DSM North America, Inc.

2019 Health Summary Plan Description

For Retirees

HEALTH · NUTRITION · MATERIALS

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 health care plan provided by DSM North America Inc. (“DSM”) under its Consolidated Retiree Welfare Benefit Plan (the “Plan”) to eligible retirees and their eligible dependents of the Plan’s Participating Companies. The term "health care plan" refers to the Medical Plan (including prescription drug benefits). This SPD describes the benefits in effect under the Plan, as amended and restated, 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, even after your retirement. 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 Plan 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. Please refer to the separate SPD for the DSM Consolidated Welfare Benefit Plan for a description of benefits provided to active employees and their eligible dependents.

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. No vested benefits are intended nor implied.

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*

Health Summary Plan Description

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

This SPD sometimes refers to the "Medical Plan," and sometimes to "health care benefits." Please remember that references to medical or health care benefits also include prescription drug coverage. Other SPDs describe other benefits provided under the Plan.

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 retirees of the Participating Companies (see "Additional Information," beginning on page 54, for a list of Participating Companies).

The SPD is intended to give you an overall understanding of the Medical 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 any discrepancy 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 4
The Medical Plan 14
Prescription Drug Benefits 45
Additional Information 54

Eligibility and Enrollment

To be covered under the Medical Plan, 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 5
- Eligible Retirees 5
- Eligible Dependents 6
- Who is Not Eligible 8

Enrollment and Coverage Effective Dates 9
- New Retirees 9
- Annual Enrollment 9
- Benefit Options and Coverage Categories 9

Changing Your Health Elections 10
- Life Events 11
- Retiree Coverage 12
- Dependent Coverage 12
- Termination for Cause 12

Retiree Contributions 13

Contributions for Domestic Partners 13

Eligibility and Enrollment for Health Benefits

This section explains the rules for eligibility and enrollment in the Medical Plan (including prescription drug benefits).

Eligible Retirees

Eligible retirees are those individuals classified in the sole discretion of a Participating Company as its retired U.S. nonbargained employees who meet the following eligibility requirements. See “Additional Information,” beginning on page 54, for a list of Participating Companies.

Pre-65 Retiree Medical Benefits

If you retire before age 65, your eligibility for the Medical Plan will depend on your retirement date, as shown in the following table.

If you retired…	
Before January 1, 2010	**On or after January 1, 2010**
You must have satisfied the eligibility requirements for a retiree medical benefit option offered by DSM at the time of your retirement.	All of the following must apply to you: ▪ As of June 30, 2009, you were at least age 45 with 15 or more years of service, or you were at least age 55 with 10 or more years of service ▪ As of December 31, 2009, you were actively employed by a Participating Company that offered retiree medical benefits ▪ You retire from DSM on or after attaining age 55

Regardless of your retirement date, your eligibility for retiree medical benefits will depend on the following:

- You must not decline retiree medical benefits when you are first eligible
- You must not opt out of retiree medical coverage after your retirement date
- You must continue to make any required contributions to maintain your retiree medical benefits
- Your Participating Company as of December 31, 2009 must continue to offer retiree medical benefits

In all circumstances, the Plan Administrator has the sole authority to determine whether an individual is eligible to participate in the Medical Plan.

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

Post-65 Retiree Medical Benefits

In general, coverage under the Medical Plan will end on the last day of the month in which you attain age 65, unless you are a Post-65 eligible retiree. Eligibility for post-65 retiree medical benefits will depend on your retirement date, as shown in the following table.

If you retired…	
Before January 1, 2010	**On or after January 1, 2010**
Both of the following must apply to you: ▪ As of December 31, 2009, you were covered under a retiree medical benefit option offered by DSM ▪ You retired from a Participating Company that offered post-65 retiree medical benefits	All of the following must apply to you: ▪ As of June 30, 2009, you were at least age 55 with 10 or more years of service. (**Note:** For non-union employees of DSM NeoResins, Inc. who were not formerly employed by DSM NeoSol, this requirement is age 50 as of June 30, 2009. In addition, your age plus years of service on that date must be at least 70.) ▪ As of December 31, 2009, you were actively employed by a Participating Company that offered post-65 retiree medical benefits ▪ You retire from DSM on or after attaining age 55

Eligible Dependents

If you are an eligible retiree, 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 DSM employee, that individual will not be an eligible dependent.
- Same and opposite-sex 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)

Your dependents are eligible for the Medical Plan only while you are covered under the Medical Plan. If you opt out of coverage at a later date, your dependents are no longer eligible for coverage.

Dependent Status

It is the retiree's responsibility to keep DSM informed of changes in his/her dependents' status. Failure to remove ineligible dependents may result in unexpected expenses for care provided when you or your dependents are no longer covered by 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 falsification of records and is a serious disciplinary offense which could jeopardize your eligibility for the Plan. The other penalties for providing incomplete, false, or inaccurate information include the denial of payment of benefits and/or other legal action.

Domestic Partners

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

An individual and an eligible retiree are domestic partners if the two individuals meet one of the following two 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; or
- 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 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

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.

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 an employee hired after such dependent attained age 26, 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, and

- Once enrolled in the Plan, remain enrolled continuously while disabled; and
- Do not have coverage available through their own employer

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 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 billed to you. 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.

