is separate from the $10,000 maximum that applies to infertility prescription drugs. Diagnostic services necessary to diagnose the condition of infertility are not counted towards the lifetime maximum.

Injections

Most immunizations(and related administration expenses), including but not limited to, vaccines approved by the Federal Drug Administration (FDA), flu shots, FluMist, Gardasil, Synagis (precertification may be required), rabies, shingles and toxoids administered in an in-network physician's office (non-hospital setting) are covered at 100% if they are performed in an in-network physician's office (non-hospital setting) but no office visit copay is made.

Vaccines purchased at a pharmacy for your provider to administer are covered subject to the prescription drug benefit design.

Major complex and/or invasive injections administered in a physician's office to treat illnesses or medical conditions (and the administration of these injections) are covered subject to the applicable deductible and coinsurance.

Injections (and related administrative expenses), as noted above, administered by an out-of-network provider are covered subject to the applicable deductible and coinsurance.

Inherited Metabolic Disease Benefits

Treatment for inherited metabolic diseases is a covered expense. All medical foods and modified food products prescribed for the therapeutic treatment of inherited metabolic diseases are covered subject to the applicable deductible and coinsurance.

Maternity Care

The Medical Plan covers an initial office visit to confirm a pregnancy. For the PPO options, this visit is covered at 100%, subject to the applicable office visit copay (unless it is covered at 100% without a copy as preventive care). For the CDHP, this visit is subject to the deductible and coinsurance, except as otherwise required by federal law as preventive care. All other services, including prenatal visits, delivery and post-natal visits, are covered under a global fee subject to the applicable deductible and coinsurance, unless covered as preventive care in accordance with federal guidelines. Prenatal screenings for gestational diabetes and Hepatitis B are paid at 100%, without the deductible, when provided in-network. Out-of-network maternity care is subject to the applicable deductible and coinsurance.

Subsequent maternity care for the confirmed pregnancy, including office visits for continued prenatal care, labor and delivery, and postnatal care services are subject to the applicable deductible and coinsurance. If a visit qualifies as preventive care, see the Preventive Care section on page 43.

Delivery and routine nursery charges, including hospital physician's charges, are billed as part of the mother's hospital stay. In the event that a newborn child requires non-routine medical care and charges for that care are billed separately, those charges will be subject to the newborn's applicable deductible and coinsurance. (See "Enrolling Newborn Children" on page 11 for information on enrolling newborn children for medical coverage.)

Mental Health and Substance Abuse Treatment

The Medical Plan covers the assessment, diagnosis and treatment of mental or nervous conditions and alcohol and drug dependency performed in a hospital, residential treatment center, chemical or drug dependency treatment center, partial hospitalization program and on an outpatient basis.

The term treatment center means an institution that provides treatment for people with mental health and/or substance abuse or alcoholism problems, carries out its stated purpose under all relevant state and local laws and is:

- Accredited by the Joint Commission
- Approved by Medicare, or
- Accredited or licensed by the state in which it is located to provide mental health services

Precertification is required for all inpatient mental health and substance abuse treatments.

Nurse Practitioner Benefits

For the PPO options, in-network care performed in a physician's office and provided by a nurse practitioner or an advanced nurse practitioner is covered subject to a $20 office visit copay. For the CDHP Option and all out-of-network care provided by a nurse practitioner or advanced nurse practitioner, charges are covered subject to the applicable deductible and coinsurance.

Nutritional Counseling

In-network nutritional counseling is covered at 100%. Out-of-network nutritional counseling is covered subject to the applicable deductible and coinsurance. Any nutritional counseling performed in a facility setting is subject to the applicable deductible and coinsurance.

Organ Transplants

Charges associated with non-experimental, approved organ transplant services are covered including immunosuppressive medication, organ procurement costs and donor's medical costs. Donor's medical costs will be reduced by the amount payable for those costs from any other plan. Inpatient hospital charges must be precertified (see "Precertification" on page 27).

The Medical Plan covers pre-approved services and supplies for the following types of transplants:

- Allogeneic bone marrow
- Autologous bone marrow
- Cornea
- Heart
- Heart-valve
- Heart-lung
- Kidney
- Lung
- Liver
- Pancreas
- Stem cell

Benefits include surgical, storage and transportation services that are directly related to the donation of the organ and billed by the hospital.

Certified transplants are covered at the applicable deductible and coinsurance.

The hospital or other facility must prenotify BCBS of any planned transplant procedure.

Organ Transplant Travel Benefit
The Medical Plan will pay 100% of eligible travel expenses up to $10,000 incurred by you or your eligible dependent in connection with an organ transplant which has been preapproved by BCBS. Travel expense benefits are available if you or your eligible dependent is receiving preapproved transplant-related services during any of the following: evaluation, candidacy, transplant event or post-transplant care.

If approved, covered expenses for the person receiving the transplant and one "companion" may include transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility) and lodging and food while at, or traveling to and from, the transplant site. The term "companion" may include a spouse, domestic partner, family member, legal guardian of you or your eligible dependent or any person not related to you but actively involved as your caregiver. In the case of a transplant recipient who is a minor child, expenses will be considered for both parents.

Travel expenses will not include any charges for:

- Transplant travel benefit costs incurred due to travel within 60 miles of the recipient's home
- Air travel via air ambulance
- Laundry or telephone bills
- Alcohol or tobacco products
- Transportation charges which exceed coach class rates
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator
- Child care

Certain transplants may not be covered, and special rules apply to organ transplants. Call BCBS before you incur any expenses.

The Blue Quality Centers for Transplant Program

The Blue Quality Centers for Transplant (BQCT) Program is a center of excellence bone marrow and organ transplant program offered through participating BCBS plans. All institutions selected as BQCT centers of excellence must meet stringent Program criteria. BQCT includes, for covered transplants, seven individual networks: heart; lung; heart/lung; liver, lung, simultaneous kidney-pancreas; pancreas and bone marrow (autologous and allogeneic).

Institutions are selected for the BQCT Program based on their ability to meet defined clinical criteria that are unique for each type of transplant. Panels of transplant surgeons and physicians advise the BCBS Association on selection criteria, which are updated in response to medical advances.

Physician Office Visits

For covered preventive care expenses under all the Medical Plan options, in-network physician office visits are covered at 100% with no deductible, coinsurance or copay.

For non-preventive care under the PPO options, the Medical Plan covers charges associated with an in-network physician office visit at 100% after the required copay ($20 for primary care physicians and $40 for specialists). For the CDHP, charges associated with an in-network physician office visit are subject to the applicable deductible and coinsurance.

Items that will be covered as part of an in-network physician's office visit (non-hospital setting) and subject to the office visit copay in the PPO options are:

- X-rays (except advanced radiology, such as CAT/PET scans and MRIs, and nuclear radiology) including professional interpretation of X-rays
- Injections (see "Injections" on page 40)
- Administration of specialty drugs, including but not limited to those for multiple sclerosis and rheumatoid arthritis
- Certain supplies provided in a physician's office that are related to the treatment of asthma. Respiratory supplies include, but are not limited to, aerochambers, peak flow meters and nebulizers. (**Note:** To encourage individuals to actively manage their respiratory conditions, certain respiratory supplies are also covered at a pharmacy subject to the prescription drug copays. Refer to "Covered Expenses" in the Prescription Drug Benefits section, on page 62, for more information.)
- Specimen handling charges/fees

These items are covered at 100% in-network (and not subject to the deductible and coinsurance) if performed in the physician's office (non-hospital setting) and no office visit charge is made for the PPO options.

Services such as radiation therapy performed in a physician's office are covered subject to the applicable deductible and coinsurance. In addition, chemotherapy and in network dialysis are also covered subject to the applicable deductible and coinsurance regardless of where those services are received. Out of network dialysis services are not covered.

Out-of-network office visits are subject to the deductible and coinsurance. Injections administered by an out-of-network provider (and related administrative expenses) are covered subject to the applicable deductible and coinsurance.

Preventive Care

The Medical Plan covers preventive services in accordance with the Patient Protection and Affordable Care Act for adults and children, subject to certain limits and requirements. The following chart is not exhaustive but provides examples of common preventive services. For the PPO options, if preventive services are billed separately from the office visit or other facility visit, the applicable office visit or facility copay may apply when the primary purpose is not for routine preventive services. If it is not billed separately and the primary purpose of the office visit is not for preventive care, the applicable cost-sharing will apply for the office visit. However, the Plan will cover the first in-network mammogram and colonoscopy submitted for reimbursement during the year at 100% and will deem it preventive. Any additional mammograms or colonoscopies during the remainder of the year for such individual will not be deemed to be for preventive care. For those covered by the CDHP, the colonoscopy or mammogram must be determined preventive for it to be covered at 100% before the deductible is satisfied.

In case of illness, services may be covered by other plan provisions. Follow-up services resulting from a preventive care visit may be subject to the applicable deductible, copay or coinsurance.

Preventive Care generally includes evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force for the applicable year with respect to the individual involved. For those recommendations that apply specifically to high risk groups, the individual's attending physician will determine whether the individual is in the high risk group.

Preventive Care also includes immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Service Administration.

For the PPO plans, approved Health Care Reform (HCR) preventive care and drugs (including any HCR-approved travel vaccines, as well as any other travel vaccines not defined as preventive under HCR) are covered at 100% in-network. The correlating facility and professional services costs associated with administering those vaccines will also be paid at 100%.

For the CDHP, approved Health Care Reform preventive care and drugs (including any HCR-approved travel vaccines) are covered at 100% in-network. All other non-HCR defined preventive care and/or drugs are subject to the deductible and coinsurance.

All out-of-network vaccines are subject to the deductible and coinsurance.

3D Mammograms are covered subject to preventive care limits.

For more information on which services are deemed preventive and currently covered under the Medical Plan can be found in the following table, or at *www.healthcare.gov/coverage/preventive-care-benefits/*. If federal law does not specify a limitation on the frequency, method, treatment or setting for a particular preventive service, the Medical Plan will apply reasonable limitations.

Preventive Care Coverage Limits	
For...	**The limit is...**
Routine Physicals/Immunizations (age 18 and older)	One per calendar year
Well-Child Care/Immunizations (up to age 18*)	• **Newborn to Age 1:** Seven visits • **Age 1 to Age 2:** Three visits • **Age 2 to Age 3:** Three visits • **Age 3 to Age 18:** One visit every calendar year
Well-Woman Exams and Pap Tests	One per calendar year
Mammograms including 3D Mammograms	• **Ages 34 to 39:** One baseline mammogram per calendar year • **Age 40 or older:** One mammogram per calendar year
Prostate Specific Antigen (PSA) Tests	One per calendar year for men age 50 or older
Digital Rectal Exams	One per calendar year for participants age 40 or older
Colonoscopies or Sigmoidoscopies	One per calendar year for participants age 50 or older
Bone Density Tests	One per calendar year for participants age 60 or older
Routine Preventive Hearing Tests	One per calendar year
Skin Cancer Screening	One per calendar year

Lung Cancer Screening	One per calendar year for participants age 55 or older have smoked for more than 30 years

* *Frequency based on American Academy of Pediatrics recommendations and other applicable guidelines under the Patient Protection and Affordable Care Act.*

Additional routine screenings and tests during the same calendar year are not covered. Non-routine tests and screenings are generally covered subject to the applicable deductible and coinsurance. Contact BCBS for additional information on specific non-routine tests and screenings.

Out-of-network well child care/immunizations are subject to the same frequency recommendations from the American Academy of Pediatricians and guidelines under the Patient Protection and Affordable Care Act.

If you inform BCBS there is not a Network provider available within 50 miles of your residence, you and your covered dependents may still be eligible to receive in-network benefits when using an out-of-network provider. If you have trouble finding a network provider, contact BCBS for assistance before seeking care from an out-of-network provider.

Certain additional preventive care for women is covered, in-network, at 100%, including screenings for gestational diabetes, breastfeeding support, screening and counseling for domestic abuse, HPV testing, counseling for sexually transmitted infections and HIV, genetic counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes and coverage for certain contraceptives and sterilization. (See http://www.hrsa.gov/womensguidelines/ or contact BCBS for more details.)

Private Duty Nursing

The Medical Plan covers outpatient charges for Private Duty Nursing care which have been ordered by a physician.

Private Duty Nursing care is available to you or your covered dependents in your home if the services provided require the skills of a nurse. No benefits will be provided for the services of a nurse who ordinarily resides in your home or is a member of your immediate family.

Private Duty Nursing benefits are limited to 240 hours combined in- and out-of-network per calendar year.

Skilled Nursing Facility

The Medical Plan covers facilities that mainly provide full-time skilled nursing care for ill or injured people who do not need to be in a hospital. The Skilled Nursing Facility must carry out its stated purpose under all relevant state and local laws and is either:

- Accredited for its stated purpose by the Joint Commission, or
- Approved for its stated purpose by Medicare

In some places, a Skilled Nursing Facility may be called an Extended Care Center or a Skilled Nursing Center.

Skilled Nursing Facility benefits are limited to 60 days per calendar year combined In and out-of-network services. Skilled Nursing Facility benefits require precertification (see “Precertification” on page 27).

Surgery

The Medical Plan covers the services of surgeons, assistant surgeons and co-surgeons. When more than one surgical procedure is performed at the same time, the maximum amount payable will be the amount otherwise payable for the most expensive procedure and half of the amount otherwise payable for all the other surgical procedures. Reimbursement for charges made by an out-of-network assistant surgeon or co-surgeon will be limited to 20% of the surgeon's allowance.

Telemedicine

Through Horizon CareOnline℠, you can talk with a licensed doctor via computer conference, chat or phone anytime and from anywhere in the country. Participants enrolled in a DSM medical plan can get help with non-emergency medical issues, such as: cold and flu symptoms, behavioral health, migraines, allergies, pinkeye and stomach pain. Doctors can diagnose, treat and prescribe prescriptions for many medical issues. Please refer to myDSMbenefits.com for service restrictions.

For those enrolled in a PPO plan, the copay for a health visit is $5. At the time of the online visit, $5 will be charged to your credit or debit card regardless of which medical plan you are enrolled in. If you have reached the out-of- pocket limit, you will not be charged the $5 fee. If you are in the CDHP plan, once the claim has been processed, the amount you are responsible for will be determined and any remaining amount owed based on your plan's in-network primary care office visit benefit, will be charged to your card. If you are in the CDHP plan, you will be charged the full amount of the visit until you have satisfied the applicable deductible and then the coinsurance amounts will apply. Behavioral health consultation costs vary based on the type of service and therapist.

* In order to be billed the appropriate fees for the Telemedicine visit, the correct key of DSM must be entered at the time of visit

X-ray/Radiology

In-network non-routine X-rays/radiology services performed in a free-standing outpatient radiology facility (non-hospital setting) are covered at 100%; under the PPO plans the applicable copay applies when the prescribing physician charges for a non-routine office visit. For the CDHP, the deductible and coinsurance will apply.

In-network non-routine X-rays and ultrasounds performed in a free-standing radiology facility (non-hospital setting) are covered at 100%. Under the PPO plans, the copay will apply when the prescribing physician charges for a non-routine office visit. For the CDHP, the deductible and coinsurance will apply. The following types of X-rays, ultrasounds, and radiation services and their professional interpretation are subject to the applicable deductible and coinsurance:

- X-rays and ultrasounds taken in or billed by the provider (including those for maternity care) as:
  - In-network outpatient radiology services in a hospital setting
  - Out-of-network services
- Advanced radiology (such as CAT/PET scans and MRIs) and nuclear radiology, regardless of setting

If you are enrolled in a DSM Medical Plan and you need diagnostic imaging service, such as an MRI, CAT/PET scan, AIM Specialty Health will consult with the doctor's office about service and provider options.

AIM will contact you if there are good alternative providers based on cost and quality that you may want to consider. If you decide to use another provider, AIM will help you schedule your appointment with the new provider. There is no additional cost to you for this service. The alternate choices allow you to make an informed decision on selecting a diagnostic imaging provider, while managing your cost of care.

Other Covered Expenses

The Medical Plan covers the following medically necessary expenses:

- Acupuncture and acupressure rendered by a provider licensed as an acupuncturist and/or MD in the respective state where the services are performed
- Advanced radiology services (MRI, CAT scans, PET scans) and nuclear radiology, including professional interpretation, subject to the applicable deductible and coinsurance
- Anesthetics and their administration
- Blood transfusions and blood not donated or replaced
- Cochlear implants; subject to medical necessity and precertification (see "Precertification" on page 27)
- Custom-molded orthotics, prescribed by a physician, are covered up to $750 per pair per calendar year
- Dental care for accidental injury of sound, natural teeth
- Diagnostic X-ray and laboratory tests; X-ray, radium and radioactive isotope treatment; and chemotherapy
- Dressings, casts, crutches, colostomy bags and other health care supplies required for an illness or injury
- Durable medical equipment (DME), such as crutches, braces, sleep apnea devices and wheelchairs; the Medical Plan covers rental or, at BCBS's option, purchase of DME, which may require precertification (see "Precertification" on page 27)
- Eye exams when the result of a medical diagnosis only, such as the result of injury, accident or disease
- FDA-approved immunizations and vaccines
- Foot care only as a result of injury, accident or disease
- Genetic testing when one partner has medical history or other risk factors. All genetic testing is subject to review for medical necessity
- Hearing aids are covered up to $1,500 per ear every 36 months
- Hospitalization, surgery or medical charges for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by accident, injury or therapeutic surgery to correct a congenital defect
- Infusion therapies (chemotherapy, dialysis, IV therapies, etc.), subject to precertification (see "Precertification" on page 27) and the applicable deductible and coinsurance

- Infertility treatment (In-Vitro Fertilization, Gamete Intra Fallopian Transfer (GIFT), Intracytoplasmic Sperm Injection (ICSI), Zygote Intra Fallopian Transfer (ZIFT) and Artificial Insemination)
- Insertion of lens after cataract surgery
- Oral surgery, including the removal of impacted teeth, malignant tumors and other oral surgical procedures resulting from accidental injury
- Oxygen and other gases and their administration
- Prescription drugs, only if provided on an inpatient basis (see "Prescription Drug Benefits," beginning on page55, for additional information on retail and mail order drugs)
- Prosthetics and orthopedic braces to support or replace all or part of a body function or organ; fitting, repair or replacement of prosthetics or orthopedic braces prescribed by a physician due to changes in medical condition or body structure
- Renal dialysis treatment
- Respiratory therapy supplies, such as aero chambers, spacers and peak flow meters
- Services to prescribe and fit contraceptives and devices and to administer implantable contraceptives including, but not limited to, intra-uterine devices (IUDs), Norplant, Depo-Provera
- Short Term Therapy for mental health diagnosis such as Autism and ASD (ABA compliant)
- Sleep management is supported through the AIM Specialty Health's sleep management program. Your doctor will contact AIM Specialty Health to coordinate care from diagnosis to treatment.
- Vasectomy, tubal ligation and termination of pregnancy
- Wigs for medically induced or congenital hair loss due to treatment of a disease by radiation or chemicals or second/third degree burns (up to $500 per calendar year)

Exclusions

Items excluded from coverage under the Medical Plan include, but are not limited to, those listed below. BCBS has the discretionary authority to determine whether a medical expense is covered under the plan. You should always check with BCBS to determine whether or not a service is covered.

- Services and/or supplies that are not medically necessary and/or not specifically covered under the plan, as determined by the Claims Administrator
- Experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices (except for certain routine costs provided to those enrolled in approved clinical trials, see the Clinical Trials section on page 36s)
- Charges in excess of the allowance
- Any service and/or supply for which a claim is not received within 12 months after receipt of the service
- Services and/or supplies for treatment of an illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Admitting fees or deposits
- Anesthesia and consultation services when they are given in connection with services not covered by the plan
- Blood, blood plasma or other blood derivatives or components which are replaced by an individual

- Broken appointments
- Care, treatment, services or supplies that are not prescribed, recommended or approved by the attending physician
- Completion of claim forms
- Complications arising from non-covered conditions
- Conditions classified as V-codes (conditions not arising from a mental disorder recognized in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association). This includes, but is not limited to, services typically received from an Employee Assistance Program
- Conditions that the plan determines lack a recognizable III-R classification in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. This includes, but is not limited to, services typically received from an Employee Assistance Program.
- Convalescent, custodial or sanitarium care or rest cures, even if recommended by an attending physician
- Dental care or treatment, including appliances, except as specified in "Other Covered Expenses," beginning on page 47.
- Diversional/recreational therapy or activity
- Education or training while an individual is confined in an institution that is primarily an institution for learning or training
- Routine eye examinations, eyeglasses, sunglasses, contact lenses, and all fittings, except as specified in "Other Covered Expenses," beginning on page 47; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy and LASIK; corneal refractive therapy; and orthokeratology
- Herbal, holistic or homeopathic medicines
- Hospitalization, surgery or medical charges for cosmetic purposes except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by accident, injury or therapeutic surgery to correct a congenital defect
- Housekeeping services except as an incidental part of the eligible services of a Home Health Care Agency
- Hypnotism and hypnotherapy
- Infertility services including, but not limited to:
  - Cryopreservation and storage of sperm, eggs and embryos
  - Experimental or investigational infertility treatment
  - Medical services for a surrogate where the surrogate is not covered under the plan
  - Non-medical costs of an egg or sperm donor
  - Ovulation kits and sperm testing kits and supplies
  - Reversal of voluntary sterilization
  - Storage fees
- Inpatient Private Duty Nursing
- Maintenance sessions for physical, occupational, speech, and cognitive therapy, as well as chiropractic care
- Mandated treatment, including court-ordered treatment, unless such treatment is medically necessary
- Marriage, career, educational, family and pastoral counseling unless covered elsewhere

- Medical care for injuries or disease resulting from committing an illegal act, such as a felony, or from an act of war, declared or undeclared
- Membership costs for health clubs, weight loss clinics and similar programs
- Milieu therapy; excluded services include inpatient services and supplies that are primarily for milieu therapy even though eligible treatment may also be provided
- Orthoptic therapy for the treatment of eye conditions
- Orthopedic shoes
- Out of Network Dialysis treatment
- Personal comfort and convenience items, such as charges for telephone calls or television rental
- Prescription drugs that are not FDA-approved
- Prescription, non-prescription drugs and vaccines purchased from a retail pharmacy or through the mail-order program. (The "Medical Plan" does not cover these items; please refer to the "Prescription Drug Benefits" section of this SPD beginning on page 55, for additional information on coverage)
- Psychoanalysis to complete the requirements of an educational degree or residency program
- Psychological testing for educational purposes
- Routine foot care, such as treatment for corns and calluses
- Self-administered services such as biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training
- Services for injuries resulting from a motor vehicle accident if such services are eligible for payment under the Personal Injury Protection or compulsory medical payments provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law
- Services performed by a resident physician or intern
- Services required as a condition of employment
- Services or supplies:
  - Eligible for payment under either federal or state programs (except Medicare or Medicaid). This provision applies whether or not the individual asserts his rights to obtain this coverage or payment for these services
  - For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair
  - For which the provider has not received a certificate of need or such other approvals as are required by law
  - For which the individual would not have been charged if he did not have health care coverage
  - Furnished by one of the following members of the individual's family: spouse or domestic partner, child, parent, in-law, brother or sister
  - In connection with any procedure or examination not necessary for the diagnosis or treatment of injury or sickness for which a bona fide diagnosis has been made because of existing symptoms except as otherwise specifically provided
  - Paid for under any government law or as the result of military service and for which an individual is not legally obligated to pay
  - Provided while an individual is not covered under the plan
- Smoking cessation except as required as preventive care (see "Prescription Drug Benefits," beginning on page 57, for additional information)

- Special medical reports not directly related to treatment of the individual (e.g., employment physicals, reports prepared in connection with litigation)
- Surgery for the treatment of varicose veins unless medically necessary
- Telephone consultations, except as the Medical Plan may request or through the Telemedicine program
- Transplants, except as otherwise stated in this Summary Plan Description
- Transportation and travel, except as otherwise stated in this Summary Plan Description
- Treatment of Temporomandibular Joint Dysfunction (TMJ) with intraoral prosthetic devices or by any other method to alter vertical dimension (see "Other Covered Expenses," beginning on page 47, for additional information)
- Vision benefits, including exams, therapy, visual acuity training, orthoptics, pleoptics and lenses, except as required as preventive care (see "Vision Plan," beginning on page 79, for additional information)
- Vitamins and dietary supplements (see "Prescription Drug Benefits," beginning on page 57, for additional information)
- Weight loss programs, special foods, food supplements, liquid diets, diet plans or any related products

Federally-Mandated Disclosures

All Medical Plan options comply with current federal laws and regulations including those described in the following sections.

The Women's Health and Cancer Rights Act of 1998

If you are covered under one of the Medical Plan's medical options, you have certain rights to benefits provided under the plan in connection with a mastectomy. Among other things, you have the right for coverage to be provided in a manner determined in consultation with your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce asymmetrical appearance and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

These benefits are subject to the deductible, copay and coinsurance rules applicable to the medical plan in which you are enrolled.

The 1996 Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal, non-cesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Patient Protection and Affordable Care Act

Under the Medical Plan, you do not need prior authorization to obtain access to obstetrical or gynecological care from a health care professional in the applicable network and who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call BCBS at 1-800-810-2583.

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

If you are eligible for medical coverage under the Medical Plan, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your eligible dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can call your state Medicaid or CHIP office to find out if premium assistance is available. If you or your eligible dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your eligible dependents might be eligible for either of these programs, you can call your state Medicaid or CHIP office or call 1-877-KIDS NOW or go to *www.insurekidsnow.gov* to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for the plan.

Once it is determined that you or your eligible dependents are eligible for premium assistance under Medicaid or CHIP, the Medical Plan is required to permit you and your eligible dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the plan. This is called a "special enrollment" opportunity, and ***you must request coverage within 60 days of being determined eligible for premium assistance***. Please see the HIPAA Notice of Special Enrollment Rights for further information.

You may be eligible for assistance paying your employer health plan premiums. You should call your state for further information on eligibility. The list of States that have a premium assistance program is available online at the DSM Benefits website www.myDSMbenefits.com.

How to File Claims

In-Network

If you or your eligible dependents use in-network health care providers, there are no claim forms or other paperwork to file. Just present your plan ID card and the provider will bill the plan directly for covered expenses after you pay any required copay or coinsurance. The provider will bill you for any additional amounts you are required to pay. For example, if a service is covered at 90%, the provider will bill you for the other 10% not covered by the Medical Plan.

For assistance in finding an in-network provider, you can call BCBS at 1-800-810-2583 or visit the BCBS Website at *www.horizonblue.com/DSM*.

Out-of-Network

If you use out-of-network providers, you will have to file a claim form with itemized bills from your provider to obtain payment for covered expenses from the plan. You may obtain claim forms from the DSM Benefits Website at *www.myDSMbenefits.com*, by calling BCBS at the number on the back of your ID card or by printing a copy from the BCBS Website (*www.horizonblue.com/DSM*). All fully completed claim forms and bills must be sent directly to BCBS at the address shown on the claim form.

It is best to file a claim form along with your itemized bills as soon as you have incurred covered expenses. If you receive further treatment and have additional bills after the first claims submission, you should file them periodically along with new claim forms. Claims not filed within 12 months of the date expenses are incurred are not eligible for reimbursement under the Medical Plan.

Prompt filing of fully completed claim forms with all required itemized bills will result in faster processing of your claim.

Key Terms

You will see certain terms used throughout this section. It is important that you are familiar with their meanings.

Allowance - an amount determined by the plan as the least of the following amounts:

- The actual charge made by the provider for the service or supply
- For an in-network provider, the amount that the provider has agreed to accept for the service or supply
- For an out-of-network provider, the amount determined as 250% of the amount that would be reimbursed for the service or supply under Medicare

Coinsurance amount - the percentage of covered expenses that you pay after you meet the annual deductible. For example, if a service is covered at 90%, your coinsurance amount will be the other 10% of the covered expense (negotiated fee or allowance, as applicable) not paid by the Medical Plan.

Copay - if you enroll in a PPO option, the flat fee you pay each time for certain services when you use participating in-network providers. After you pay your copay, the health care provider will bill the Medical Plan directly for the balance. Copays do not count toward your annual deductible. After you reach your deductible, you will continue to be responsible for copays.

Covered expenses - those expenses that are eligible for reimbursement, subject to any deductible, copay, coinsurance amount or specified maximum.

Deductible - the amount you pay, with the exception of required copays and certain other expenses, before the plan begins to pay benefits for some services.

Experimental or investigational - any treatment, procedure, facility, equipment, drug, device or supply (collectively "technology") which, as determined by the Medical Plan, fails to satisfy the following criteria:

- With respect to items requiring government approval (e.g., biological products and devices), the technology must have final approval from the appropriate government regulatory bodies for commercial distribution for use in the treatment of the condition under review. However, final approval does not necessarily imply that the technology will be an accepted standard of care under the Medical Plan
- No coverage will be provided for prescription drugs for any experimental or investigational drug or any drug which the Food and Drug Administration (FDA) has determined to be contraindicated for the specific treatment for which the drug has been prescribed. The Medical Plan may evaluate prescription drugs for uses other than those approved by FDA, provided the drug is recognized to be medically necessary for a specific condition under the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information

- With respect to items not requiring governmental approval, scientific evidence, including peer literature, must exist which demonstrates, as determined by the Medical Plan, that the technology improves net health outcomes. If the peer literature on the technology is insufficient or questionable, the Medical Plan may consider the opinions or evaluations of specialty advisory committees and/or specialty consultants when making a determination
- The technology must be as beneficial as any established alternatives
- The measurable improvement in net health outcome must be attainable under the usual conditions of medical practice, outside of the investigative research setting

In-network provider - physicians, facilities (such as hospitals) and other health care providers who participate in BCBS's network.

Medical emergency - the sudden, unexpected onset, due to illness or accidental injury, of a medical condition that a prudent layperson with average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in either a threat to life, serious impairment to bodily functions or serious dysfunction of a bodily organ or part. Examples of a medical emergency include but are not limited to heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning and loss of consciousness. Emergency services are services n necessary to stabilize the patient with respect to a medical emergency.

Medically necessary - a covered service or supply that the Medical Plan determines is:

- Necessary for the symptoms and diagnosis or treatment of the condition, illness or injury
- Provided for the diagnosis, or the direct care and treatment, of the condition, illness or injury
- In accordance with generally accepted medical practice
- Not for your convenience
- The most appropriate level of medical care you need
- Accepted by a professional medical society in the U.S. as beneficial for the control or cure of the illness or injury being treated
- Furnished within the framework of generally accepted methods of medical management currently used in the U.S.

The fact that an attending practitioner prescribes, orders, recommends or approves the service or supply or the length of time services or supplies are to be received, does not make the services or supplies medically necessary and appropriate.

Negotiated fee - the specified amount a network provider has agreed to accept for a service.

Network - a group of physicians, facilities (such as hospitals) and other health care providers that have entered into a formal contract with BCBS to provide services for negotiated fees.

Out-of-network provider - physicians, facilities (such as hospitals) and other health care providers who do not participate in BCBS's network.

Out-of-pocket maximum - the most you have to pay for each year for covered expenses. The annual deductible and coinsurance count toward reaching the out-of-pocket maximum. For the PPO options, copays for medical services (but not prescriptions) apply to the medical out-of-pocket maximum. Prescription drug copays apply to the separate prescription drug out-of-pocket maximum for the High Option and Low Option PPO plans. Once you reach this limit, the plan will pay 100% of certain eligible expenses for the rest of the calendar year. (You will still pay copays for some services in the High Option and Low Option PPO plans.) The combined out-of-pocket maximum for in-network services will not exceed the maximum provided under the Affordable Care Act.

Physician – a licensed, practicing doctor or dentist who is not related to the participant's family by blood or marriage. The definition includes: Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery, Doctor of Podiatry, Doctor of Chiropractic and Doctor of Psychiatry. While not licensed as doctors, services provided by Psychologists and Social Workers are covered under the Medical Plan.

Prescription Drug Benefits

Prescription drugs play an important role in your overall health, so it's important that you understand how your benefits work. If you enroll in the Medical Plan, you also receive prescription drug benefits that are administered by Express Scripts (ESI). You cannot have prescription drug benefits coverage if you are not enrolled in a medical option.

Key Terms

Turn to page 65 for definitions of key terms used in this section.

In This Section **See Page**

Prescription Drug Benefits

If you enroll in the Medical Plan, you also receive prescription drug benefits that are administered by Express Scripts (ESI).

Enrolling

You will automatically be enrolled in the same coverage category for your prescription drug benefits that you choose for your medical coverage. There is no separate enrollment for prescription drug benefits, and the cost for prescription drug coverage is included in your medical benefits contribution. For more information on enrollment and eligibility, see “Eligibility and Enrollment,” beginning on page 5.

Using the Prescription Drug Benefits

The prescription drug benefits have a three-tier design – generic, preferred brand name and non-preferred brand name drugs. This design maintains a broad choice of covered drugs for patients and their physicians, while providing an incentive to use medications that are effective and less costly. Frequently, there is more than one prescription drug that your physician could prescribe for a particular illness or condition. Talk with your physician about your options to determine the best choice for you.

The High and Low Option PPO has a calendar year out-of-pocket maximum. The out-of-pocket maximum limits how much you have to pay for covered prescription drug expenses during the year. Each Prescription Drug option will have an out-of-pocket maximum for employee only, employee plus one dependent and family (employee plus two or more dependents) coverage. The prescription drug out-of-pocket maximum for the High and Low Option PPO is not combined with the medical plan out-of-pocket maximum.

If you enroll in the CDHP the prescription drug out-of-pocket maximum is combined with the medical out-of-pocket maximum.

Prescription drug copays and coinsurance vary by type of drug and whether you fill your prescription at a retail pharmacy or through mail order. In addition, prescriptions for certain FDA approved contraception purchased in-network will be covered at no cost, as required by federal law. Certain drugs are also covered at 100% if prescribed and covered as preventive care, such as aspirin to prevent cardiovascular disease for men age 45-79 and for women age 55-79. Contact ESI for details of the prescription expenses that are covered at no cost.