Ways to Enroll or Change Your Elections

You can enroll online through the DSM Benefits Web site at *https://my.adp.com/dsm* or by calling the DSM Benefits Center at 1-866-353-9740.

Who Is Not Eligible

The following individuals are not eligible dependents:

- A spouse or domestic partner who is an eligible DSM employee
- Anyone for whom you do not provide proof of dependent status acceptable to DSM within the time and in the manner required

Enrollment and Coverage Effective Dates

New Retirees

If you are a newly eligible retiree, you will receive enrollment materials explaining your benefit options and the cost of coverage shortly after you retire. You must complete your enrollment online or over the phone ***within 30 days of the day you first become eligible(your last active date of employment with DSM)***.

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

Please note that if you are eligible for coverage under the Retiree Medical Plan but instead elect coverage under COBRA under the medical plan for active employees, you will no longer be eligible for coverage under this Medical Plan following the end of your COBRA coverage period. That is, at retirement, you must choose either COBRA coverage under the active plan or, as an alternative, coverage under this Medical Plan.

When Enrolling Dependents

Social Security numbers or ITINs 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 Enroll

If you do not enroll yourself and, if applicable, your eligible dependents, within your first 30 days of eligibility, you will not be eligible to enroll in DSM's or any Participating Company's retiree medical or prescription drug coverage at a later date.

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) election 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. However, 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. If this occurs, you must make a new election in order to continue coverage.

Benefit Options and Coverage Categories

Within the Medical Plan you may:

- Enroll in or waive coverage. More than one option is currently available.
- Elect from one of the following coverage categories:
  - Retiree Only
  - Retiree and Spouse/Domestic Partner
  - Retiree and Child(ren)
  - Family

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 an ID card for your medical and prescription drug benefits. You may also receive new ID cards in future Plan years.

Enrollment Documentation

During initial and Annual Enrollments, you must certify:

- 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, possibly retroactively, to the extent permitted by law. 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 (Retiree Only, Retiree and Spouse/Domestic Partner, Retiree and Child[ren], or Family), ***you may only change your election or add dependents during the Plan's Annual Enrollment period, except in limited circumstances***. You can remove dependents from coverage at any time if they are no longer eligible. Once the Annual Enrollment period ends, no further coverage changes or additions can be made unless you experience a Life Event, as defined in this section.

If you terminate your Plan coverage, you will no longer be eligible to participate in the Plan, and you may not re-enroll at a future time.

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 of the event.*** For example, if you are covering yourself and you get married and want to enroll your new spouse, you must make an election change within 30 days of the marriage to add your new spouse to your coverage. All Life Event changes must be reported by visiting ***https://my.adp.com/dsm***, 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 Plan:

- 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)
- Your employment by DSM (active employees cannot be covered under this Medical Plan)
- 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
- Receipt of a Qualified Medical Child Support Order
- 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 Medical Plan permits the election change. Contact the DSM Benefits Center at 1-866-353-9740 if you have questions.

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/domestic partner/child(ren) within 30 days of the marriage or birth - ***even if you already have family coverage***.

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 *https://my.adp.com/dsm DSM*, using the ADP mobile app, or calling the DSM Benefits Center at 1-866-353-9740.

Enrolling Newborn Children

A newborn child of an eligible retiree 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 retiree will be responsible for all expenses of the newborn.

See “The Medical Plan,” beginning on page 14, 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.

When Coverage Ends

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

Retiree Coverage

Retiree coverage will terminate on the earliest of the following dates:

- The date the Medical Plan or applicable benefit option is terminated
- The last day of the month in which your enrollment in the Medical Plan ends
- The date you no longer meet the Medical Plan’s eligibility requirements
- The last day of the month in which you attain age 65, unless you are a Post-65 eligible retiree (see “Post-65 Retiree Medical Benefits,” beginning on page 6)
- 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
- The date of the retiree’s death
- The date the retiree enrolls in Medicare Part D

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) is available, what conditions apply and how to elect it see “Continuing Coverage,” beginning on page 65.

- The date the Medical Plan, the applicable benefit option or dependent coverage for benefits is terminated
- The date that the retiree's coverage under the Plan terminates for any reason, including death
- The date of divorce, legal separation or annulment from the Retiree, with respect to a covered spouse
- The last day of the month in which a child ceases to be an eligible dependent
- 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
- The date the dependent enrolls in Medicare Part D

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

Retiree Contributions

You share the cost of your medical coverage with DSM. Your Medical Plan contributions include the cost of prescription drug coverage. 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 will notified of any changes in contributions. You will be billed for your coverage.

Contributions for Domestic Partners

If you cover a domestic partner (and children of the domestic partner, if applicable), tax law requires that you must 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. This is referred to as “imputed income.” Federal law requires that you pay taxes on imputed income.

Prior to enrolling your domestic partner and his/her eligible child(ren), if applicable, for medical coverage, call the DSM Benefits Center at 1-866-353-9740 to obtain the current premium amounts on which income will be imputed. 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, each year your domestic partner is eligible you may submit an affidavit stating that he or she is a tax dependent. 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.