Prescription Drug Benefits Overview

Prescription Drug Benefits (Your In-Network Cost)*	**High Option PPO**	**Low Option PPO**	**Consumer Directed Health Plan**
Out-of-Pocket Maximum			
	In and Out-of-Network[1]	In and Out -of-Network[1]	In-Network[2] Out-of Network[2]
Employee Only Employee +1 Family (Employee + 2 or more dependents)	$1,200 $2,400 $3,600	$1,200 $2,400 $3,600	$4,500 $ 9,000 $9,000* $18,000 $12,700* $25,400
Retail (30-day supply)			
Generic	$15	$15	20% coinsurance after CDHP deductible
Preferred brand	$30	$30	
Non-preferred brand	30% coinsurance ($50 minimum and $100 maximum)	30% coinsurance ($50 minimum and $100 maximum)	40% coinsurance after CDHP deductible
Specialty			
Generic	$15	$15	20% coinsurance after CDHP deductible ($125 maximum)
Preferred brand	$30	$30	
Non-preferred brand	30% coinsurance ($50 minimum and $100 maximum)	30% coinsurance ($50 minimum and $100 maximum)	20% coinsurance after CDHP deductible ($125 maximum)
Mail (90-day supply)			
Generic	$37.50	$37.50	20% coinsurance after CDHP deductible
Preferred brand	$75	$75	
Non-preferred brand	30% coinsurance ($125 minimum and $250 maximum)	30% coinsurance ($125 minimum and $250 maximum)	40% coinsurance after CDHP deductible
Specialty			
Generic	$15	$15	20% coinsurance after CDHP deductible ($312 maximum)
Preferred brand	$30	$30	
Non-preferred brand	30% coinsurance ($50 minimum and $100 maximum)	30% coinsurance ($50 minimum and $100 maximum)	20% coinsurance after CDHP deductible ($312 maximum)

[1] Whether you receive prescription drugs from in-network or out-of-network providers, all out-of-pocket covered prescription drug expenses are added together to satisfy the out-of-pocket maximum.
[2] For the CDHP Option, the prescription drug and medical plan out-of-pocket maximums are combined.
*The out-of-pocket maximum is limited to $6,850 for only in-network care for each individual in the CDHP

Note: Eligible out-of-network retail pharmacy claims will be reimbursed at the network billed rate for the drug less the applicable copay/coinsurance. For certain drugs, such as controlled substances, prescription drug benefits may be limited by state or federal law. Out-of-network mail-order pharmacy claims are not covered under the plan.

Brand Name and Generic Drugs

A brand name drug features a trade name under which it is advertised and sold and is protected by a patent. Generic drugs are drugs for which the brand name patent has expired, allowing other manufacturers to produce and distribute the product – usually at a lower cost than the brand name drug. A generic drug has the same active ingredients as its brand name counterpart and manufacturers of generic drugs must follow stringent Food and Drug Administration (FDA) regulations for safety.

Note that, unless your physician indicates otherwise, mail order and retail pharmacies will automatically dispense a generic if available, unless you request the brand name medication and are willing to pay the cost difference between the generic and brand name medication.

Preferred Drug List (Formulary)

A brand name drug that is on ESI's preferred drug list is generally less expensive than a brand name drug that is not on the preferred list. The preferred drug list, also called a formulary, is a list of recommended prescription medications that is created, reviewed and regularly updated by a team of physicians and pharmacists. The list contains a wide range of generic and brand name preferred products that have been approved by the FDA.

Use of a preferred drug is voluntary; however, your prescription cost will be higher if your physician does not prescribe a drug on the preferred list. If your physician prefers you to take a specific drug, your physician may specify that the prescription be "dispensed as written" (DAW).

If your physician prescribes a non-preferred drug, the pharmacist may ask your physician whether an alternative preferred drug might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. A confirmation will be sent to you and your physician explaining the change.

Generic Equivalent and Non-Preferred Brand Drugs

If a generic equivalent is available and *you choose* to receive the non-preferred brand name, you will pay the higher copay/ coinsurance amount. Plus, you will pay the difference between the retail cost of the generic and the non-preferred brand name in addition to the copay/coinsurance. But if your physician prefers you to fill your prescription as a brand name, if he or she writes "dispense as written" on the prescription, you will pay only the non-preferred copay/coinsurance.

You should ask your physician if you have questions about the prescription change. Your physician always makes the final decision on your medication, and you can always choose to fill the original prescription. Pharmacies will dispense only the medication authorized by your physician.

Newly Approved Drugs

The Express Scripts Therapeutics Assessment Committee reviews all drugs that are newly approved by the FDA. The committee evaluates drugs for therapeutic treatment and safety. Findings are then made available to the Express Scripts Value Assessment Committee, which reviews the information and develops a formulary placement recommendation that is forwarded to the Express Scripts National Pharmacy and Therapeutics Committee for final approval. The three-step process is designed to ensure a clinically sound formulary while providing cost-effective care for employers and their employees.

Even after a drug is included on the preferred drug list, this evaluation process continues at least quarterly or as new information becomes available.

Retail Pharmacy Purchases

The Medical Plan covers prescriptions purchased at any retail pharmacy. When you purchase your medications at participating network pharmacies, you pay a set copay or coinsurance depending on the Medical Plan option you enroll in and the type of medication you request. When you fill your prescription at a non-participating pharmacy, you pay the full retail cost for the medication at the time of purchase. You may then complete and submit a claim form to ESI for reimbursement. Eligible prescription charges from non-participating pharmacies will be reimbursed at the network contracted rate for the drug minus the applicable copay/coinsurance amount.

Finding an In-Network Pharmacy

You receive a higher level of prescription drug benefits when you use any of ESI's in-network pharmacies. For assistance in finding an in-network pharmacy, you can call ESI at 1-866-851-0145 or visit the Express Scripts Website at *www.express-scripts.com*.

When you have your prescription filled at a participating retail pharmacy, remember to present your prescription drug ID card. This card is separate from your medical ID card and provides your pharmacist with the required information to accurately process your claim and collect the appropriate copay/coinsurance amount. By presenting your prescription drug ID card at the time of purchase, you should not have to complete and submit a claim form directly to ESI.

You can initially purchase up to a 30-day supply of a prescription medication from any participating retail pharmacy. Once you have about ¼ of the medication remaining, you may purchase a refill if needed. As an alternative, you have the option of ordering your maintenance medications through ESI's mail order (Home Delivery) program, which typically offers a better value for a 90-day supply of the same maintenance medications.

Note: If you are enrolled in the CDHP, you must meet the annual medical deductible before prescription drug costs are covered, other than certain preventive medications.

Mail Order Pharmacy Purchases

Through ESI's mail order (Home Delivery) program, you can order prescription maintenance medications for up to a 90 day supply as prescribed by your physician. Prescription maintenance medications are those drugs taken regularly for treating long-term chronic conditions such as asthma, diabetes, high cholesterol, hypertension or arthritis.

Typically, a pharmacist at ESI will fill your prescription with a generic drug (if available) unless you specify otherwise. In addition, the pharmacist may call your physician if your prescription needs clarification, or to ask whether a substitution or change may be made to the prescription he/she has written.

To order a prescription from the mail order program, you may use one of two easy ways:

- After obtaining a Home Delivery order form from ESI, simply complete and mail your order form directly to ESI. You must include your written prescription for a 90-day supply of the medication (with up to one year of refills, if appropriate) and the applicable copay/coinsurance amount.

Tell ESI How You Want Your Maintenance Medications Filled

After two maintenance medication fills at a retail pharmacy, you must tell ESI if you will continue filling your prescription at a retail pharmacy or whether you plan to enroll in ESI's Home Delivery program. If you do not provide this information within 60 days after your second fill, you must pay the full cost of subsequent prescriptions. You may contact ESI at 1-866-851-0145 with your decision.

- Request that ESI contact your doctor directly to get a new prescription for home delivery. Just visit *www.starthomedelivery.com*

For new prescription orders, you will usually receive your medication within 14 days from the date ESI receives your order. If you need your medication sooner, ask your doctor to write two prescriptions:

- One for up to a 30-day supply to be filled immediately at a retail pharmacy and, paid at the retail copay/coinsurance amount and
- Another that you can send to the mail order program for an additional 90-day supply and paid at the mail order copay/coinsurance amount

In the event your Home Delivery refill will not reach you before your current supply of medication runs out, you may contact ESI for an interim supply while your Home Delivery order is filled. Contact ESI directly at 1-866-851-0145 and request that they authorize an override for a 30-day fill at a retail pharmacy.

Once your mail order prescription is down to a 34-day supply, you may order a refill through the Home Delivery Program. You may order refills as necessary for up to one year. After a year, you must provide a new prescription.

Filling Your Prescription

When you fill a prescription, what you pay depends on whether your doctor writes you a prescription for a generic or brand name drug.

Generic Drug

If your physician writes your prescription for a generic drug, you pay the applicable copay/coinsurance amount for a generic drug, which is less than the cost for a brand name drug.

Brand Name Drug

If your physician writes your prescription for a brand name drug and ***no generic equivalent is available***, you will pay the applicable brand name copay/coinsurance amount for your prescription.

If a generic equivalent is available, the amount you pay will depend on whether or not your physician prefers that you receive the brand name drug. When your physician has a specific preference that you receive a brand name version, he or she indicates this by instructing that the prescription be dispensed as written (DAW).

- ***If a generic is available but your physician writes the prescription as DAW***, you will automatically receive the brand name drug as prescribed – even though a generic equivalent is available. You will pay the applicable brand name copay/coinsurance amount for your prescription.
- ***If a generic is available and your physician does not indicate that the prescription must be DAW,*** you will automatically receive the generic equivalent and pay the applicable copay/coinsurance for generic drugs. If you choose to receive the brand name drug instead of the generic equivalent, you will pay the applicable brand name copay/coinsurance amount. If the brand name drug is ***not*** on the preferred list, you will ***also*** pay the difference in price between the brand name and the generic drug.

Prior Authorization Required

Some drugs or compounds are covered only if they are prescribed for a specific use. For this reason, these medications must receive prior authorization from ESI before they can be covered under the program. If the prescribed medication must be pre-authorized, your pharmacist will inform you. The prior authorization program is not intended to restrict or deny your access to drugs or take the place of your own physician's medical advice.

The prior authorization review process typically takes two business days and may be initiated by the pharmacist, or you may ask your physician to call a special toll-free phone number that will be supplied by your pharmacist. The patient and/or physician will be notified when the review process is completed. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

Your medication may require prior authorization if it is used to treat one of the following disease states: Pulmonary Hypertension, Inflammatory Conditions, Growth Deficiency, Psoriasis, Multiple Sclerosis, Acne, Osteoarthritis, or RSV Prevention. Contact ESI at 1-866-851-0145 for information on a specific medication to treat disease states not mentioned above.

Other Express Scripts Programs

Accredo

If you use injectable or other specialty drugs, you must enroll in the Accredo program through ESI after your first refill. Accredo is a specialty pharmacy that manages the special handling requirements associated with most injectable and specialty drugs. Under the Accredo program, you are limited to a 30-day supply of any injectable or specialty drug, even if it is mailed directly to your home.

Retrospective Case Management

ESI is committed to safety of medication use even after a prescription has been filled. This retrospective case management program notifies physicians of safety risks identified through this review and provides recommendations for management where appropriate.

Covered Expenses

Generally, ESI covers retail and mail order drugs that require a prescription for dispensing, are medically necessary, have been approved by the FDA and are not experimental in nature. This includes:

- All approved Health Care Reform preventive drugs, including travel vaccines
- Certain compounded products covered by the plan as approved by the claims administrator.
- Contraceptives covered at 100%:
  - Barrier Contraceptives - Diaphragms Only
  - Hormonal Contraceptives - Generics Only
  - Emergency Contraceptives - Generics Only
  - Implant Contraceptive Device – Mirena Only

  Brand-name contraceptives may be covered only at 100% only if a generic is not available or the brand-name is medically necessary as determined by your physician. Other contraceptives may be covered, subject to the copay or coinsurance (and for the CDHP option, the deductible); call ESI for information about coverage for specific contraceptives
- Diabetic supplies, including pumps, lancets, urine tests, blood glucose calibration solutions, blood test strips (such as Glucose or Ketone), swabs, syringes, needles, devices, pump supplies and blood monitors).

- EpiPen; one per dispensing
- Estrogen replacement (such as Estring); for the PPO options, three copays for 90-day supply; two copays for 60-day supply; for the CDHP, you pay 20% coinsurance after the deductible
- Fertility agents including injectable (such as Profasi, HCG) and non-injectable (such as Clomid, Crinone); covered with a $10,000 lifetime benefit maximum. This maximum lifetime benefit is separate from the $15,000 maximum that applies to infertility treatment under the Medical Plan. See "Infertility," beginning on page39, for information on medical benefits related to infertility.
- Flouride products; pediatric (such as Luride, Poly-Vi-Flor) and dental (such as paste, gel, mouthwash)
- Flu shots and FluMist (based on FDA-approved indications and federal law)
- Gardisil vaccine is only covered for those ages 9 through 26 years old
- Impotence; injectable (such as Caverject, Edex) and non-injectable (such as Viagra, Muse) in limited quantity
- Injectable drugs (other than insulin) are covered along with specialty medications available through the Care Logic program and dispensed by a Accredo pharmacy
- Insulin
- Non-Insulin syringes/needles
- Oral and injectable prescription vitamins including, but not limited to:
  - Legend vitamins and multivitamins
  - Therapeutic agents used for specific deficiencies and conditions
  - Hemopoetic agents used to treat anemia
  - Prenatal agents used in pregnancy
- Respiratory therapy supplies (such as aerochambers, spacers, nebulizers)
- Smoking cessation products available through prescription only (such as Chantix, Nicotrol); up to $350 per person per year; $1,000 lifetime benefit maximum per person under all Medical Plan options combined
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (such as Retin-A); up to age 25 (after age 25, prior authorization is required)
- Vaccines and vaccinations not received or available during a physician office visit

This is not intended to be an exhaustive list and is subject to change without notice. If you have any questions, call ESI at 1-866-851-0145.

Exclusions

Prescription drugs excluded from coverage include, but are not limited to, those listed below.

- Drugs, services and/or supplies that are not medically necessary and/or not specifically covered under prescription drug benefits, as determined by the Claims Administrator
- Any drug labeled "Caution: Limited By Federal Law To Investigational Use" or experimental drugs
- Any drug, service and/or supply for which a claim is not received within 12 months after receipt of the service
- Drugs, services and/or supplies for treatment of an illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Allergens
- Charges for administration of a prescription drug or insulin. These charges may be covered under a Medical Plan option
- Charges for prescription refills in excess of the number specified by the physician

- Charges in excess of contracted in-network rates
- Contraceptives that are not specifically stated as covered, such as condoms, foams, jellies, implants (such as Norplant), or ointments (see "Covered Expenses" on page 61 for covered contraceptives; although implants are not covered under "Prescription Drug Benefits," see "The Medical Plan," beginning on page 18, for additional coverage information on implants)
- Depigmentation products used for skin conditions requiring a bleaching agent
- Diagnostic, testing and imaging supplies
- Drugs or supplies:
  - Covered under any other group health plan that pays primary to this plan
  - Eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the individual asserts his rights to obtain this coverage or payment for these services
  - For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair
  - For which the individual would not have been charged if he did not have health care coverage
  - Paid for under any government law or as the result of military service and for which an individual is not legally obligated to pay
  - Purchased while not covered under DSM's prescription drug benefits
- Hair growth agents, such as Propecia or Vaniqa
- Homeopathic drugs
- Injectable cosmetics, such as Botox cosmetic and other drugs used for cosmetic purposes
- Lymerix
- Medications furnished on an inpatient and outpatient basis (see "The Medical Plan," beginning on page 18, for additional information)
- Ostomy supplies (see "The Medical Plan," beginning on page 18, for additional information)
- Over-the-counter drugs that can be legally dispensed without a prescription, such as Claritin, etc., even though they may be prescribed by a physician (except as may be required as preventive care under federal law, provided they are prescribed)
- Peak flow meters (see "The Medical Plan," beginning on page 18, for additional information)
- Photo-aged skin products, such as Renova
- Prescription drugs for injuries or disease resulting from committing an illegal act, such as a felony, or from an act of war, declared or undeclared
- Rhogam (see "The Medical Plan," beginning on page 18, for additional information)
- Serums and toxoids (see "The Medical Plan," beginning on page 18, for additional information)
- Supplies or medications that are not prescribed, recommended, or approved by the attending physician
- Supplies or medications for injuries resulting from a motor vehicle accident if such services are eligible for payment under the Personal Injury Protection or compulsory medical payments provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law
- Support garments and other non-medical substances (see "The Medical Plan," beginning on page 18, for additional information)
- Synagis (see "The Medical Plan," beginning on page 18 and the section regarding "Prior Authorization Required" for additional information)

- Vitamins, except those listed in "Covered Expenses" on page 61
- Weight loss programs, special foods, food supplements, liquid diets, diet plans or any related products (see the section regarding "Prior Authorization Required" for more information)
- Yohimbine

This is not intended to be an exhaustive list and is subject to change without notice. If you have any questions, call ESI at 1-866-851-0145. Other drugs are subject to exclusion as determined by the Express Scripts Formulary which is subject to change.

Key Terms

This section provides definitions for key terms used throughout this section.

Coinsurance amount for the CDHP option - the percentage of covered expenses that you pay for prescription drugs after you meet the annual medical deductible. Any coinsurance amounts you pay for prescription drugs count toward meeting your Medical Plan out-of-pocket maximum.

Coinsurance amount for the PPO options - the percentage of covered expenses that you pay for certain non-preferred drugs when you use a participating network pharmacy. Any coinsurance amounts you pay for prescription drugs do not count toward meeting your Medical Plan deductible or your out-of-pocket maximum.

Copays for the PPO options - the flat dollar amount you pay for generic and preferred brand name drugs when you use a participating network pharmacy. Copays for prescription drugs do not count toward meeting your Medical Plan deductible.

Covered expenses - those expenses that are eligible for reimbursement, subject to any copay, coinsurance amount or specified maximum.

Legend - refers to prescriptions that carry the "Federal Legend" and can only be obtained with a written prescription.