You have a choice of two medical options administered by Blue Cross Blue Shield (BCBS): the High Option PPO and the Low Option PPO.

Key Terms

Turn to page 42 for definitions of key terms used in this section.

Both of the options use a Preferred Provider Organization (PPO). The PPO plans allow you to choose between In-Network and Out-of-Network providers. Out-of-pocket costs are lower when In-Network providers are utilized. Both PPO medical options include the same prescription drug coverage, administered by Express Scripts.

In This Section **See Page**

The Medical Plan at a Glance 15
Medical Benefits 15
How Coverage Works 16
Using the PPO Options 17
Deductibles 17
Out-of-Pocket Maximums 18
Lifetime Benefit Maximum 20
Managing Your Health Care 20
Precertification 20
Continued Stay Review 22
Predetermination of Benefits 22
Case Management 23
Covered Expenses 23
Important Information on Certain Covered Expenses 28
Other Covered Expenses 37
Exclusions 38
Federally-Mandated Benefits 42
How to File Claims 42
Key Terms 42

The Medical Plan at a Glance

This section summarizes the basic facts of the Medical Plan.

	High Option PPO Benefits		Low Option PPO Benefits	
	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Deductible Individual/Family	$350/$1,050	$700/$2,100	$1,050/$3,150	$2,100/$6,300
Out-of-Pocket Maximum* Individual/Family	$1,850/$5,550	$3,700/$11,100	$4,050/$12,150	$8,100/$24,300
What the Medical Plan Pays				
Preventive Care	100%	70% 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
Coinsurance – for many covered services	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Lifetime Maximum	$2,000,000			

* *Excludes deductibles and copays.*

** *Amounts paid by the Plan are based on the Allowance; participant is responsible for 100% of charges above the Allowance*

Both the High and Low Option PPOs provide the same prescription drug benefits. More information on prescription drug coverage is contained in “Prescription Drug Benefits,” beginning on page 45.

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 two BCBS Preferred Provider Organization (PPO) options to provide medical benefits. The options are:

- High Option PPO
- Low Option PPO

You may also waive medical coverage.

Within each option, the following coverage categories are available:

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

See “Eligibility and Enrollment,” beginning on page 4, for more information.

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.

How Coverage Works

Both PPO 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.

A PPO is a network of doctors, hospitals and other health care providers who have agreed to offer care at negotiated rates. When you enroll in one of these 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 necessary. As 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 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.

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

- **For covered preventive care,** 100% for both the High and Low Option PPOs
- **For all other covered care,** 90% of the negotiated fee after the deductible in the High Option PPO, and 80% of the negotiated fee after the deductible in the Low Option PPO

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, and 60% of the allowance after the deductible in the Low Option PPO.

You are responsible for paying the difference between the total service charge and the amount paid by BCBS. The difference between the total service charge and the allowance can be significant.

Allowance

An amount determined by the plan to be 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 for the service or supply based on:
  - The amount determined as 250% of the amount that would be reimbursed for the service or supply under Medicare
  - Profiles compiled by BCBS based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or
  - Similar profiles compiled by outside vendors

The plan's allowance is sometimes referred to as the "reasonable and customary charge."

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 PPO 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.

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. Further, you are responsible for all charges in excess of the allowance.

Finding an In-Network Provider

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

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 PPO network.

ID Cards

Once 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 Retiree Only coverage). You may request additional ID cards from BCBS.

Using the PPO Options

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

Deductibles

With both PPO options, 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 individual and family annual deductibles.

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 **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.

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.

Individual and family deductibles are shown in the following table.

Annual Deductibles				
	High Option PPO		Low Option PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	$350	$700	$1,050	$2,100
Individual Plus 1 or more dependents	$700	$1,400	$2,100	$4,200
Family	$1,050	$2,100	$3,150	$6,300

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

In-Network Family Deductible Example

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

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.

Out-of-Pocket Maximums

Both PPO options have calendar year out-of-pocket maximums. The out-of-pocket maximum limits how much you have to pay for each person's covered medical expenses during the year. Each option has individual and family out-of-pocket maximums. The annual deductible counts toward reaching the 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 any required copays and certain other 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 ***family out-of-pocket maximum*** is the most you have to pay for in-network covered expenses for all covered family members for the year with the exception of any required copays and certain other 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.

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. Individual and family out-of-pocket maximums are shown in the following table.

Out-of-Pocket Maximums				
	High Option PPO		Low Option PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	$1,850	$3,700	$4,050	$8,100
Individual Plus 1 dependent	$3700	$7400	$8,100	$16,200
Family	$5,550	$11,100	$12,150	$24,300

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

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 towards 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 $600, $1,400, and $1,700. 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 plan.

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.

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

Lifetime Benefit Maximum

For you and each of your eligible dependents, the PPO options have a lifetime maximum for all covered medical expenses of $2,000,000. In addition, there are specific lifetime benefit maximums that apply to infertility treatment and hospice care. See “Important Information on Certain Covered Expenses,” beginning on page 28, for more information.

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 collect. 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)
- Hospice Care
- Infusion Therapy
- Cochlear Implants
- Rhogam and its administration
- Synagis and its administration
- Durable Medical Equipment – rental or purchase over $500
- Transplant services
- Inpatient cardiac catheterizations
- Pacemakers
- Reconstructive Surgery
- All Possible Cosmetic or Plastic procedures
- Specialty Pharmaceuticals not covered under the prescription drug plan
- Sinus (Nasal) Surgery does not require prior authorization but can be subject to 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 pre-determination process which reviews the requests preservice.

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
- 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 20 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.

Case Management

About Copays

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.

Telemedicine

Through Horizon CareOnline[SM], 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. Telemedicine services are only available to those DSM Retirees under age 65. Please refer to myDSMbenefits.com for service restrictions.

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.

* 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

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 28 for more specific information on some of the items in the following chart.

	High Option PPO Benefits		Low Option PPO Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Information				
Deductible				
Individual	$350	$700	$1,050	$2,100
Individual +1	$700	$1,400	$2,100	$4,200
Family	$1,050	$2,100	$3,150	$6,300

	High Option PPO Benefits		Low Option PPO Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Maximum				
Individual	$1,850	$3,700	$4,050	$8,100
Individual +1	$3,700	$7,400	$8,100	$16,200
Family	$5,550	$11,100	$12,150	$24,300
Lifetime Benefit Maximum	$2,000,000		$2,000,000	
Physician Office Visits [1]				
Primary physician office visit	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible
Specialist physician office visit	100% after $40 copay	70% after deductible	100% after $40 copay	60% after deductible
Urgent Care Center office visit	100% after $20 primary care/ $40 specialist copay	70% after deductible	100% after $20 primary care/ $40 specialist copay	60% after deductible
Preventive Care				
Well child care/immunizations (to age 18) [2]	100%	70% after deductible (deductible waived to age 5)	100%	60% after deductible (deductible waived to age 5)
Routine physicals/immunizations (one per calendar year, age 18 and older)	100%	70% after deductible	100%	60% after deductible
Well-woman exams including Pap tests (one per calendar year)	100%	70% after deductible	100%	60% after deductible
Mammograms including 3D mammograms (one baseline, ages 34-39; one per calendar year, age 40 and older)	100%	70% after deductible	100%	60% after deductible
Prostate Specific Antigen (PSA) tests (one per calendar year, age 50 and older)	100%	70% after deductible	100%	60% after deductible
Colonoscopies or sigmoidoscopies (one per calendar year, age 50 and older)	100%	70% after deductible	100%	60% after deductible
Digital Rectal Exam (one per calendar year, age 40 and older)	100%	70% after deductible	100%	60% after deductible
Routine hearing exams (one per calendar year)	100%	70% after deductible	100%	60% after deductible
Skin Cancer Screenings	100%	70% after deductible	100%	70% after deductible
Lung Cancer Screenings (if you are 55 or older and have smoked for more than 30 years)	100%	70% after deductible	100%	70% after deductible

	High Option PPO Benefits		Low Option PPO Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Laboratory Services				
Performed in physician's office or outpatient non-hospital lab 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
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
X-ray Services [3]				
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
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
Allergy Testing and Treatment				
Performed in physician's office or outpatient non-hospital facility	100%; copay applies if physician charges for office visit	70% after deductible	100%; copay applies if physician charges for office visit	60% after deductible
Performed in inpatient or outpatient hospital facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Hospital Coverage				
Inpatient (including physician's visits and consultations) [4]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Outpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Surgery [4]				
Physician's Office	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Inpatient Facility Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Outpatient Surgical Facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Inpatient Physician Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Surgeon's Fees	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Second Surgical Opinion	100% after $20 primary care/$40 specialist copay	70% after deductible	100% after $20 primary care/$40 specialist copay	60% after deductible

	High Option PPO Benefits		Low Option PPO Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient/Preadmission Testing				
Primary physician office visit	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible
Specialist physician office visit	100% after $40 copay	70% after deductible	100% after $40 copay	60% after deductible
Outpatient Facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Emergency Room				
For medical emergencies	100% after $100 copay per visit; copay waived if admitted	100% of covered amount after $100 copay per visit; copay waived if admitted	100% after $100 copay per visit; copay waived if admitted	100% of covered amount after $100 copay per visit; copay waived if admitted
For non-medical emergencies	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Ambulance				
For medical emergencies	90% after deductible	90% after deductible	80% after deductible	80% after deductible
For non-medical emergencies	Not covered	Not covered	Not covered	Not covered
Maternity Care				
Initial office visit to confirm pregnancy	100% after $20 copay	70% after deductible	100% after $20 copay	60% after deductible
All subsequent physician's charges for pre- and postnatal visits and delivery [4]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Infertility Care [5]				
Initial office visit	100% after $20 primary care/$40 specialist copay	70% after deductible	100% after $20 primary care/$40 specialist copay	60% after deductible
All other covered expenses	90% after deductible	70% 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
Short-Term Therapies (includes Speech, Occupational, and Cognitive Therapies – 30-visit maximum per calendar year) [6]				
Performed in a provider's office or outpatient non-hospital facility	100% after $40 copay	70% after deductible	100% after $40 copay	60% after deductible
Performed in inpatient or outpatient hospital facility	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Physical Therapy (60-visit maximum per calendar year) [7]				
Performed in a provider's office or outpatient non-hospital facility	100% after $30 copay	70% after deductible	100% after $30 copay	60% after deductible