Medical emergency - the sudden, unexpected onset, due to illness or accidental injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of a medical emergency include but are not limited to heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning and loss of consciousness.

Network - a group of pharmacies that have entered into a formal contract with a health plan (such as ESI) to provide prescriptions at negotiated rates.

Network pharmacy - a pharmacy that participates in the ESI network.

Out-of-network pharmacy - a pharmacy or other provider that does not participate in the ESI network and does ***not*** have an agreement with ESI to furnish covered prescriptions.

The Dental Plan

The Dental Plan is designed to assist you with the cost of dental care by providing a wide range of dental benefits for you and your eligible dependents.

In the Dental Plan, you have a choice of two options administered by Delta Dental: the High Option PPO and Low Option PPO.

Key Terms

Turn to page 77 for definitions of key terms used in this section.

The plans allow you to choose between in-network and out-of-network providers. Out-of-pocket costs are lower when network providers are utilized.

In This Section **See Page**

Dental Benefits

The Dental Plan features two Delta Dental Preferred Provider Organization (PPO) options to provide dental benefits. The options are:

- High Option PPO
- Low Option PPO

You may also waive dental coverage.

Within each option, the following coverage categories are available:

- Employee Only
- Employee and Spouse/Domestic Partner
- Employee and Child(ren)
- Family

See "Eligibility and Enrollment," beginning on page 5, for more information.

Preexisting Conditions

The Dental Plan has no preexisting condition limitations. This means you and your eligible dependents are eligible for covered services when your dental coverage becomes effective.

How Coverage Works

Both PPO options are administered by Delta Dental and both cover similar expenses – with the exception of orthodontia, which is only covered under the High Option PPO. Keep in mind, the plan only covers necessary and customary assessment, diagnosis and treatment of certain conditions as determined by the standards of generally accepted dental practice.

Both the High and Low options feature a network of preferred dentists and other dental providers who have agreed to participate in Delta Dental's Premier Network and to offer care at lower, negotiated rates. When you enroll in one of these options, you may choose between having your dental care provided by either in-network or out-of-network providers. Your out-of-pocket costs will generally be lower when you use in-network providers.

You and the Dental Plan will each pay a portion of your covered expenses. The amount of covered expenses that you pay depends in part on which PPO option you enroll in, the type of service provided, whether you choose an in-network or out-of-network provider and whether you have satisfied any required deductible.

Using In-Network vs. Out-of-Network Providers

Although your deductible and coinsurance percentages are the same whether you use in-network or out-of-network providers, your actual coinsurance amount will be lower when in-network providers are used. This is because the Dental Plan's payment percentage is applied to the discounted fee, which generally results in lower out-of-pocket costs to you.

In addition, even though you are always responsible for deductibles, coinsurance amounts and all charges once plan maximums are reached, patients who utilize in-network providers are not responsible for the portion of the dentist's fee that exceeds the discounted allowable charge. When out-of-network providers are used, you are responsible for any portion of the dentist's fees that exceeds Reasonable and Customary (R&C) charges.

Finally, when you use in-network providers, you do not have to file claims – these are filed by the in-network provider. However, you are responsible for filing claims for services performed by out-of-network providers.

Finding an In-Network Provider

The Dental Plan is administered by Delta Dental of North Carolina regardless of where you live. To find out if your dentist participates in the Delta Dental PPO Network or Delta Dental Premier Network and if there is an in-network dentist in your area, call Delta Dental at 1-800-662-8856 or visit Delta Dental's Website at *www.deltadentalnc.com*.

Deductibles and Benefit Maximums

Deductibles

The Dental Plan requires that you and your eligible dependents satisfy a deductible each calendar year before benefits for basic, major restorative, and prosthodontic services are paid. Preventive and diagnostic services are not subject to the deductible.

With both PPO options, when services are obtained from in-network or out-of-network providers, the Dental Plan pays a percentage of most covered dental expenses after you pay a portion of these expenses each year. The portion you must pay first is called the annual deductible. Each Dental Plan option has individual and family annual deductibles.

*The **individual deductible*** is the amount you pay for each person's covered expenses each calendar year before the Dental Plan begins to make payments.

*The **family deductible*** is the maximum you would have to pay in deductibles for all covered family members each calendar year. You pay the covered expenses for each covered family member until that person's expenses have reached the individual deductible amount. However, if the amount you pay toward the deductibles of all covered family members combined reaches the family deductible, you do not need to pay any more toward deductibles for the remainder of the year.

Family Deductible Example

Let's say your family of four elects dental coverage through the High Option PPO. You, your spouse and one of your children each satisfy a $50 individual deductible. Together you have satisfied the family deductible. This means that your other child will not have to satisfy an individual deductible.

Benefit Maximums

The Dental PPO options have an annual benefit maximum – this is the maximum the plan will pay in benefits per person in a calendar year, excluding orthodontia, preventive and diagnostic care. Note there is also a lifetime benefit maximum in the High Option PPO for orthodontia. No benefits will be paid in excess of these maximums.

Annual Deductibles and Benefit Maximums		
	High Option PPO Benefits	Low Option PPO Benefits
Annual Deductible Individual/Family*	$50/$150	$50/$150

Annual Deductibles and Benefit Maximums		
	High Option PPO Benefits	Low Option PPO Benefits
Annual Benefit Maximum (Per person for all services except preventive, diagnostic, and orthodontic services)	$2,000	$1,500
Orthodontia Lifetime Maximum (Per person)	$2,000	Not covered

** No covered person may satisfy more than $50 of the annual deductible. Preventive and diagnostic charges are not subject to the deductible.*

Pretreatment Estimates

In general, whenever dental work is proposed involving charges of $200 or more – such as cast restorations, crowns or prosthodontics – your dentist should submit a predetermination form to Delta Dental describing the services to be performed, the itemized cost of each service and the estimated length of treatment. Predetermination of benefits is strongly recommended but is not required. Delta Dental will determine if the proposed treatment is covered and the estimated amount the plan will pay toward the cost of such treatment. In case you are using an out-of-network provider, obtaining a predetermination of benefits will give you a good idea of what your out-of-pocket expenses might be. The predetermination information will be returned to your dentist.

Note: A predetermination estimate is not a guarantee of payment.

After discussions with your dentist, you will know the estimated amount payable by the plan and the amount of your financial obligation if the services are performed within the period of authorization (90 days from the date of the plan's approval) as indicated to your dentist on the predetermination form. Your claim form must then be filed for reimbursement with the Dental Plan upon completion of the services.

How Alternate Procedures Could Affect Your Benefits

Often there are several ways to treat a dental problem and each method may cost a different amount. In such cases, your benefit will be based on the covered treatment that costs the least. Regardless of the plan's payment, you may choose to have the more expensive treatment. However, you may have higher out-of-pocket expenses if you choose the treatment that costs more because the plan's payment will still be based on the least expensive treatment.

Note: If you choose a treatment whose cost exceeds the amount covered by the Dental Plan, those charges in excess of what the plan covers do not apply towards the annual benefit maximum.

Covered Expenses

To be covered by the Dental Plan, ***all benefits and expenses must be necessary and customary*** as determined by the standards of generally accepted dental practice. Both the High and Low Option PPOs cover the same services except that the High Option PPO also offers coverage for orthodontia.

For all covered services, benefits received from an in-network provider are based on negotiated fees. Benefits received from an out-of-network provider are based on R&C charges.

The Dental Plan

The following chart outlines how benefits are paid under the plan.

	High Option PPO Benefits	Low Option PPO Benefits
Annual Deductible [1] Individual/Family	$50/$150	$50/$150
Annual Benefit Maximum (Per person for all services except preventive, diagnostic, and orthodontic services)	$2,000	$1,500
Preventive and Diagnostic Services (Including Exams, X-rays Cleanings and Brush Biopsies)	100% with no deductible [2]	100% with no deductible [2]
Basic Services (Including Fillings, Root Canal Work and Periodontics)	80% after deductible [2]	80% after deductible [2]
Major Restorative and Prosthodontic Services (Including Crowns, Onlays, Endosteal Implants, Dentures and Bridges)	60% after deductible [2]	50% after deductible [2]
Orthodontic Treatment (For children under age 19 only)	50% after deductible [3]	Not covered
Orthodontia Lifetime Benefit Maximum (Per person)	$2,000	Not covered

1 *Applies to basic, major restorative, and prosthodontic services.*

2 *The Dental Plan pays the same percentage for listed covered services whether in-network or out-of-network providers are used. If in-network providers are used, your coinsurance amount is based on the network negotiated rate. If out-of-network providers are used, payment of your coinsurance amount is based on R&C charges.*

3 *The Orthodontia Treatment provided on an in-network basis only under the High Option PPO. This covers children under age 19 only.*

Important Information on Certain Covered Expenses

Covered expenses under the Dental Plan include, but are not limited to, those listed below. You should always check with Delta Dental to determine whether or not a service is covered. Certain covered dental expenses have limitations associated with them. Please refer to "Plan Limitations" on page 74, for a detailed listing of these limitations.

Preventive and Diagnostic

Preventive and diagnostic services include:

- Routine oral examinations; twice each calendar year
- Scaling and cleaning of teeth (prophylaxis) including Periodontal maintenance; twice each calendar year. (Members with certain health conditions may be eligible for up to four scalings and cleanings per year. Contact Delta Dental for details)
- Sealants for children up to age 14; on first and second permanent molars without decay and limited to one application per tooth per lifetime (repair or replacement of a sealant is not covered)
- Topical application of fluoride for children up to age 19; twice each calendar year
- Space maintainers to replace prematurely lost teeth for children up to age 14
- Brush biopsies for the early detection of oral cancer
- X-rays
  - Full mouth series or panoramic; once in any 36 consecutive months (three years)
  - Bitewing; twice each calendar year

Basic

Basic services include:

- Fillings such as amalgam, acrylic, plastic, or silicate cement fillings to restore diseased or decayed teeth. In addition, composite resins will also be allowed for any/all teeth when needed to restore diseased or decayed teeth
- Extractions (including pre- and post-operative care)
- Oral surgery (except for procedures covered under the Medical Plan)
- General anesthesia when medically necessary and when performed by a dentist in connection with covered oral surgery
- Endodontic treatment, including root canal therapy
- Periodontal treatment (a pre-treatment estimate is recommended)

Major Restorative and Prosthodontic

Major restorative and prosthodontic services include:

- Crowns and onlays (including inlays) once every five years; see "Individual Crowns" on page 73 for additional restrictions for children under age 12
- Initial installation of fixed bridgework (if a removable device is inadequate); once every five years
- Initial installation of full or partial removable dentures, including adjustments during the first six months following installation
- Coverage for dental implants
- Coverage for one occlusal guard per lifetime. This includes initial placement, three limited adjustments or one complete adjustment every five years

Orthodontia

Orthodontic services are covered at 50% under the High Option PPO, to a lifetime maximum of $2,000 per person, for children under age 19. Covered services include:

- Braces, including Invisalign
- Installation and checking of retainers (if included in dentist's treatment plan)
- Orthodontic procedures and procedures related to orthodontic services, such as, but not limited to, X-rays and orthodontic appliance adjustments

Note: There is no orthodontic coverage available in the Low Option PPO.

If extractions, surgery, or other non-related orthodontic treatment is needed while your dependent child is receiving orthodontic treatment, those expenses may be covered under the other parts of the Dental Plan, provided those charges are separately itemized on the claim form.

Please note the following limitations on orthodontia benefits:

- Maximum initial payment for orthodontic services is 30% of the total treatment fee. The remaining balance is paid on a monthly basis through the term of the treatment plan, as determined by the attending orthodontist
- If you terminate treatment, the plan will pay benefits only to the date of termination
- If the eligible member is no longer eligible for benefits before completion of the case, the plan will only pay up to the date on which eligibility ended
- The plan will not pay for the repair or replacement of an orthodontic appliance
- Treatment may be terminated by the dentist, by written notification to Delta Dental and to the patient, for lack of patient interest and cooperation
- Diagnostic casts/study models/molds are a benefit once per case in conjunction with orthodontic services (the expense of these casts is part of the overall treatment plan and is paid at the respective coinsurance level for orthodontic coverage)

Note: Orthodontic expenses do not count toward the calendar year maximum.

Plan Limitations

Dental Plan benefits and services are limited as follows:

- Benefits for a seven vertical bitewing series are not provided more frequently than once each year
- Full mouth X-rays are subject to specific time and frequency limitations identified in the "Covered Expenses" section on page 71. A panoramic film in conjunction with a complete intraoral survey is not a separate benefit
- If a more expensive service or benefit is selected than is needed, the plan will pay the applicable percentage of the fee for the service or benefit that is needed to restore the tooth or dental arch to contour and function. The remainder of the fee is not a covered expense
- Inlays are covered on the basis of charges for an equal surface amalgam (silver restoration) with the patient being responsible for the difference in cost, if any
- Payment is made for a surface only once within a 24-month period regardless of the number or combinations of restorations placed therein. Sedative fillings are a once per lifetime benefit
- Recementation of space maintainers are covered once per year
- Sealants are limited to first and second permanent molars with no caries (cavities caused by decay) or restorations. Restoration of occlusal caries is a benefit only once in any two-year period following application of a sealant. Sealants are limited to one per lifetime

- Services, supplies or devices furnished after the date the patient ceases to be covered, except for prosthetic devices which were ordered and fitted prior to such date and then only if such devices are delivered to such person within 31 days after such termination of coverage provided. However, if a service, supply or device is approved prior to the date of termination, then such service, supply or device must be delivered within 60 days from the date approval was given
- When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the allocation of payment to each dentist

Individual Crowns

- Crown build-ups are considered part of the preparation for a completed restoration, except as expressly approved by Delta Dental
- Individual crowns on the same tooth are a covered benefit only once in any five-year period unless it is needed because of injury. Said time period is to be measured from the date the crown was supplied whether or not the plan was in effect
- Only one repair per crown will be allowed in a one year period
- Porcelain crowns, porcelain fused to metal or resin processed to metal type crowns are not covered benefits for any person under 12 years of age
- Recementation of a crown may be allowed for payment only once in a 12 consecutive month period; recementation by the same dental office within six months of initial placement is not covered
- Stainless steel crowns are limited to once in a 24-month period when placed on dependent children under the age of 12

Prosthetic Appliances

- A partial denture, fixed bridge, or removable bridge may not be provided for any eligible person more often than once in any five-year period. Said time period is to be measured from the date the denture or bridge was last supplied to the eligible person whether or not the plan was in effect
- Benefits for tissue conditioning are limited to no more than two per arch per 36 months
- Crowns used for abutment purposes are covered at the same coinsurance percentage as provided under this agreement for bridges and complete and partial dentures
- Denture reline and rebase is a covered benefit only once in any 36-month period for any one eligible person
- Denture adjustments are a covered benefit only two times in any 12-month period for any one eligible person
- Fixed prosthodontics are not a benefit for children under 16 years of age
- If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial towards the procedure submitted. If a fixed bridge or other more expensive procedure is selected, the remainder of the fee is not a covered benefit
- No replacement will be made of any existing denture that, in the opinion of Delta Dental, is satisfactory or can be made satisfactory
- No more than one full upper and one full lower denture will be constructed in any five-year period for any one eligible person. Said time period is to be measured from the date the denture was last supplied to the eligible person whether or not the plan was in effect
- Only one repair per prosthesis, such as bridges, partials or dentures, will be allowed in a one-year period subject to review
- Recementation of a bridge may be allowed for payment once per year

Endodontic Procedures

- Coverage for pulp caps includes sedative restorations
- Canal preparations and fitting of a preformed dowel post are regarded as incomplete treatment and part of another procedure
- Payment for root canal therapy is limited to only once in any 24-month period
- Pulpotomy is a benefit only for deciduous (primary) teeth

Periodontic Procedures

- Allowance for multiple periodontal procedures in the same quadrant is based on fees for a single, comprehensive procedure
- Payment for procedures is limited to only once in any 36-month period for all periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis which is benefited as a prophylaxis, subject to the same limitations and is limited to one per lifetime
- Series of subgingival curettage and root planing, once accomplished for a specific area, will not be a benefit more than once in any 24-month period. Gingival curettage and root planing are considered components of a single procedure. A prophylaxis (cleaning) done on the same day as a curettage or root planing is considered to be part of and included in those procedures

Exclusions

Items excluded from coverage under the Dental Plan include, but are not limited to, those listed below. Delta Dental has the authority to determine whether a dental expense is covered as identified by the appropriate plan design and in accordance with accepted American Dental Association practices. You should always check with Delta Dental to determine whether or not a service is covered.

- Services and/or supplies that are not necessary and customary as determined by the standards of generally accepted dental practice and/or not specifically covered under the plan, as determined by Delta Dental
- Experimental or investigational treatments, procedures or materials that are not used universally or accepted by the dental care profession or approved by the American Dental Association
- Charges in excess of Reasonable and Customary (R&C) charges
- Any service, supply or appliance for which a claim is not received within 12 months after receipt of the service or appliance
- Services and/or supplies for treatment of an illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Anesthesia and IV (intravenous) sedation except for covered surgical extractions; general anesthesia is excluded for restorative services
- Appliances or restorations for altering vertical dimension, for restoring occlusion (changing the bite), for replacing tooth structure lost by attrition, abrasion, bruxism, erosion or abfractions; for aesthetic purposes; splinting or equilibration
- Benefits for sleep apnea devices, or for sports-related devices
- Benefits or services which are determined by the plan to be cosmetic, such as bleaching, veneers, or crowns to improve appearance or personalization of characterization of dentures

- Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the patient became eligible under the plan. The exception to this is that orthodontic treatment in progress will be covered if such orthodontic coverage was provided under the employer's group dental program in effect immediately preceding the effective date and you enroll in coverage in the High Option PPO
- Broken appointments
- Completion of forms
- Crowns and endodontic treatment in conjunction with an overdenture
- Dental benefits and services which are initiated but are not completed
- Dental benefits and services resulting from accidental injuries arising out of a motor vehicle accident to the extent such benefits and services are payable under any medical or dental expense payment provision (by whatever terminology used, including such benefits mandated by law) of any automobile insurance policy
- Dental injuries or disease resulting from committing an illegal act, such as a felony, or from an act of war, declared or undeclared
- Diagnosis or treatment of temporomandibular joint dysfunction (TMJ) (see "The Medical Plan," beginning on page 17, for additional information)
- Duplication of X-rays
- Educational services and prevention control programs and supplies, such as oral hygiene instructions, caries susceptibility tests, nutritional or tobacco counseling, behavior management and home fluoride rinses
- Expenses for which payment is not required or for which payment is unlawful where the patient resides when the expenses are incurred
- Gold restorations, unless tooth cannot be filled with another material covered under the plan
- Hospital, health care facility or medical emergency room charges (see "The Medical Plan," beginning on page 18 and "Prescription Drug Benefits," beginning on page 57, for additional information)
- Laboratory charges
- Maxillofacial surgery and prosthetic appliances
- Orthodontic procedures and procedures related to orthodontic services, such as, but not limited to, X-rays, extractions, orthodontic appliance adjustments, unless enrolled in the High Option PPO
- Periodontal charting, chemical irrigation, delivery of local chemotherapeutic substances, application of desensitizing medicine, synthetic bone grafts and guided tissue regeneration
- Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting
- Prescription and non-prescription drugs, premedications and relative analgesia (see "The Medical Plan," beginning on page 18 and "Prescription Drug Benefits," beginning on page 57, for additional information)
- Replacement of lost or stolen dentures, dentures that were negligently or intentionally damaged or destroyed, or charges for duplicate dentures
- Replacement of a lost, stolen or missing prosthetic device or duplication of prosthetic devices
- Services or supplies for accidental injury to sound, natural teeth (see "The Medical Plan," beginning on page 18, for additional information)
- Services performed for the purpose of full mouth reconstruction
- Services or supplies:
  - Covered under any other group health and/or dental plan
  - Eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the individual asserts his rights to obtain this coverage or payment for these services

  - For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair
  - For which the provider has not received a certificate of need or such other approvals as are required by law
  - For which the individual would not have been charged if he did not have health or dental care coverage
  - Furnished by one of the following members of the individual's family: spouse or domestic partner, child, parent, in-law, brother or sister
  - Paid for under any government law or as the result of military service and for which an individual is not legally obligated to pay
  - Provided while an individual is not covered under the plan
- Specialized or personalized services, such as overdentures and root canals associated with overdentures or gold foils
- Temporary services, procedures and appliances, including, but not limited to, temporary fillings, sedative bases, temporary crowns, temporary prosthetic devices, and pulp caps
- Tooth guidance appliance, minor tooth movement, prosthetic orthodontics or other orthodontic treatment except as specifically covered under the High Option PPO for dependent children under age 19
- Treatment by a person other than a licensed dentist or physician, except scaling or cleaning of teeth and topical application of fluoride can be performed by a qualified dental auxiliary if the treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards
- Treatment to correct congenital or developmental malformations
- X-rays taken in conjunction with non-covered services such as, but not limited to, temporomandibular joint dysfunction (TMJ) cases

How to File Claims

In-Network

If you use an in-network provider, the in-network provider will submit the claim form for you. Delta Dental will send you a statement showing your exact out-of-pocket expense for the treatment. You will be billed by the dentist for any applicable deductible, coinsurance amounts and amounts in excess of plan maximums.

Out-of-Network

If you use an out-of-network provider, it is your responsibility to complete a claim form ***within 12 months of the date the expense was incurred***. Complete your section of the claim form, have the dentist complete his/her section and submit the form to Delta Dental at the address shown on the claim form. Delta Dental will pay you directly. You are responsible for paying your dentist.

You may obtain claim forms by calling Delta Dental at 1-800-662-8856 or by visiting their Website at *www.deltadentalnc.com*, or by visiting the DSM Benefit Website *www.myDSMbenefits.com*.

Key Terms

You will see certain terms used throughout this section. It is important that you are familiar with their meanings.

Coinsurance amount – the percentage of covered expenses that you pay after you satisfy any required deductible. For example, if a service is covered at 80%, your coinsurance amount will be the other 20% of the covered expense not paid by the Dental Plan.

Covered expenses – those expenses which are eligible for reimbursement up to the Reasonable and Customary charge or Negotiated Fee, subject to any deductible, coinsurance amount or specified maximum.

Experimental or investigational – any treatment, procedure, facility, equipment, device or supply (collectively "technology") which, as determined by the Dental Plan, is not approved by the American Dental Association.

In-network provider – providers who participate in Delta Dental's network.

Medically necessary – a covered service or supply that the Dental Plan determines is:

- Necessary for the symptoms and diagnosis or treatment of the condition, illness or injury
- Provided for the diagnosis, or the direct care and treatment, of the condition, illness or injury
- In accordance with generally accepted dental practice
- Not for your convenience
- The most appropriate level of dental care you need
- Accepted by a professional dental society in the U.S. as beneficial for the control or cure of the illness or injury being treated
- Furnished within the framework of generally accepted methods of dental care currently used in the U.S.

The fact that an attending provider prescribes, orders, recommends or approves the service or supply or the length of time services or supplies are to be received, does not make the services or supplies necessary and appropriate.

Negotiated fee – the specified amount a network provider has agreed to accept for a service.

Out-of-network provider – a provider, or covered services and supplies provided by a provider, who does ***not*** have an agreement with Delta Dental to furnish covered services or supplies.

Provider – a licensed, practicing dentist or dental facility that is not related to the participant's family by blood or marriage.

Reasonable and Customary (R&C) charge – the maximum plan allowance or an amount that does not exceed the general level of charges for a similar service made by providers of similar standing in the locality where the charge is incurred. Any charge over and above R&C will not count towards your deductible or annual maximum and you will be responsible for it. R&C generally applies to out-of-network benefits.

The Vision Plan

The Vision Plan provides benefits that can reduce your cost for eye care. You and your family can take advantage of low-cost eye examinations and discounts for eyeglasses and contact lenses when you use in-network providers. With the Vision Plan, you can choose to see any provider you want. However, your out-of-pocket costs will be lower when you use in-network providers.

Key Terms

Turn to page 86 for definitions of key terms used in this section.

In This Section **See Page**

Vision Benefits

The Vision Plan features in-network and out-of-network coverage for covered vision expenses. In-network coverage is offered through a comprehensive network of providers.

The following coverage categories are available:

- Employee Only
- Employee and Spouse/Domestic Partner
- Employee and Child(ren)
- Family

See “Eligibility and Enrollment,” beginning on page 6, for more information.

Preexisting Conditions

The Vision Plan has no preexisting condition limitations.

How Coverage Works

Each time you need care, you can choose whether to receive services in-network or out-of-network. The Vision Plan reimburses covered expenses for services provided by all licensed vision care providers. In-network providers are those who have agreed to accept a discounted fee schedule for services. Your costs will be lower if in-network providers are used.

In-Network

When making an appointment, identify yourself as a Vision Service Plan (VSP) member or the eligible dependent of a VSP member. The provider will need the covered employee’s name, date of birth and company name. The provider will contact VSP to verify eligibility and benefits and obtain authorization for services and materials.

If it is determined that lenses and/or frames are necessary, the provider will itemize any non-covered charges and have you sign a form to document that you received in-network services. VSP will pay the provider directly for covered services and materials. You are responsible for paying any required copays for the eye exam, lenses and/or frames and any amounts over the covered allowance. You are responsible for any additional costs resulting from cosmetic options or non-covered services and materials you have selected.

If you choose to obtain lenses and/or frames from an out-of-network provider, you may need to pay the provider’s full fee. You will be reimbursed by VSP in accordance with the out-of-network reimbursement schedule, less any applicable copays.

Finding an In-Network Provider
The Vision Plan is administered by VSP. To find an in-network vision care provider in your area, call VSP at 1-800-877-7195 or visit the VSP Website at *www.vsp.com*; click on the "Members" box, then click on "Find a VSP Network Doctor.” (You do not have to log in to find a VSP provider.)

Out-of-Network

The Vision Plan also covers eligible out-of-network vision expenses. You must pay the out-of-network provider the full amount of the bill at the time you receive services and request a copy of the bill that shows the amount of the eye exam, lens type and frame.

Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:

- The name, address and phone number of the out-of-network provider

- The covered member's name, address, Social Security number and phone number
- The covered member's company name (DSM North America, Inc.) and group number (the group number is 12102836)
- The patient's name, address, phone number, relationship to covered member and date of birth

You may submit the above information on any generic insurance claim form that may be available from your provider upon request or out-of-network form can be found on www.vsp.com.

Please mail the itemized bill(s) and form to the following address:

Vision Service Plan
Out-of-Network Provider Claims
PO Box 385018 Birmingham, AL 35238-0518

For more information on submitting claims as well as the process for claims review, see "How the Plans Process Claims" beginning on page 94.

Using Out-of Network Providers
If you are eligible for and obtain benefits from an out-of-network provider, you may need to pay the provider's full fee. You will be reimbursed by VSP in accordance with the out-of-network reimbursement schedule, less any applicable copays.

Note: Limited benefits will be paid when out-of-network providers are used.

You should be aware that when you choose to use the services of an out-of-network provider for a covered service in non-emergency situations, benefit payments for services rendered are paid in full to the provider and then you file a claim for reimbursement directly to VSP.

In contrast, in-network providers have agreed to accept discounted payments for services with no additional billing to you other than copays, coinsurance and charges for non-covered services or materials. You may obtain further information about the participating status of providers and information on out-of-pocket expenses through *www.vsp.com*, or by calling VSP's Customer Service Department at 1-800-877-7195.

Covered Expenses

The chart below outlines the benefits provided under the Vision Plan.

Service	In-Network Benefits	Out-of-Network Benefits
Standard Eye Exam [1] One exam every 12 months	100% after $10 copay	Reimbursement up to $50 after $10 copay
Lenses [2] **and Frames** [3] One pair of lenses and one pair of frames every 12 months		
Single	100% after $15 copay	Reimbursement up to $55 after $15 copay
Bifocal	100% after $15 copay	Reimbursement up to $75 after $15 copay
Trifocal	100% after $15 copay	Reimbursement up to $100 after $15 copay
Lenticular	100% after $15 copay	Reimbursement up to $125 after $15 copay
Frames	Allowance up to $160 toward the *retail* cost of frames after $15 copay; extra $20 off select featured frame brands	Reimbursement up to $70 after $15 copay
Contact Lenses (in lieu of all other lens and frame benefits) One set of contact lenses every 12 months		
Elective Contacts	$160 allowance for contact lens material; up to $60 for contact lens exam[5]	Reimbursement up to $105
Medically Necessary Contacts [6] (precertification required)	100% after $15 copay	Reimbursement up to $210 after $15 copay
Low Vision (precertification required) Maximum benefit for all low vision benefits is $1,000 every two years		
Supplemental Testing	100%	Reimbursement up to $125
Supplemental Aids	75% of approved amount	75% of approved amount

1 *Coverage described is for standard eye exam only and does not include special services such as contact lens exam or fitting. Dilation included as necessary.*

2 *Coverage described is for standard lenses to correct vision only and does not include cosmetic options.*

3 *The lenses and frames copay is a one-time copay per calendar year per member and applies to lenses and/or frames.*

4 *If you choose a frame valued at more than the $160 allowance, you will receive a 20% discount on the amount over your allowance.*

5 *The contact lens fitting is a separate cost from the eye exam. You get a 15% discount off the cost of the contact lens exam when you use the same VSP doctor who provided your eye exam within the last 12 months.*

6 *Medically necessary contacts only covered if required for certain medical conditions (as determined by VSP) that prevent you from wearing eyeglasses and only if approved in advance by VSP.*

Important Information on Certain Covered Expenses

Spectacle Lenses/Glasses

If glasses are prescribed, the coverage described in the "Covered Expenses" chart above is for standard lenses to correct vision only and does not include cosmetic options. Certain cosmetic options and other non-covered items, including additional pairs of glasses, may be available from In-Network providers at discounted member pricing. Contact your In-Network provider for details.

Frame Allowance

When you purchase frames from an in-network provider, the plan will pay up to $160 toward the retail cost of the frames. However, if you choose a pair of frames with a retail price greater than the $160 allowance, you will receive a 20% discount on the amount by which the price exceeds that allowance. The Vision Plan also provides benefits for frames obtained from out-of-network providers.

The following chart shows how the plan pays in- and out-of-network benefits for frames.

Example of Frame Allowance	In-Network	Out-of-Network
Retail frame price	$180	$180
Plan allowance	$160	$70
Difference between retail price and plan allowance	$20	$110
Your cost	$16 ($20 minus a 20% discount)	$110 (No discount)

In this example, if you enrolled in the Vision Plan and purchased frames from an in-network provider, you would have paid $16 in addition to the plan copay for a pair of frames that would normally cost you $180 retail.

Please remember that the above is only an example and your actual out-of-pocket costs will vary. The plan fully covers a wide selection of frames. If you purchase frames from an in-network provider, you save even if you choose a frame valued at more than the plan's allowance because the difference you'll pay is based on the plan's discounted member pricing.

Contact Lenses

Elective or medically necessary contact lenses are only covered if purchased instead of glasses.

Medically Necessary Contact Lenses
Medically necessary contact lenses are only covered if required for certain medical conditions (as determined by VSP) that prevent you from wearing eyeglasses. Your provider must contact VSP in advance of ordering contact lenses to determine whether VSP will consider the lenses to be medically necessary. Benefits for medically necessary contact lenses must be precertified (approved in advance) by VSP before any benefits will be paid.

Contact Lens Exam and Fitting
Contact lenses require a special fitting exam for ensuring their proper fit and evaluating your vision with the contacts. This fitting is not the same as the standard eye exam which is covered in-network in full, after a $15 copay. However, when you use an in-network provider, you receive a plan allowance to cover your exam and contact lenses. You are responsible for any difference in cost between a standard exam for glasses and a contact lens exam. VSP providers give you an additional 15% discount on the contact lens exam. The difference in exam fees plus any cost for materials (such as your contact lenses) ***less*** the allowance for contact lenses is your financial responsibility. In-network providers offer the contact lens exam at a discounted price. You are responsible for paying any additional fees for a special contact lens exam.

Low Vision

The plan provides a benefit for professional services, as necessary, for severe visual problems not correctable with regular lenses. Low vision benefits include supplemental testing, such as evaluation, diagnosis and prescription of vision aids where indicated and supplemental aids. If you are eligible for supplemental aids after VSP's determination, you will receive an approved benefit for these items and the plan will cover 75% of this approved amount.

The maximum benefit for all low vision services is $1,000 every two years.

If you receive low vision services from an out-of-network provider, you should pay the provider's full fee at the time of service and then submit a claim. Covered expenses will be reimbursed up to the same level VSP would pay an in-network provider, (except the supplementary testing, covered in full in-network and $125 out-of-network) for the same services and materials. You are responsible for any amounts charged above the VSP reimbursement.

You must contact VSP to precertify benefits for low vision care. VSP reviews these requests for medical necessity and appropriateness based on the patient's symptoms, diagnoses and/or medical conditions.

Diabetic Eye Care Program

The Diabetic Eye Care Program is available to you and your covered dependents if you have been diagnosed with Type 1 diabetes and specific ophthalmological conditions. Your Vision Plan network doctor will provide certain eyecare evaluation services as needed following your routine eye examination. No referrals or authorizations are required for services under the Diabetic Eye Care Program. A $20 copay is required for each ophthalmological service and office visit under the Diabetic Eye Care Program.

Precertification

You must contact VSP to precertify certain benefits before such benefits are covered. ***Benefit coverage will be denied if the appropriate precertification is not obtained***. Precertification is required for:

- Medically necessary contact lenses
- Vision therapy
- Low vision evaluations and aids

VSP's precertification determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

- ***Initial Determination*** – VSP will approve or deny requests for prior authorization of services within 15 calendar days of receipt of the request from your provider. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than 15 calendar days
- ***Appeals*** – If VSP denies the provider's request for prior authorization, the provider, you or your authorized representative may request an appeal of the denial. Please refer to the claim and appeals section, beginning on page 94, for details on how to request an appeal.