	High Option PPO Benefits		Low Option PPO Benefits	
	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
Chiropractic Care (30-visit maximum per calendar year)[, 8]	100% after $30 copay	70% after deductible	100% after $30 copay	60% after deductible
Special Services				
Skilled Nursing Facility (60-day maximum/calendar year) [4, 7]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Home Health Care (100-visit maximum/ calendar year) [4, 7]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Hospice Care (180-day lifetime maximum) [4, 7]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Private Duty Nursing (240-hour maximum/ calendar year) [4, 7]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment [4]	90% after deductible	70% after deductible	80% after deductible	60% after deductible
External Prosthetics	90% after deductible	70% 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
Mental Health and Substance Abuse Treatment				
Inpatient [4]	90% after deductible	70% 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
Outpatient (other)	90% after deductible	70% after deductible	80% after deductible	60% after deductible
All Other Covered Expenses				
Other Covered Expenses	90% after deductible	70% after deductible	80% after deductible	60% after deductible

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

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

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

[4] *Precertification required.*

[5] *$15,000 lifetime benefit maximum applies on a combined basis for all In-and Out-of-Network care received under all DSM medical options and includes injectable prescription drugs, which are paid by the medical plan.*

[6] *Includes speech, occupational and cognitive therapies (30 visits/calendar year each). Visit limits are combined for In-and Out-of-Network benefits. Charges for maintenance therapies are not covered.*

[7] *Combined In-and Out-of-Network.*

[8] *Chiropractic care is for therapeutic manipulations only.*

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 both PPO 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 23.**

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.

Diabetic Education Benefits

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), Out-of-Network diabetic education benefits are covered subject to the applicable deductible and coinsurance. Any diabetic education services performed in a facility setting are subject to the applicable deductible and coinsurance.

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 20 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 20).

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.

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 20).

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 after payment of any required copay (the emergency care copay is waived if the patient is admitted to the hospital)
- **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.)

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 (do not count toward lifetime maximum)
- Surgery (i.e. Laparoscopy, Hysteroscopy, etc.)
- Artificial Insemination
- In-Vitro Fertilization (IVF)
- 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 both the High and Low PPO Options combined. See “Prescription Drug Benefits,” beginning on page 46, 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.

Injections

Most injections (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 as part of an office visit and subject to a $20 primary care or $40 specialist office visit copay. These items 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. This visit is covered at 100%, subject to the applicable office visit copay. All other services, including prenatal visits, delivery and post-natal visits, are covered under a global fee subject to the applicable deductible and coinsurance. Out-of-Network maternity care is subject to the applicable deductible and coinsurance. Certain prenatal services may also be covered as preventive care, to the extent required by law. Such services are paid at 100%, without deductible, when provided in-network.

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.

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.

Charges made for the treatment of any physiological conditions related to a mental health disorder or substance abuse are not considered charges for mental health or substance abuse treatment and are instead treated as services for a medical condition.

Nurse Practitioner Benefits

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. Out-of-Network care provided by a nurse practitioner or advanced nurse practitioner is covered subject to the applicable deductible and coinsurance.

Nutritional Counseling

In-Network nutritional counseling when rendered at a provider's office, is covered at 100% after the required copay ($20 for primary care physicians and $40 for specialists), 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 20).

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

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). The copay is not required for preventive care expenses.

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 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 31)
- 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 page61, for more information.)
- Specimen handling charges/fees
- Injectable/implantable contraceptives and devices, including but not limited to intra-uterine devices (IUDs), Depo-Provera and Norplant, as well as the services to prescribe, fit or administer the contraceptives and devices

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.

Services such as radiation therapy performed in a physician's office are covered subject to the applicable deductible and coinsurance. In addition, chemotherapy and dialysis are also covered subject to the applicable deductible and coinsurance regardless of where those services are received. Effective January 1, 2019, dialysis is covered only if it is provided in-network.

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 for adults and children, subject to certain limits and requirements. The following chart is not exhaustive but provides examples of common preventive services. 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. 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 current recommendations of the United States Preventive Services Task Force 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.

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%. 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/center/regulations/ prevention.html*. 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 (age 18 and older)	One per calendar year
Well-Child Care (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 • **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 and have smoked for more than 30 years

* *Frequency based on American Academy of Pediatrics recommendations and other applicable guidelines.*

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 there is not a Network provider who can provide the particular preventive care item or service that you need, the Plan may cover the item or service when performed by an out-of-network provider at 100%. 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 mutation in BRCA1 or BRCA2 genes, and coverage for certain contraceptives and sterilization. (See http://www.hrsa.gov/womensguidelines or contact BCBS for more details.)

Although the Affordable Care Act requirements do not apply to this Medical Plan, preventive care benefits are provided in accordance with the requirements of that Act.

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 20).

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, migraines, allergies, pinkeye and stomach pain. Doctors can diagnose and treat many medical issues. Doctors can even prescribe medication and treat behavioral health issues. Telemedicine services are only available to covered participants under age 65. Behavioral health consultation costs vary based on the type of service and therapist.

The copay for a visit is $5 and will be charged to your credit or debit card at this time of your visit.

- *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% when the prescribing physician charges for a non-routine office visit.

In-network non-routine X-rays and ultrasounds performed in a free standing radiology facility (non-hospital setting) are covered at 100% when the prescribing physician charges for a non-routine office visit.

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 under age 65 and enrolled in a DSM Medical Plan and 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 20)
- 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 20)
- 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 20) and the applicable deductible and coinsurance. Effective January 1, 2019, dialysis is covered only if obtained through an in-network provider.
- 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 page 45, 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, but only if in-network
- 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 incident)

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
- 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
- Bariatric surgery
- 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 37
- Diversional/recreational therapy or activity
- Dialysis services Out of Network
- 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 37; 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 education, testing or training related to learning disabilities, behavioral problems, developmental disorders or social adjustments including autism, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and mental retardation unless otherwise covered under ABA
- 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 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 (see "Prescription Drug Benefits," beginning on page 45, for additional information)
- Special medical reports not directly related to treatment of the individual (e.g., reports prepared in connection with litigation)
- Speech therapy for the treatment of developmental anomalies
- Surgery, sex hormones and related medical and psychiatric services to change sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders; sex therapy
- Surgery for the treatment of varicose veins unless medically necessary
- Telephone consultations, except as the Medical Plan may request or as otherwise specifically provided as a covered expense
- 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 37, for additional information)
- Vision benefits, including exams, therapy, visual acuity training, orthoptics, pleoptics and lenses
- Vitamins and dietary supplements (see "Prescription Drug Benefits," beginning on page 45, for additional information)
- Weight loss programs, special foods, food supplements, liquid diets, diet plans or any related products

Federally-Mandated Benefits

Both PPO options comply with current federal laws and regulations that apply to retiree-only plans. Accordingly, we provide the following notice:

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).

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. 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 Web site 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 Center Web site at https://my.adp.com/dsm , by calling BCBS at the number on the back of your ID card or by printing a copy from the BCBS Web site (*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 for the service or supply based on:
  - The Resource Based Relative Value System used by the Centers for Medicare and Medicaid Services
  - Profiles compiled by BCBS based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or
  - Similar profiles compiled by outside vendors

The plan’s allowance is sometimes referred to as the “reasonable and customary charge.”

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 **–** 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 or out-of-pocket maximum. After you reach your deductible or out-of-pocket maximum, 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

Regardless of the above, the Medical Plan provides benefits for services and supplies for routine patient costs for items and services incurred by a qualified individual in connection with participations in an approved clinical trial. Routine patient costs does not include the investigational items, devices or services themselves or those that are inconsistent with widely accepted and established standards of care for a particular diagnosis. Instead, this refers to those items and services that would typically be covered under the Medical Plan for individuals not participating in a clinical trial. If a network provider is participating in the approved clinical trial, you must use the network provider for the approved clinical trial, if the provider will accept you as a patient. Contact BCBS for details, such as whether you are a qualified individual and what clinical trials are approved.

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 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 Medical Plan limit you have to pay for each person's covered medical expenses during the year, with the exception of required copays and certain other expenses. The annual deductible does not count toward reaching the out-of-pocket maximum. Once you reach this limit, the plan will pay 100% of certain eligible expenses for the rest of the calendar year.

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 is 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). The same prescription drug benefits are available regardless of which medical option you select. You cannot have prescription drug benefits coverage if you are not enrolled in a medical option.

Key Terms

Turn to page 53 for definitions of key terms used in this section.

In This Section **See Page**

Prescription Drug Benefits 46
Enrolling 46
Using the Prescription Drug Benefits 46
Prescription Drug Benefits Overview 46
Brand Name and Generic Drugs 47
Preferred Drug List (Formulary) 47
Retail Pharmacy Purchases 48
Mail Order Pharmacy Purchases 48
Filling Your Prescription 49
Prior Authorization Required 50
Other Express Scripts Programs 50
Accredo 50
Retrospective Case Management 50
Covered Expenses 50
Exclusions 51
Key Terms 53

Prescription Drug Benefits

If you enroll in the Medical Plan, you also receive prescription drug benefits that are administered by Express Scripts (ESI). The same prescription drug benefits are available regardless of which medical option you choose.

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 4.

Using the Prescription Drug Benefits

The prescription drug benefits have a three-tier copay 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.

Prescription drug copays vary by type of drug and whether you fill your prescription at a retail pharmacy or through mail order.

Prescription Drug Benefits Overview

Type of Drug	In-Network Retail Pharmacy (up to a 30-day supply)	Mail-Order Pharmacy (up to a 90-day supply)
Generic	$15 Copay	$37.50 Copay
Preferred Brand (Formulary)	$30 Copay	$75 Copay
Non-preferred Brand (Non-Formulary)	$50 or 30% coinsurance, whichever is greater ($100 maximum copay per prescription)	$125 or 30% coinsurance, whichever is greater ($250 maximum copay per prescription)

Note: Eligible Out-of-Network retail pharmacy claims will be reimbursed at the network contracted 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.

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.

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.

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 retirees.

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 depending on 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.