VSP will provide the requestor with a final review determination within 30 calendar days from the date the request is received. A second level appeal and other remedies as described here, are also available. VSP shall resolve any second level appeal within 30 calendar days. A covered person may designate any person as a covered person's authorized representative. When a covered person does not designate an authorized representative, the provider will be deemed to be the authorized representative. For more information regarding VSP's criteria for authorizing or denying Vision Plan benefits, please contact VSP's Customer Service Department

Discounted Options/Services Offered by In-Network Providers

The Vision Plan is designed to cover vision services and materials that are not cosmetic. However, non-covered or otherwise limited options and services may be available from in-network providers at discounted member pricing. Please remember that these items are not covered by the Vision Plan. Therefore, if you select any of the following options or services, you will be responsible for any additional charges incurred:

- Laser vision corrective surgery. LASIK is available at a discount through contracted laser centers. Program availability may vary by location. Visit VSP's Website at *www.vsp.com* to learn more about this program
- Options that may enhance the appearance, durability and/or function of your lenses including:
  - Anti-reflective coating
  - Color coating
  - Mirror coating
  - Scratch coating
  - Blended lenses
  - Cosmetic lenses
  - Laminated lenses
  - Ultra-violet (UV) protected lenses
  - Optional cosmetic processes
  - Oversize lenses (61 mm or larger)
  - Photochromic or tinted lenses other than Pink #1 or Pink #2
  - Polycarbonate lenses covered for children up to age 18
  - Progressive multifocal lenses
  - Certain limitations on low vision care
- 15% discount on the cost of your contact lens exam when you receive contact lens services from a VSP provider (this discount does not apply to the contact lenses)
- 30% off additional glasses and sunglasses, including lens options, from the same provider on the same day as your WellVision Exam. Or get 20% off and VSP provider within 12 months of the last WellVision Exam

Discount Details

Contact your in-network provider for details and prices related to various options and discount programs.

Exclusions

Items excluded from coverage under the Vision Plan include, but are not limited to, those listed below. VSP has the discretionary authority to determine whether an expense is covered under the plan. You should always check with VSP to determine whether a service is covered.

- Services and/or supplies that are not medically necessary and/or not specifically covered under the plan, as determined by VSP
- Experimental or investigational treatments, procedures or materials that are not generally accepted by the vision care profession
- Charges in excess of Reasonable and Customary (R&C) fees

- Any service and/or supply for which a claim is not received within 12 months after receipt of the service
- Services and/or supplies for treatment of an illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under Workers' Compensation, employer's liability, occupational disease or similar law
- Additional office visits associated with contact lens pathology
- Artistically-painted contact lenses
- Balances for services and supplies after payment has been made under the plan
- Broken appointments
- Completion of claim forms
- Contact lens modification, polishing or cleaning; refitting of contact lenses after the initial (90-day) fitting period; or insurance policies and service contracts
- Corneal Refractive Therapy (CRT)
- Corrective vision services and materials of an experimental nature
- Cosmetic services or materials
- Costs for services and/or materials exceeding plan allowances by in-network or out-of-network providers
- Eye exam or corrective eyewear as a condition of employment
- Eye injuries or disease resulting from committing an illegal act, such as a felony, or from an act of war, declared or undeclared
- LASIK; however, discounts are available (see "Discounted Options/Services offered by In-Network Providers" on page 84 for additional information)
- Medical or surgical treatment of the eyes (see "The Medical Plan," beginning on page 18, for additional information)
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia)
- Orthoptics or vision training and any associated supplemental testing except as covered under low vision covered expenses (see "Low Vision" on page 83 for additional information)
- Plano lenses (lenses with refractive correction of less than ± .50 diopter) or lenses to change eye color cosmetically
- Prescription and non-prescription drugs (see "Prescription Drug Benefits," beginning on page 57 for additional information)
- Replacement of lenses and frames furnished under this plan that are lost or broken, except at the normal intervals when services are otherwise available
- Services or supplies:
  - Eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the individual asserts his rights to obtain this coverage or payment for these services
  - For which a charge is not usually made, such as a practitioner treating a professional or business associate, or services at a public health fair
  - For which the individual would not have been charged if he did not have health or vision care coverage
  - Furnished by one of the following members of the individual's family: spouse or domestic partner, child, parent, in-law, brother or sister
  - Paid for under any government law or as the result of military service and for which an individual is not legally obligated to pay
  - Provided while an individual is not covered under the plan
- Two pair of glasses in lieu of bifocals

Key Terms

You will see certain terms used throughout this section. It is important that you are familiar with their meanings.

Allowance – the maximum amount allowed for a particular covered expense under the plan.

Copay – the flat dollar amount you pay for certain services when you use participating in-network providers.

Covered expenses – those expenses that are eligible for reimbursement, subject to any copay or allowance.

In-network provider – physicians, facilities (such as eye care stores) and other vision care providers who participate in VSP's network.

Negotiated fee – the specified amount an in-network provider has agreed to accept for a service or materials.

Network – a group of physicians, facilities (such as eye care stores) and other vision care providers that have entered into a formal contract with a health plan (such as VSP) to provide services at negotiated rates.

Out-of-network provider – physicians, facilities (such as eye care stores) and other vision care providers who are not in VSP's network.

Precertification – certain services and treatments that must be approved in advance by VSP.

Provider – a licensed, practicing doctor who is not related to the participant's family by blood or marriage. The definition includes Optometrists, Ophthalmologists and dispensing Opticians.

Reasonable and Customary (R&C) charge – an amount that does not exceed the general level of charges for a similar service made by providers of similar standing in the locality where the charge is incurred. R&C generally applies to out-of-network benefits.

Additional Information

This section provides additional important information about the DSM benefit plans.

In This Section **See Page**

If You Have Other Coverage (Coordination of Benefits)

As with most group health care plans, the Medical Plan (including prescription drug coverage), Dental Plan and Vision Plan include a Coordination of Benefits (COB) provision called "non-duplication of benefits." This provision is used when you and your covered dependents (spouse, domestic partner or child) receive services that are eligible for payment under more than one health plan. Other health plan coverage includes, whether insured or not insured, another employer's group benefit plan, another arrangement of individuals in a group, Medicare (to the extent permitted by law), individual insurance or health coverage and insurance that pays without consideration of fault.

If you and/or your covered dependents are covered by more than one health plan, the plans must coordinate their benefits to determine which plan will be responsible for paying which part of the bill. This coordination between plans ensures that the combined payments from all plans are not more than the amount the DSM Medical, Dental or Vision Plan would pay if it were the only plan. In this coordination of benefits, one plan will be considered primary (the plan that considers the charges first) and the other will be considered secondary (the plan that considers the charges second). When you file a claim, it is your responsibility to know which plan is primary and which plan is secondary for you and/or your covered dependents. As a result, the benefits of one plan are reduced to the extent they are payable by another plan.

- **When the DSM Medical, Dental and/or Vision Plan is primary,** that plan will pay its benefits first and without regard to any benefits that may be payable under the secondary plan
- **When the DSM Medical, Dental and/or Vision Plan is secondary,** that plan will pay the difference between the benefits paid by the primary plan and what the plan would have paid had it been primary

When determining whether the DSM Medical, Dental and/or Vision Plan is primary or secondary, the following rules are applied. The other plan is considered primary and the DSM Medical, Dental and/or Vision Plan is secondary when the other plan:

- Has no order of benefit determination rules
- Has determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules
- Uses the same coordination of benefit rules and under those rules, that plan is primary

If the above rules do not establish which plan is primary, the following rules apply:

1. The plan that covers a person as an employee, retired employee, member, or subscriber pays before a plan that covers the person as a dependent
2. The plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary
3. If a dependent child is covered under both parents' group plans, the child's primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year
4. If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:
    a. The plan of the parent with custody pays benefits first
    b. The plan of the spouse of the parent with custody pays second

   c. The plan of the parent without custody pays third
   d. The plan of the spouse of the parent without custody pays fourth
5. If none of the above rule establishes which plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage
6. Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, always is secondary to other coverage, except as required by law
7. If you and/or an eligible dependent are confined to a hospital when first becoming covered under the Medical, Dental and/or Vision Plan, that plan is secondary to any plan (including a company-sponsored health care plan) already covering you and/or your dependent for the eligible expenses related to that hospital admission. If you and/or your dependent does not have other coverage for hospital and related expenses, the Medical, Dental and/or Vision Plan is primary

If you receive greater benefits than you should have when your benefits are coordinated, you are required to repay any overpayment.

The following box contains two examples of how COB works, using care received under the Medical Plan (including prescription drugs) as an illustration. The COB process works similarly if care is received under the Dental Plan or the Vision Plan.

Coordination of Benefits (COB) Examples

Example 1

- Under the High Option PPO, your spouse incurs $1,000 in covered expenses from in-network providers that are reimbursable at 90% under the Medical Plan (assumes the deductible has been satisfied)
- Your spouse is covered under both the Medical Plan and his/her own employer's medical plan
- This means your spouse's employer's plan pays first and the Medical Plan pays second for your spouse's covered expenses
- Your spouse's plan paid $500 of the expense

The Medical Plan will first determine how much it would have paid if there were no other coverage. Since these are covered expenses reimbursable at 90%, the Medical Plan would have paid $900 of the covered expenses ($1,000 × 90%) if there were no other coverage. The Medical Plan will then pay the claim as follows:

• Amount Medical Plan would pay if no other coverage:	$900
• Less amount paid by spouse's plan:	– $500
• Amount Medical Plan will pay as secondary payer:	$400

Example 2

If, in Example 1, your spouse's plan had paid $900 instead of $500, the Medical Plan would pay nothing:

• Amount Medical Plan would pay if no other coverage:	$900
• Less amount paid by spouse's plan:	– $900
• Amount Medical Plan will pay as secondary payer:	$0

Coordination with Medicare

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person who is in current employment status, such as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

Treatment of end-stage renal disease is covered by the Medical Plan for the first 30 months following Medicare entitlement due to end-stage renal disease and Medicare provides secondary coverage. After this 30-month period, Medicare provides primary coverage and the Medical Plan provides secondary coverage.

If you or your dependent become eligible for Medicare while you are actively employed by DSM and covered under the Medical Plan, the medical plan is generally primary as long as you remain in current employment.

The same holds true for your eligible dependents. If your eligible dependents are eligible for Medicare, the Medical Plan is generally primary as long as you remain in current employment status. Once Medicare becomes the primary plan, all bills must be submitted to Medicare first. Different rules apply if your eligible dependents have group insurance coverage of their own.

Note: When you are no longer an active employee and you or your dependent are eligible for Medicare due to a disability or the attainment of age 65, you and/or your dependent should enroll for Medicare. If you are not in current employment status Medicare typically becomes primary and all bills must be submitted to Medicare first, your benefits will be coordinated with Medicare to the full extent permitted by law, regardless of whether you actually enrolled in Medicare. To enroll for Medicare Parts A and B, you should contact your Social Security office.

Once you are not in active employment and Medicare is the primary plan or, if timely elected, would be the primary plan, the Medical Plan will not pay any medical expenses unless a Medicare Explanation of Benefits is attached to the claim form. If Medicare does not cover your expenses either because you did not sign up for Medicare Parts A and B, you declined Parts A and B or because you did not pay the required premiums, then the Medical Plan will calculate the benefits payable under the plan as if you do have Medicare Parts A and B and it will reduce benefits payable under the plan accordingly. The Medical Plan calculates its benefits and then reduces them by the amount Medicare would have paid for the same expenses, regardless of whether the individual has actually enrolled in Medicare. DSM will not reimburse any surcharges for late applications for Medicare; so it is important to enroll in Medicare (Parts A and B) when eligible, if Medicare would be primary.

How the Medical Plan Works with Medicare

If you are a former DSM employee over age 65 covered under COBRA, for example, Medicare Parts A and B would cover most of your medical expenses, while the Medical Plan may pay for some of the expenses that are not covered by Medicare Parts A and B, to the maximum allowed coverage level. Medicare would be the primary plan (payer), while the Medical Plan would be the secondary plan.

In this case, to determine benefits when you have medical expenses, the Medical Plan assumes you enrolled in Medicare Parts A and B on the date you reached age 65.

The benefits you receive from the Medical Plan will depend on whether your health care provider accepts assignment, does not accept assignment, or is a private contract provider.

- **If your provider accepts assignment,** the provider submits a bill directly to Medicare. Medicare pays the provider for services rendered up to the Medicare-approved amount (usually 80% of the charges). Next, the Medical Plan calculates the benefits it would pay if the plan was primary. The Medical Plan will then pay the difference between what it would have paid and what Medicare paid, up to the maximum allowed by Medicare. You pay the remainder, if any, directly to the provider.
- **If your provider does not accept assignment,** the provider may request payment from you at the time of the service. In this case, the provider submits a claim to Medicare and Medicare reimburses you or your provider (based on whether you paid your provider directly) for the services rendered up to the Medicare approved amount (usually 80% of the approved charges). Next, the Medical Plan calculates the benefits it would have paid if there was no other coverage. (You should note that providers who do not accept assignment can charge up to 115% of the Medicare-approved amount for services, which may increase your out-of-pocket costs.) The Medical Plan will then pay the difference between what Medicare paid and the maximum allowed by the plan. You are responsible for the remainder, if any.
- **A private insurance contract is a written agreement between you and an insurance provider** who has decided not to provide services through the Medicare program. You will be asked to sign a private contract with your chosen provider, and he or she must tell you if the provider has been excluded from the Medicare program. You have to pay all charges for the services you receive from a private contract provider. Services obtained through a provider under a private contract are not paid for by Medicare, Medigap policies and many other Medicare health plans. In addition, the Medical Plan does not pay for benefits obtained through a private contract provider.

The following examples demonstrate provider assignment, how it affects what Medicare pays, how much the Medical Plan pays and how much you pay. In each case, these examples assume that your annual deductible has been met.

Medicare Pays the Provider Directly				
Cost for Inpatient Hospital Stay	**Medicare-Approved Amount**	**Medicare Pays**	**Medical Plan Pays**	**You Pay**
$5,000	$5,000	$4,000 (80% x $5,000)	$500 ([90% x $5,000] - $4,000)	$500

Medicare Reimburses You and the Provider Charges 115% of Medicare-Approved Amount				
Cost for Inpatient Hospital Stay	**Medicare-Approved Amount**	**Medicare Pays**	**Medical Plan Pays**	**You Pay**
$5,750	$5,000	$4,000 (80% x $5,000)	$1,175 ([90% x $5,750] - $4,000)	$575

You Sign a Private Contract Directly with Provider				
Cost for Inpatient Hospital Stay	**Medicare-Approved Amount**	**Medicare Pays**	**Medical Plan Pays**	**You Pay**
$5,750	$5,000	$0	$0	$5,750

As you can see, the benefits you receive from the Medical Plan would depend on how your provider is paid. Remember, the Medical Plan doesn't pay benefits until you meet the deductible, although the same expenses can be used to meet the deductible for both Medicare and the Medical Plan. In no case will your payment from both Medicare and the Medical Plan be greater than the amount that would be paid by the Plan if you were not eligible for Medicare.

Prior to obtaining services from a provider, you should find out if the provider does or does not accept assignment, or whether the provider has a private contract.

If You Do Not Enroll in Medicare

Many people will automatically be enrolled in Medicare when they become eligible—for example, if you are already receiving Social Security benefits when you turn age 65, or if you are receiving Social Security benefits at any age because you are disabled. However, some people must sign up to receive Medicare benefits. This might apply to you if you turn age 65 before you begin receiving Social Security benefits, or if have End-Stage Renal (Kidney) Disease.

If you are covered as an active employee (or dependent of an active employee), the Medical Plan pays primary, whether or not you enroll in Medicare. However, in those situations where this plan pays secondary, the Medical Plan will pay benefits as if you are enrolled in Medicare, even if you fail to enroll. If you are not in current employment status with DSM, it is important that you enroll in both Medicare Parts A and B when you become eligible. You will be responsible for any amounts that the Medical Plan does not cover.

Coordination with Medicaid If you or any of your covered dependents qualify for coverage under Medicaid, your medical benefits under the Medical Plan will be paid before any Medicaid benefits are paid and eligibility and benefits under the Medical Plan are not affected by Medicaid eligibility.

Automobile Insurance

You may live in a state where you are given the option to have either your automobile insurance or your employer's health insurance plan provide primary coverage for covered expenses resulting from an automobile accident. Please note that the **Medical (including prescription drugs) and/or Dental Plans** are self-insured and, therefore, you cannot elect the plans as primary coverage for covered expenses resulting from an automobile injury in states where automobile liability coverage is required or provided under state statute.

The **Medical (including prescription drugs) and/or Dental Plan** will not cover expenses that could be covered under an automobile policy issued in a state requiring mandatory liability coverage. This will be the case whether or not you have selected your automobile policy to provide primary coverage.

In states that do not mandate health care coverage under an automobile policy, you will be required to submit a written denial of health care expenses from your automobile insurance carrier before such charges will be considered by the plans.

Right of Subrogation, Reimbursement and Recovery

If a covered employee or dependent (Participant) incurs medical (including prescription drug), dental and/or vision expenses as the result of injuries caused by the actions or omissions of a third party, the Participant may have a claim against that person. The Participant is required to provide the applicable plan or the service providers information concerning any claim or lawsuit the Participant may have against a third party and must provide any documents or information relevant to protect the plan's right to recovery, reimbursement or subrogation (these rights are referred to collectively in this section as "Recoveries"). A Participant's obligation to reimburse the plans from monies received or paid on his behalf exists even if the recovery is for less than the Participant's full loss and even if the recovery is designated as not for medical expenses. For any insured benefit, the terms of the insurance policy control to the extent it conflicts with this section.

The "make-whole" doctrine and the "common fund" doctrine or other similar rule which would require the DSM plans to share in recovery costs do not apply to the plans. Your obligation to reimburse the DSM plans will not be reduced to reflect any fees, expenses or costs, including attorneys' fees, incurred by you or your dependents in obtaining a recovery unless separately agreed to, in writing, by the Plan Administrator (or its designated agent). The plans' right of subrogation and of reimbursement, as described in this SPD and the Plan document, apply without regard to any equitable defenses that you or your dependents assert or may be entitled to assert, including without limitation any defense of unjust enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plans' right of subrogation or reimbursement.