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 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.

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 Web site at *www.express-scripts.com*.

You can initially purchase up to a 30-day supply of a prescription medication from any participating retail pharmacy. Once your prescription medication is reduced to ¼ of the original amount, 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: After two fills of a maintenance medication at a retail pharmacy, you must tell ESI whether you will continue filling your prescription at a retail pharmacy or enroll in ESI's Home Delivery program, as described in the following section. If you do not contact ESI with your decision, you will have to pay the full retail cost of any subsequent fills until you provide this information.

When you first fill a maintenance medication at a retail pharmacy, ESI will send you a letter explaining your options if you continue taking that medication for longer than two fills. After your second fill, you will need to contact ESI with your decision. You may reach them directly at 1-866-851-0145.

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 after your second fill, you must pay the full retail cost of subsequent prescriptions.

You may contact ESI at 1-866-851-0145 with your decision.

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 medication (with up to one year of refills, if appropriate) and applicable copay amount.
- 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, and
- Another that you can send to the mail order program for an additional 90-day supply at the mail order copay

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 standard copay 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 standard copay 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 and 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:

- Certain compounded products covered by the plan as approved by the claims administrator.
- Contraceptives:
  - Non-injectable monthly (such as oral contraceptives, Ortho Evra, NuvaRing); one cycle at a time, one copay per cycle
  - Non-injectable 90-day supply (such as Seasonale); three copays required
  - Injectable 90-day supply only (such as Depo-Provera); three copays required
  - Injectable 30-day supply (such as Lunelle)
  - Emergency (such as Plan B, Preven)
  - Intra-Uterine Devices (IUDs)
  - Diaphragms

- 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); three copays for 90-day supply; two copays for 60-day supply
- 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 page 30, 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 (applications will be based on FDA-approved indications)
- Gardisil vaccine, subject to one copay per application
- 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 CuraScript 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, including condoms, foams, jellies, implants (Norplant), or ointments (see "Covered Expenses" on page 50 for covered contraceptives; also see "The Medical Plan," beginning on page 14, for additional 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
  - 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 14, for additional information)
- Ostomy supplies (see "The Medical Plan," beginning on page 14, 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
- Peak flow meters (see "The Medical Plan," beginning on page 14, 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 14, for additional information)
- Serums and toxoids (see "The Medical Plan," beginning on page 14, 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 14, for additional information)
- Synagis (see "The Medical Plan," beginning on page 14, for additional information)
- Vitamins, except those listed in "Covered Expenses" on page 50
- Weight loss programs, special foods, food supplements, liquid diets, diet plans or any related products
- 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.

Key Terms

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

Coinsurance amount **–** 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.

Copay **–** 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.

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) 55
Special Medical Plan Provisions 56
Automobile Insurance 59
Right of Subrogation, Reimbursement and Recovery 59
How the Plans Process Claims 61
Concurrent Care Claims 62
Urgent Care Claims 62
Pre-Service Claims 63
Post-Service Claims 63
Internal Appeals 63
Notice to Claimant of Adverse Benefit Determinations 64
Where to File a Claim 64
Continuing Coverage 65
Type of Qualifying Events 666
Adding Eligible Dependents to Existing COBRA Coverage 666
How to Obtain COBRA Continuation Coverage 678
Your ERISA Rights 69
Your HIPAA Privacy Rights 70
Other Important Information 71
ERISA Information 72

If You Have Other Coverage (Coordination of Benefits)

As with most group health care plans, the Medical Plan (including prescription drug coverage) includes 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 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 Plan is primary,** it will pay its benefits first and without regard to any benefits that may be payable under the secondary plan
- **When the DSM Medical Plan is secondary,** it 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 Plan is primary or secondary, the following rules are applied. The other plan is considered primary and the DSM Medical 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 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 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.

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

Special Medical Plan Provisions

Coordination with Medicare

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is primary to the Medical Plan.

If you become eligible for Medicare while covered under the Medical Plan, your benefits will be coordinated with Medicare to the full extent permitted by law, regardless of whether you actually enrolled in Medicare. Generally, Medicare pays benefits first, and all bills must be submitted to Medicare first.

The same holds true for your eligible dependents. 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: As a result, upon becoming eligible for Medicare, you and/or your dependent should enroll for Medicare. To enroll for Medicare Parts A and B, you should contact your Social Security office.

Once 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.

As a retired DSM employee, Medicare Parts A and B 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.

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 will 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 you have End-Stage Renal (Kidney) Disease.

If you enrolled in the Medical Plan but are not enrolled in Medicare, the Medical Plan is considered the primary plan and will pay benefits, up to the Medical Plan limits. You will be responsible for any amounts that the Medical Plan does not cover.

If you later enroll in Medicare coverage, Medicare will generally be the primary plan and pay benefits first, with the Medical Plan paying second, up to the Medical Plan limits. You will be responsible for any amounts remaining after both Medicare and the Medical Plan have paid benefits.

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 Plan (including prescription drugs) is 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 Plan (including prescription drugs) 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 retiree or dependent (Participant) incurs medical (including prescription drug) 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/her 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.

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 Plan (including prescription drugs) processes 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.

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 page 64.