Benefits under the plans are conditioned on the plan's right to Recoveries and each Participant, by participating in the plan(s), grants the plan(s) a right to a first priority lien and claims and right of recovery, in the amount of benefits paid or payable by the **Medical Plan** and the cost of any related collection costs, against the proceeds of any settlement, verdict, insurance proceeds or other amounts received from or on behalf of any third party that may be responsible, the right to impose a constructive trust on any such proceeds paid by or on behalf of a third party to the Participant, dependent(s) or any other person or entity holding the proceeds (such as a legal representative or trust) and the right to bring any legal action to enforce these rights.

For purposes of the plans' right to Recoveries, a "party" means any individual, entity or other party responsible for making any payment due to an injury, illness or condition, including but not limited to no fault insurance coverage, uninsured motorist coverage, automobile insurance, personal umbrella coverage, personal injury protection insurance coverage, med-pay coverage, Workers' Compensation coverage and any other first-party insurance coverage, as well as any settlement or award. However, a "party" does not include any individual insurance plan covering the Participant that pays indemnity benefits without regard to the amount of medical expenses incurred or based on a fixed amount per day or other period of hospitalization.

By participating in the plan(s), each Participant agrees:

- The plans are subrogated to (stand in the place of) all rights of recovery a Participant or beneficiary has against any party with respect to any payment made by such party due to a Participant's injury, illness or condition to the full extent of benefits provided or to be provided by the plan
- The plans are entitled to full recovery regardless of whether any liability for payment is admitted by the responsible party and regardless of whether the settlement or judgment identifies the benefits the plans provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than for health expenses. The plans are entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only

- To refrain from doing anything to prejudice the plans' right to Recoveries or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid
- To cooperate fully and exclusively with the plans and their appointed agents regarding their rights to Recoveries, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation, recovery or reimbursement rights
- That, by accepting benefits (whether payment is made to the Participant, beneficiary or made on behalf of the Participant to another person or provider), the Participant or beneficiary from a party as a result of an injury, illness or condition, such person will serve as a constructive trustee over the funds that constitute such payment. Such funds received will be held in constructive trust for the reimbursement of the plans until the plans have been fully reimbursed
- To direct any attorneys of fiscal intermediaries to hold recovery of all funds related to the injury in trust for the benefit of the plans and to direct that such parties deal exclusively with the cost recovery agent for the plans
- To assign to the plans and its designees all rights against such agents and attorneys to enforce the direction to hold funds in trust
- To reimburse the plans in full before any amounts (including, but not limited to, attorney fees, expenses or costs) are deducted from such funds

No Assignment Permitted

Your rights and benefits under this Plan cannot be assigned, sold or transferred to any person, including your healthcare provider.

- At its option, the Claims Administrator may make payments directly to a healthcare provider, but a direct payment to a healthcare provider will not constitute an assignment of health benefits or rights under the Plan. Any purported assignments of benefits or rights under the Plan shall be void and shall not apply to the Plan.
- In addition, you may authorize the Claims Administrator, on behalf of the Company, to make payments directly to participating network providers for covered services. These are assignments of payments, and not assignments of benefits. To the extent that a healthcare provider's assignment of payment includes an assignment of benefits, any assignment of benefits will be void and will not apply to the Plan.
- The Claims Administrator may also make payments directly to you. Payments, as well as notice regarding the receipt and/or adjudication of claims, may also be made to an alternate recipient or that person's custodial parent or authorized representative. This payment will fulfill the Plan's obligation to pay for covered services. You cannot assign your right to receive payment to anyone else, except as allowed by a "Qualified Medical Child Support Order."
- In addition to the above, any assignment of payments to a healthcare provider or any direct payments from a carrier to a healthcare provider will not be an assignment of benefits.

How the Plans Process Claims

Following is a description of how the Medical (including prescription drugs), Dental and Vision Plans process claims for benefits and eligibility.

A benefit claim is a request for a particular plan benefit, made by you, your covered dependents or your authorized representative (each of these are sometimes referred to as the "claimant"), which complies with the plan's procedures for making benefit claims. An eligibility claim is a claim to participate in a plan or to change an election to participate during the year.

The Claims Fiduciary (that is, the individual or entity with the discretionary authority to make a final decision regarding a claim) for an eligibility claim is the Plan Administrator or its designee; the Claims Fiduciary for a benefit claim is the Claims Administrator for the applicable plan, except with respect to the Dental Plan.

There are different kinds of claims and each one has a specific timetable for approval, payment, requesting further information or denial of the claim. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances, but in no event later than the timeframes set forth in the following sections. With respect to claims for benefits, if a period of time is extended due to a claimant's failure to submit necessary information, the period from the date on which notification of the extension is sent to the claimant to the date on which the claimant responds to the request for additional information will not be counted towards the timetable. All references to "days" means calendar days.

Read further for details about the claims filing requirements and your right to appeal a claim denial. If you have any questions regarding these requirements, please contact the applicable claims fiduciary, as shown in "Where to File a Claim" beginning on page101.

All claims and appeals must be submitted in writing to the appropriate Claims Administrator or Claims Fiduciary.

When filing a claim, you should include a description of the benefits you are requesting, the reason(s) for the request and any relevant documentation supporting your request. If you are filing an urgent care claim, you should state that you are filing an urgent care claim. If the claim relates to an in-network medical expense, the network provider typically will file the initial claim for you. If you need to file a claim, you must provide all the information requested on the appropriate claim form. **You must submit claims within 12 months of the date the expense is incurred or service is provided**. Claims filed after this period are not eligible for reimbursement.

Concurrent Care Claims

A **medical (excluding prescription drug)** concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

- Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments and
- Where an extension is requested beyond the initially approved period of time or number of treatments

A decision by the Claims Administrator to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed. Notification to the claimant of a decision to reduce or terminate an initially approved course of treatment will be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination. The appeal of a decision to reduce or terminate an initially approved course of treatment will be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend a concurrent care decision will be decided in the appeal time frame for a pre-service, urgent care, or post-service claim, as appropriate to the request.

Urgent Care Claims

A claim involving Urgent Care is any claim for **medical care** or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A physician with knowledge of the claimant's medical condition may determine if a claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of a plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a properly submitted claim involving Urgent Care, the following timetable applies:

Urgent Care Claims	
Notification to claimant of benefit determination	72 hours
Insufficient information on the claim, or failure to follow the plan's procedure for filing a claim:	
• Notification to claimant, orally or in writing	24 hours
• Response by claimant, orally or in writing	48 hours
• Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
• Reduction or termination before the end of treatment	72 hours
• Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the plan's benefit determination on review, may be transmitted between the plan and the claimant by telephone, facsimile or other similarly expeditious method.

Pre-Service Claims

A Pre-Service claim means a claim for benefits where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining care. These are, for example, claims subject to predetermination of benefits or precertification.

In the case of a properly submitted Pre-Service claim, the following timetable applies:

Pre-Service Claims	
Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the plan	15 days
Insufficient information on the claim:	
• Notification to claimant, orally or in writing	15 days
• Response by claimant, orally or in writing	45 days
Notification, orally or in writing, of failure to follow the plan's procedures for filing a claim	5 days
Ongoing courses of treatment:	
• Reduction or termination before the end of the treatment	15 days
• Request to extend course of treatment	15 days
Review of adverse benefit determination (appeal)	30 days

Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claims

A Post-Service claim means any benefit claim that is not a claim involving Urgent Care or a Pre-Service claim. It is a request for payment under the plan for covered services already received by the claimant.

Most claims are Post-Service claims. It is unusual for a claim for dental or vision benefits to be something other than a Post-Service claim.

In the case of a properly submitted Post-Service claim, the following timetable applies:

Post-Service Claims	
Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the plan	15 days
Extension due to insufficient information on the claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination (appeal)	60 days

Internal Appeals

If the claimant receives an adverse benefit determination, including rescission of coverage or denial of eligibility and would like the claim reconsidered, the claimant has 180 days following receipt of the notification in which to appeal the decision to the Claims Fiduciary in writing. However, appeals for medical benefits (excluding prescription drug benefits) can be made up to one year following receipt of the denial. A claimant may submit written comments, documents, records and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim.

Legal action may be brought only after a plan's appeal procedures have been exhausted and in no event later than one year after the denial on appeal. Please refer to the section below regarding exhaustion of remedies and limitations on legal action for more information.

The period of time within which a benefit or eligibility determination on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the applicable plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of a plan in connection with the initial determination will be identified.

Full and Fair Review Rules

The plan will provide the claimant with any new or additional evidence considered, relied upon or generated by the plan in connection with the claim, such evidence to be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal determination is required to be provided so that the claimant may have a reasonable opportunity to respond prior to that date.

Before the plan can issue a final determination on an appeal based on a new or additional rationale, the claimant must be provided with the rationale and the rationale must be provided as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided as set forth above to give the claimant reasonable opportunity to respond prior to that date.

Benefits for an ongoing course of treatment will not be reduced or terminated without providing advance notice and an opportunity for an appeal in advance of the end of the ongoing course of treatment.

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care claims, an adverse benefit determination may be made orally by the Claims Fiduciary, followed by written or electronic notification within three days of the oral notification. The notice will state, in a manner calculated to be understood by the claimant:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the provider and the claim amount) and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings)
- The specific reason(s) for the adverse determination, including the denial code (and its meaning) and a description of any standard that was used in the denial of the appeal
- Reference to the specific plan provisions on which the determination was based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- A description of the plan's review procedures (except for notices on appeals) and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA, as amended, following an adverse benefit determination on review
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim
- If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request

- If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Medical, Dental and/or Vision Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request
- A description of available external review processes, including information on how to initiate the appeal
- The availability of, and contact information for, an applicable health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes

Foreign Language Assistance

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the Medical Plan must provide the following language assistance:

- Oral language services in the applicable non-English language for claims, appeals and external review;
- Upon request, an explanation of benefits (EOB) or other adverse benefit determination in the applicable non-English language; and
- Provide in English versions of EOBs and other adverse benefit determinations a statement in any applicable non-English language indicating how to access the language services.

If you have any questions regarding this foreign language assistance, please see the statements on your EOBs or otherwise contact the Claims Administrator or the HR Shared Services Center.

External Review of Medical Procedures

Note: This provision applies only to the Medical Plan (including prescription drug coverage), and only to the extent required by federal law.

The external review process discussed in this section does not apply to eligibility appeals. It also does not apply to appeals for dental or vision benefits. External review is available for adverse benefit determinations that involve medical judgments (including those based on medical necessity, appropriateness, health care setting, level of care or experimental or investigational determinations). They also apply to rescissions of coverage and whether a rescission has any effect on a particular benefit at the time of the rescission.

When You Can Request an External Review

If your internal claim for benefits is denied and you have properly filed an internal appeal of that benefit claim which is also denied, an additional external review may be available. If you would like your claim reviewed through the external review process, you must file the request in writing with the Claims Administrator ***within four months*** after the date of receipt of a denied internal appeal. If there is no corresponding date four months after the date of receipt of the denied internal appeal, then the request must be filed by the first day of the fifth month following the receipt of the denied internal appeal. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Procedures after an External Appeal Request is Filed

Within five business days following the date of receipt of the external appeal request, the Claims Administrator will complete a preliminary review of the request to determine whether:

- You are or were covered under the medical benefit option at the time the item or service was requested or, in the case of a retrospective review, were covered at the time the health care item or service was provided
- The denied appeal does not relate to your failure to meet the requirements for eligibility
- You have exhausted the internal appeal process and
- You have provided all the information and forms required to process an external appeal

Within one business day after completing the preliminary review, the Claims Administrator will notify you in writing of its decision. If the claim is not eligible for external review, the notice will include the reasons for its ineligibility. If the request is not complete, the notice will describe the information or materials needed to complete the request, and you will have until the later of the remaining time within the four-month filing period (described above) or 48 hours following the receipt of the notice to complete your request for an external review.

Procedures after your Request is Approved

If your request for an external appeal is approved, the Claims Administrator will assign it to an independent review organization (IRO).

Note: These IRO procedures are intended to comply with applicable law. The following is a general description of those procedures, but they may be updated or revised as additional guidance is issued with respect to the external appeal process, as provided under federal law.

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of the receipt of the notice and additional information that the IRO must consider when conducting the external appeal. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days. Any additional information received by the IRO from you will be shared with the Claims Administrator and the Medical Plan. If, upon receipt of this information, the Claims Administrator decides to review its decision and then reverses its prior decision and fully approves the internal appeal, then your claim will be paid accordingly and the external appeal will be terminated.

If the external appeal is not terminated as noted above, the IRO will review all information and documents related to your denied internal appeal. The IRO is not bound by any decisions or conclusions reached by the applicable Claims Administrator during the internal claim and appeal process.

The IRO will provide written notice to you and the applicable Claims Administrator of the final external review decision within 45 days after it receives the request for review. Such notice will contain:

- A general description of the reason for the request for the review and information sufficient to identify the claim
- The date the IRO received the assignment to conduct the review and the date of the IRO's decision
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
- A discussion of the principal reason(s) for its decision, including the rational for its decision and any evidence-based standards that were relied on in making its decision

- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law to either the Medical Plan or to you
- A statement that judicial review may be available to you and
- Current contact information, including a telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act

If the IRO reverses the internal decision, the Claims Administrator will provide the applicable coverage or payment for the claim.

Expedited External Appeal Requests

You may also make an expedited external appeal request to the Claims Administrator at the time you receive:

- A denied urgent care internal claim if you have also filed at the same time an internal appeal
- A denied urgent care internal appeal, or
- A denied internal appeal, which concerns an admission, availability of care, conducted stay or medical care item or service for which you have received emergency services and have not been discharged from the facility

Upon receipt of the request for expedited external review, the Claims Administrator will conduct a preliminary review to determine whether the request meets the requirements for an expedited review. If it does, you will be notified within 72 hours that your request is eligible for an expedited external review. Upon a determination that a request is eligible for expedited external appeal, the IRO will follow the procedures discussed above with respect to standard external appeals, except that the IRO will provide notice of the external appeal decision, as expeditiously as the circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external appeal.

Where to File a Claim

Eligibility claims and appeals must be filed in writing with the Plan Administrator:

DSM North America, Inc.
Attn: HR Shared Services /Appeals
45 Waterview Blvd.
Parsippany, NJ 07054-1298

Benefits claims and appeals must be filed with the applicable Claims Fiduciary. Your point of contact depends on whether you are filing an initial claim or an appeal as indicated below.

Coverage	For initial claims...	For appeals...
Medical	Horizon Blue Cross Blue Shield of New Jersey P.O. Box 1219 Newark, NJ 07101	Horizon Blue Cross Blue Shield of New Jersey Appeals Mail Station PP10B P.O. Box 1010 Newark, NJ 07101
Prescription Drug	Express Scripts, Inc. ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872	Express Scripts, Inc. Pharmacy Appeals - DSM - MCMC Mail Route BL0390 6625 W. 78th Street Bloomington, MN 55439

Dental	Delta Dental P.O. Box 9089 Farmington Hills, MI 48333-9089	DSM North America, Inc. Attn: HR Shared Services Dental Appeals 45 Waterview Blvd. Parsippany, NJ 07054-1298
Vision	VSP, Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670	

How You Could Lose Benefits

The Medical (including prescription drugs), Dental and Vision Plans are designed and maintained by DSM to give you a coordinated, comprehensive program of health care protection. Yet, you should be aware that there are certain circumstances that could result in a loss of benefits including, but not limited to the following:

- If DSM no longer provides coverage under the applicable benefit option, your coverage under that option will end
- If you do not make required contributions, your coverage will end
- If coverage terminates and you or your dependents, as applicable, do not elect COBRA continuation coverage, if available, within the required time period, the opportunity to continue coverage will be lost
- If you do not apply for benefits or provide the necessary claim information within 12 months of the time the expense is incurred, no benefits will be paid
- Misrepresentation or falsification of claims, like any other falsification of records, is a serious disciplinary offense which could jeopardize your employment. The other penalties for providing incomplete, false or inaccurate information may include the denial of payment of benefits, suspension of coverage in the Medical, Dental and/or Vision Plan and/or other legal action

Continuing Coverage

Employees, spouses, and dependent children covered under the Medical (including prescription drug benefits), Dental and Vision Plans are eligible for a temporary extension of coverage (called "continuation coverage" or "COBRA coverage") without proof of good health, if that coverage would otherwise end due to certain events (called "Qualifying Events"). Employees and dependents who are eligible for continuation coverage are known as "Qualified Beneficiaries." This section is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. Although not required by law, DSM provides the same rights to continuation coverage to covered domestic partners and their dependents, subject to the same conditions as spouses and other covered dependents.

What is COBRA coverage?

COBRA is a temporary extension of coverage made available if your coverage ends due to certain "Qualifying Events."

COBRA provides Qualified Beneficiaries who experience a Qualifying Event that results in loss of health coverage the opportunity to continue coverage at 102% of the group rate for a specified amount of time. The chart, shown next, lists the Qualifying Events that trigger COBRA eligibility, the duration of coverage available, extensions that may apply and time limits for electing coverage. In certain cases the filing of a bankruptcy proceeding under Title 11 of the United States Code can be considered a Qualifying Event. If a bankruptcy proceeding is filed with respect to DSM which results in the loss of medical coverage, you (and your surviving spouse and/or dependent children) may become a qualified beneficiary with respect to the bankruptcy.

Additional Information

Generally, continuation coverage is available for up to 18 months following a termination of employment or reduction in hours and for up to 36 months following death, divorce or loss of dependent status. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA coverage for other qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Qualified Beneficiaries are only eligible to continue the type of health coverage in which they are enrolled on the day before the Qualifying Event occurs. However, if you were on an FMLA leave, did not elect health coverage during the leave and then do not return from the leave, you may be eligible to elect continuation coverage if you had health coverage immediately before your FMLA leave.