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 you must have approval in advance of obtaining care in order to receive Plan benefits, in whole or in part. 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 • Response by claimant, orally or in writing	 15 days 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 • Request to extend course of treatment	 15 days 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 Medical Plan for covered services already received by the claimant. Most claims are Post-Service claims.

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 one year following receipt of the notification in which to appeal the decision to the Claims Fiduciary in writing. 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.

Additional Information

Legal action may be brought only after a plan's appeal procedures have been exhausted but not 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 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.

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:

- The specific reason(s) for the adverse determination
- 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 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.

Where to File a Claim

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

DSM North America, Inc.
Attn: HR 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: Claims Dept. P.O. Box 66773 St. Louis, MO 63166-6773	Express Scripts, Inc. Attn: Pharmacy Appeals 6625 West 78th Street, Mail Route BL0390 Bloomington, MN 55431

Continuing Coverage

Spouses and dependent children covered under the Medical Plan (including prescription drug benefits) 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"). Retirees 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 file with respect to DSM which results in the loss of medical coverage, you (and your spouse, surviving spouse and/or dependent children) may become a qualified beneficiary with respect to the bankruptcy. An employer's bankruptcy is the only Qualifying Event that can cause you to become a qualified beneficiary entitled to COBRA continuation coverage under this Plan.

Generally, continuation coverage is available for spouses and dependents for up to 36 months following death, divorce, loss of dependent status, or loss of coverage due to Medicare entitlement (for spouses and dependents of retirees who are not Post-65 eligible retirees).

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.

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 retirees or dependents. If this coverage changes for similarly situated retirees 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.

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	Period During Which You Must Apply for Continuation
Medicare entitlement	Spouse/domestic partner and child(ren) of a retiree who is not a Post-65 eligible retiree	36 months	Within 60 days of the loss of coverage due to Retiree's Medicare entitlement
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
Death of retiree	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

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.

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, or (3) entitlement to Medicare, ***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 to WageWorks COBRA Services, PO Box 3028, Alpharetta, GA, 30023-3028, by fax to (800) 578-5698or by calling1-800-526-2720 . Your notice must include the fact that you, your spouse, domestic partner and/or dependents participate in the Medical 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.

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 your other options for obtaining medical coverage. For example, you should consider that you have special enrollment rights under federal law and you may be able to obtain coverage through the Marketplace within a specified period following your loss of coverage.
- 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.

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

- A COBRA covered person turns age 65. As a result, 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.
- The date coverage would otherwise terminate, such as due to providing false information, fraud or misrepresentation
- 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)

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 your 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

Other Important Information

No Guarantee

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.

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 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 the earlier of one year from the date the final appeal is denied with respect to eligibility or benefit claims or two years after you knew or should know of the actions or events that give rise to the claim for other types of claims.

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 page 69. The information in the following table is required to be included in this SPD under ERISA.

<table>
<tr><td>Plan Name</td><td colspan="2">The DSM Consolidated Retiree Welfare Benefit Plan</td></tr>
<tr><td>Plan Number</td><td colspan="2">511</td></tr>
<tr><td>Plan Sponsor</td><td colspan="2">DSM North America, Inc.
45 Waterview Blvd.
Parsippany, NJ 07054-1298
1-973-257-8500</td></tr>
<tr><td>Plan Administrator</td><td colspan="2">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.</td></tr>
<tr><td>Plan Sponsor’s Employer Identification Number (EIN)</td><td colspan="2">58-1858661</td></tr>
<tr><td>Agent for Service of Legal Process</td><td colspan="2">General Counsel
DSM North America, Inc.
45 Waterview Blvd.
Parsippany, NJ 07054-1298</td></tr>
<tr><td>Plan Costs/Funding</td><td colspan="2">The Medical Plan (including prescription drugs) is funded through the general assets of the Participating Companies. Retiree contributions may be required.</td></tr>
<tr><td>Plan Year</td><td colspan="2">January 1 – December 31</td></tr>
<tr><td>Type of Plan</td><td colspan="2">Welfare Benefit Plan</td></tr>
<tr><td>Participating Companies
(Note: Participating Companies with an * also provide Post-65 retiree medical coverage)</td><td>▪ DSM Desotech Inc.*
▪ Grandfathered groups from DSM NeoResins Inc.*
▪ Grandfathered groups from the former DSM Powder Coating Resins, Inc.*
▪ DSM Coating Resins, Inc.*</td><td>▪ Grandfathered groups from the former DSM Melamine Americas*
▪ Grandfathered groups from the former DSM Thermoplastic Elastomers</td></tr>
<tr><td>Claims Administrator and Claims Fiduciary</td><td>Medical Plan
Medical Benefits
Horizon Blue Cross Blue Shield of New Jersey
3 Penn Plaza
Newark, NJ 07105</td><td>Medical Plan
Prescription Drug Benefits
Express Scripts, Inc.
Member Reimbursements
P.O. Box 66583
St. Louis, MO 63166</td></tr>
<tr><td>COBRA Administrator</td><td>COBRA Benefits
WageWorks - COBRA
PO Box 3028
Alpharetta, GA 30023-3028</td><td></td></tr>
</table>

January 2019

©DSM 2015