If a Qualified Beneficiary elects continuation coverage, the coverage provided will be identical to the coverage provided under the applicable DSM health plan(s) to similarly situated employees or dependents. If this coverage changes for similarly situated employees or dependents, the coverage available to Qualified Beneficiaries will change accordingly.

Separate COBRA Elections

Eligible dependents may make separate elections to continue coverage, even if the employee declines coverage.

When making the decision of whether to elect COBRA continuation coverage, you should consider that there may be other coverage options for you and your family. Under the Affordable Care Act, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for this coverage or a tax credit through the Marketplace. Before you make a decision to enroll in coverage offered through the Marketplace, you can see what premiums, deductibles and out-of-pocket costs will be. You should compare plans so that you can see which coverage is right for you. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Keep in mind that if you elect COBRA, you can only enroll through the Marketplace during an annual enrollment period or when you exhaust your COBRA coverage. Also, please keep in mind that coverage purchased through the Marketplace is prospective, so you should plan carefully.

Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

Additional Information

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Type of Qualifying Events

The following chart highlights the qualifying events for continuing coverage, who is eligible and how long that coverage can last.

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period from Qualifying Date	Possible Extension	Period During Which You Must Apply for Continuation
• **Termination of regular employment other than due to gross misconduct** • **Reduction in hours that results in loss of coverage or increase in premium**	Employee	18 months	29 months (only if you qualify for the "Disability Extension")	Within 60 days of the later of the: • Date COBRA notice is received or • Date coverage is lost due to Qualifying Event
	Spouse/domestic partner and child(ren)	18 months*	36 months (only if another Qualifying Event occurs within initial 18-month continuation period) or 29 months (only if you qualify for the "Disability Extension")	Same as above ***plus*** Qualified Beneficiaries must notify the COBRA Administrator within 60 days of a second Qualifying Event
Divorce, legal separation or termination of domestic partnership	Spouse/domestic partner and child(ren)	36 months		Within 60 days of divorce, legal separation or termination of domestic partnership

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period from Qualifying Date	Possible Extension	Period During Which You Must Apply for Continuation
Death of employee	Spouse/domestic partner and child(ren)	36 months		Within 60 days of death
Child ceases to meet definition of eligible dependent	Child who ceases to be an eligible dependent	36 months		Within 60 days after ceasing to be eligible

* *If you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA coverage for other qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).*

Disability Extension

If the Social Security Administration (SSA) determines that a Qualified Beneficiary is totally disabled at the time of the Qualifying Event or within the first 60 days of a continuation coverage period, health coverage for all of your Qualified Beneficiaries may be continued for up to 29 months instead of 18 months (regardless of whether the disabled family member elects COBRA). This Disability Extension is also available to newborn and adopted eligible dependent children who are determined to be disabled by the SSA within 60 days of birth or placement for adoption.

To get this additional 11 months of coverage you or the disabled qualified beneficiary (or a representative) must provide notice to the COBRA Administrator in writing of the SSA's determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of the date:

- The qualified beneficiary is determined to be disabled by the SSA
- You terminated or reduced your hours of employment, or
- On which the qualified beneficiary would lose coverage under the Medical Plan as a result of your termination or reduction in hours of employment

You also must notify the COBRA Administrator within 30 days of the date the SSA makes a final determination that the applicable person is no longer disabled. Coverage can only be extended to the earlier of:

- 29 months from the employee’s initial Qualifying Event date, or
- The month that begins more than 30 days after the SSA makes a final determination that the person is no longer disabled

Failure to timely and properly provide notice of a disability determination will eliminate the right to extend the period of COBRA coverage.

The monthly cost for continuation coverage for all covered participants during months 19 to 29 may be increased from 102% of the total cost to 150% of the total cost if the person who has been declared disabled by the SSA has elected continuation coverage. Please contact the COBRA Administrator for the current 150% costs if you are in this category.

Special Rules for Spouses, Domestic Partners and Children

If you are the covered spouse, domestic partner or child of an employee, your coverage ceases when the employee's coverage ceases. Spouses, domestic partners and/or children may make separate elections to continue coverage under COBRA even if the employee declines continuation coverage.

Multiple Qualifying Events

If you are the covered spouse or child of a DSM employee or former employee and, during your initial 18-month continuation coverage period, you experience a second Qualifying Event (i.e., divorce, legal separation or death of the employee), you may extend continuation coverage up to a maximum of 36 months from the original Qualifying Event date (the date of the employee's termination or reduction in hours, as applicable). However, if an employee has a Qualifying Event due to a reduction in hours, a subsequent termination of employment is not considered a second Qualifying Event. Qualified Beneficiaries must inform the COBRA Administrator that a second Qualifying Event has occurred within 60 days of the second event.

Failure to timely and properly provide notice of a second Qualifying Event will eliminate the right to extend the period of COBRA coverage.

Adding Eligible Dependents to Existing COBRA Coverage

Qualified Beneficiaries who acquire new eligible dependents as a result of marriage, birth, adoption, placement for adoption or initiation of a domestic partner relationship may add these eligible dependents to existing COBRA coverage, provided they do so within 30 days of the marriage, birth, adoption, placement for adoption or initiation of a domestic partner relationship. Coverage for the new dependent will end on the earlier of the day your COBRA period ends or the day he/she no longer meets the Plan's definition of eligible dependent.

Special Rules under the Trade Act

Special COBRA rights may apply if you lose coverage because of termination of employment or a reduction in hours of employment and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. While this law remains in effect, you may be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if you did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after your initial loss of coverage. You must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act or you will lose these special COBRA rights. If you have questions about these Trade Act provisions, you may call the Health Coverage Tax Credit Customer Contact Center at 1-866-628-4282. TTD/TTY callers may call at 1-866-626-4282. More information is also available at *www.doleta.gov/tradeact*.

How to Obtain COBRA Continuation Coverage

You Must Notify DSM of Certain Qualifying Events to Be Eligible for COBRA

If you, your spouse, domestic partner or dependents experience a Qualifying Event that is (1) divorce, legal separation or cessation of domestic partnership, (2) loss of dependent child status, (3) a second Qualifying Event following termination of employment/reduction in hours of employment, (4) an SSA determination of disability for someone on COBRA, or (5) a determination by the SSA that someone who has extended COBRA due to disability is no longer totally disabled, ***you must notify the COBRA Administrator in accordance with the procedures described in this section within the 60 day period described below. Failure to follow these procedures will impact your ability to elect COBRA coverage.***

You may provide the notice in writing, by fax to WageWorks COBRA Services, PO Box 3028, Alpharetta, GA, 30023-3028, by fax to (800) 578-5698 or by calling 1-800-526-2720 . Your notice must include the type of group health plans that you, your spouse, domestic partner and/or dependents participate in (such as the Medical, Dental or Vision Plan), the name and address of the employee covered under these benefit options and the names and addresses of the Qualified Beneficiaries (a Qualified Beneficiary is someone who will lose coverage under the benefit option because of a Qualifying Event). In addition, the notice must identify the Qualifying Event and the date it occurred.

The notice of a Qualifying Event must be post-marked (or received if submitted by fax or over the phone), ***within 60 days*** of the later date of the Qualifying Event or the date coverage would be lost due to the Qualifying Event. With respect to a notice relating to an extension of COBRA due to disability, your notice must be provided within 60 days of the later of the date:

- The qualified beneficiary is determined to be disabled by the SSA
- You terminated or reduced your hours of employment; or
- On which the qualified beneficiary would lose coverage under the Plan as a result of your termination or reduction in hours of employment, but in no event later than the end of the initial 18-month COBRA period

Once You Receive Your COBRA Notification Package

- Complete the enrollment form. You must return the form within 60 days of its receipt to the address on the instruction sheet. Your COBRA package will include premium payment instructions
- You have 45 days from the date you elect continuation coverage to pay your first month's premium. If your initial payment is not received within 45 days of the date your request form is submitted, you will lose your right to continue coverage. All subsequent monthly payments must be received within 30 days of the first day of the month due or coverage will be lost and may not be reinstated
- Failure to follow the required procedures in the enrollment material will result in loss of the right to elect continuation coverage. ***If you do not elect COBRA coverage by the deadline or if you fail to provide notice of a Qualifying Event as required, you lose your right to elect COBRA coverage***
- In deciding whether to elect COBRA coverage, you should consider that a failure to continue coverage may affect your future rights under federal law and you should consider that you have special enrollment rights under federal law and that you may be entitled to obtain coverage through the Marketplace
- You have the right to request special enrollment in another group health plan for which you may be eligible within 30 days after you lose coverage due to a Qualifying Event. If you elect COBRA coverage under this Plan, you will also have a special enrollment right under such other group plan if you continue to be covered by COBRA for the maximum period available. If you elect COBRA but drop it before the maximum period expires, you will not have a special enrollment right
- If you elect continuation coverage under the Medical Plan, your prescription drug coverage will also continue. You cannot elect prescription drug coverage without electing Medical Plan coverage

COBRA Coverage After Age 65

If an employee turns 65 after their termination of employment it is important to note:

- When one first becomes eligible for Medicare, there is a 7-month Initial Enrollment period to sign up for Parts A and/or B. This 7-month timeframe begins 3 months before the month turning age 65, includes the month in which they turn age 65, and ends 3 months after the month they turn age 65.
- If former employee is enrolled in COBRA coverage and turns age 65 then medical coverage through COBRA will end. COBRA coverage may be maintained for extra benefits like prescription drug (if the Company does not offer creditable prescription drug coverage) or dental coverage, but not for medical coverage.
- DSM's prescription drug coverage offered under COBRA is considered creditable therefore, enrollment in the Medicare Part D drug plan can be delayed, without penalty, to the end of the COBRA enrollment period.
- There is requirement to enroll in the Medicare Part D drug plan within 63 days of the end of COBRA coverage. If enrollment is not completed within 63 days a penalty can be assessed for the amount of time one was eligible but didn't join a Medicare Prescription Drug Plan. Please note that the cost of coverage changes annually therefore if you are required to pay a penalty for delayed enrollment, the penalty will also increase annually.
- *In both scenarios, family members who are enrolled in COBRA through the former employee's plan, may be able to continue their COBRA coverage for the authorized period of time, even after the employee becomes eligible for Medicare.

When Coverage Ends

Continuation coverage under COBRA will terminate for any of the following reasons:

- DSM no longer provides group health plan coverage to any of its employees
- The date coverage would otherwise terminate, such as due to providing false information, fraud or misrepresentation
- The date the covered person turns age 65 on the COBRA medical plan
- The premium for continuation coverage is not paid on a timely basis
- After electing COBRA coverage, the covered person becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition that applies to the covered person
- After electing COBRA coverage, the covered person becomes covered by Medicare (either Part A or B)

USERRA Continuation Coverage

If the employee is on military leave of absence pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended, the employee may continue to participate in the health care plans for a maximum of 30 days after the commencement of the leave of absence (subject to any Plan exclusions for injuries sustained in war) and at the end of such 30-day period, participation in the Plan will terminate. At that time, continued coverage (similar to COBRA) will be available.

The maximum period of coverage for a person under such an election shall be the lesser of:

- The 24-month period beginning on the date on which the person's absence begins
- The day after the date on which the person was required to apply for or return to a position of employment and fails to do so
- The date the Plan is terminated, or the employee's Participating Company terminates participation in the Plan
- The day the employee fails to make a required contribution to the Plan

A person who elects to continue health plan coverage must pay up to 102% of the full cost under the Plan (but only for leaves under USERRA that are for more than 30 days).

An exclusion may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

USERRA continuation coverage is concurrent with COBRA coverage. That is, any period of COBRA coverage will be reduced by the period of USERRA coverage already received by the employee. The rules for electing and paying for COBRA coverage also apply to USERRA coverage.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee and Retirement Security Act of 1974 (ERISA), as amended.

ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA")
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for copying costs
- Receive a summary of the Plan's annual financial report each year that includes important funding information about the Plan. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report
- Continue group health plan coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan are called "fiduciaries" of the Plan and have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in federal court, but only after you have exhausted the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the EBSA by calling the toll-free hotline at 1-866-444-EBSA (3272). You will be automatically transferred to the nearest EBSA office (based on the area code of the telephone used to place the call). Alternatively, you can write to the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by contacting EBSA by telephone or mail (at the number and address stated above) or online at *www.dol.gov/ebsa*.

Your HIPAA Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. The notice will describe how the Plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Refer to the Plan's privacy notice for more information.

You can obtain a copy of the notice by contacting:

DSM North America, Inc.
45 Waterview Blvd.
Parsippany, NJ 07054-1298
Attn: HIPAA Privacy Officer

Compliance with the Affordable Care Act

It is DSM's policy and intent to comply with all applicable provisions of the Affordable Care Act and its related regulations and other governmental guidance. DSM will investigate fully any complaint that it or the Plan has not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that DSM or the Plan has violated a provision of the Affordable Care Act, you are encouraged to share your complaint with DSM by contacting the DSM Benefits Center at 1-866-353-9740. Please provide as much information as you can regarding your complaint to help DSM with its investigation. DSM will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under the Affordable Care Act.

Other Important Information

No Guarantee of Employment

The descriptions of the DSM benefit plans in this SPD do not constitute a contract. This means that no promise of any kind is intended by the benefits described herein. Nothing in the SPD or the plans described in it gives, or is intended to give any person the right to be retained in the employment of DSM, or to interfere with the right of DSM to terminate the employment of any person.

Discretionary Authority

Benefits under the plans will be paid only if the Plan Administrator (or Claims Administrator, as applicable) determines that the applicant is entitled to them.

Future of the Plans

The benefit plans described in this SPD are established by DSM voluntarily and may be amended or terminated at any time by DSM, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., with respect to current or future employees, retirees or other terminated employees or their dependents or survivors, regardless of whether they are participating in the Plan(s) at the time of amendment. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. You will be required to repay any amounts paid in error under the Plan.

Exhaustion of Administrative Remedies and Limitations on Legal Actions

Before filing any claim or action in court or in another tribunal with respect to the Plan, you must first fully exhaust all of your actual or potential rights under the claims procedures provided above by filing an initial claim and then seeking a timely appeal of any denial. This relates to claims for benefits under the Plan and to any other issue, matter, or dispute with respect to the Plan (including any Plan eligibility, interpretation or amendment issue). This exhaustion requirement applies even if the Plan Administrator has not previously defined or established specific claims procedures that directly apply to the submission and consideration of a particular issue, matter or dispute. After you have filed your initial claim, the Plan Administrator will inform you of any specific claims procedures that will apply to your particular issue, matter or dispute, or it will apply the claims procedures above that apply to claims for benefits.

If you want to bring legal action, you must do so within one year from the date the final appeal is denied with respect to a claim for benefits or eligibility, or (c) with respect to any other type of claim, within two years after you knew or should know of the actions or events that give rise to the claim.

Any claim or action filed in connection with the plan must be brought or filed in the United States District Court for the District of New Jersey.

ERISA Information

The Plan is in compliance with ERISA. For information relative to your rights under ERISA, please refer to "Your ERISA Rights" beginning on page109. The information in the following table is required to be included in this SPD under ERISA.

Plan Name	The DSM Consolidated Welfare Benefit Plan	
Plan Number	510	
Plan Sponsor	DSM North America. 45 Waterview Blvd. Parsippany, NJ 07054-1298 1-973-257-8500	
Plan Administrator	DSM North America, Inc. 45 Waterview Blvd. Parsippany, NJ 07054-1298 1-973-257-8500 DSM has full discretionary authority to administer, interpret and determine eligibility for the Plan.	
Plan Sponsor's Employer Identification Number (EIN)	58-1858661	
Agent for Service of Legal Process	General Counsel DSM North America, Inc. 45 Waterview Blvd. Parsippany, NJ 07054-1298	
Plan Costs/Funding	The Medical (including prescription drugs) and Dental Plans are funded through the general assets of the Participating Companies. Vision Plan coverage is provided through an insurance contract. Employee contributions for the Medical (including prescription drugs), Dental and Vision Plans may be required and are generally made pre-tax under the cafeteria plan.	
Plan Year	January 1 – December 31	
Type of Plan	Welfare Benefit Plan	
Participating Companies	• DSM Biomedical Inc. • DSM Desotech Inc. • DSM Dyneema LLC • DSM Engineering Plastics, Inc. • DSM Food Specialties USA, Inc. •	• DSM Coating Resins, Inc. • DSM Nutritional Products, LLC • DSM North America, Inc. • i-Health, Inc.
Claims Administrator and Claims Fiduciary	**Medical Plan** **Medical Benefits** Horizon Blue Cross Blue Shield of New Jersey 3 Penn Plaza Newark, NJ 07105	**Medical Plan** **Prescription Drug Benefits** Express Scripts, Inc. Member Reimbursements P.O. Box 66583 St. Louis, MO 63166
	Dental Plan **Claims Administrator:** Delta Dental P.O. Box 9089 Farmington Hills, MI 48333-9089 **Claims Fiduciary:** DSM North America, Inc. 45 Waterview Blvd. Parsippany, NJ 07054	**Vision Plan** Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670

Additional Information

Benefits Administrator	**DSM Benefits Center** **ADP** P.O. Box 22489 Louisville, KY 40252	**COBRA Benefits** **WageWorks COBRA Services** PO Box 3028 Alpharetta, GA, 30023-3028

January 2019